





# ANEXAS EUROPE

## **Lean Six Sigma Master Black Belt**

Certificate

Awarded to

#### DR. KHALID ABU ISSA

for successfully completing
Lean Six Sigma Master Black Belt
certification on May 2020, passing the exam
and demonstrating adequate competence
and skills as Six Sigma Master Black Belt.
He is a certified Lean and Six Sigma Trainer
and Master Black Belt in good standing.



www.anexas.net

Amitabh Saxena

May 25, 2020

Certificate No. MBBKSA200520/1599/13

















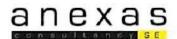








# Certified Green Belt



# ANEXAS EUROPE Lean Six Sigma Green Belt Certificate

Awarded to

#### YASIR ABDELAZEEM ALKHALIFA

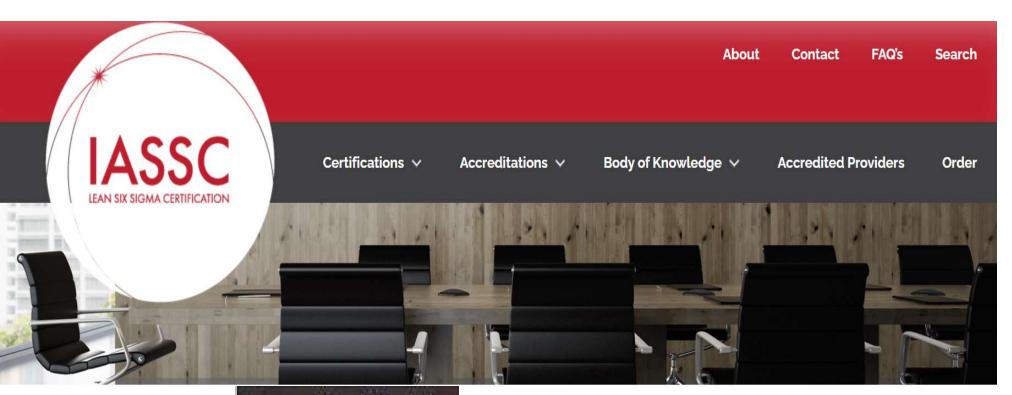
for successfully completing
Lean and Six Sigma Green Belt during
Feb 2021; passing the examination conducted by
Anexas Europe and getting certified as Green Belt
by demonstrating adequate competence in application
of Lean Six Sigma tools and techniques.



Amitabh Saxena

Feb 13, 2021

Certificate No. GBKSA120221/1810/08





Accredited Training
Organization
of International
Association of
Six Sigma
Certification
(IASSC)



## **Course Topics**

- Understanding Lean Six Sigma
- History and the 8 Waste of Lean
- History Of Six Sigma
- Six Sigma Methodology & Tools
- Roles and Responsibilities
- How you can use Six Sigma



## LEAN SIX SIGMA IS Platform, Open Source



لين 6 سيقما هي منهجية لا تعتمد على قطاع معين و ممكن العمل بها في أي مجال.

لنفترض أنني أعمل الآن في مجال الرعاية الصحية ' وأرغب بعد فترة بالإنتقال إلى وظيفة أخرى في مصنع او شركة او بنك او في عمل خاص بك ، فإنه يمكن استخدام 6 سيقما ، فالمنهجية واحدة ولكن الإختلاف فقط في طريقة العمل؛ لأن كل منظمة لديها عمليتها و طرقها الخاصة بها.

بالتالي 6 سيقما مصدر مفتوح ممكن استخدامها في أي مكان حتى في تطوير ذاتك



## What is Six Sigma?

ماهي سته سيقما؟

**Six Sigma** is a business statistical strategy to identify defects removing them from the process of products to improve quality

سته سيقما هي استراتيجية احصائية للعمل للتعرّف على الخلل و استبعاده من عملية المنتج لتحسين جودته

A <u>defect</u> is defined as any process output that does not meet customer specifications

الخلل يعرّف بأي نتاج للعمليه لا يلتقي مع مواصفات العميل



# Six Sigma Belts



White belts

Yellow belts

**Green belts** 

Black belts

Master black belts







IS LEAN SIX SIGMA

**ONE OR TWO** 

**METHODOLOGIES** 



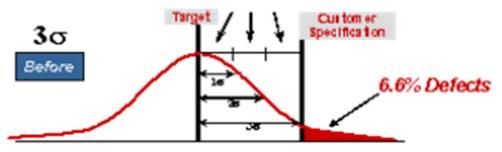




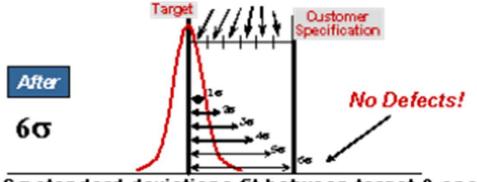
#### anexas



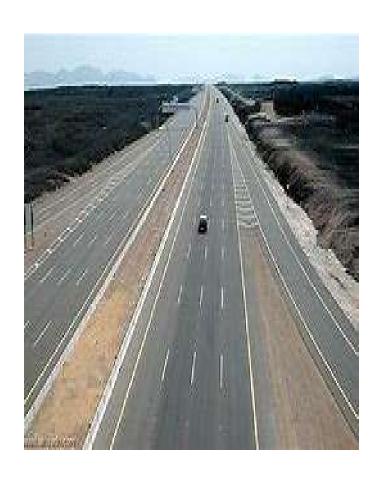
#### 3σ standard deviations fit between target & spec



#### Variation Reduction



6σ standard deviations fit between target & spec







## **Lean Six Sigma is one Methodology**





**a2** asma, 21-08-2022

# لين 6 سيقما وعلاقتها بالجودة

هي عباره عن منهجية معينه لحل المشكلات و تطوير جودة الاعمال داخل المؤسسة

الهدف الأساسي من هذه الدورة هو تمكين الافراد من تطوير العمليات داخل المؤسسة و استكشاف الأخطاء وتقليلها لأقصى حد ممكن

ويقوم نظام 6 سيقما على تعريف المشكلات و قياسها ومن ثم تحليلها للتعرف الى أسبابها ومحاولة حلها

فهناك علاقه قوية بين لين 6 سيقما و الجودة و تطويرها

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To do a Right thing at the Right Time and from the First Time

Freedom from deficiencies or defects

**Patient Safety** 



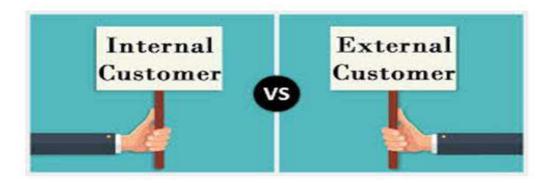
CUSTOMER SATISFACTION SCORE (CSAT)



Conformance of standard

CUSTOMER SATISFACTION







## What is the common Relationship in these pictures









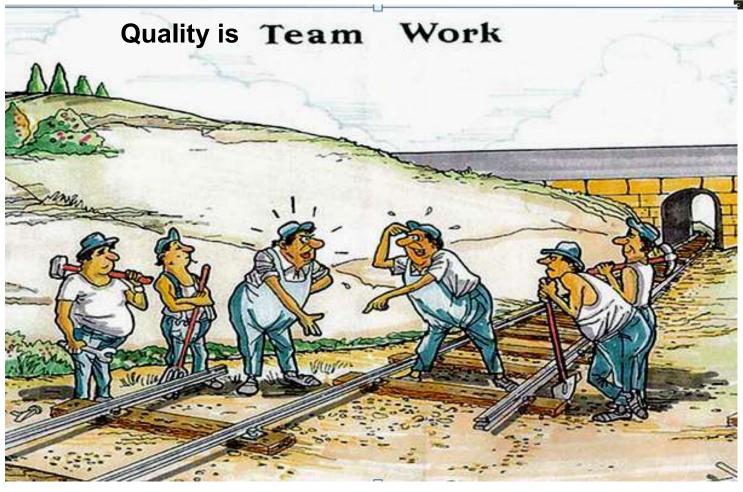






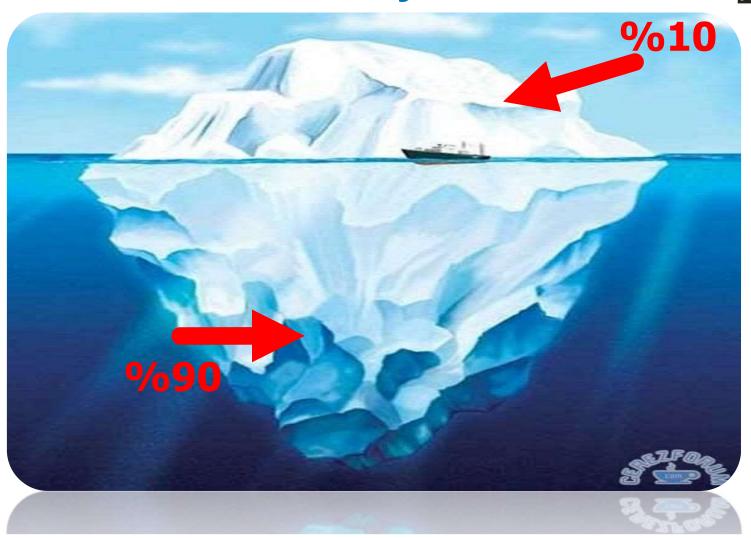






# **Quality**





# Why to apply Quality

#### anexas













## **Work Perfection**





# **The Speed of Change**



THE SPEED OF CHANGE
MAKES YOU WONDER
WHAT WILL BECOME
OF ARCHITECTURE

\_\_\_\_

### **High Customer Expectation and Satisfaction**



# Competition







# **HOW WE CAN BUILD QUALITY?**

### What is the Requirement of Quality?





## **Individual and Organizational Requirements**



#### **Individual Level**



#### 1- Way Of Thinking (Mentality)

- Positive Thinking
- Change before you have to
- You will see it when you believe it





#### 2- Commitment

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#### The Hierarchy of Commitment

COMMITMENT | will do it! | will lead others to do it | COMPLIANCE | I can do it when I am told to... | Why should I do it? | If nobody says so... | will not do it! | I will influence others...







# Knowledge is of no value unless you put it into practice. nton Chekhov







Requirement in "Organizational" Level

## **Transformation Thinking**



Requirement in "Organizational" Level

### Alignment



- - - - -

Requirement in "Organizational" Level

### **Investment**



Requirement in "Organizational" Level

# **Participation**



## **Learning Organization**



Requirement in "Organizational" Level

### **Transparency**



Requirement in "Organizational" Level

# Respect of Employee



Requirement in "Organizational" Level

# All Win









## **Quality All Responsibility**





Is

the access road to quality furnished with

# Flowers!

# **Barriers**



# Conceptually .....



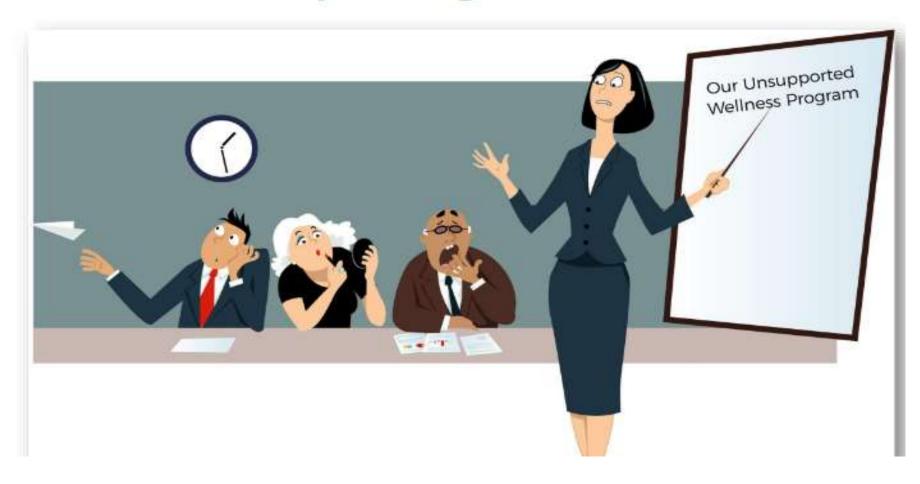
## At the Resource level .....



name Landson

#### anexas

# At the Top Management level .....



#### an a v a c

## At the Staff level .....



#### anavac

# At the System level .....





## A POWERFUL UNION

LEAN

SAFETY
DELIVERY
SPEED
QUALITY
LESS WASTE

SIX SIGMA

CONSISTENCY ACCURACY STABILITY QUALITY

MEET CUSTOMER EXPECTATIONS
EMPLOYEE & PARTNERSHIP GROWTH
IMPROVED PROFITABILITY
EXPANDED CAPACITY
GREATER FLEXIBILITY

### Lean + Six Sigma = Lean Six Sigma

#### Lean

## Systematic Methodology Introduced by <u>Toyota 1970</u>

#### **Process Drive Methodology**

- · Reduce waste from process.
- Remove non value added from the process.
- Streamlines a process.
- Increase process speed.
- Improve the process.

#### 6 Sigma

## Set of techniques and tools Introduced by Motorola 1990

- Data driven methodology.
- Reduces variation 6 timed from the customer requirements.
- Solve problems.
- Optimize the process steps and improve quality.

### Lean Six Sigma

## Lean Accelerates Six Sigma

- Implemented at 2004
- Faster and more efficient.
- Problem solving and improvement of a process.





Whats Lean?

Lean means slim

By reducing waste

How to become slim?

Dose not add any value to the process.

#### Value added

- 1- the customer is willing to pay for it.
- 2- The thing must physically change..







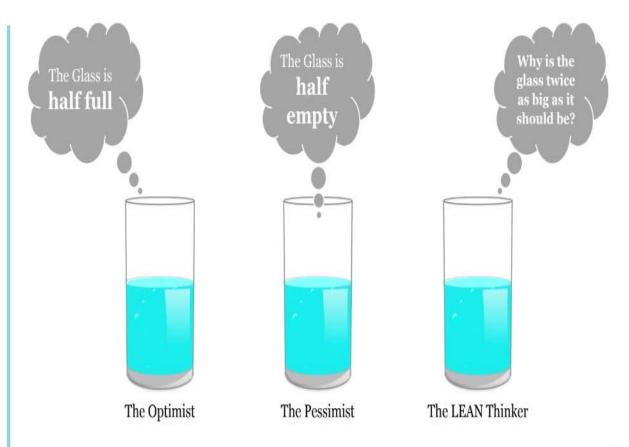
**Waste** is any activity that consumes time, resources, or space but does not add any value to the product or service.





# What do you think?







# A very, very brief history of Lean

- **1950**
- one of the Toyota founders, Eiji Toyoda
- Visited Ford motor plants in Dearborn
- The Toyota Way or Toyota Production System (TPS)
- smaller batches of parts to be used 'just-in-time'
- empowered workers to stop the line
- encouraged their workers to propose improvements



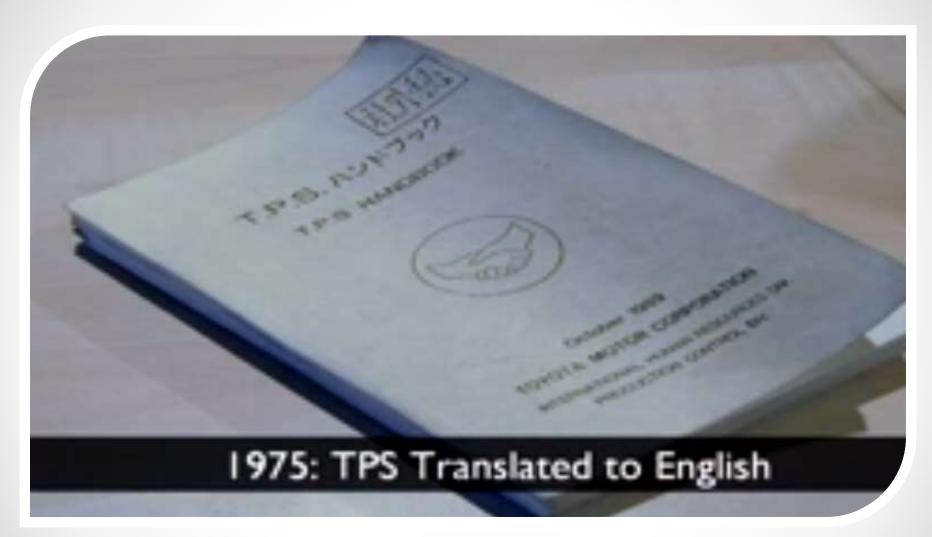


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# A very, very brief history of Lean

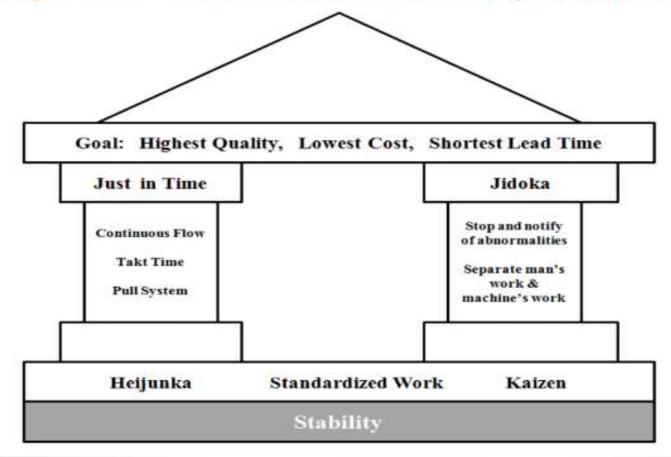
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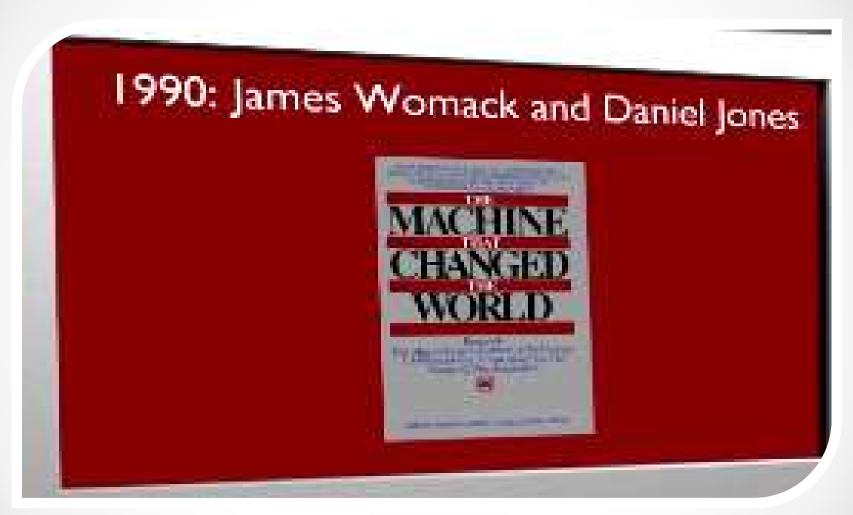


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# **Toyota Production System**









### 7 Wastes of Lean

#### Defects

Not right first time, repetition or correction of a process

Back Log [



Unneccessary movement things (parts or machines) between processes

#### Transportation



#### Inventory

Raw material, work in progress or finished goods which is not having value added to it



the standard required by the customer



#### Movement

Unnecessary movement of people within a process

#### Overproduction

To produce sooner, faster or in greater quantities than the customer demands



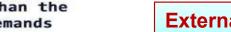
#### Waiting

People or parts tha Internal wait for a work cycle to be complete













#### **Waste Simple Mnemonics:-**

### **TIMWOOD**

### DOWNTIME

1. Transportation

2. Inventory

3. Motion

4. Waiting

5. Over Processing

6. Over Production

7. Defects

8. Skills

Defect

**Over Production** 

Waiting

**Non Talent** 

Transportation

**Inventory** 

Motion



## 1.Defect





### 2. Over Production





# 3.Waiting



# 4.Non-Utilized People





# 5. Transportation





# 6.Inventory



# 7. Motion



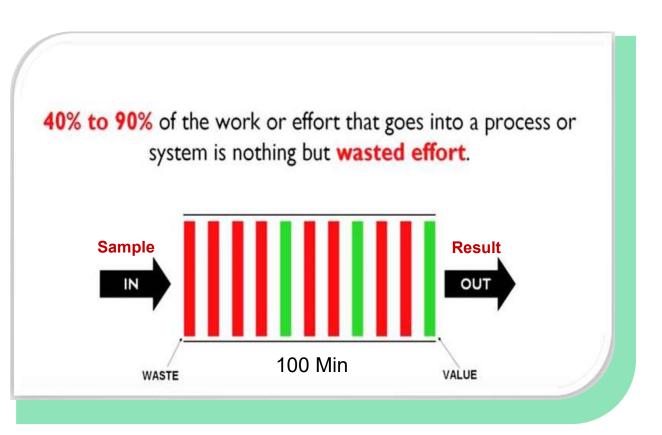


# 8. Extra Processing





### Focus on Processes that deliver customer value

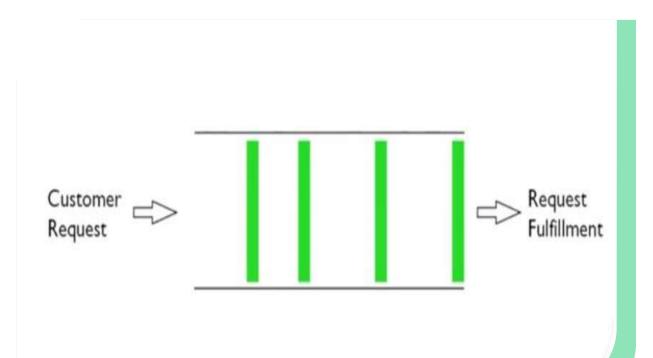


### **Processes definition:**

Particular method of doing something.

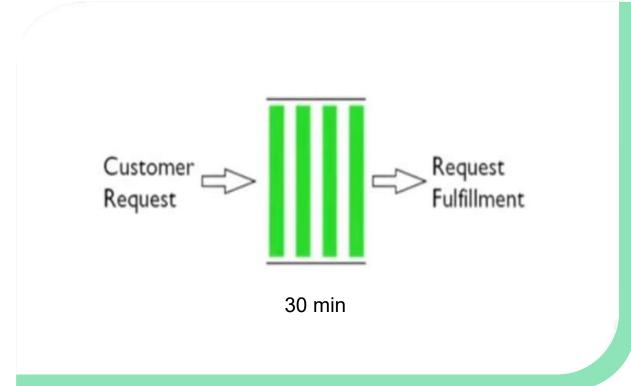
Generally involving a number of steps, activities or operations.





### **Eliminate or remove waste**

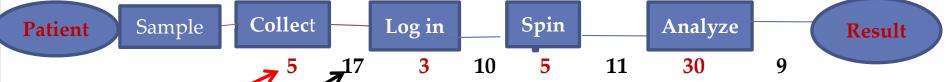




### **Eliminate or remove waste**



# 1 - Identify Value:-



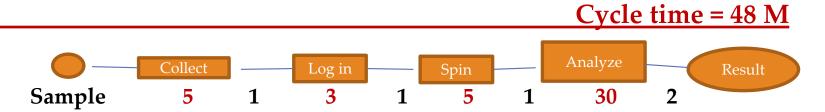
VSM (VALUE STREAM MAPPING):-

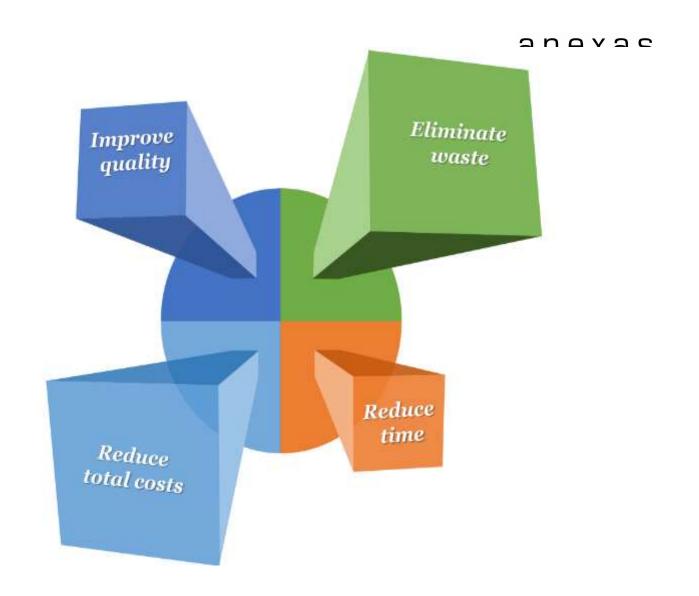
Cycle Time = 80 M

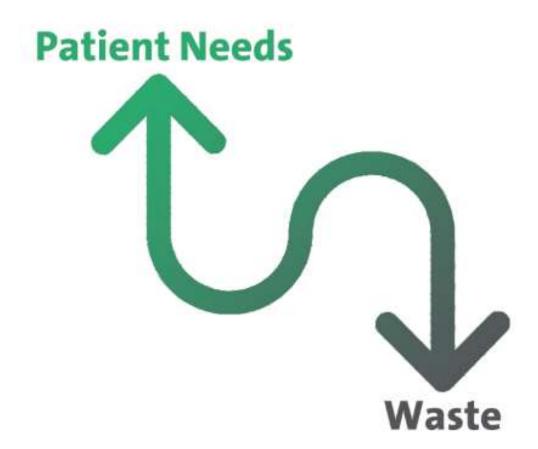
**Touch Time**: The time used for doing the activity = 43 min

Lag Time: The time between the two continuous activities = 47 min

### After reducing waste (Non Value Added)









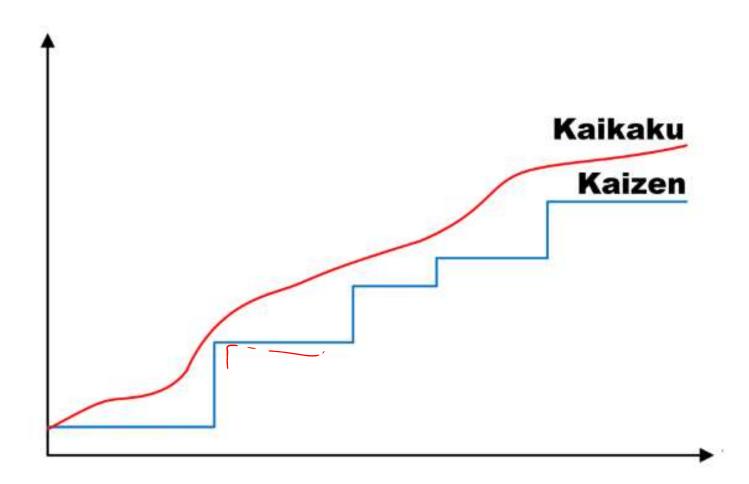
# Get Lean in 90 Seconds

video by Quality Schnallity Inc.



# Lean Methods

- Kaizen Events (or SCORE events)
  - Select
  - Clarify
  - Organize
  - Run
  - Evaluate
- 5S –Sort, Store, Shine, Standardize and Sustain
- Kanban a Japanese term that can be translated as "signal," "card," or "sign."





### SORT Tool: Red Tag

### **KANABAN**



Red Tag Strategy

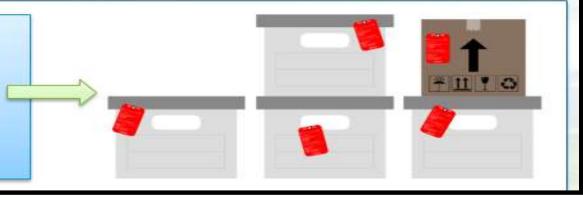
Tag potentially unneeded items in the factory, supply cabinet, or in the process

### Three Questions for Red Tagged items:

- 1) Is this item needed?
- 2) If it is needed, is it needed in this quantity?
- 3) If it is needed, does it need to be located here?
  - No Red Tagging people!

### **Red Tag Holding Area**

A temporary place to store Red Tagged items for a designated period of time



# Visual Management

# **Examples of Visual Displays**



Floor Marking for Pallets



Hazardous area marking



Safe Work Instruction



**Tools Shadow Board** 



Floor Marking for trolleys



Standard work display

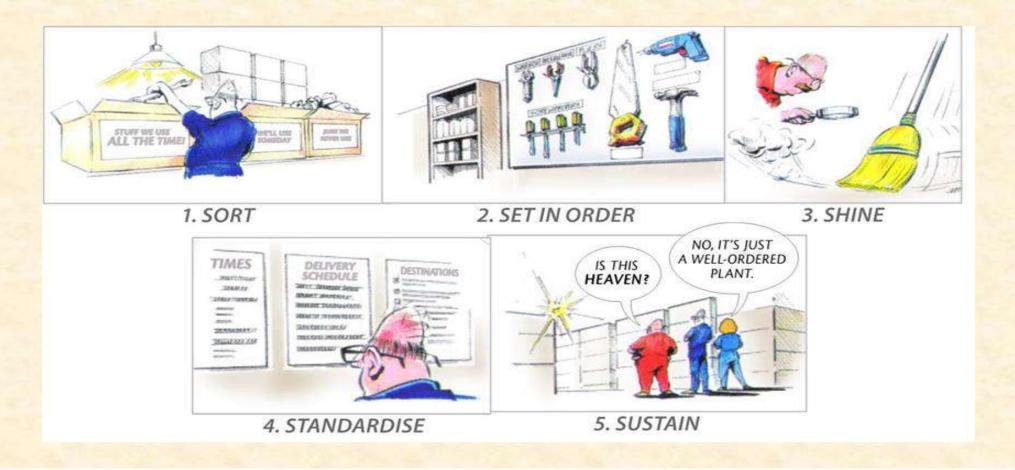


**Product Identification** 

# **IMPROVE**



# 5S Explained



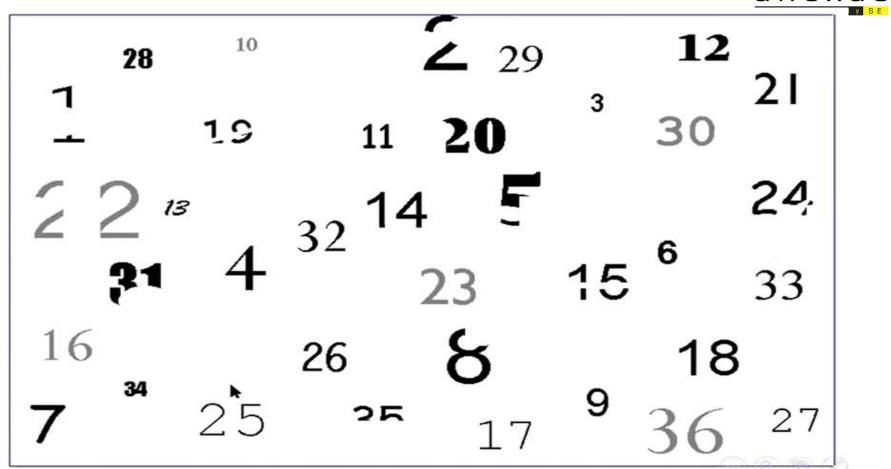
# Improvement Methodology anexas **5 S** ONE Seiri Sort Shitsuke Seiton The 5S **5S** System Standardize Seiketsu Seiso Before SS After 58 STATE OF THE PARTY IN COMMENTS

Town or to the last of the las













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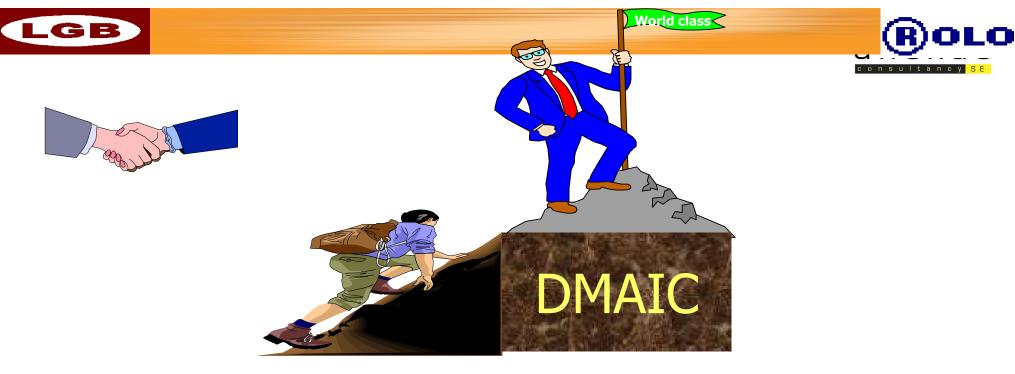


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31	32	33	34	35	36

1	2	3	4	5	6
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19	20	21	22	23	24
25	26	27	28		30
31	32	33	34	35	36



# Ferrari F1 Perfection



# The 6 SIGMA journey Towards Excellence Continues... Thanks







# History of six sigma



- Conceptualized at <u>Motorola</u> during 1979 when in a management meeting an executive proclaimed.
   ۱۹۷۹ عام ۱۹۷۹ خلال عام ۱۹۷۹.
  - · "The real problem at Motorola is that our quality stinks"
- <u>Chief Executive Bob Galvin</u> threw a challenge in 1981 to achieve 5-10 fold improvement in a span of five years.
- Bill Smith, an Engineer of Motorola presented a paper in 1985, established in a correlation between the extent of repair a product underwent during manufacturing and its field life.
- Mikel Harry, subsequently developed a structured Six Sigma approach.





# The real problem at Motorola is the quality Stinks and Xas

### **Bob Galvin CEO**



**Bill Smith** 

**Father of** Six Sigma

**Mikel Harry** 

(Black Belt in KARATE)



# -Motorola

- Savings \$ 15 billion in 11 years
- Sales grew over 9 years by 4.6 x
- Mfg costs reduced by \$ 1.4 billion from 1987 to 1994
- Profits went up 9.2 x
- Stock rose 5.5 x
- Pager order to shipment came down from 56 days to < 1 hour</li>
- Cycle time to file patents came down from 2 years to < 90 days</li>







### 0 0 0 0 0





- Benefits \$12 billion over 5 years
- Annual benefits over 2.5 billion
- 1% increase in uptime

We bring good things to life.



•GE Lighting

"The best Six Signe projects begin outside the organisation not inside. How can we make our oustoner more competitive, What is critical to my outsides a success."

GE Director

•GE Power

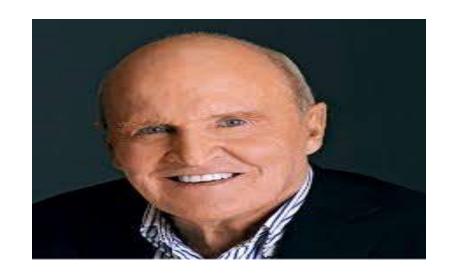








Jack Welch, GE Comp CEO



#### HISTORY OF SIX SIGMA

Period of

Evolution

Period of

Design

Period of

Refinement

Developed by Mikel Harry and Bill Smith, Motorola. تم تطوير ها من قبل ميكل هاري و بيل 1999 - today سميث،مو تورو لا 1997 - 1998 Motorola was amongst the first recipients of the Malcolm Amex 1996 - 1997 Baldrige Award. Ford 1994 - 1996 Lockheed Dupont Martin 1993 - 1994 Dow Sony Chemical Polaroid Nokia 1986 - 1992 Bank of Allied Signal Avery Bombardier America 1979 - 1986 Asea Brown Crane General Siebel Infosys Boveri Motorola Electric Wipro Allied Signal Thousands Texas Motorola of Others Instrument

Period of

Results

Period of

**Awareness** 

Period of

Adaptation

Period of

Enlightenment

## **Companies Implemented Six Sigma**





# What is Six Sigma?

ماهي سته سيقما؟

<u>Six Sigma</u> is a business statistical strategy to identify defects removing them from the process of products to improve quality

سته سيقما هي استراتيجية احصائية للعمل للتعرّف على الخلل و استبعاده من عملية المنتج لتحسين جودته

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الخلل يعرّف بأي نتاج للعمليه لا يلتقي مع مواصفات العميل

## WHAT IS LEAN SIX SIGMA

## **Lean Six Sigma:**

is a specific methodology for solving problems and developing business quality within an organization.

## The primary aim of this methodology:

is to enable individuals to develop processes within the organization and to troubleshoot and minimize errors by define the problems, measure them and then analyze them to identify their causes

منهجية لين 6 سيقما: هي عبارة عن منهجية إحصائية ؛ لحل المشكلات و تطوير جودة الأعمال داخل المؤسسة.

والهدف الأساسي من هذه المنهجية:

هو تمكين الأفراد من تطوير العمليات داخل المؤسسة ، و استكشاف الأخطاء و تقليلها لأقصى حد ممكن ، وهذا يكون بتعريف المشكلات وقياسها ومن ثم تحليلها ؛ للتعرف على أسبابها ومعرفة حلها.







تشتمل منهجية DMAIC على خمسة مراحل لتحسين الجودة



Improve

التحسين

ما الذي يجب القيام به

تحسين وتنفيذ الإجراءات ومحاولة معرفة الأفكار الجديدة وطرق للقيام بعمل أفضل من السابق لجذب



Control

C

التحكم

كيف نضمن الأداء

التحكم في النظم والسياسات القائمة لمنع تكرار المشاكل والحفاظ على الحل وضمان استدامة النتائج على المدى الطويل

a A Define Measure

M

القياس كيف نفعل

قياس المشكلة فهم المشكلة ووصفها بدقة أكبر



Analyze

A

التحليل

ما الخطاء

تحليل السبب الجذري للمشكلة والبدء في البحث على أفضل الحلول

D

التعريف ما هو مهم تحديد المشكلة حدد بدقة نطاق المشكلة

# سته سيقما

#### تركيز العميل

قياس (CTQ's) والخلل بناءً عى متطلبات العميل و توقعاته. (التركيز الحقيقي على العميل)

#### الاعتماد على البيانات

المفهوم الإحصائي للمصطلح سنه سيقما يقصد به العمليات التي تتم بشكل مثالي تقريباً، اي تحقيق ٣,٤ اخطاء لكل مليون فرصة (تقود للمثالية)

#### duscio, a lagua din

هذا المنطلق لسته سيقما يتعرّف على نهج اساسي و صارم يعرف بـ DMAIC (التعريف،القياس،التحليل ، التحسين ، الضبط) (منهجية تعتمد على النظام لعملية التحسين)

## Six Sigma

#### Customer Focus

Measure CTQs, and Defects based on customer needs/expectations (Genuine focus on customer)

#### Data Driven

The statistical concept of the term six sigma means that processes are working nearly perfectly, delivering only 3.4 defects per million opportunities. (Drive for Perfection)

#### Six Sigma is a methodology

This view of Six Sigma recognizes the underlying and rigorous approach known as DMAIC (define, measure, analyze, improve and control) (Systematic approach for process improvement)



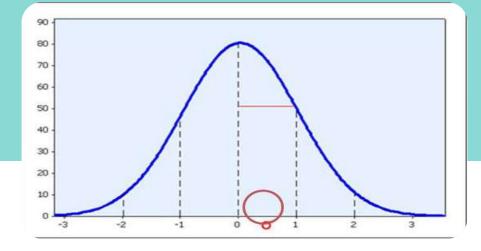
# What is in a name?

n of a

**Sigma** is the Greek letter representing the standard deviation of a population of data.

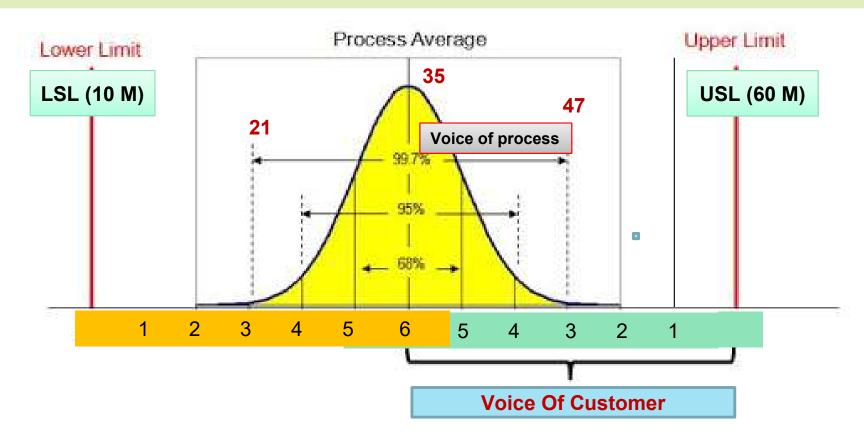
**Sigma** is a measure of variation (the data spread).

**Six(6)** means reduce variation 6 times from the customer need.

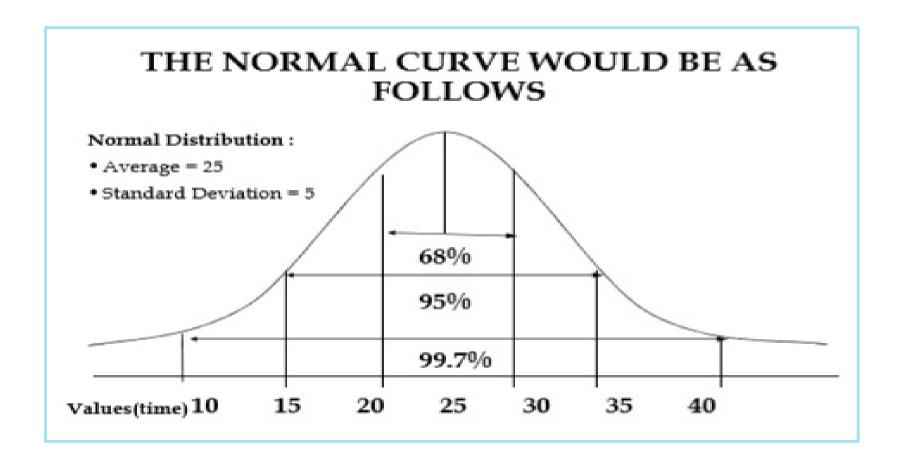




This Six in six sigma implies that there are six standard deviations (also called sigma) between the average of the process and the allowed service level limits by customer.





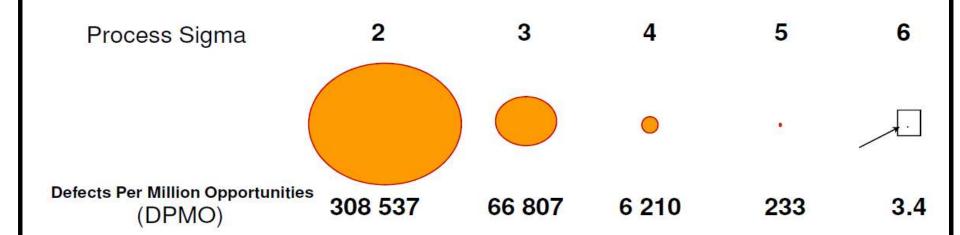






 A measurement scale which compares the output of a process to the customer's requirements

3.4 Defect per Million opportunity



# Six Sigma Scale

SIGMA	% GOOD	% DEFECTS	DPMO
1	30.9 %	69.1 %	691.462
2	69.1 %	30.9 %	308.638
3	93.3 %	6.7 %	66.807
4	99.38 %	0.62 %	6210
5	99.977 %	0.023 %	233
6	99.9997 %	0.00034 %	3.4







8 Sigma

At least 10-12 sigma



## Attitude & Discipline

- Customer Focus
  - View Quality externally from the customer's perspective
  - Measure the same way that the customer does
- Meet customer expectations every time
  - Continuous improvement cycle

Systematic

Scientific

Fact-based

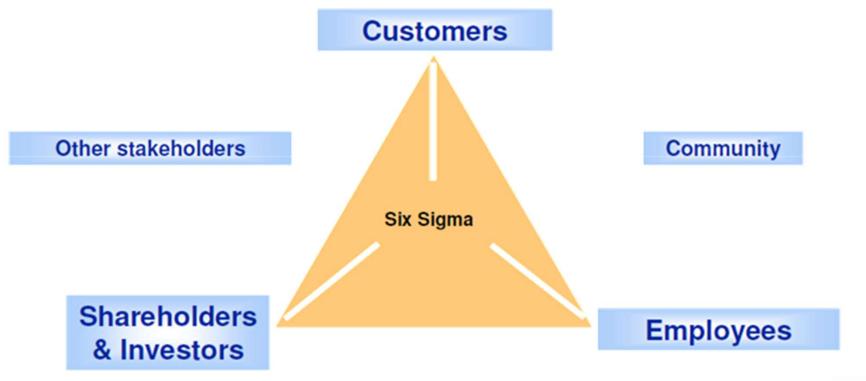
Data-driven

Process focus

Customers Have All The Votes Concerning Extent Of Satisfaction And Value

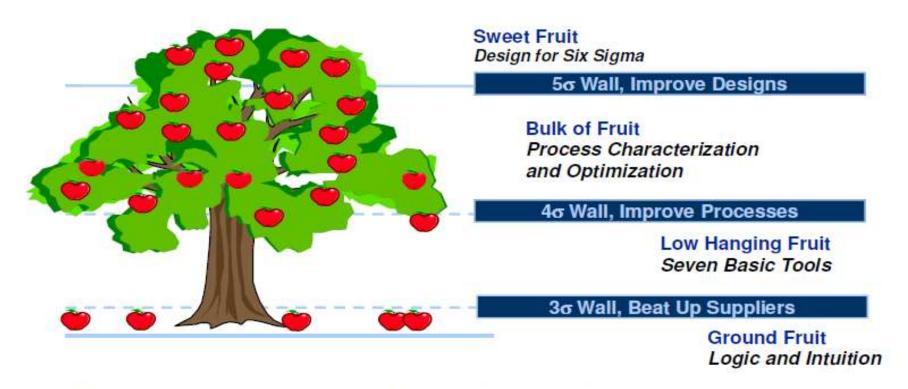


## **Commitments**





# Harvesting the Fruit of Six Sigma



Many organizations in the world have achieved huge savings and improved bottom lines by implementing Six Sigma 0 1994 Dr. Mikel J. Harry - V4.0



## **DfSS**

anexas

## 5 – Robustness

## 6 Sigma

- Robust processes
- Design for Six Sigma
- Quality Function Deployment

## 4 - Capability

- Reducing variation
- In-process control
- Statistical tools

## Lean

## 3 - Stability

- Stable processes
  - **Eliminating Waste** Flow & Pull

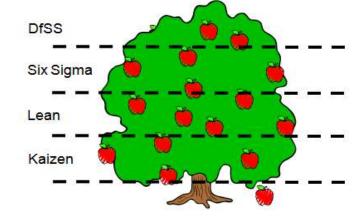
## 2 - Overview & Insight

- Visual Management KPI's
- WIP control
- Continuous improvement culture

### 1 - Structure

**5**S

- Work environment
- Procedures & instructions
- Abnormalities visible



Kaizen

Where to start

# anexas

مكونات تحليل SIX SIGMA

هناك نوعان من المنهجيات في Six Sigma



DMAIC

يهتم DMAIC بالتحديد والقياس والتحليل والتحسين والتحكم يستخدم منهج DMAIC لتحسين العملية القائمة.



يهتم DMADVبالتحديد والقياس والتحليل والتصميم والتحقق، والتي يتم استخدامها لإنشاء تصاميم المنتجات الجديدة أو التصاميم العملية

# Roles & Responsibilities

الأدوار و المسوؤوليات

6 o CHAMPION











# Six Sigma Belts





White belts

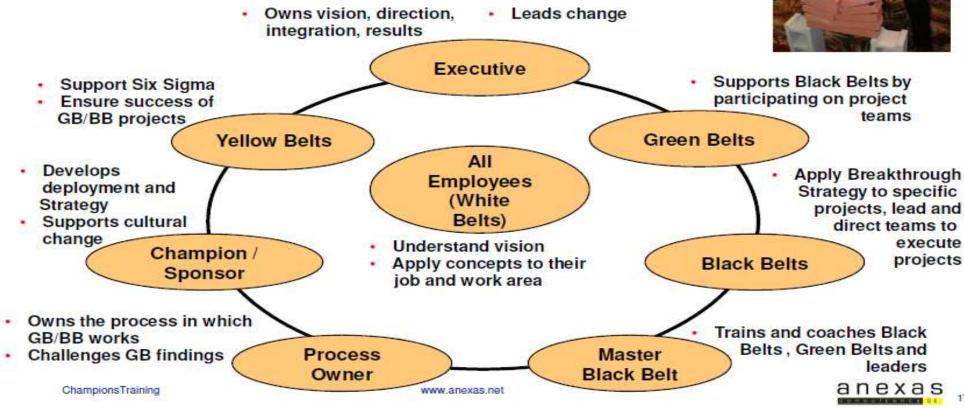
Yellow belts

Green belts

Black belts

Master black belts

#### Roles & Responsibilities



REST CH

# A Typical one Wave Implementation Plan at an organization

## High Level Improvement Timeline

THE RESIDENCE OF THE PARTY OF T	Aug		Sept			Oct			Nov				De	С		ın		F	eb			
	2 3	4	1 2	3 4	1 1	2	3 4	1	2	3	4	1 2	2 3	3 4	1	2	3 4	1	1 2	3	4	Deliverables
Define	Survey	for	Proj	ect S	elect	tion																Charter Customer Focus SIPOC
Measure																						Measures Collection Plan Baseline Sigma
Analyse			10									5										Mapping/Analysis Vital Few Opportunity quantification
Improve														- 1								Solutions Evaluate Implementation Plan
Control/Verif	y						J															Procedures Monitoring Communication





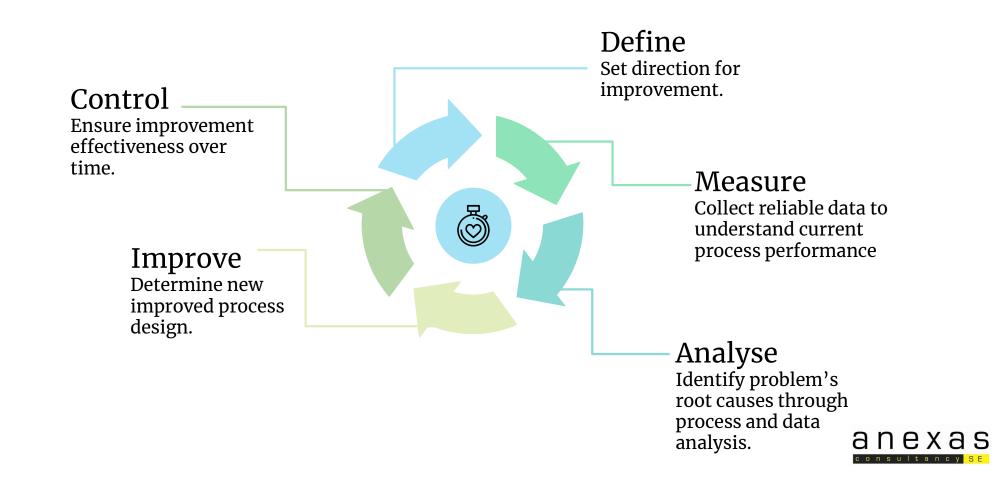
## Operational Excellence

- "Eighty-five percent of the reasons for failure to meet customer expectations are related to deficiencies in systems and processes, not to the fact that our employees are not up to the challenge..."
- "The Manager's role is to promote process improvement."

DEMING



# DMAIC: An Improvement Methodology









## تدريب على التفتيش

أوجد عدد المرات التي يتكرر فيها حرف (f) القطعة التالية:

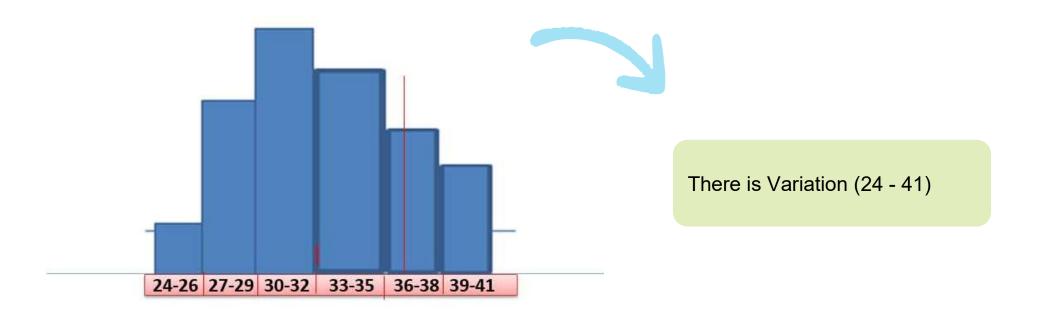
The necessity of training farm hands for first class farms in the fatherly handling of farm livestock is foremost in the eyes of farm owners.

Since the forefathers of the farm owners trained the farm hands for first class farms in the fatherly handling of farm live stock, the farm owners feel they should carry on with the family tradition of training farm hands of first class

farmers in the fatherly handling of farm live stock because they believe it is the basis of good fundamental farm management.



# Histogram





# Analyze

#### What is the Root Causes for Variation?

- Distance
- Small Letters
- Time
- Brightness
- Repetitive Letters
- Age

Choose the most important causes and improve it by:

Fish Bone Diagram , 5Y Scatter Diagram Pareto Chart



# **Improve**

- Brain Storming
- Getting Ideas by: (Round Robin), (5-3-5)
- Do FMEA (Risk Management)
- Choose Best Solutions (Impact Effort Matrix)
- Check Data Before and After Improve



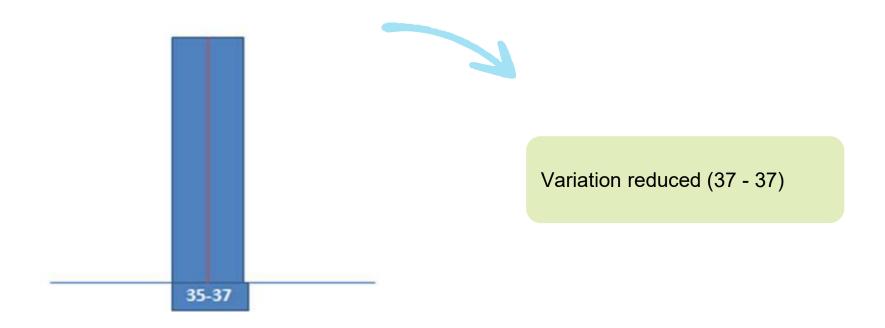
# After Improve

The necessity of training farm hands for first class farms in the fatherly handling of farm live stock is foremost in the eyes of farm owners.

Since the forefathers of the farm owners trained the farm hands for first class farms in the fatherly handling of farm live stock, the farm owners feel they should carry on with the family tradition of training farm hands of first class farmers in the fatherly handling of farm live stock because they believe it is the basis of good fundamental farm management.



# After Improve





# Thanks!

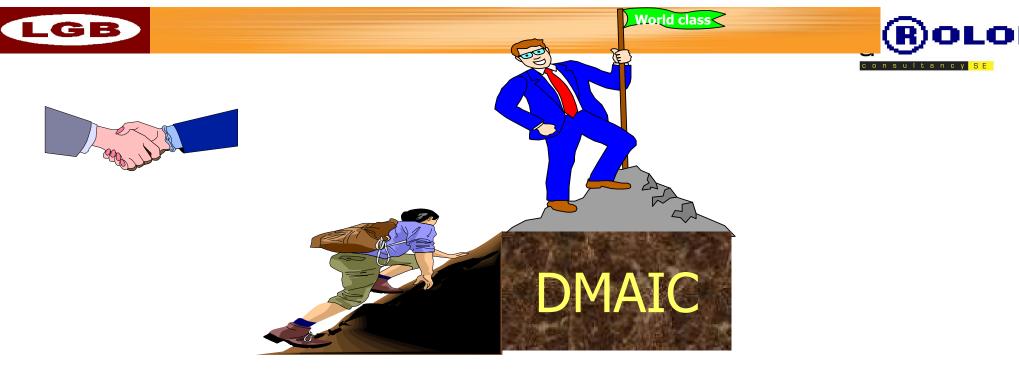
Dr Khalid Abu Issa Mobile: 505279422

Email: kabuissa8@gmail.com



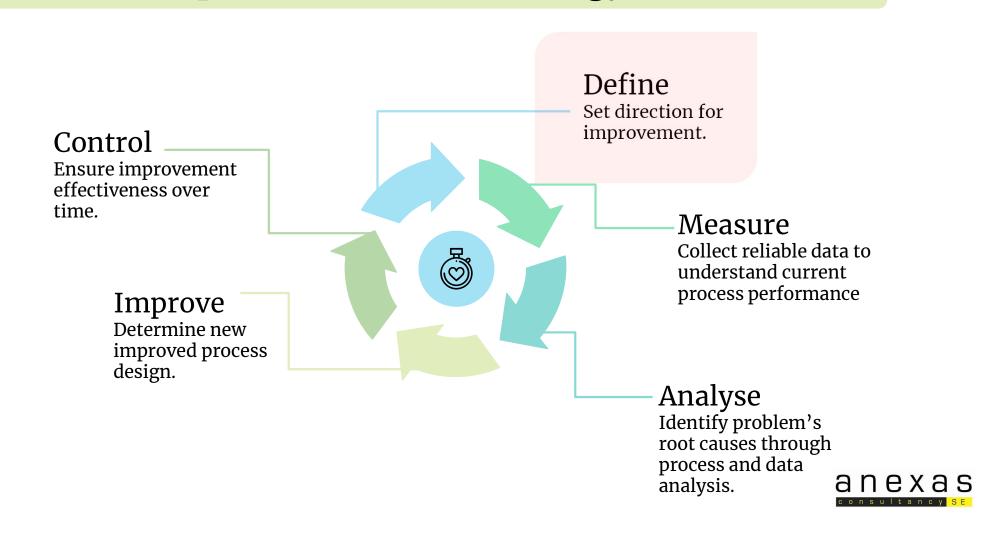


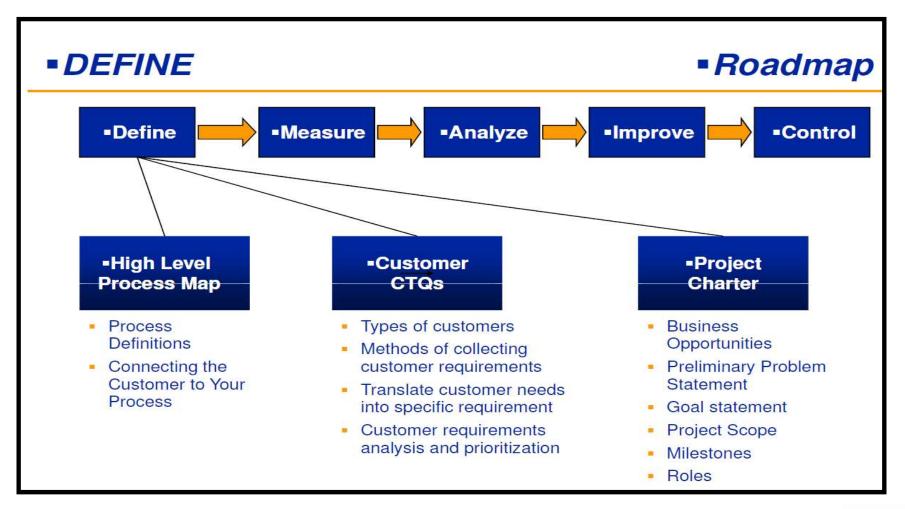




# The 6 SIGMA journey Towards Excellence Continues...

# DMAIC: An Improvement Methodology



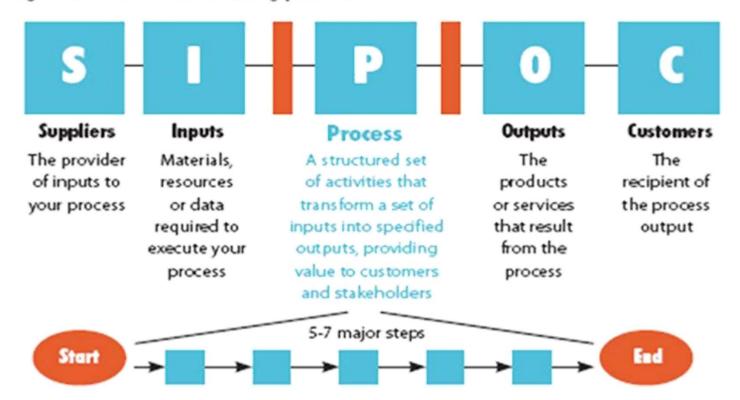




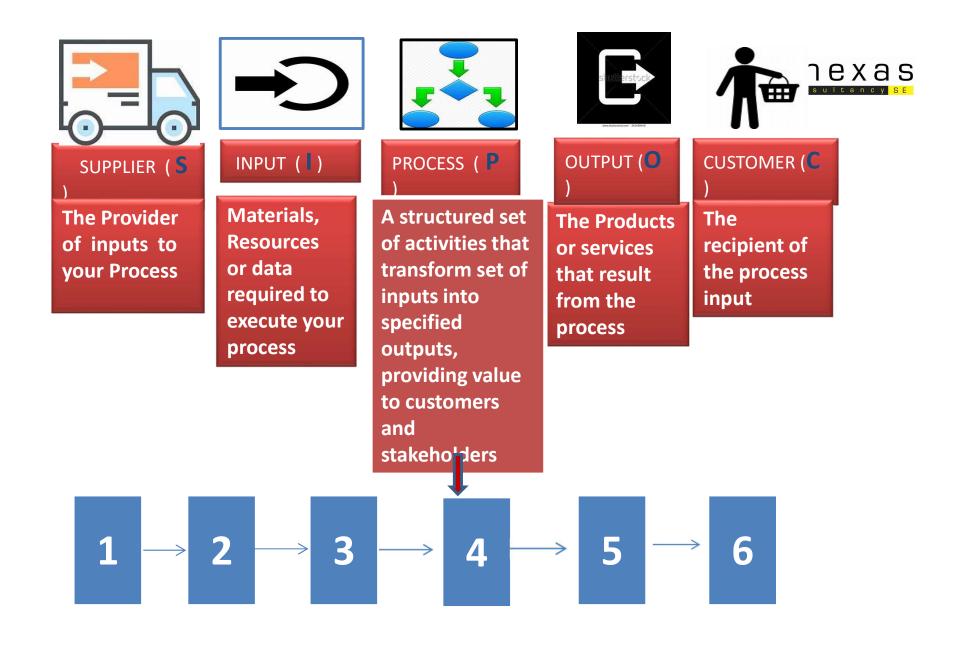
# SIPOC / COPIS

#### ( Suppliers, Inputs, Process, Outputs, Customers,

Figure 1. SIPOC - understanding processes







# **Project Name: Reducing LAB TAT**

**SIPOC** 



supplier

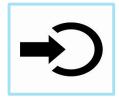
مریض Patient ممرضه Nurse

me الموظفين

**Ware House** 

**Med Comp** 

ITA



Input

Sample

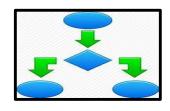
Lab Tech , System

Machine

**Analyzer** 

Computer

**System** 



**Process** 

**Receive The Sample** 

Log In the Sample

Centrifuge the sample

Analyze the sample

Check the result

Verify the result



Output

Lab Result

Output



Customer

**Patient** 

**Doctor** 

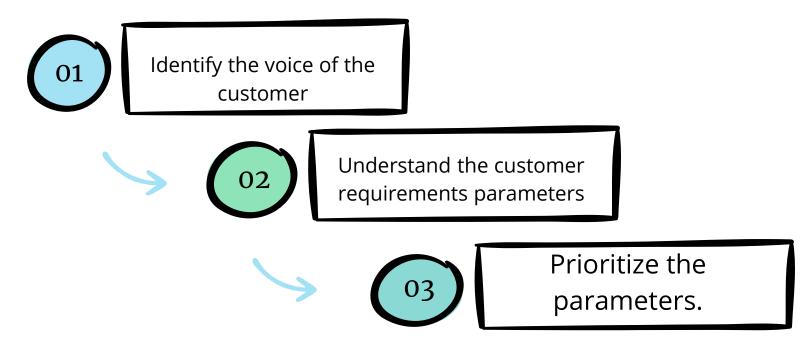
Nurse



#### **Process Mapping: Top Down Charting** D M A Profile the Rx Receiving Rx Prepare Rx Check Rx Dispense Rx Giving queuing Enter Rx in Check Call patient Dispense computer medicines as medicines slip per Rx against original Check queuing Stick the other Check container slip part of slip Check expiry medicines Check and duplication Check Rx for Patient counsel stick labels completion Hang labels Check Put all medicines Dispense Rx medicines in interaction tray Check right dose Clarify with prescriber Print labels ancadS

consultancy SE

## **CTQ** (critical to quality)



#### Ask these questions:

How does the customer view my process?

What does the customer look at to measure my performance?



Convert the requirements into GTOS

# Understanding the Voice of the Customer



The term Voice of the Customer (VOC) is used to describe customers' needs and their perceptions of your product or service





# **Understand the Voice of Customer**



# **Understand the Voice of Customer**

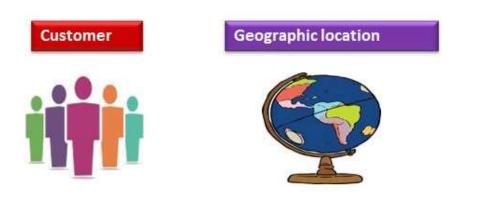


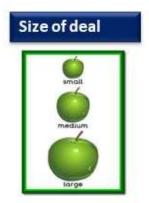
## **Define Customer Segments**

**Segmentation** is recommended to focus customer research on the most important customers:

Review your list of customers.

Determine logical customer segments.







# Basic VOC Systems

#### 1. Reactive systems

 Information comes to you whether or not you take action

#### 2. Proactive systems

 You need to put effort into gathering the information



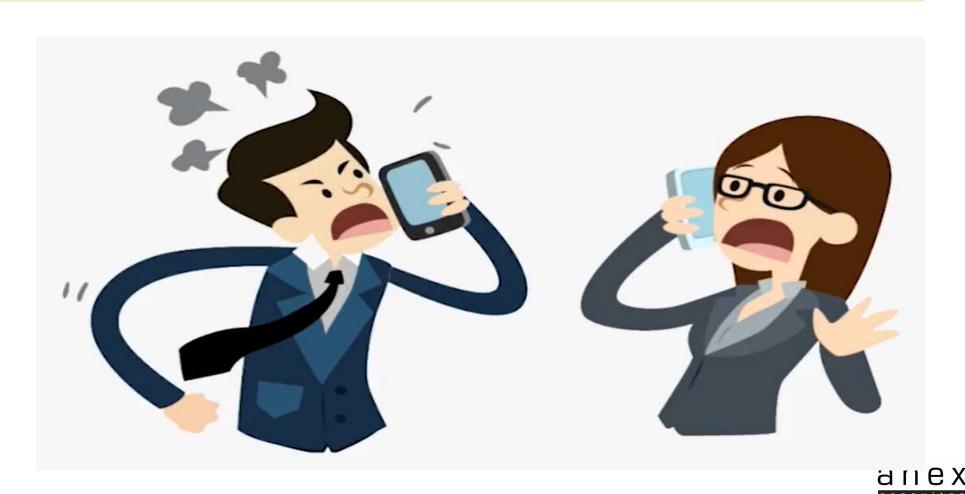


# Typical Reactive VOC Systems

- Customer complaints (phone or written)
- Technical support calls
- Claims, credits, contested payments
- Product return information
- Problem or service hotlines
- Customer service calls
- Sales reporting
- Warranty claims
- Webpage activity



# **Customer Complain**

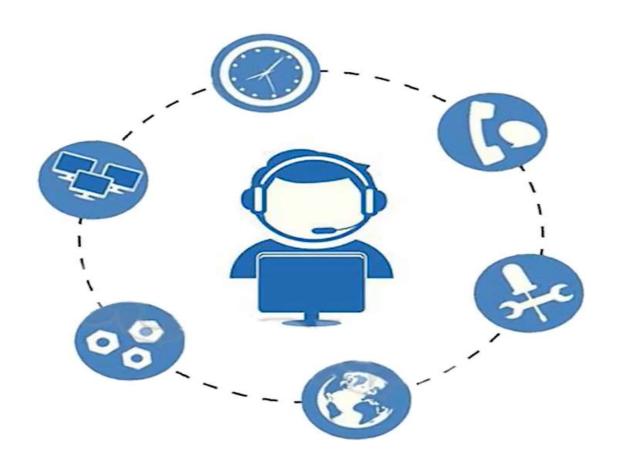


# **Customer Service Call**





# **Technical Support Call**





# Web Page Activity





### Proactive VOC Systems

- Direct customer observation
- Interviews
- Focus groups
- Surveys
- Comment cards
- Data gathering during sales visits or calls
- Market research, market monitoring
- Benchmarking



# **Direct Customer Observation**





# **Interview**





# **Focus Group**





# Survey



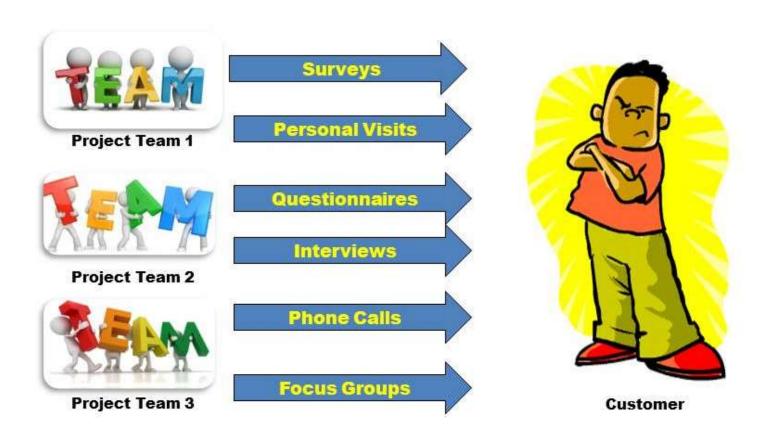


# **Comment Cards**



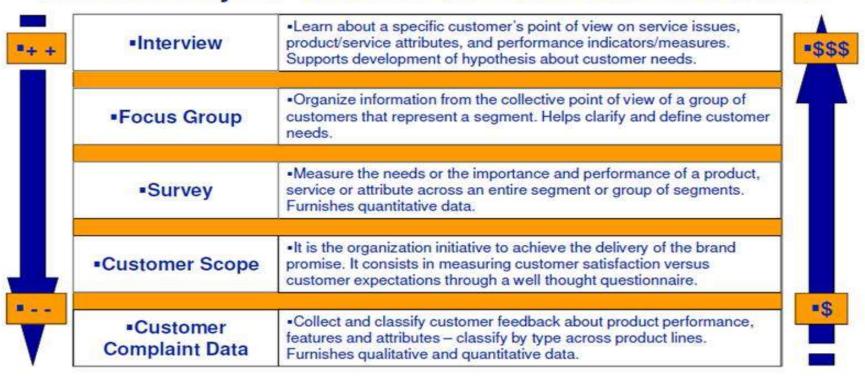


# Gather VOC data (voice of customer)





#### Different Ways to Listen to the Voice of the Customer



# Critical To Quality (CTQ)

Customer	Voice of Customer	Quality Issue	Specific Need Statement
Patient 01	Delay of services	Time	I need to finished my ER journey within 1 hour
Patient 02	Proper diagnoses	Efficiency	I expect 100% of the doctor decisions are complimented with my compliant
Patient 03	Improper communication	Respect	I expect 100% of Staff conversations with me to be in respective manner
Patient 04	Lack of prioritization system in providing ER services	Equity	I need to deal with equal system in 100% of steps of my ER journey
Patient 05	lack of providing my special needs during my journey in ER	Patient Centered	I need to find 100% special needs during my journey in ER







#### Accurate Translation for the Customer Need is Critical!

- Must be written from the customer's perspective
- Write the need, not the solution
- Write the need in complete sentences, examples help
- Use measurable terms
- · Be concise
- Write from a positive perspective
- Validate the need with the customer



# Your Project Example

# Identify the CTQs

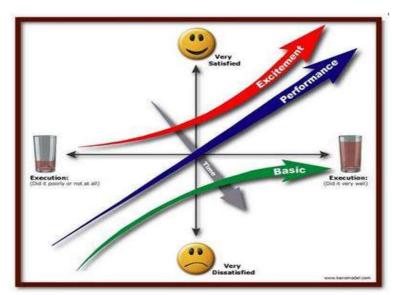
### Identify your CTQs (10 Minutes)

What	How	Who	Timi ng
Introduction	Introduce the purpose of the exercise	Trainer	2 min
Preparation	List the CTQs of your project	Participants	5 min
Write on flip chart	Write the CTQs on flip chart	Participants	2min
Present your CTQs	Present your CTQs to everyone	Presenter from your group	1min





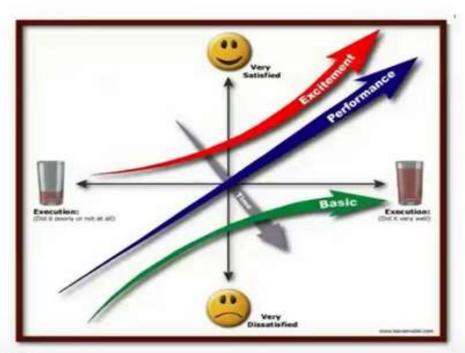
#### **Prioritize your Customers CTQs**



# Must have! Cup clean Coffee hot Choice in flavor Choice in type Chocolate square Chocolate nut



# **KANO Model**





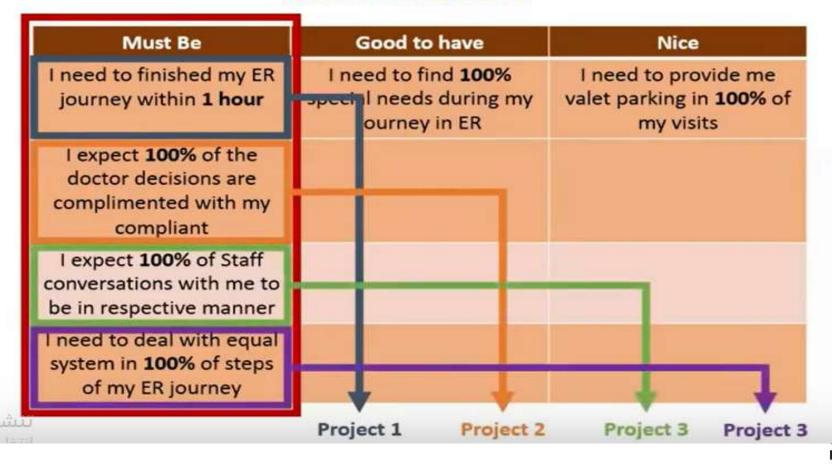
تنشيط ows



# **KANO Model**

Must Be	Good to have	Nice
I need to finished my ER journey within <b>1 hour</b>	I need to find 100% special needs during my journey in ER	I need to provide me valet parking in <b>100%</b> of my visits
I expect 100% of the doctor decisions are complimented with my compliant		
I expect <b>100</b> % of Staff conversations with me to be in respective manner		
I need to deal with equal system in 100% of steps of my ER journey		

#### **KANO Model**



	DMAIC Project Charter		
Was and a second		Project No.:	
Project Name:	Process :		
Resource Plan		Team Members	
Champion / Sponsor: Green / Black Belt: Functional Managers/Process Owner: Coach / Master Black Belt:	Text		
Problem Statement		Scope	
Text	Text		
Goal Statement		Customer CTQ's	
ext .	Text		
Estimate Financial Opportunities		High Level Project Milestone	
ext	Text		
	Validation		
Green / Black Belt	Master Black Belt	Process Owner	
CEO	Financial Analyst	Champion / Sponsor	



#### PROJECT CHARTER

#### Resource Plan

Champion:

Green/Black Belt:

Process Owner:

Coach / Master Black Belt:

#### **Problem Statement**

(when)

(where)

Don't use WHY & WHO

(what)

(how big).

(how it impact).

#### **Goal Statement**

Starts with a verb ( reduce, eliminate,....)
Focus of project ( Cycle time, Accuracy )

#### Estimate Intangiibile, Financial Benefits

**Reducing Waiting Time** 

Reduce the Cost

#### **Team Members**

Name of the Team working on the project

#### Scope

What process will the team focus on What are the boundaries of the process

#### **Customer CTQs**

**Customer Requirement** 

#### High-level project Milestone

Define: 12 days Measure: 15 days Analyze: 30 days Improve: 60 days



#### **Project name: Reduce LAB TAT**

#### Resource Plan

Champion: AHMAD

Green/Black Belt : MOHAMAD

Process Owner: NASSER

Coach / Master Black Belt : KHALID

#### **Problem Statement**

For The Last 2 years in the lab average TAT for Stat Lab results is more than 2 hours. This affect delaying of lab results affecting Patient Care.

#### **Goal Statement**

To reduce TAT from more than 2 hours to less than 1 hour in next month

#### Estimate Intangiibile, Financial Benefits

Reducing Waiting Time Reduce the Cost

#### **Team Members**

**ABDULLAH** 

REEM MOATH

TAREQ

#### Scope

TAT OF STAT LAB RESULTS

#### **Customer CTQs**

LESS THAN ONE HOUR

#### High-level project Milestone

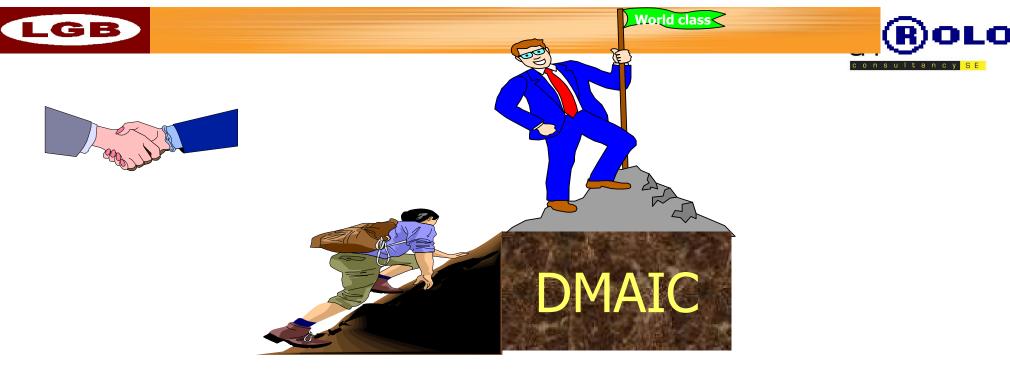
Define : 12 days Measure: 30 days Analyze : 20 days Improve : 15 days

# Thanks!

Khalid Abu Issa Mobile: 505279422

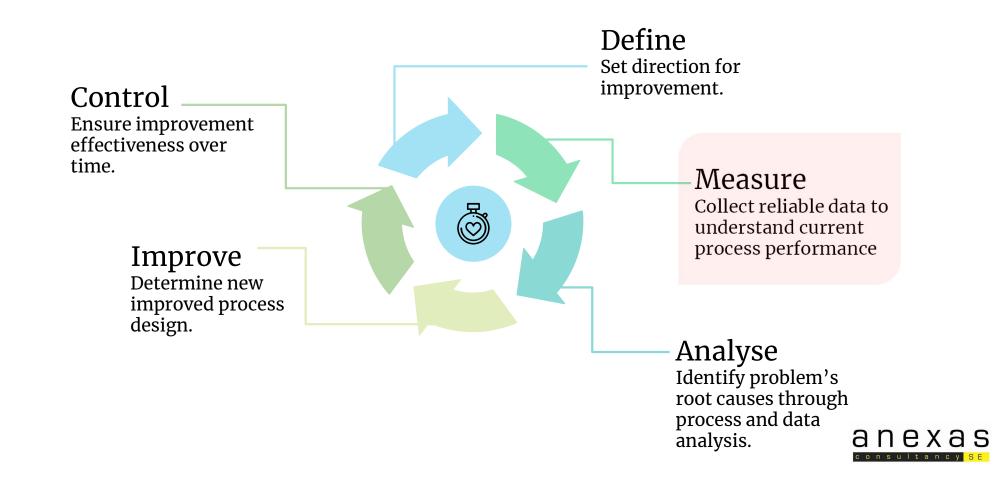
Email: kabuissa8@gmail.com





# The 6 SIGMA journey Towards Excellence Continues...

# DMAIC: An Improvement Methodology







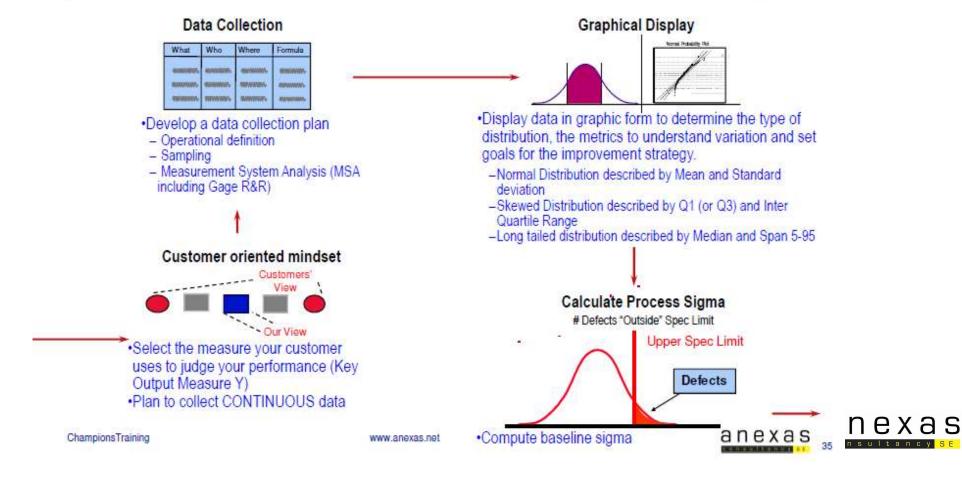
# Ferrari F1 Perfection



#### **MEASURE**

Purpose: To measure and understand baseline performance for the current process

by collecting reliable data (quantitative & qualitative)



#### MEASURE: Measure the Current Situation

#### Goal

 Collect data to gather information on the current situation



#### Output

- Data that pinpoints problem location or occurrence
- Baseline data on how well the process meets customer needs (to determine current process sigma)
- Understanding of how current process operates
- Display the collected data as histogram, graphs and charts



#### Overview

**□** Objective:

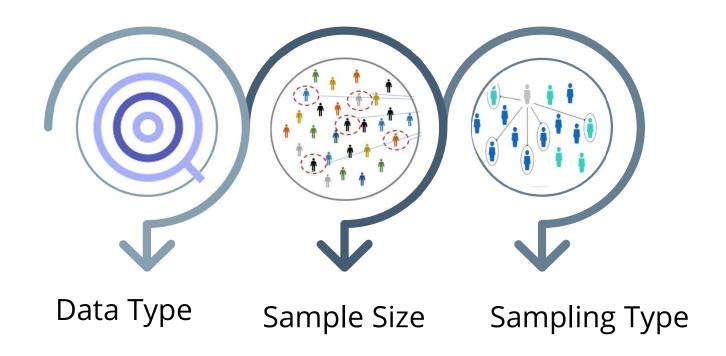
collect reliable data to understand current process performance.

#### **☐** Steps:

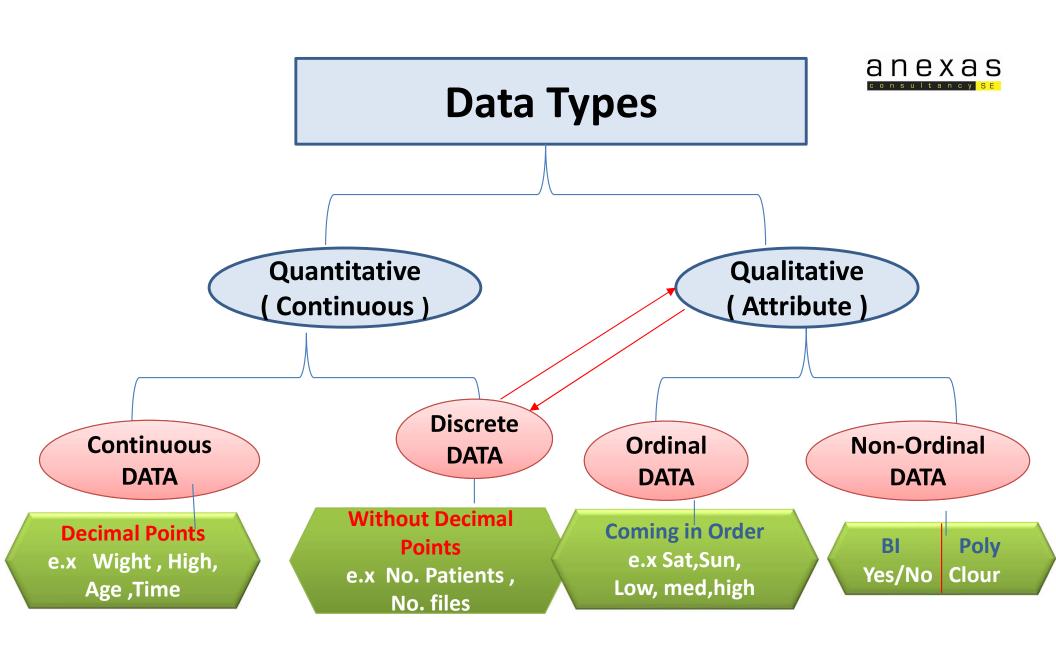
- Choose the data to be collected. (data selection)
- Organize data collection plan.
- Study process variation.
- Calculate sigma level.
- Process capability.



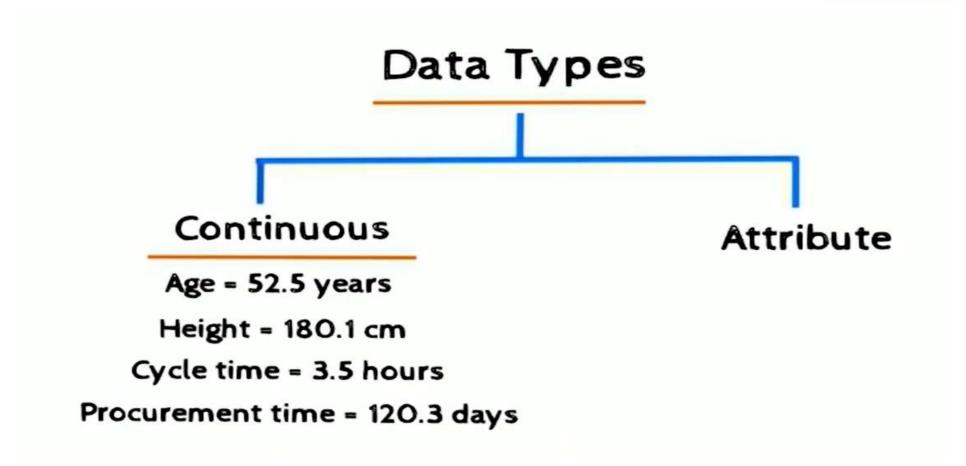
# Data collection plan













# Attribute

Attribute	Category	Count	Proportion
Happiness	Нарру	60	0.6
	Unhappy	40	0.4
		100	1.0



## Why Use Six Sigma as a Metric?

# Process sigma is a more sensitive indicator than quality percentage

Quality Percent	DPMO	Sigma Level
93	66,807	3.0
98	22,750	3.5
99	6,210	4.0
99.87	1,350	4.5
99.977	233	5.0
99.9997	3.4	6.0

#### Sample vs Population

• **Population**: All the items that have the "property of interest" under study.

• **Sample**: A significantly smaller subset of the population used to make an inference.





# Sample Size

Quantitative (Continuous) 30 – 50 Sample

 $N = \left(\frac{2S}{d}\right)^2 \frac{(SD)}{(precision)}$ 

**Qualitative** 

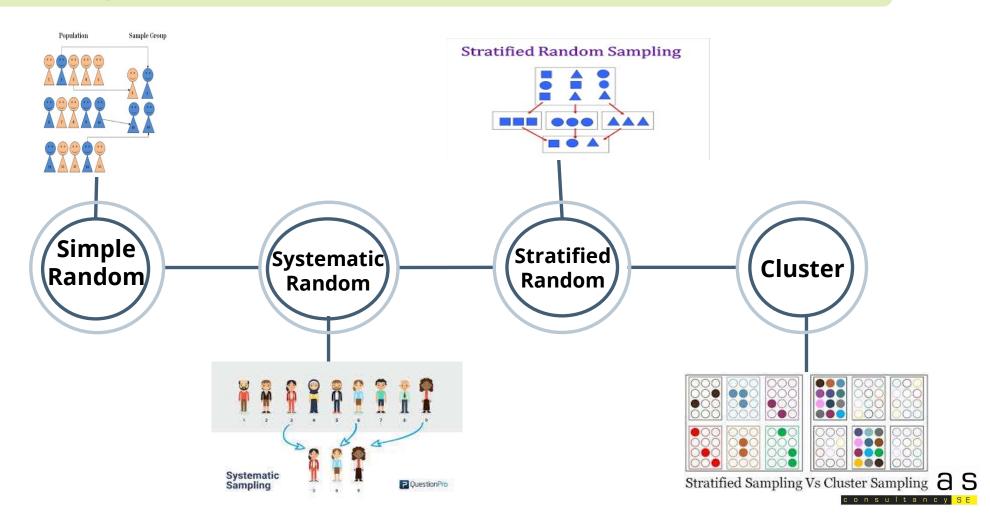
( **Attribute** ) 200 – 1100 S

N = 2 (p)(1-P) Proportion

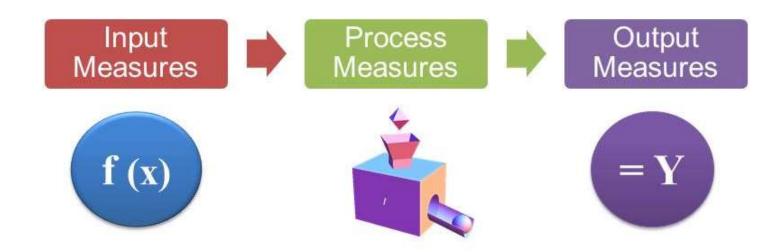
If N < 100 , n = 30  $\,$  if N 100 - 1000 , n = 20 % if N 1000 - 10000 , n = 10 % for one Month ( L.T ) better than ( S.T ) collected in one week



# Sampling Techniques



#### Choose the data to be collected



#### **Prediction**

- Independent
- Input/Process
- Cause
- Problem

#### Response

- Dependent
- Output
- Effect
- Symptom



# Data Collection for Potential Causes (Y = F(X))

		Y-	<b>X</b> 1	X2	Х3	<b>X4</b>	X5	Х6	X7	X8	X9	X1	φ <b>_</b> }	. f	(X)
Patient N	▼ Dat(▼	TAT ▼	Time to send bloc	Time to Log in Syste	Time to Start sp	Spining Tin 🔻	Waiting time between spin & Analys	Analysis Tin 🔻							
2	13-May	138	15	56	100000000000000000000000000000000000000	10	10	30	3	К	1	R,H,B	General	А	Before 10
3	13-May	62	5	6	9	10	10	20	2	K	1	R,H,B	1000	CLINIC	
4	13-May	80	2	3	5	10	10	45	5	K	1	R,H		CLINIC	
5	13-May	61	1	4	8	10	7	30	1	K	1	R,H	General	CLINIC	After 10
6	13-May	240	125	11	4	10	25	63	2	K	1	R,H,B	General	В	Before 10
7	13-May	49	1	1	3	10	5	25	4	J	1	R,H,B	General	CLINIC	After 10
8	13-May	160	1	1	8	10	10	70	60	J	1	R,H	General	CLINIC	Before 10
9	13-May	155	18	2	35	10	10	75	5	J	1	R,H	General	В	Before 10
10	13-May	262	85	40	45	5	30	55	2	K	1	R,H	General	В	Before 10
11	13-May	97	1	4	10	10	5	65	2	K	1	R,H,B	General	CLINIC	Before 10
12	13-May	66	10	18	2	10	5	20	1	J	1	R,H,B	General	CLINIC	Before 10
13	13-May	172	70	20	30	10	5	36	1	J	1	R,H,B	General	Α	Before 10
14	13-May	185	70	21	14	10	10	58	2	J	1	R,H,B	General	Α	Before 10
15	13-May	162	69	22	14	10	10	36	1	K	1	R,H,B	General	Α	Before 10
16	13-May	72	5	4	6	10	5	40	2	K	1	R,H	General	CLINIC	Before 10
17	13-May	198	68	27	26	9	5	62	1	K	1	R,H	General	D	Before 10
18	13-May	96	20	36	14	10	2	13	1	K	1	R,H	General	CLINIC	After 10
20	13-May	176	65	30	12	10	8	48	3	J	1	R,H	General	Α	Before 10
21	13-May	54	5	3	7	10	5	22	2	J	1	R,H,B	General	В	Before 10
22	13-May	110	0	6	4	10	15	45	30	J	2	R,H	General	CLINIC	After 10
23	13-May	44	2	10		10	7	22	3	J	2	R,H	General	CLINIC	After 10
24	13-May	70	5	7		15	5	40	5	J	2	R,H,B	General	CLINIC	After 10
25	13-May	<b>161</b>	20	30	10	10	10	78	3	K	2	R,H,B	General	В	Before 10
26	13-May	112	20	20	20	10	11	29	2	K	2	R,H	General	Α	Before 10
27	13-May	82	2	3	10	10	3	52	2	J	2	R,H	General	Α	Before 10
28	13-May	66	2	5	3	13	7	35	1	K	2	R,H	General	CLINIC	Before 10



# Data collection plan

What?	Why?	When?	Who?	How?	How many?

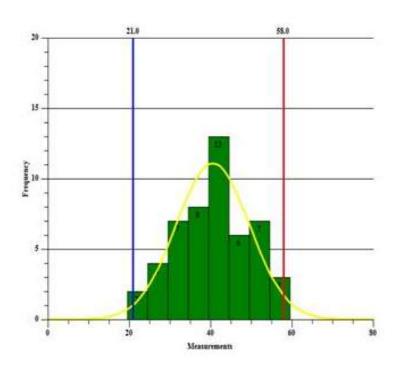


# Study process variation

#### Histogram

The Histogram illustrates the shape (or distribution) of the data by indicating how often different values appear.



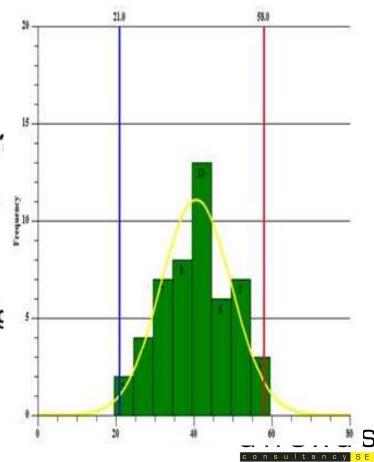




# Interpretation of histogram

#### **Key Questions:**

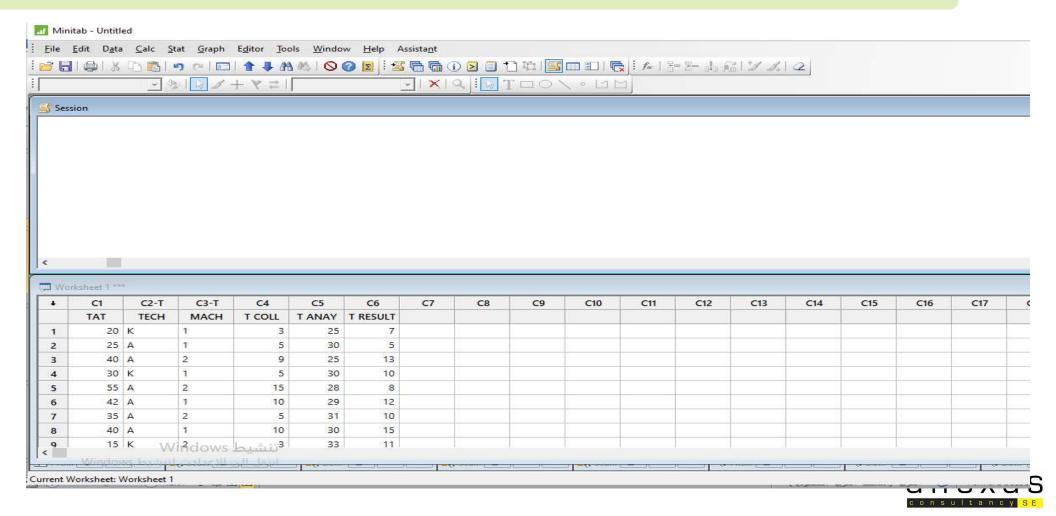
- What is the shape of the distribution?
- What is the central trend ("center") of the distribution '
- What is the variation ("spread") of the distribution? Is the curve wide or narrow?
- Are we confronted with a problem of "process centring within the limits of customers' expectations or do we have a problem of "too much variation"?



## Data Collection for Potential Causes

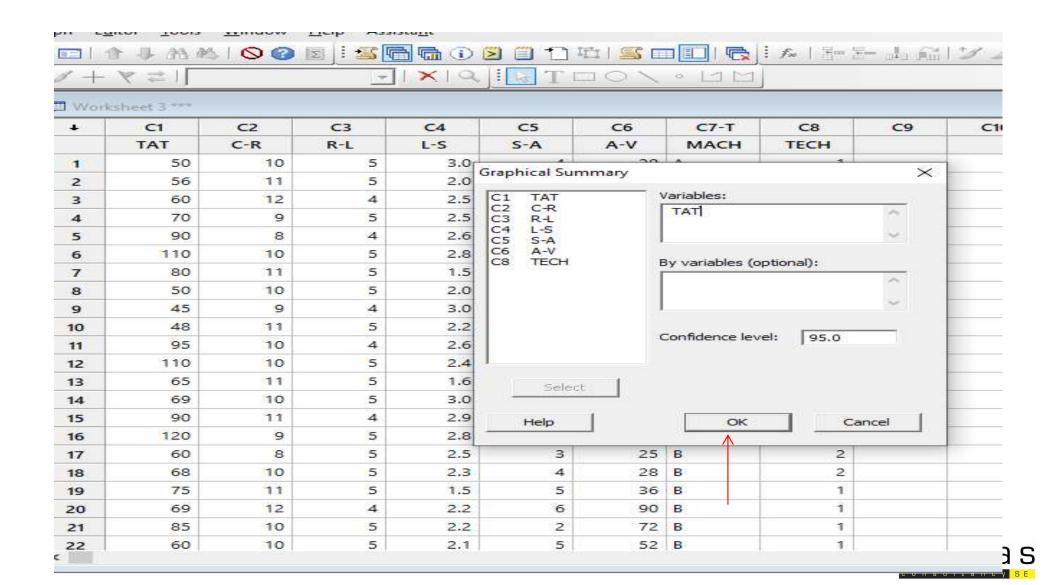
Patient N 💌	Dat( -	TAT -
2	13-May	138
3	13-May	62
4	13-May	80
5	13-May	61
6	13-May	240
7	13-May	49
8	13-May	160
9	13-May	155
10	13-May	262
11	13-May	97
12	13-May	66
13	13-May	172
14	13-May	185
15	13-May	162
16	13-May	72
17	13-May	198
18	13-May	96
20	13-May	176
21	13-May	54
22	13-May	110
23	13-May	44
24	13-May	70
25	13-May	161
26	13-May	112
27	13-May	82
28	13-May	66



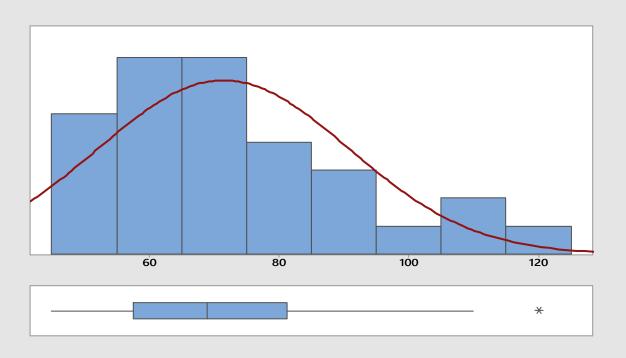


#### MINITAB SOFTARE PRACTICE: HOW TO DO GRAPHICAL SUMMARY

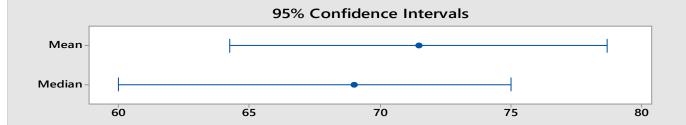
-	<u>D</u> isplay Descriptive Statistics  Store Descriptive Statistics										· 1 = E	شكر مان -	121.
	gression		0.30						0 \	· LIM			
<u>A</u> NOVA ▶			2=	<u>G</u> raphica	Graphical Summary								
DOE Control Charts Quality Tools  Reliability/Survival  ▶		<b>b</b>	μ <sup>z</sup> μ μ μ-μ	1-Sample <u>Z</u> 1-Sample t  2-Sample t  Paired t			Graphical Summary  Summarize your data with descriptive statistics, such as the mean and the standard deviation, and describe the			nean and the d describe the	C8 ECH	C9	C
Mu	ultivariate	▶.	25.5	distribu				ution with graphs.			2		
Tirr	ne <u>S</u> eries	►		1 Proport		24.5		5	23	A	1		
Tab	bles	▶.	111	2 Proport				3	20	A	2		
No	onparametrics	►.	λ_	1-Samp <u>l</u> e Poisson Rate				7	35	A	1		
Equ	uivalence Tests		λ	2-Sample	-	2	55	A	1				
Pov	wer and Sample S	Size▶	$\sigma^2$	1 Varianc	€			5	50	A	2		
	8	50	G2/G2	2 V <u>a</u> riano	V <u>a</u> riances			ı	40	A	2		
	9	45	[-1:1]	Correlatio	on			7	25	A	1		
	10 48 11 95	48	(o ²)	Covarian			5	40	A	1			
		95						3	45	A	1		
	12	110		Normalit			F	j.	50	A	2		
	13	65	C3	O <u>u</u> tlier Te	est			<b>3</b>	40	A	1		
	14	69	TT	Goodnes	s-of- <u>F</u> it Test	it Test for Poisson		1	32	A	1		
	15	90		11	4	2.9	5	5	21	A	1		
	16	120		9	5	2.8	6	i	41	В	2		
	17	60		.8	5	2.5	3		25	В	2		
	18	68		10	5	2.3	- 4		28	В	2		
	19	75		11	5	1.5	15		36	В	1		
	20	69		12	4	2.2	$\epsilon$		90	В	1		
	21	85		10	5	2.2	2	2	72	В	1		
	22	60		10	5	2.1	5	5	52	В	1		

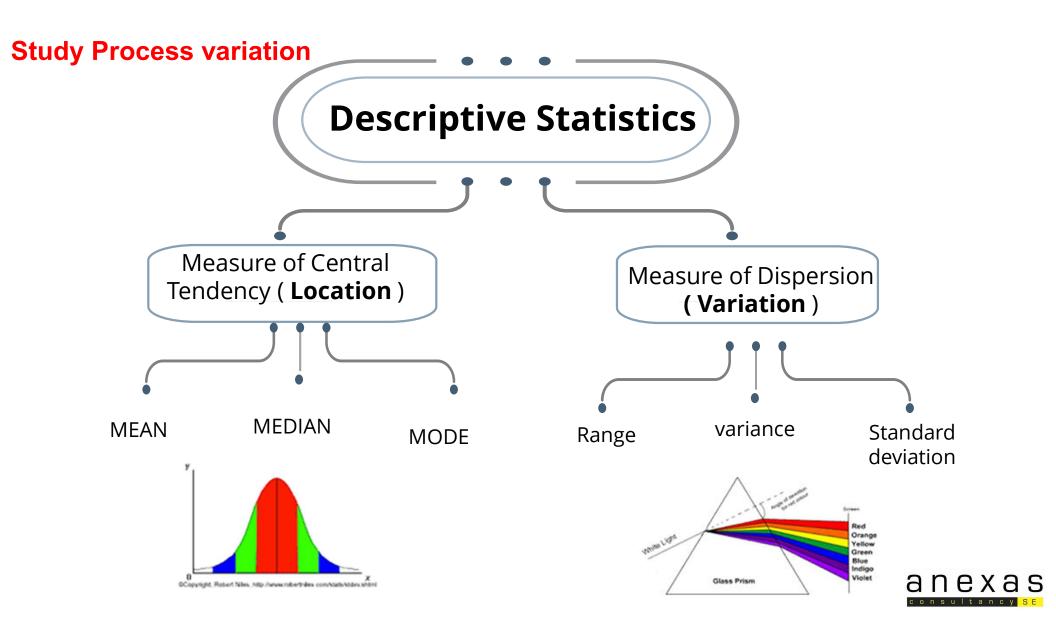


#### **Summary Report for TAT**



Anderson-Darling Normality Test									
A-Squared	0.73								
P-Value	0.051								
Mean	71.467								
StDev	19.303								
Variance	372.602								
Skewness	0.928965								
Kurtosis	0.390733								
N	30								
Minimum	45.000								
1st Quartile	57.500								
Median	69.000								
3rd Quartile	81.250								
Maximum	120.000								
95% Confidence Interval for Mean									
64.259	78.674								
95% Confidence Interval for Median									
60.000	75.000								
95% Confidence Interval for StDev									
15.373	25.949								





# Measure of Location (Central Tendency)

#### **MEAN**

Average of a set of values that does not have outliers

The Mean is the sum of all the values divided by the number of values

**Example:** Sum of Values 3, 4.5, 5, 5, 6, 6, 7, 8, 8, 99

**Number of Values: 11** 

Mean 66 / 11 = 6

#### Median

It is the middle value in an ordered data set

Useful for data sets contain outliers.

Order the values from least to greatest.

Locate the middle value

Example: 3, 4, 5, 5, 5, 6, 6, 7, 8, 8, 99 Median = 6

If the number of values is even, the median is the average of the two middle values

Mean 14

#### Mode

The Value that occurs most often in a data set.

Useful for data sets containing outliers. If there is no mode in the data set, it's of no use

Not as popular as mean or median.

How to determine the mode in a data set? Order the values from least to greatest. Locate the value that occurs the most.

#### **Example:**

3,4,5,5,6,6,6,7,8,8,99 Mode = 6

3,4,5,5,5,6,6,6,8,8,99 Mode = 5 and 6

1,2,3,4,5,6,7,8,9,10,11 No Mode

# Measure of Dispersion

# Range in Statistics

The Difference between the lowest and highest values in a data set

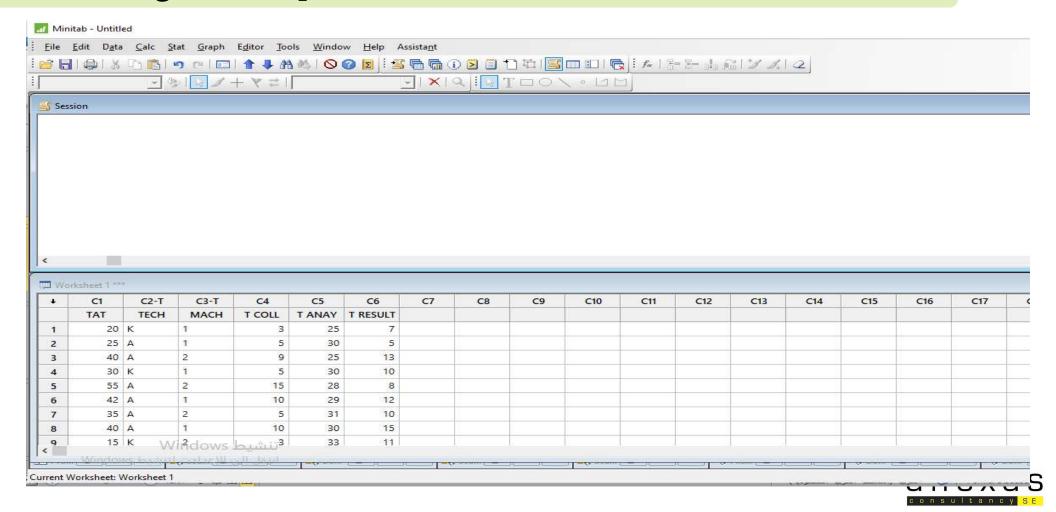
#### **Example**

Range= Highest Value – Lowest Value

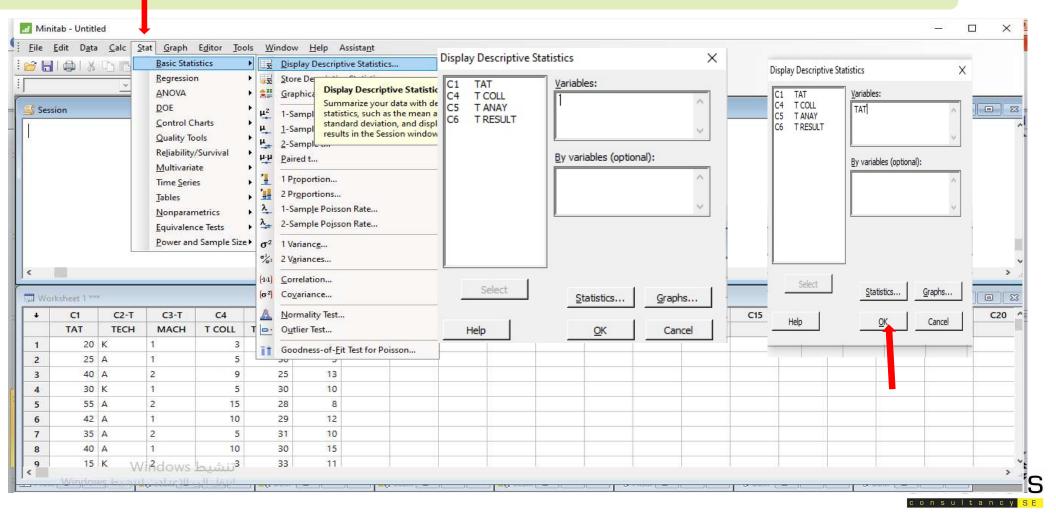
$$= 9 - 3 = 6$$



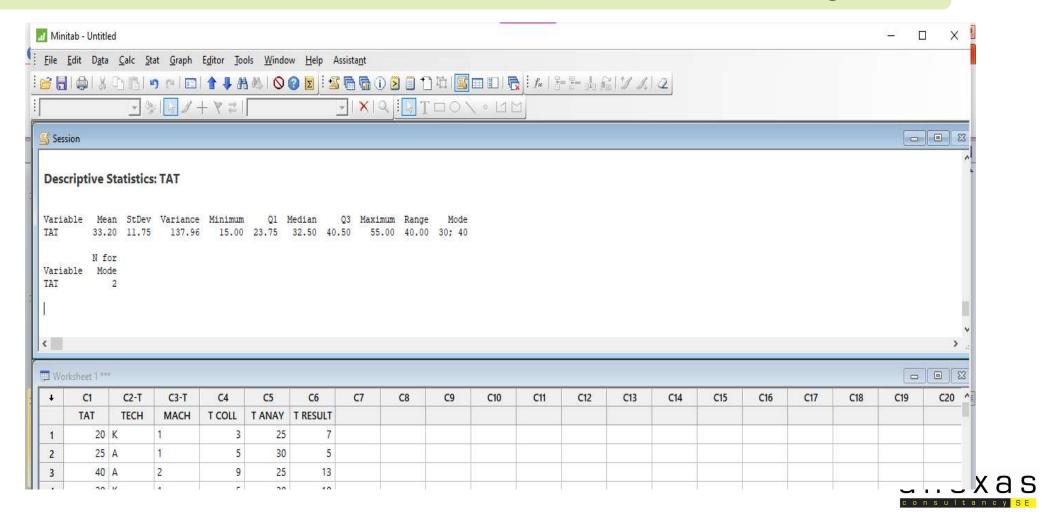
#### How to get Descriptive Statistics



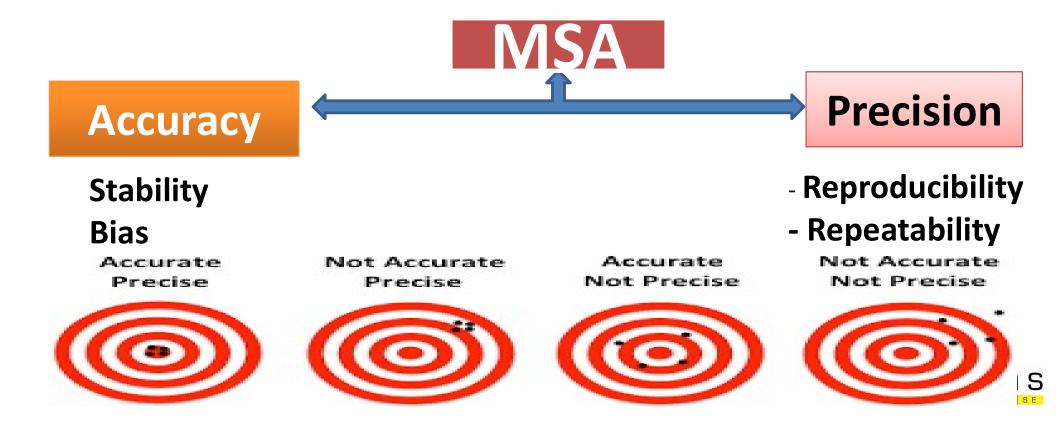
#### How to get Descriptive Statistics



#### Descriptive Statistics (Mean, Median, Mode, Range, SD)



# Measurement System Analysis (MSA)



#### Common Problems with Measurements

#### Problems with the measurements:

- 1. Bias or inaccuracy
- 2. Not Repeatable
- 3. Not reproducible
- 4. Unstable measurement system over time
- 5. Lack of resolution

(Next slides contain the details about the problems listed above)



#### **INACCURACY**

#### **GOOD MEASUREMENT SYSTEM**







#### **NOT REPEATBLE**











#### **NOT REPRODCIBILE**





#### **NOT REPRODCIBILE**



**Different People**, Machines, etc



#### **UNSTABLE MEASURMENT**



LITTLE OVER TIME







#### Improving a Measurement System

- A measurement system consists of:
  - Measuring devices
  - Procedures
  - Definitions
  - People
- To improve a measurement system, you need to:
  - Evaluate how well it works now (by asking "How much of the variation we see in our data is due to the measurement system?")
  - Evaluate the results and develop improvement strategies



### Calculate process sigma : formula

Calculate the number of Defects Per Million Opportunities

In the Sigma table, look at the Sigma value relating to the DPMO determined



### Calculate process sigma : formula

Calculate the number of Defects Per Million Opportunities

In the Sigma table, look at the Sigma value relating to the DPMO determined





## Compute process sigma

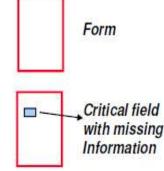
#### **Key Definitions**

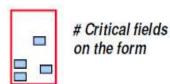
Unit: the item produced or processed

Defect: any event that does not meet the specification of a

CTQ as defined by the customer

Defect opportunity: any event which can be measured that provides a chance of not meeting a customer requirement (specification)





#### **CONVERSION TABLE**

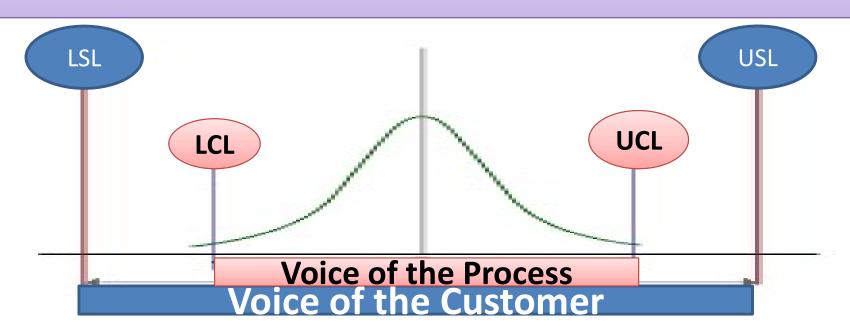
Process Sigma Yield %	DPMO	Sigma Level
6.68000	933,200	0.000
8.45500	915,450	0.125
10.56000	894,400	0.250
13.03000	869,700	0.375
15.87000	841,300	0.500
19.08000	809,200	0.625
22.66000	773,400	0.750
26.59500	734,050	0.875
30.85000	691,500	1.000
35.43500	645,650	1.125
40.13000	598,700	1.250
45.02500	549,750	1.375
50.00000	500,000	1.500
54.97500	450,250	1.625
59.87000	401,300	1.750
64.56500	354,350	1.875
69.15000	308,500	2.000
73.40500	265,950	2.125
77.34000	226,600	2.250
80.92000	190,800	2.375
84.13000	158,700	2.500
86.97000	130,300	2.625
89.44000	105,600	2.750
91.54500	84,550	2.875
93.32000	66,800	3.000

Process Sigma Level Conversion Table								
Yield %	DPMO	Sigma Level						
94.79000	52,100	3.125						
95.99000	40,100	3.250						
96.96000	30,400	3.375						
97.73000	22,700	3.500						
98.32000	16,800	3.625						
98.78000	12,200	3.750						
99.12000	8,800	3.875						
99.38000	6,200	4.000						
99.56500	4,350	4.125						
99.70000	3,000	4.250						
99.79500	2,050	4.375						
99.87000	1,300	4.500						
99.91000	900	4.625						
99.94000	600	4.750						
99.96000	400	4.875						
99.97700	230	5.000						
99.98200	180	5.125						
99.98700	130	5.250						
99.99200	80	5.375						
99.99700	30	5.500						
99.99767	23	5.625						
99.99833	17	5.750						
99.99900	10	5.875						
99.99966	3	6.000						



OPMO is known	n			_			
PMO:		DPMO:	0.0	Sigma Level (LT)	+inf	Sigma Level (ST)	+inf
PU is known							
U:		DPMO:	0.0	Sigma Level (LT)	+inf	Sigma Level (ST)	+inf
ield is known							
eld:		DPMO:	1000000.0	Sigma Level (LT)	-inf	Sigma Level (ST)	-inf
ntinuous proce	ess (normally	distributed)					
ar MEAN	98.727	DPMO:	153254.2	Sigma Level (LT)	1.02	Sigma Level (ST)	2.52
SD	17.605				î		
LSL	80						
USL	140						

# (Cp) Process Capability Voice of the customer vs. Voice of the Process



Cp = <u>VOC</u> VOP



## **Process Capability**

Process Performance Index

Process Capability Index

## Cpk

Cpk > 0 = Good

**Cpk = 0 = 50% Outside** 

**Cpk < -1 = Totally Outside** 

## Cp

Cp = 2 (6 Sigma)

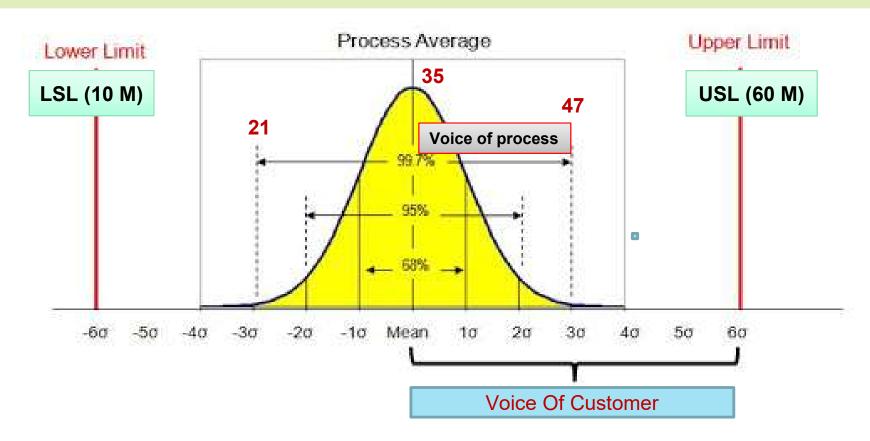
Cp = 1.66 ( 5 Sigma )

Cp = 1.33 (4 Sigma)

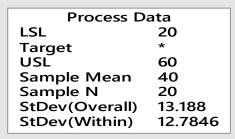
Cp = 1 (3 Sigma)

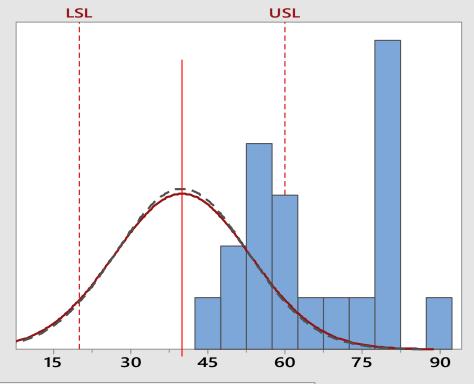


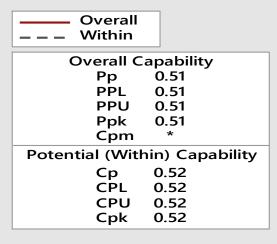
This Six in six sigma implies that there are six standard deviations (also called sigma) between the average of the process and the allowed service level limits by customer.





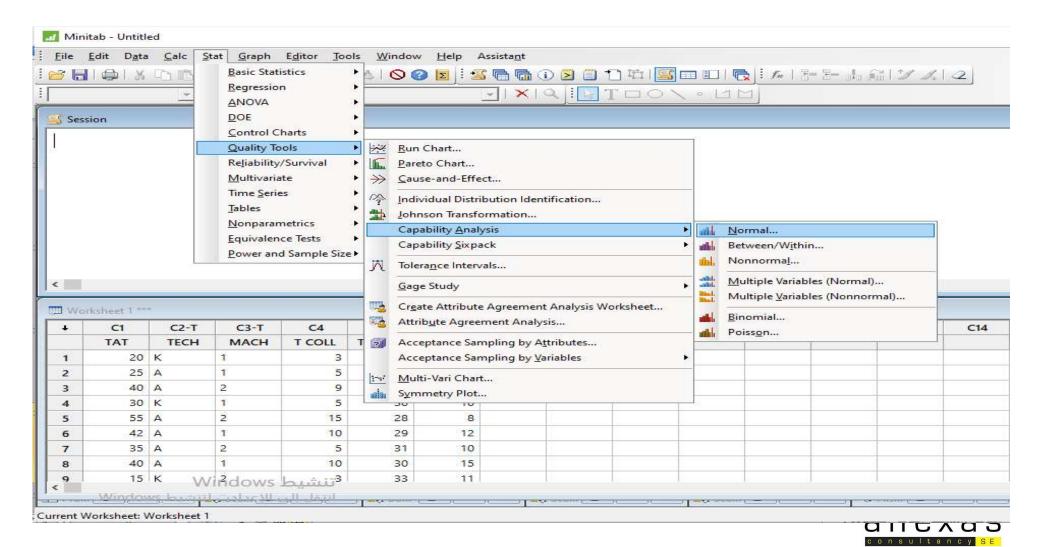


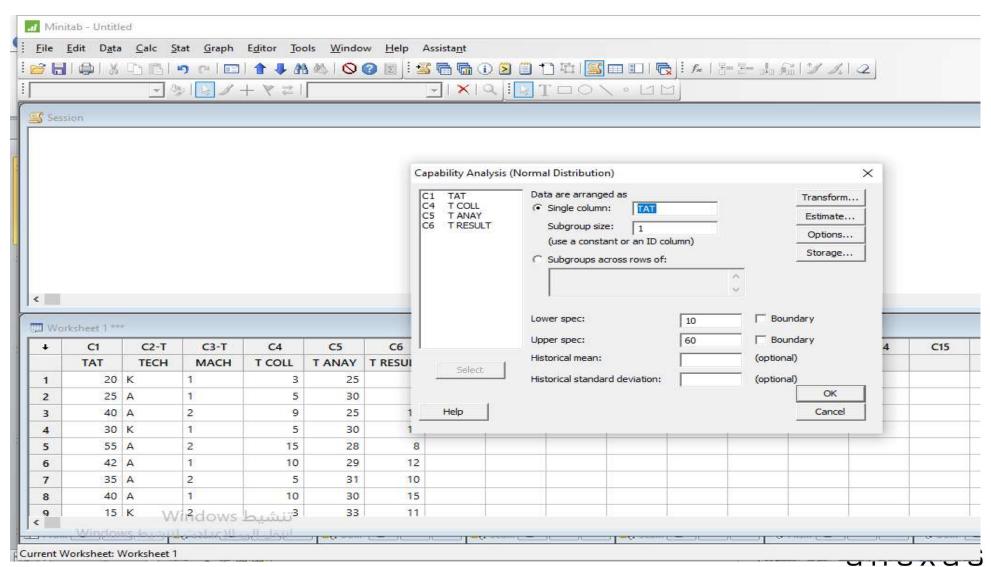


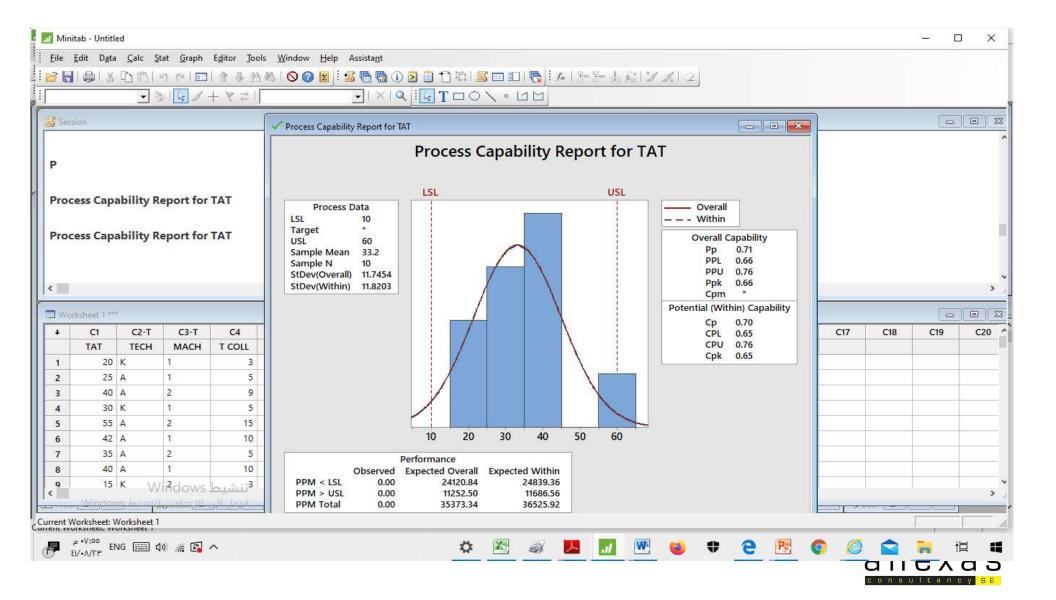


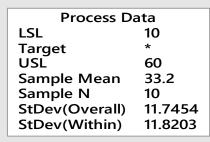
	Performance								
Observed Expected Overall Expected Within									
	PPM < LSL	0.00	64692.86	58864.23					
	PPM > USL	500000.00	64692.86	58864.23					
	PPM Total	500000.00	129385.72	117728.46					

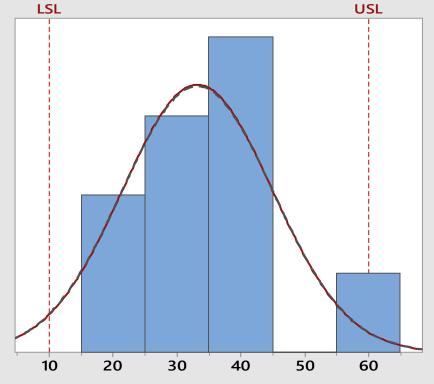


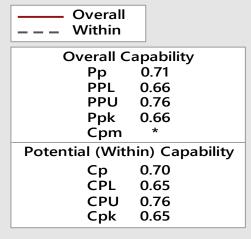












Performance							
Observed Expected Overall Expected Within							
PPM < LSL	0.00	24120.84	24839.36				
PPM > USL	0.00	11252.50	11686.56				
PPM Total	0.00	35373.34	36525.92				

## **Example**

LAB TAT is 60 Minutes

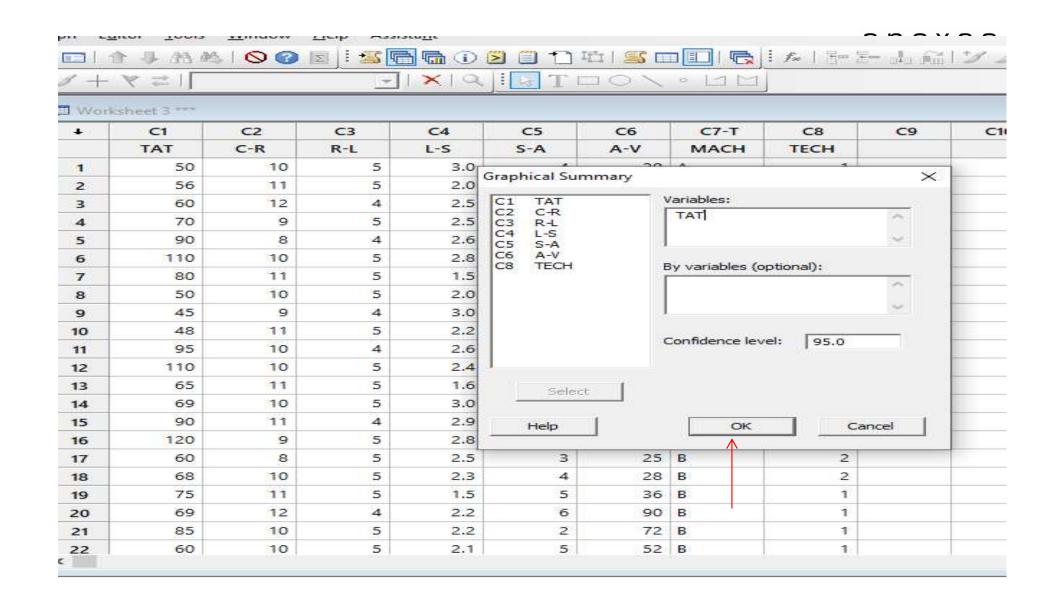
The Patient complains that I am late for more than 100 Min to get the result.

Explain?

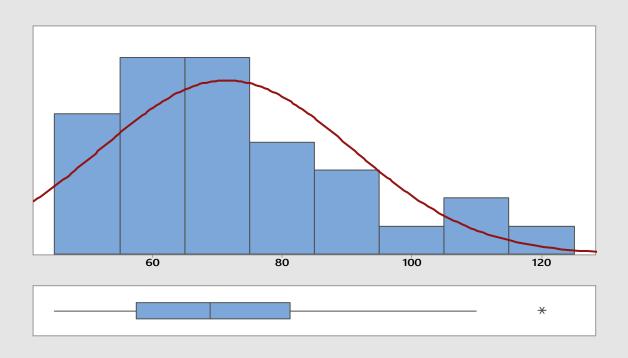
#### **EXAMPLE of TAT**

1-	A = 1		v	1X1Q	IC TO	101	· []						
Work	sheet 3 ***												
	CI s	C2	C3	C4	CS	C6	C7-T	CB	C9-T	C10	C11	C12	CI
	TAT	C-R	R-L	L-C	C-A	A-V	MACH	TECH	M			TAT.	
1	50	10	5	3.0	-4	20	A	1	F	3		51	
2	56	11	5	2.0	5	25	A	2	R	2		45	
3	60	12	-4	2.5	6	23	A	1	A	3		50	
4	70	9	5	2.5	3	20	A	2	A	-4		45	
5	90	8	-4	2.6	7	35	A	1	H	5		49	
6	110	10	5	2.8	2	55	A	1	J	6		46	
7	80	11	5	1.5	5	50	A	2	E	7		45	
8	50	10	5	2.0	4	40	A	2	T	8		50	
9	45	9	4	3.0	7	25	A	3	S	9		38	
10	48	11	5	2.2	5	40	A	1	R	10		50	
11	95	10	-4	2.6		45	A	1	w	11		48	
12	110	10	5	2.4	6	50	A	2	M	12		51	
13	65	11	5	1.6	9	40	ش	1	N	13		45	
14	69	10	5	3.0	-4	32	A	1	A	14		35	
15	90	11	4	2.9	5	21	A	1	P	15		48	
16	120	9	5	2.8	-6	41	8	2	Q	16		49	
17	60	8	5	2.5	3	25	8	2	F	17		51	
18	68	10	5	2.3	4	28		2	F	18		47	
19	75	33	5	1.5	5	36		1	H	19		48	
20	69	12	- 4	2.2	6	90		1	1	20		45	
21	85	10	5	2.2	2	72	8	1	K	21			
22	60	10	5	2.1	5	52	8	1	K	22			

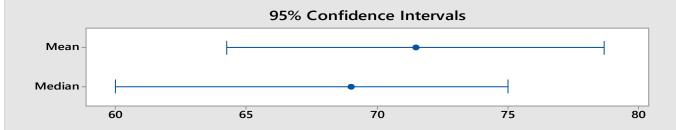
<u>B</u> asi	ic Statistics		30	Display D	escriptive S	tatistics	7	III S I		*   E E	- 10 60	1300
Regression •				Store De	scriptive Sta	tistics						
ANG	OVA	▶.	2	<u>G</u> raphica	I Summary.							
DOE		<b>•</b>	μ <sup>z</sup>	1 Samuel	- 7		=======================================			1		
Con	ntrol Charts		щ		1-Sample <u>Z</u> 1-Sample t		Graphical Summary			C8	C9	C10
Qua	ality Tools	•	μ	2-Sample					with descriptive nean and the	ECH		
Reli	ability/Surv	rival 🕨	μ-μ	Paired t			standard d	eviation, an	d describe the	1		
Mul	<u>M</u> ultivariate ▶					L.	distributio	n with graph	2			
Tim	<u>T</u> ables ▶			1 Propor			ь	23	A	1		
Tab				2 Proportions			В	20	A	2		
Nor	14 on parametrics		<u>λ</u> _	1-Samp <u>l</u> e Poisson Rate 2-Sample Po <u>i</u> sson Rate			7	35	A	1		
100000			λ				2	55	A	1		
Pow	Power and Sample Size ► σ <sup>2</sup>			1 Varianc <u>e</u> 2 V <u>a</u> riances			5	50	A	2		
	8 50 %		1				40	A	2			
	9	45	[-1:1]	Correlation Covariance Normality Test			7	25	A	1		
	10	48	(σ <sup>z</sup> )				5	40	A	1		
	11	95					В.	45	A	1		
	12	110	-				5	50	A	2		
	13	65	-	Outlier Test				40	A	1		
	14	69	TT	Goodnes	s-of- <u>F</u> it Test	for Poiss	on ‡	32	A	1		
	15	90	100	11	4	2.9	5	21	A	1		
	16	120		9	5	2.8	6	41	В	2		
	17 60			8	5	2.5	3	25	В	2		
	18	68 10 5 2		2.3	4	28	В	2				
	19	75		11 5 1.5 12 4 2.2			- 5	36	В	1		
	20	69				2052-0657-01	6	90	В	1		
	21	85		10	5	2.2	2	72	В	1		
	22	60		10	5	2.1	5	52	В	1		

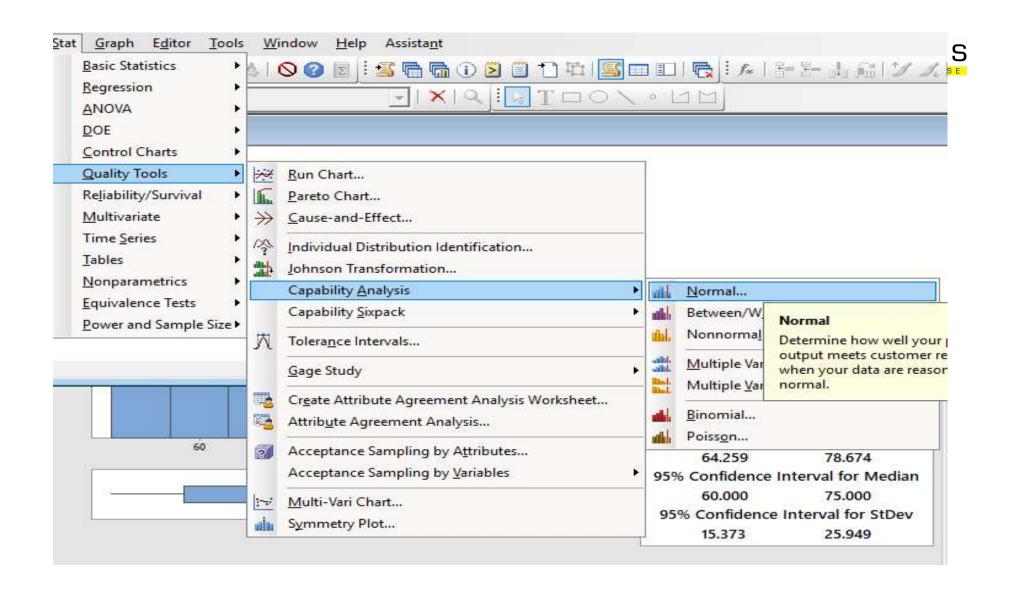


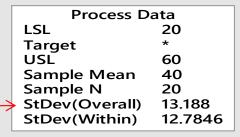
#### **Summary Report for TAT**

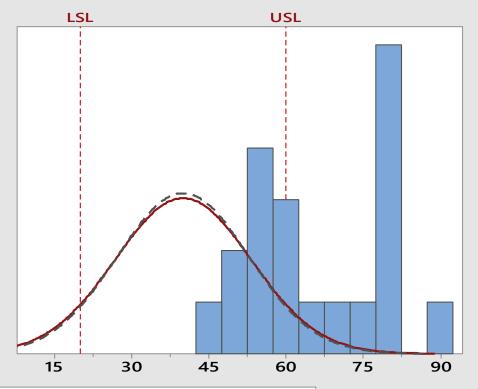


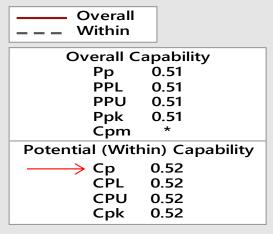
Anderson-Darling Normality Test							
A-Squared	0.73						
P-Value	0.051						
Mean	71.467						
StDev	19.303						
Variance	372.602						
Skewness	0.928965						
Kurtosis	0.390733						
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95% Confidence Int	erval for Median						
60.000	75.000						
95% Confidence In	terval for StDev						
15.373	25.949						





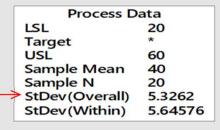


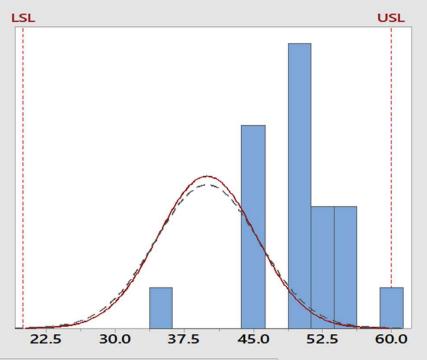


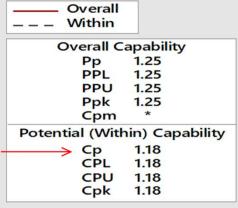


	Performance								
Observed Expected Overall Expected Withi									
	PPM < LSL	0.00	64692.86	58864.23					
	PPM > USL	500000.00	64692.86	58864.23					
	PPM Total	500000.00	129385.72	117728.46					

Sigma Level = 1.5

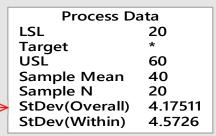


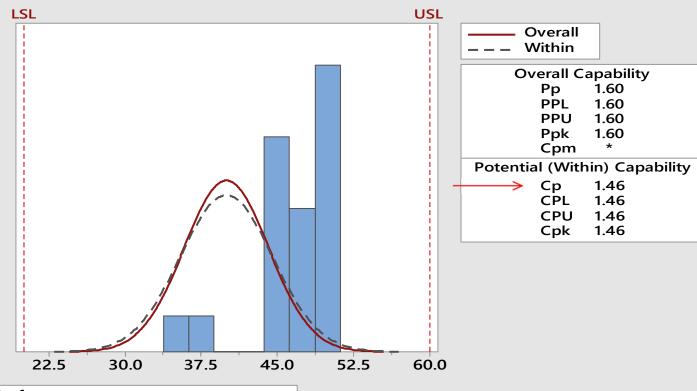




Performance								
Observed Expected Overall Expected Within								
PPM < LSL	0.00	86.66	198.19					
PPM > USL	0.00	86.66	198.19					
PPM Total	0.00	173.33	396.38					

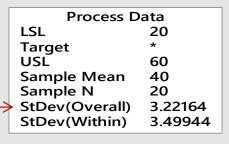
3 SIGMA ( CP = 1.18 )

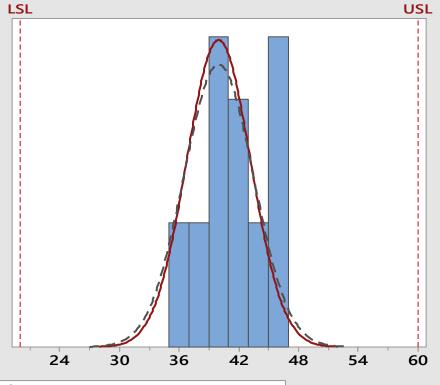




Performance								
	Observed	<b>Expected Overall</b>	<b>Expected Within</b>					
PPM < LSL	0.00	0.83	6.10					
PPM > USL	0.00	0.83	6.10					
PPM Total	0.00	1.67	12.21					

SIGMA LEVEL = 4.6





Performance							
Observed Expected Overall Expected Withir							
PPM < LSL	0.00	0.00	0.01				
PPM > USL	0.00	0.00	0.01				
PPM Total	0.00	0.00	0.01				

5.6 SIGMA

Overall

**Overall Capability** 

Potential (Within) Capability

2.07

2.07

2.07

2.07

1.91

1.91

1.91

1.91

Within

Рр

PPL

PPU

Ppk

Cpm

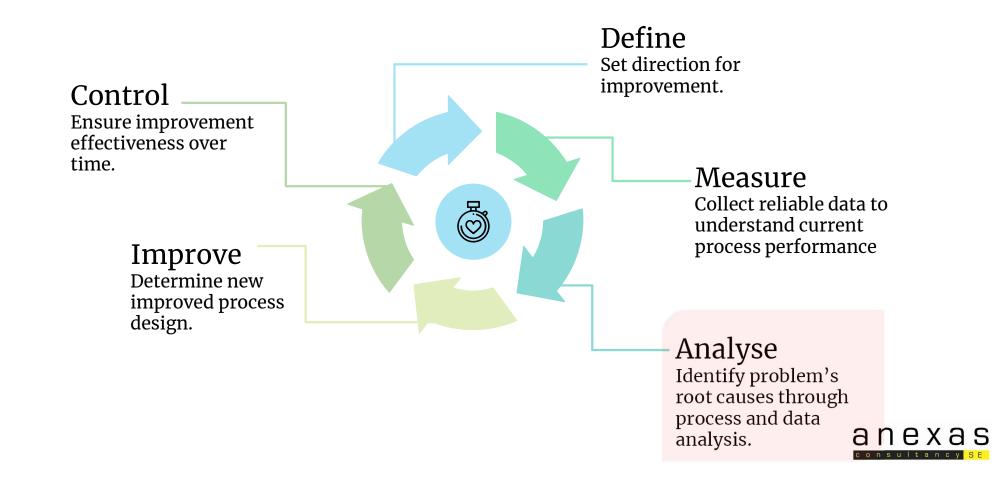
Ср

CPL

CPU

Cpk

## DMAIC: An Improvement Methodology



## Analyse

#### Objective:

 Identify problem's root causes through process and data analysis

#### Steps:

- Pareto chart
- Value analysis in using process map
- Root causes validation



#### **Root Cause Analysis**



Above the surface you see the Symptoms of the problem

> Dig deeper to find the Root Cause of the problem



#### الأعراض-الأسباب الجذرية





السبب الجذري مشاكل في الإبصار



لا تأخذ مسكنات الألم؛ بل افحص نظرك



عالج الأسباب الجذرية، وليس الأعراض فقط

### Analyze Phase (Summary)

#### Analyze

#### **Process Door**

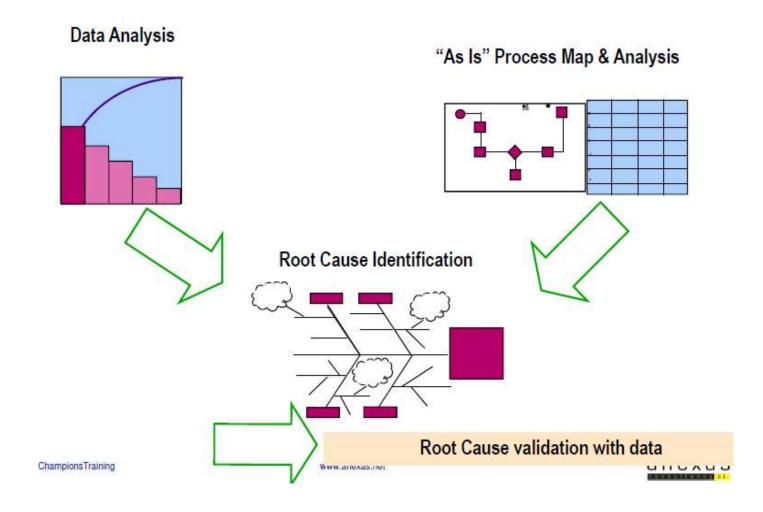
- As-is process map
- Gemba walk
- Value Added and Non Value Added Analysis

#### Data Door

- Cause and Effect Diagram
- Control Impact Matrix
- Pareto Chart
- Box Plots and Scatter Plots



## Analyze roadmap





## ANALYZE: Analyze to Identify Causes

- Goal:
  - Identify root causes and confirm them with data
- Output:
  - A theory that has been tested and confirmed





## **Analysis Doors**

anexas

**Qualitative Analysis** 

**Process Map Analysis** 

**DATA Analysis** 

**Brainstorming** 

VA / NVA

Histogram

**Affinity Diagram**  **Analysis** 

**Pareto Diagram** 

**Box Blot** 

**Fishbone Diagram** 

**FMEA** 

Scatter Diagram

## **Process Door**

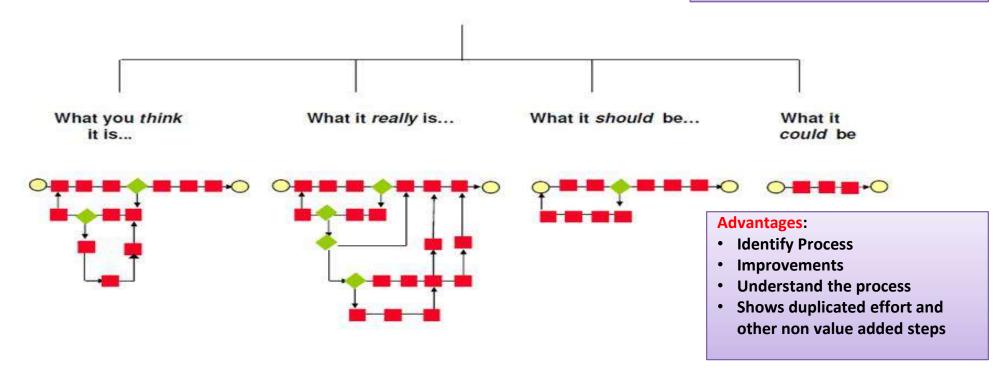


#### Process Door: Value Stream Mapping

#### Versions of a process

#### **Flow Chart**

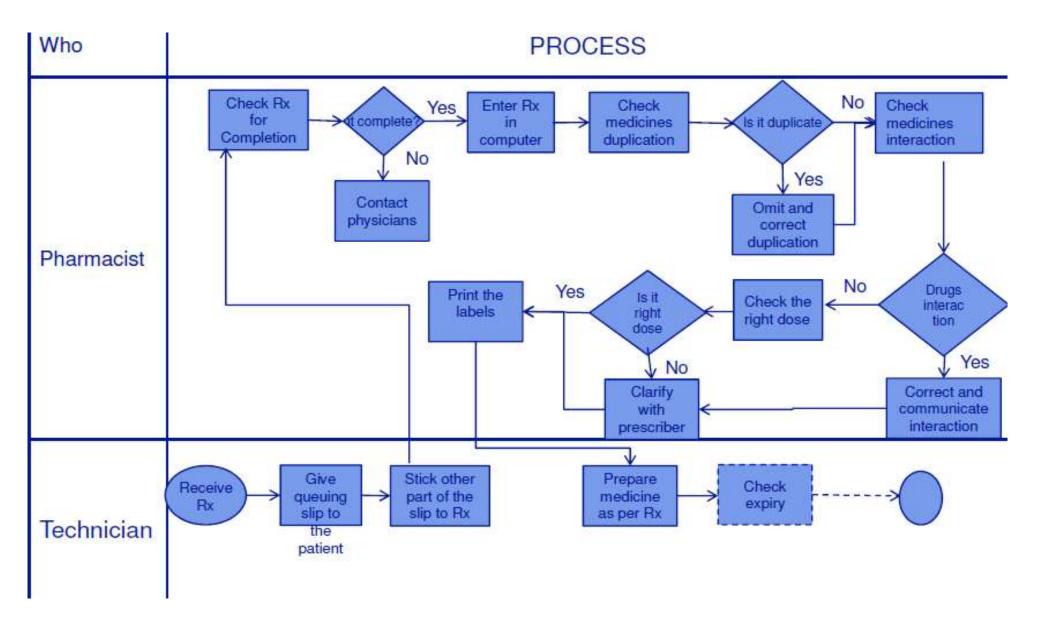
It is a visual illustration of the sequence of operations required to complete a task
It is used to help employees and organization the finite details and obtain a through description of the process





# **METHODOLOGY AND TOOLS**

Concepts	Meaning
7(8) waste	Intellect - scrap(rework) waiting Inventory Motion and Movement Transportation Over production Over processing
ESCA	Eliminate Simplify Combine Automate parallel
5s	SORTING SET IN ORDER SHINE STANDARDIZE SUSTAIN



# **Data Door**

# exas

# 1. Brain storming:

- > Use:
  - To Generate Ideas from all members
- > Steps:
  - Define the topic
  - Ask members to generate ideas
  - Record the answers
  - Combine similar or redundant ideas
  - Document your session

### > Types:

- - Round Robin
- Anti Solution
- -6-3-5
- 6 Hats









# Brainstorming Potential Causes

- Purpose: Brainstorming is a method of generating lots of ideas quickly by:
  - Encouraging creativity
  - Involving everyone
  - Generating excitement and energy
  - Separating people from ideas they suggest

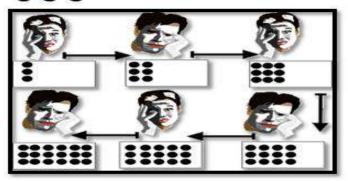


#### Types of Brainstorming

#### **Round Robin**



6-3-5



#### **Anti Solution**

#### **List of Anti-Solutions**



- · Put products on the wrong aisles
- Don't have employees to assist shoppers
- Don't train employees where products belong
- · Move products on an hourly basis
- Train the employees to tell the shopper that "if they don't see it, we don't have it".
- · Don't mark the aisles well















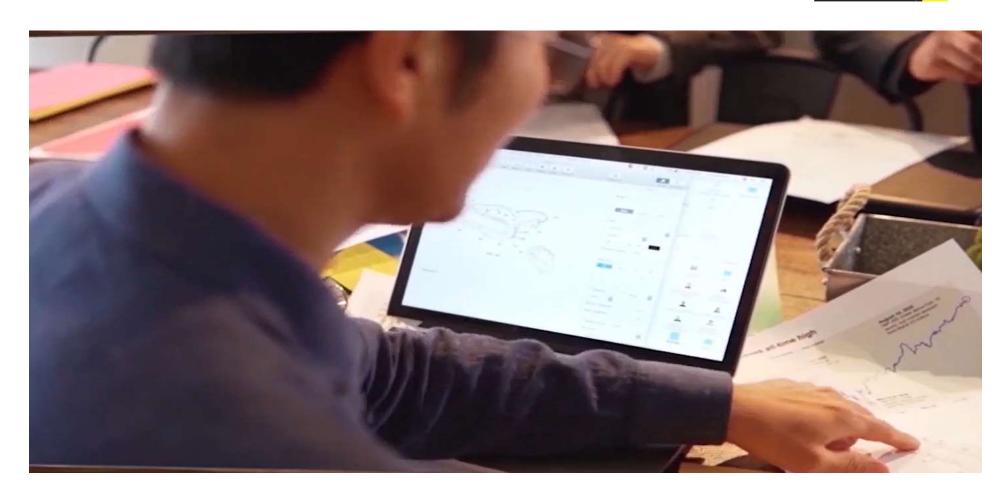
#### **Pre-requisites of Brainstorming**

- Purpose of Brainstorming
- Participants (From the process / not from the process)
- Facilitator
- Stationery
- Selection of tool of brainstorming
- · Meeting room
- Facilities
- Communication to participants about time, venue, topic in advance

#### **Rules of Brainstorming**

- Equal opportunity to everyone to participate
- Capture all the ideas (Document)
- Leave your designation and ego along with your shoes outside meeting room
- Non threatening environment to be created
- Ensure that there are no disturbances
- Focus on the topic (Create parting lot)
- Fantasize freely (Do not put breaks on your thoughts)
- Watch your time!
- Defer evaluation (Do not discuss ideas)
- Generate Quantity, do not worry about Quality

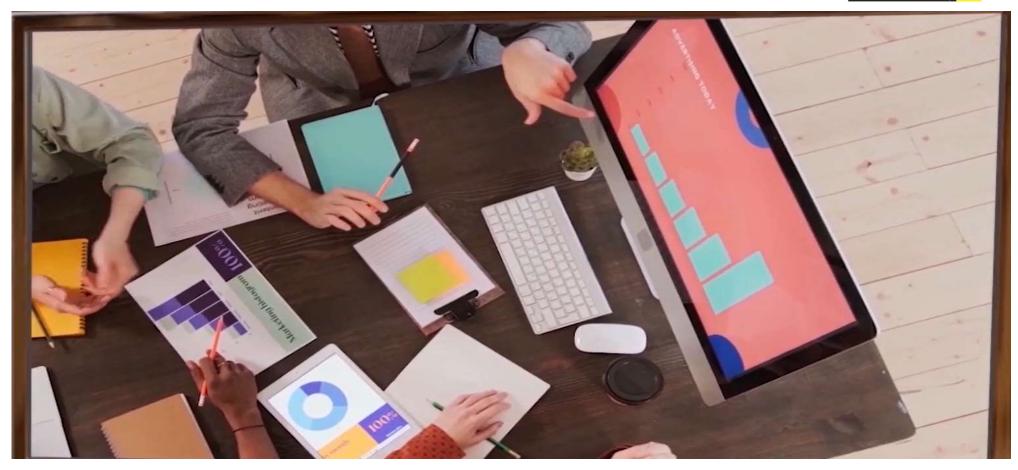


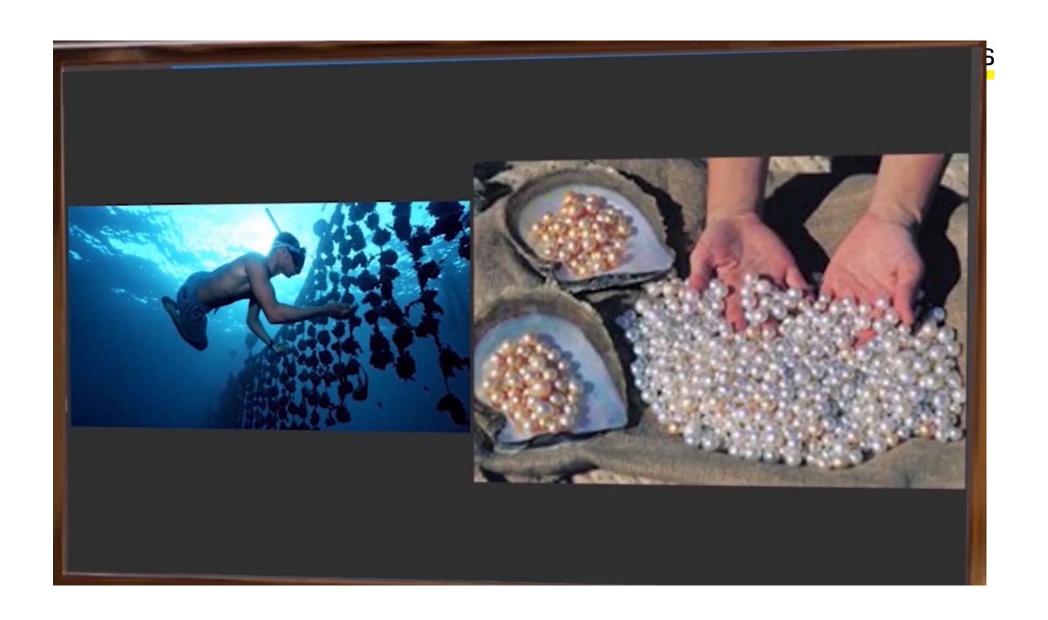










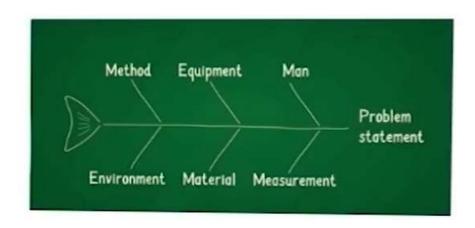




# Looking for Relationships

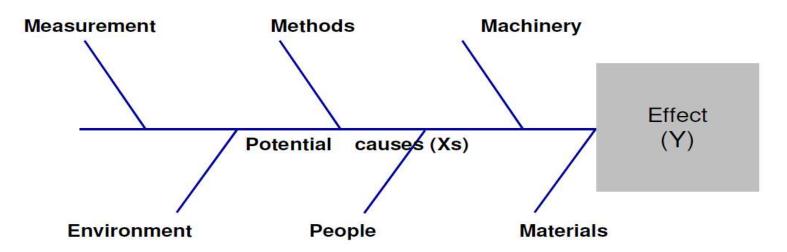
 Graphic displays can help you structure possible causes to find relationships that will shed new light on your problem

#### Cause-and-Effect Diagram



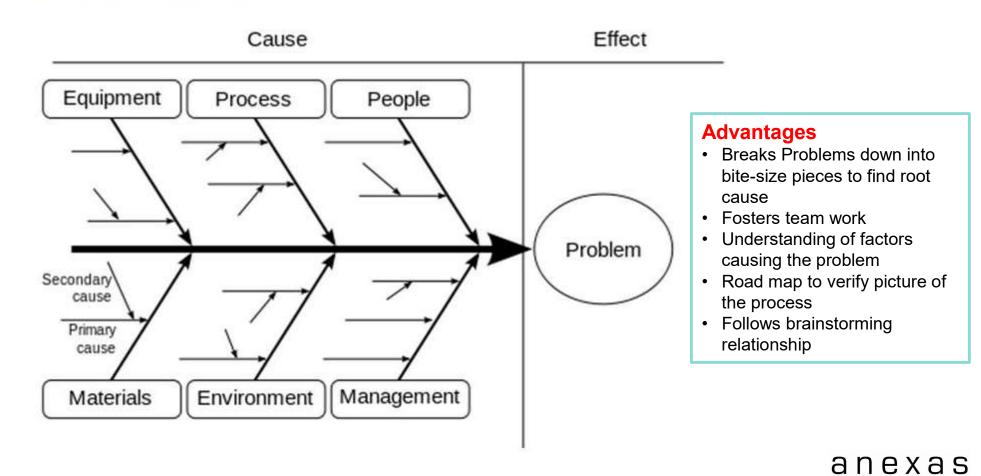


# Cause & effect diagram



- Summarise potential causes
- Allows identification of root causes
- Potential root causes need to be validated by data

### 2. Fish bone:

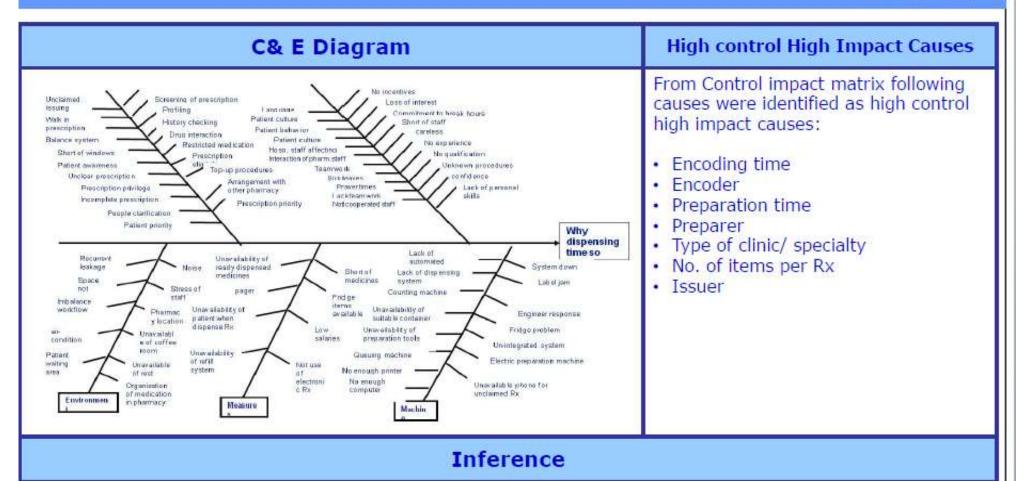


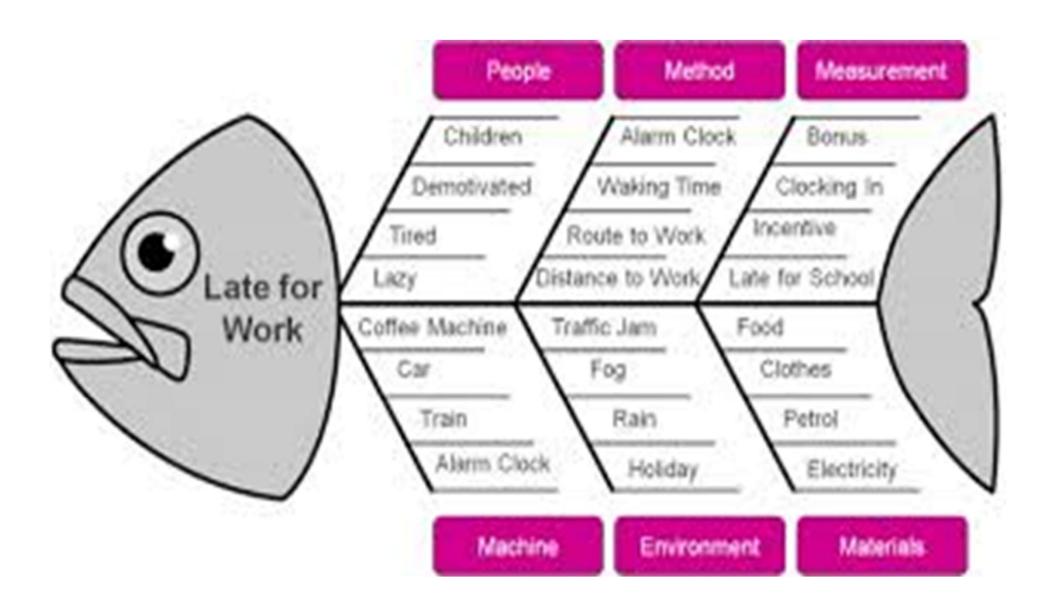
### **Pharmacy Project**

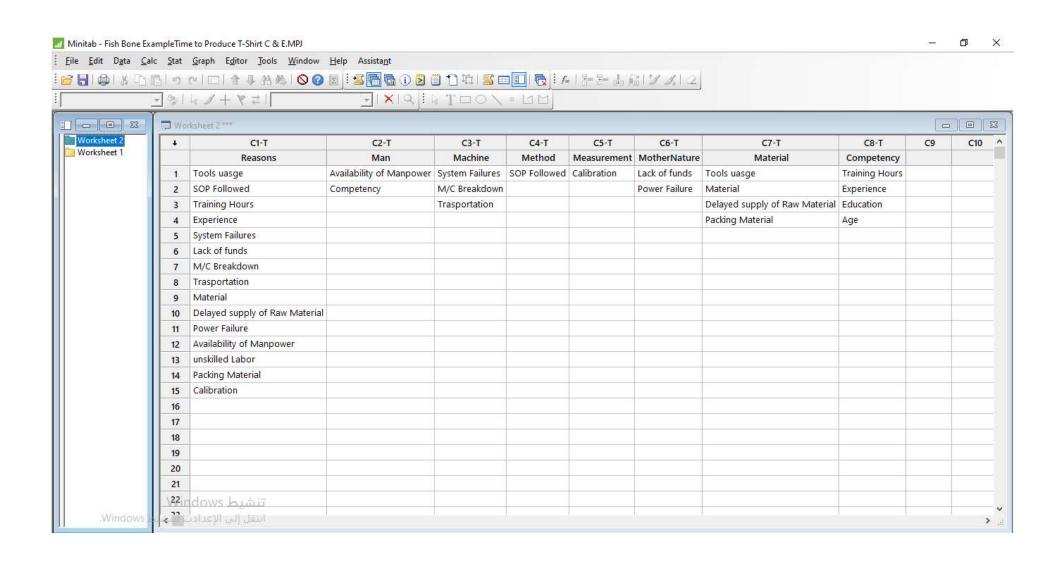
#### anexas

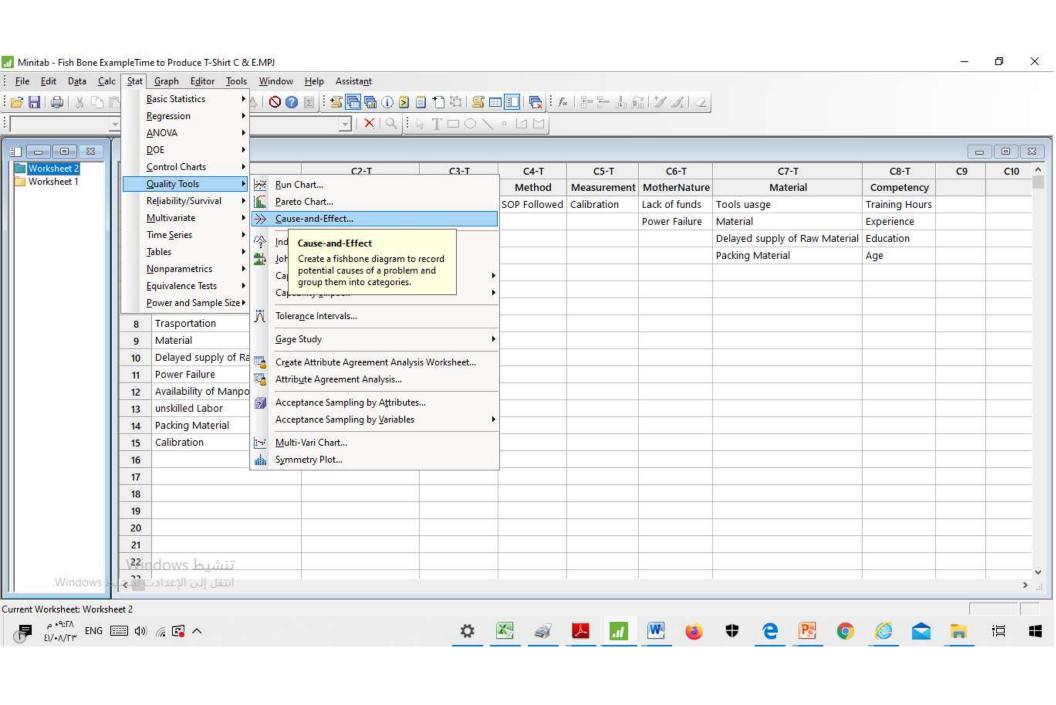
### **Identification of Potential Causes**

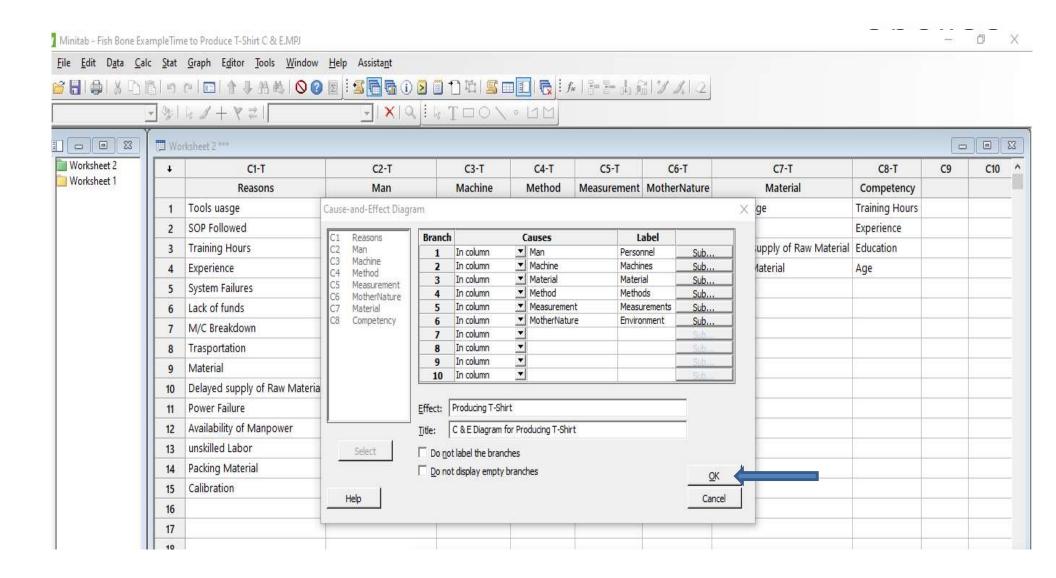


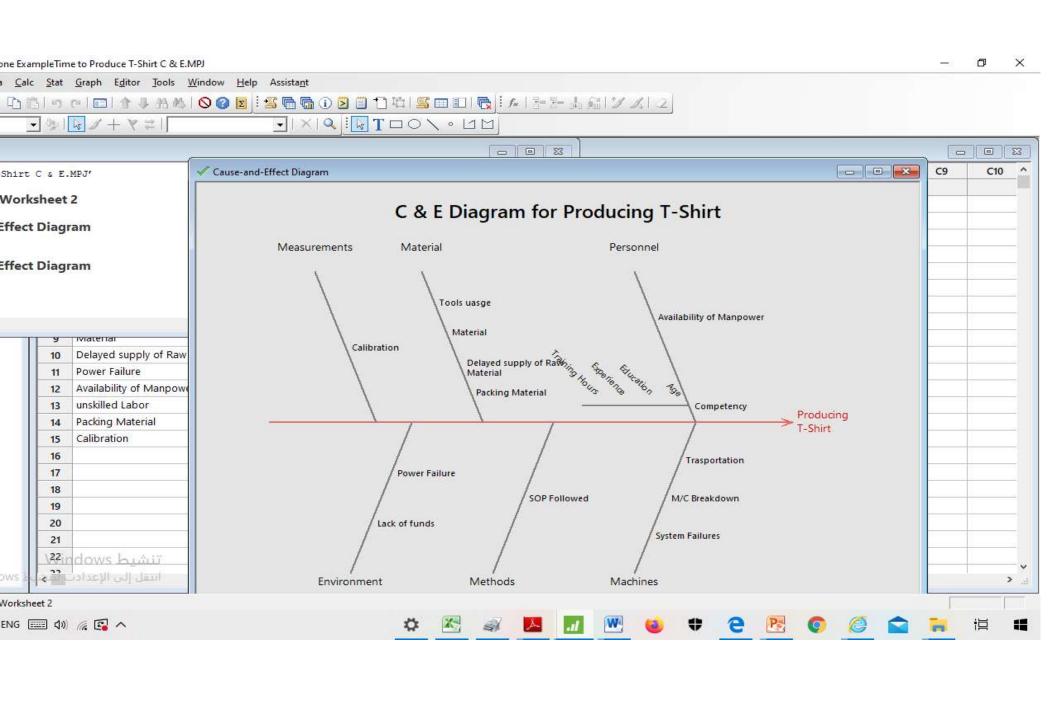




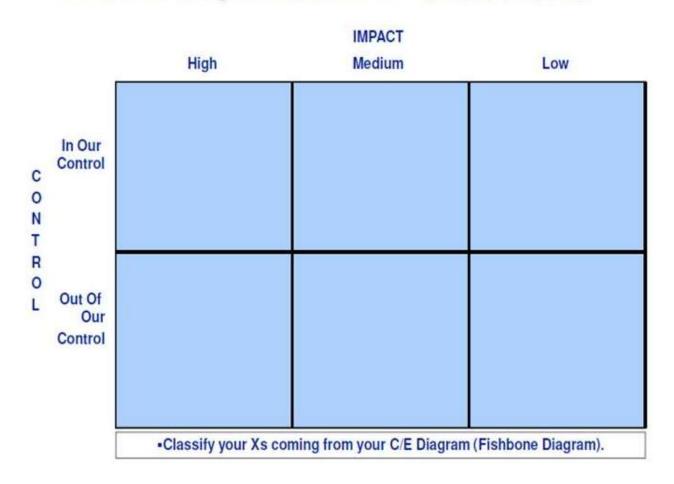








# 3. Prioritization of Xs Control / Impact Matrix Y=f (X1, X2, ..., Xn)



#### **Benefits**

- Facilitate root cause analysis
- Sensitizing people to opportunities
- Provide a visual of the problem being studied

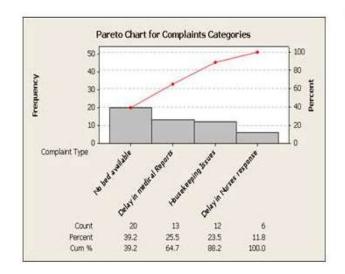


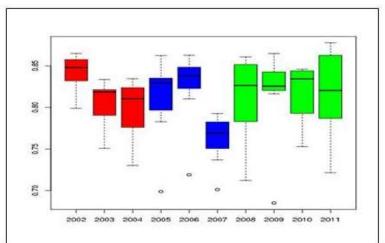
	Continuous	Attribute
Continuous	Scatter plot	Box plot
Attribute	Box Plot	Pareto Chart

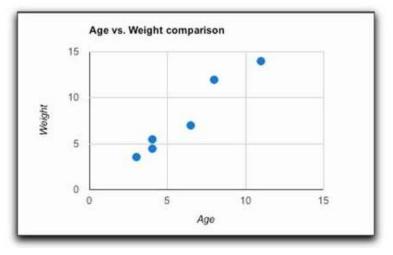


# Root cause validation

- 1. Box Plot Cont , Att
- 2. Scatter Plot Cont Cont
- 3. Pareto chart Att, Att









# **Box plot**

# Inter Quartile Range

$$IQR = Q_3 - Q_1$$

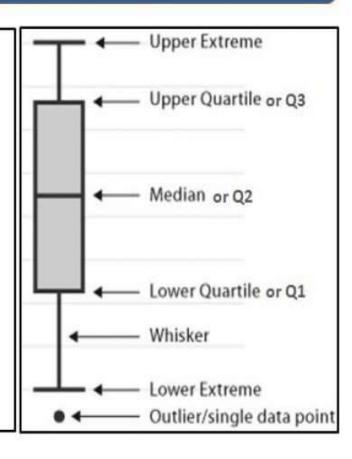
Lower Quartile (Q1)

$$Q_3 + 1.5(IQR)$$

Upper Quartile (Q3)

$$Q_1 - 1.5(IQR)$$

Note: Box plot is used to find the outliers

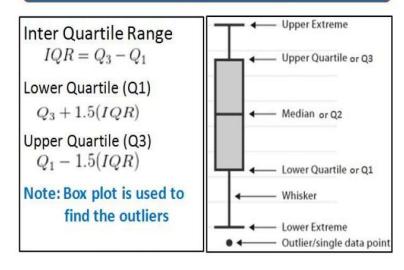


Anderson-Darling Normality Test		
A-Squared	0.55	
P-Value	0.116	
Mean	33.500	
StDev	7.778	
Variance	60.500	
Skewness	0.66142	
Kurtosis	2.19713	
N	10	
Minimum	20.000	
1st Quartile	30.000	
Median	32.000	
3rd Quartile	37.750	
Maximum	50.000	
95% Confidence Interval for Mean		
27.936	39.064	
95% Confidence Interval for Median		
30.000	38.027	
95% Confidence Interval for StDev		
5.350	14.200	

#### **Box Plots**

### **Box plot**



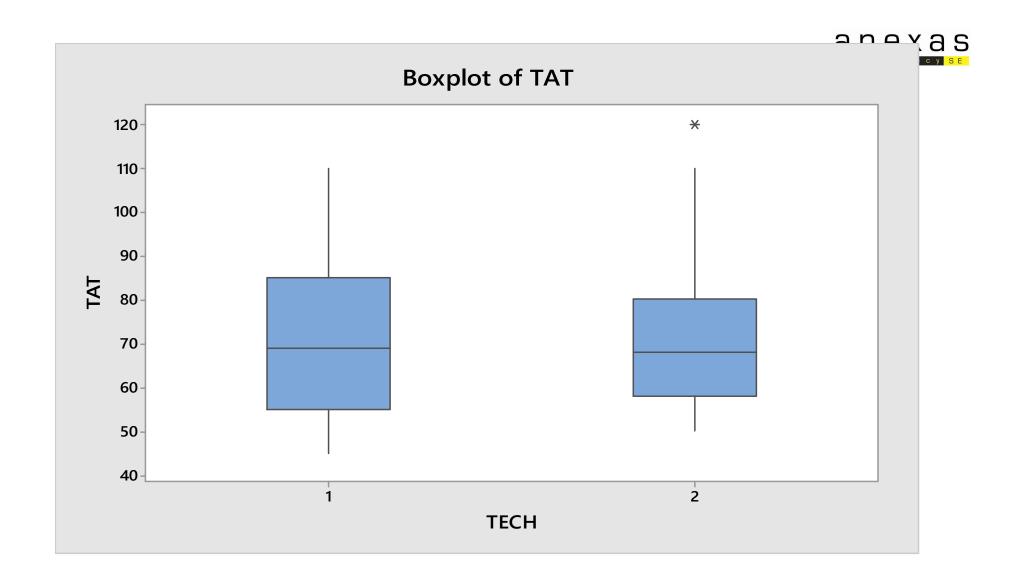


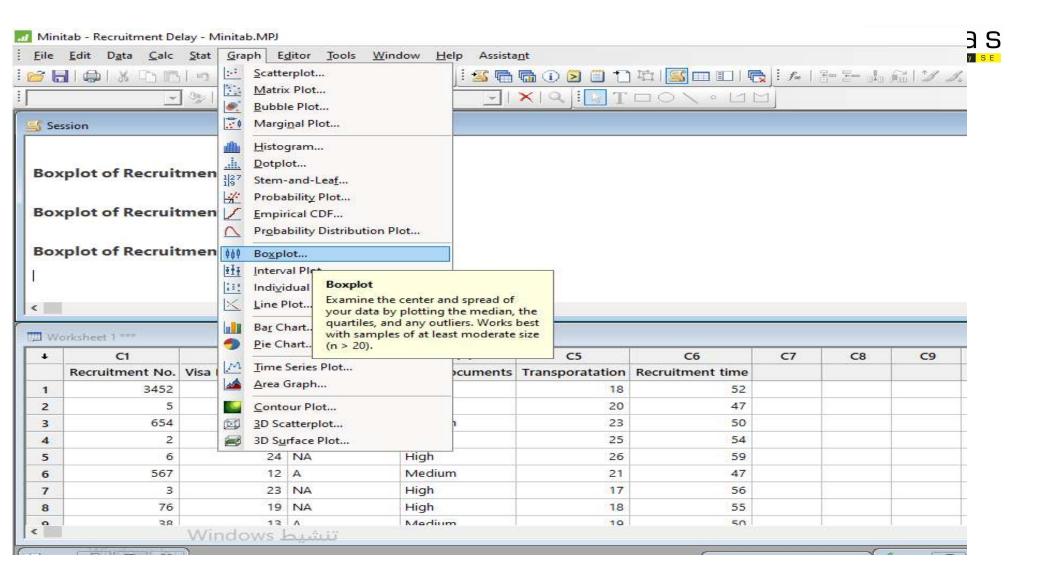
Rectangles are drawn for showing the second and third quartiles .

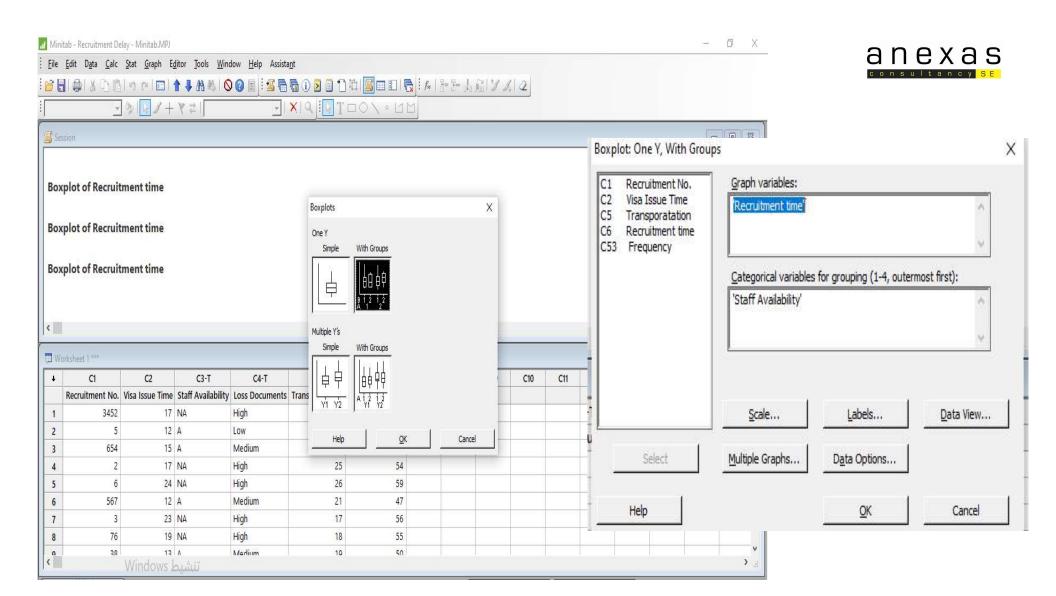
There is vertical line which shows the Median value

Box Blot are graphical tools that lets you easily visually compare variation between the data sets evaluated.

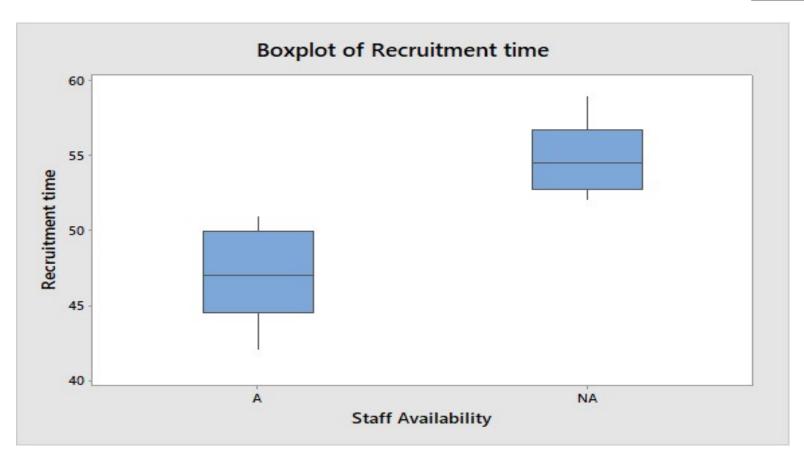
Also makes comparisons quickly and easily

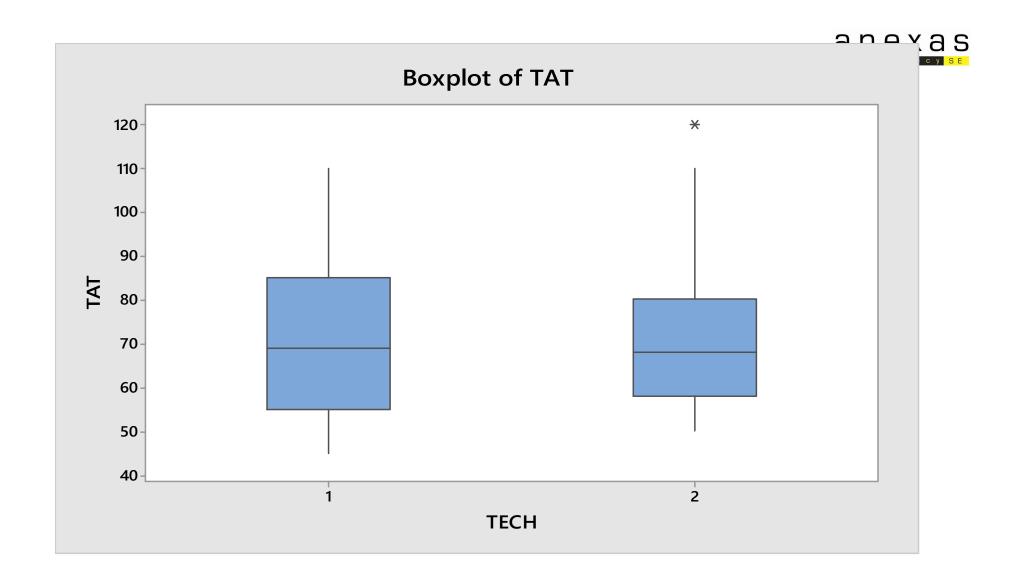


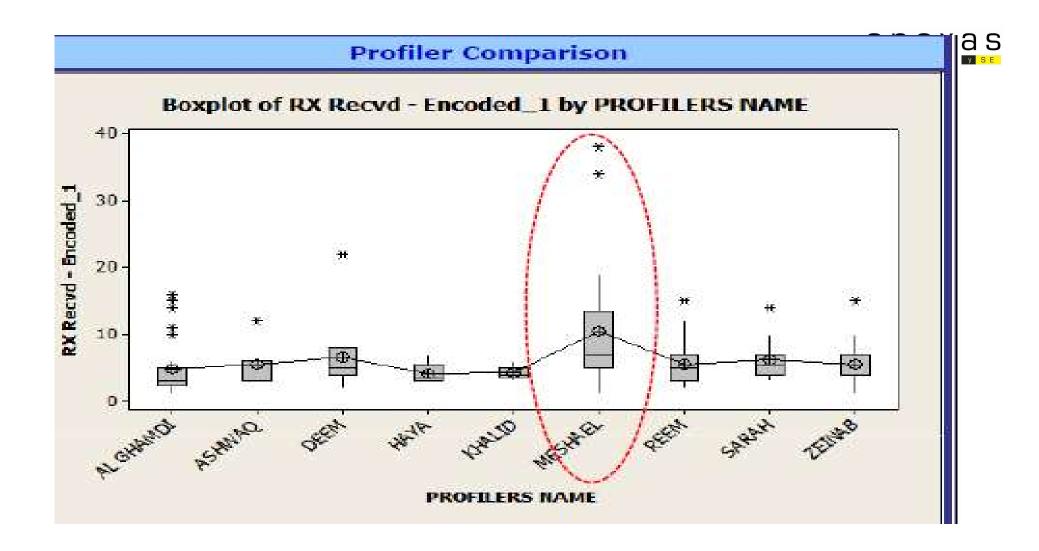












nexas

### **SCATTER PLOT**

### **Purpose:**

To identify the correlations that might exist between a quality characteristic and a factor that might be driving it

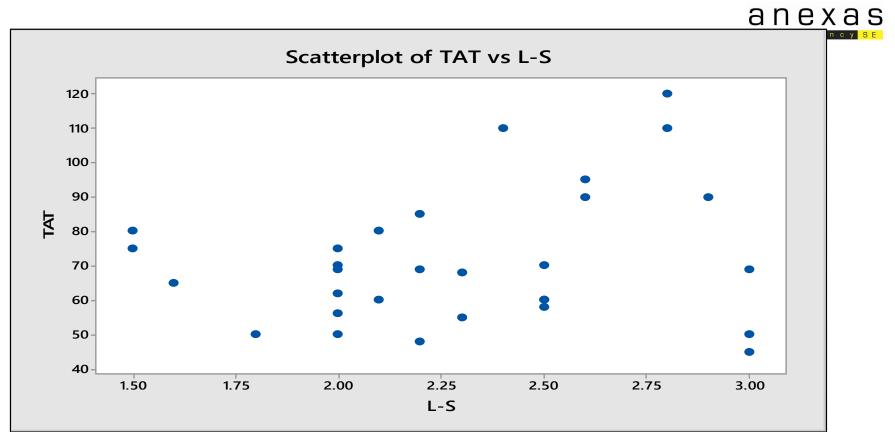
Dots representing data points are scattered on the diagram.

The extent to which the dots cluster together in a line across the diagram shows the strength with which the tow factors are related.

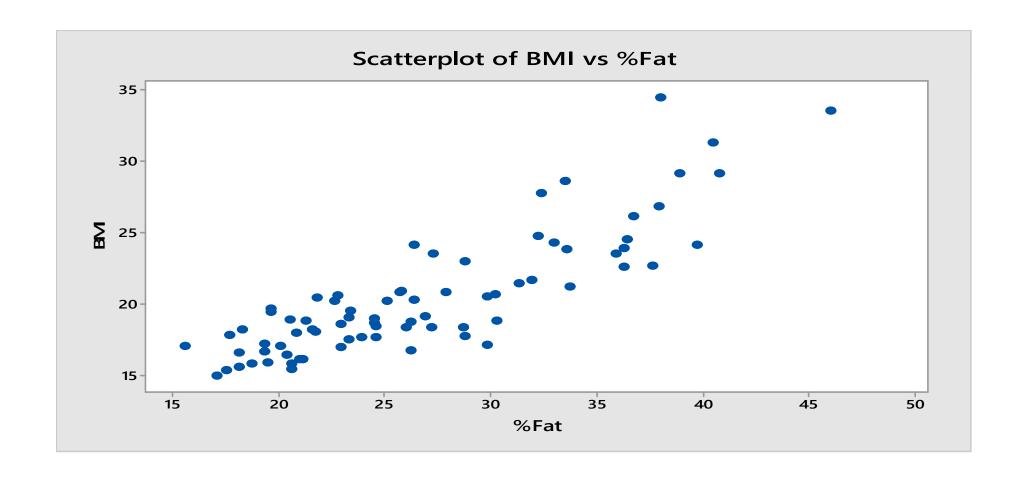
### **Advantages:**

Helps identify and test probable causes •

By knowing which elements of your process are related and how they are related. You will know what to control or what to vary to affect a quality characteristic



**SCATTERED** (No Relation)



**Positive Correlation (There is Relation)** 

es.MPJ

W 25

20

35

%Fat

40

45

*															
C3	C4	C5	C6	C7	C8	C9	C10	C11	C12	C13	C14	C15	C16	C17	C18
Activity															
266	450														
192	320														

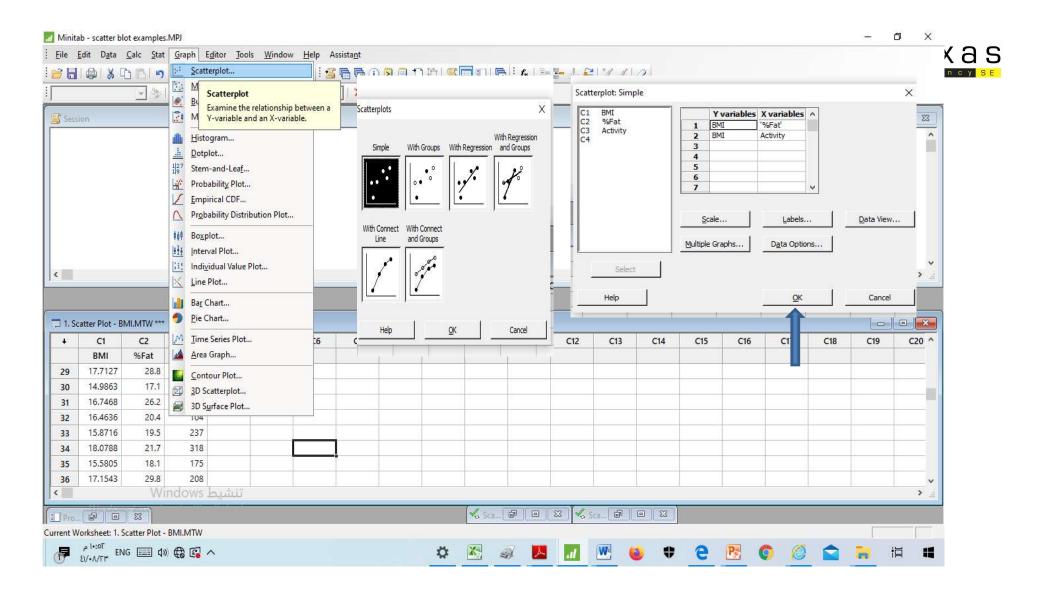
150

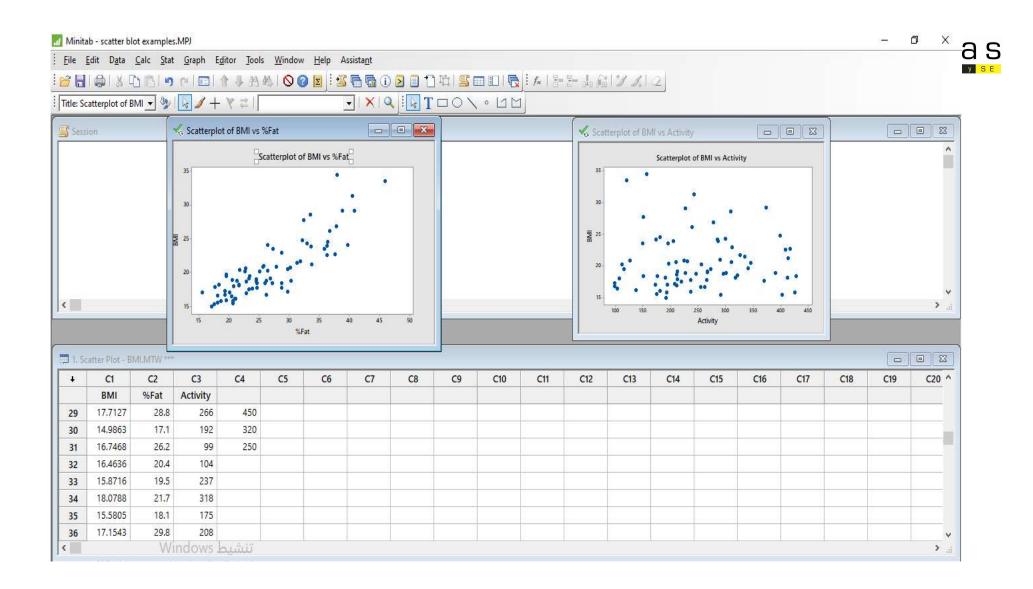
300

Activity

350

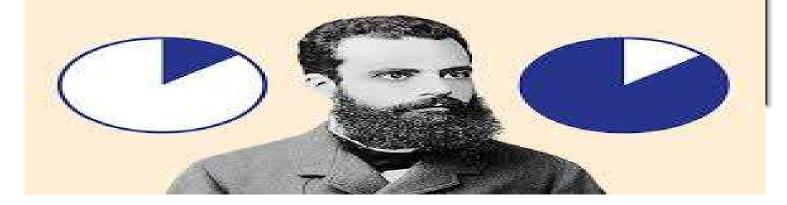
450





### Analyse

Analyse data: Pareto chart



### نستخدم قاعة 20/80

يطلق على قاعدة (20 80) قانون القلة القوية والكثرة الضعيفة.



عليك أن تبحث بذكاء عن الوسائل الـ 20% لتعطيها 80 % من جهودك. ولا يعنى هذا أبدا إهمال باقي الـ 80 % بشكل



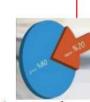


فهي ترى أن ٢٠ % من الجهد الفعال أهم بكثير من ٨٠% من الجهد العادي



تقول أن 80 % من أهدافنا يمكن تحقيقها بالتركيز على 20 % من الأسباب





مستوى للتقدم

الأهداف المنجزة ثم تحقيقه بأي الوسائل فإن هذا التغيير سيوصل إلى أفضل

بينما تحقق ال ٨٠ % الأخرى من

الأسباب ٢٠ % فقط من النتائج."

لا يجب أن تتخذ قاعدة (80/20) لبذل

20% من الجهد وتوقع الحصول على

٨٠ % من النتائج، فهذا سوء فهم

ينبغي على المدير تغيير وسائله دائماً وتحديد أهدافه المنجزة وتحديد أي

فما تقوله قاعدة ٢٠التوازن بين الأسباب

والنتائج أوبين المدخلات والمخرجات

فقاعدة 80/20 الحقيقية لا تدعو إلى

استبعاد ٨٠ % من الجهد بل لتركيز

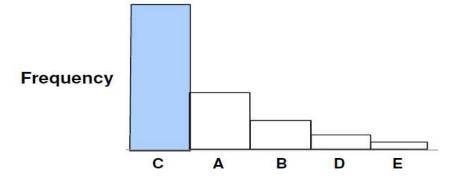
جهودك ومواردك على أهم ٢٠ % منها

وهذا يعني عندكما تحشد 100 وسيلة لتحقيق 100 هدف، فإن 20 وسيلة منها ستحقق تقريباً 80 هدفا، بينما لن تحقق ال 80 وسيلة الأخرى سوى 20 هدفا

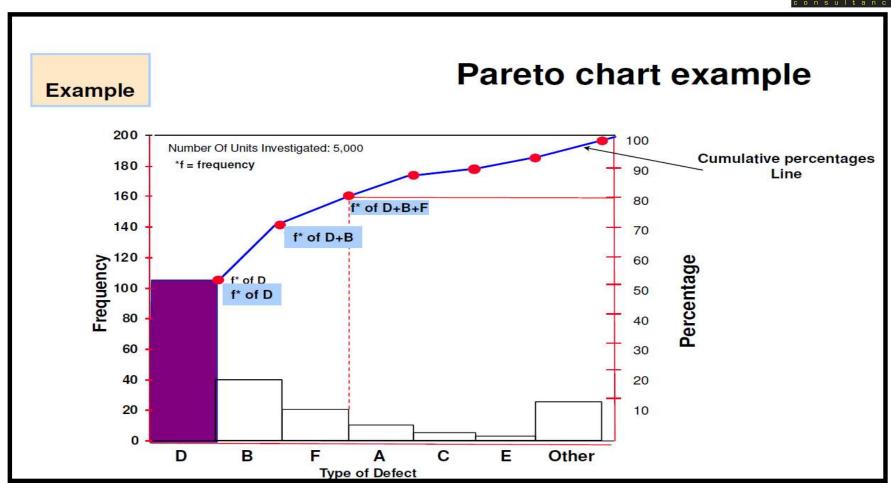
### Pareto chart

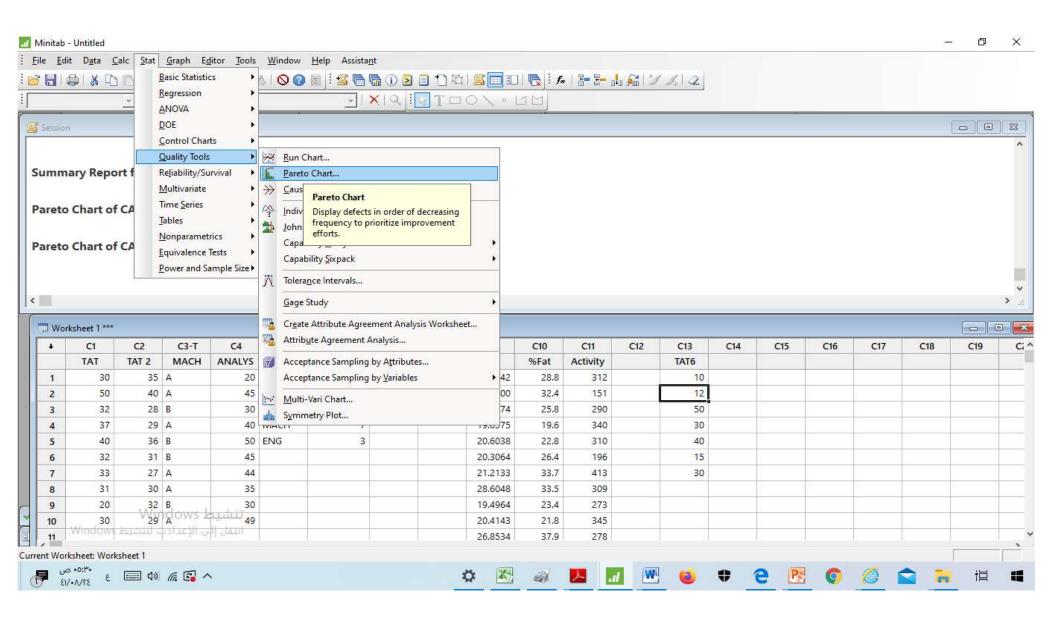
Definition

A tool to graphically represent the discrete data in categories and identify the few causes basic to most of the defects (the 80 / 20 principle)

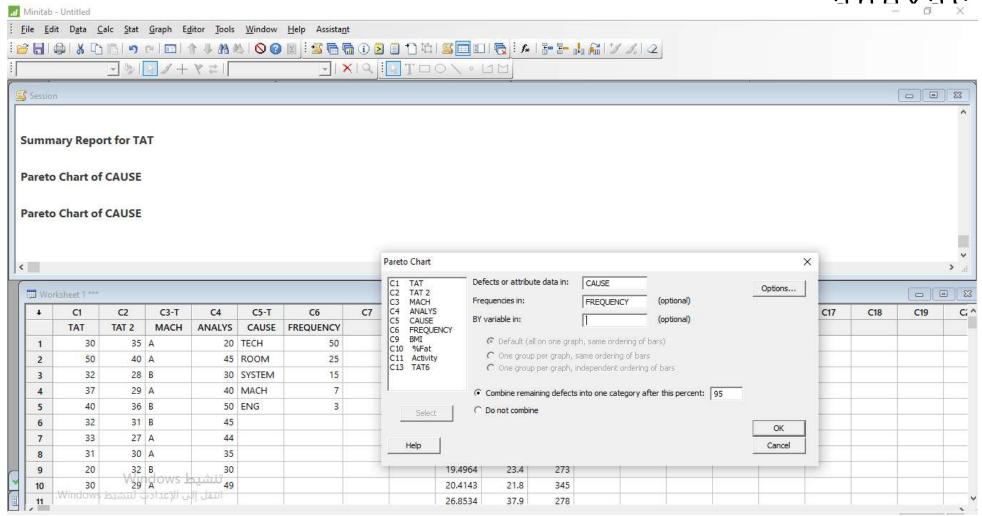


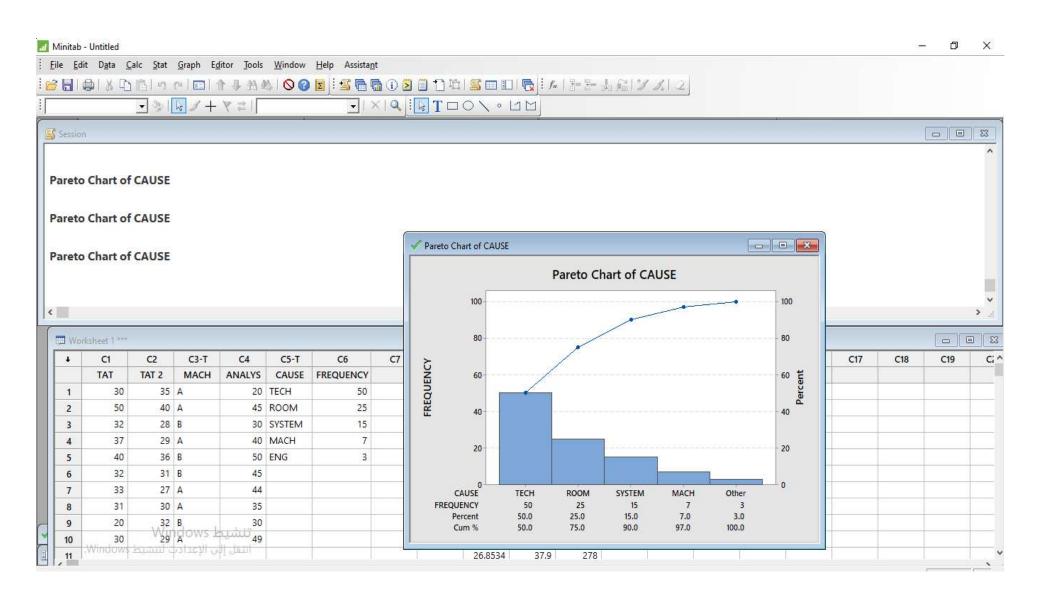


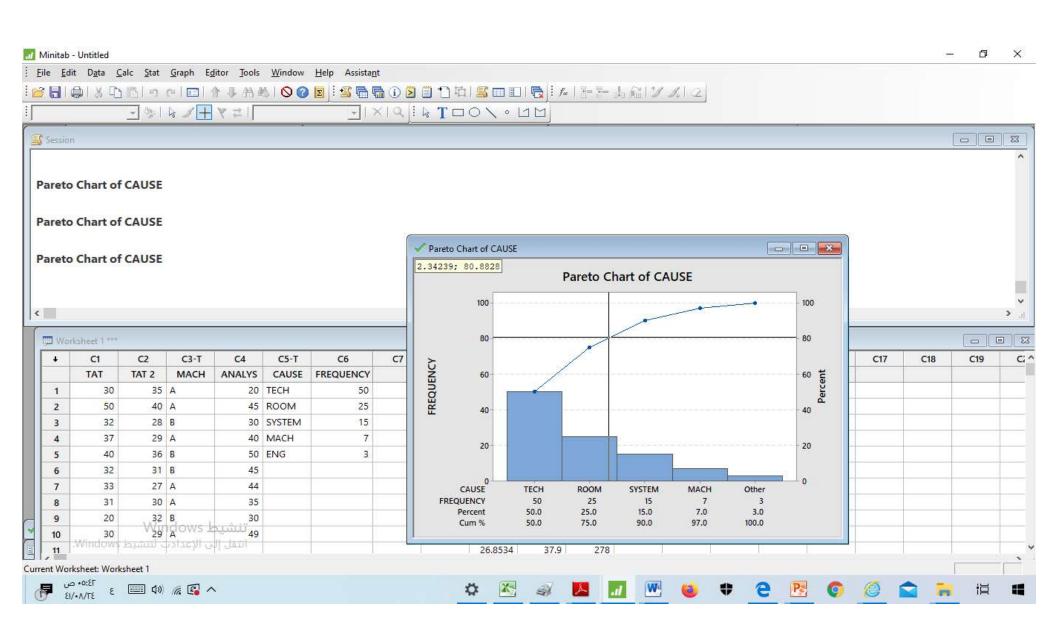












## **FMEA**

A		0	0	E	F	0	34		j	X	L	M	76	0	9
	in what ways does the Key input go wrong?	lithat is the impact on the Key Output Variables (Customer Requirements) or internal requirements?	How Severe is the effect to the cusotmer?	lithat causes the Key input to go wrong?	How often does cause China eccury	What are the existing controls and procedures (inspection and test) that present eith the cause or the Failure Mode? Should include an SOP number.	defect cause or FM 9		occurrance of the	Responsible for the recommend ed action?	What are the				
			۰		0		o	0							0
			۰		0		٥	0				П		П	0
			0		0		0	0							0
			۰		0		٥	0				П			9
			۰		0		0	0							9
			۰		0		0	0				П		П	9
			0		0		0	0							0
w mer	Worksheet / 52/		_			841	_	$\Box$				$\Box$			

## **FMEA**

Cause	Severity	Occurrence	Detection	RPN
Α	9	3	4	63
В	8	6	5	<b>*</b> 240
С	6	9	7	378
D	10	1	5	50

RPN = Sev x Occ x Det

The 6 M of Cause and Effect Diagrams include all of the following except ?	Ме	thods	Mac	chinery	Mone	<b>9</b> y	Me & u	Manen ( S
Vhat is the relationship of Brainstorming to Cause nd Effect Diagrams ?	us	oth the tools a ed only in ontrol phase	re	They are completely different took used in ISO	ls	Cause and can be per using brainstorm	forme	I nov ard
The number one rule of brainstorming that is most frequently violated is ?		wrong techniq used	ue	discussion of evaluation of ideas	=	no participa	ation	scribe writes too slowly
The method that attempts to reduce the overall risk on system is called ?	а	PDCA		FMEA		Cause-and- diagrams	effect	Pareto analysis
In a Pareto Chart, the cumulative frequency percentage line is ?	9	ascending		descending		vertical		horizontal
The first step to construct a Cause and Effect Diagram i	is?	identify a problem to be solved	e	establish category ca	uses	perform brainstorm	ing	determine how many bones; the diagram will have
If severity =5, Occurrence = 4, Detectability = 2, what is RPN	20	)	8		10		40	

## Process Improvement Project

## **Project Name:**

## Reduction in Lab Turn Around Time





## Project Charter

### **Problem Statement**

In KFSH, pathology department, as per data collected, the lab test on average take around 111 min (1 hour 50 min) vs. the expectation of 1 hour, this leads to delay in completing results, effect patient care and delay in decision making

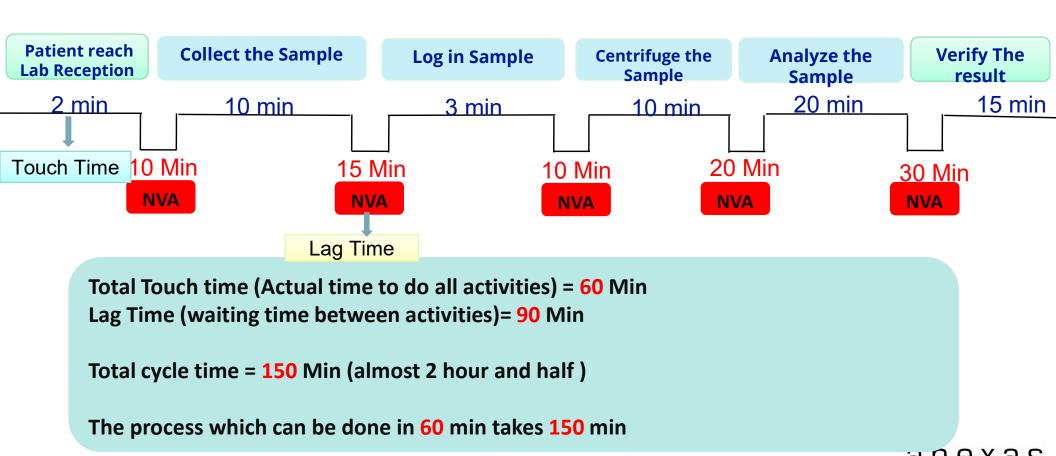
Project Scope	Goal Statement
Stat Chemistry specimen	To reduce the average turn around time of lab test from 1 hour 50 min to less than 1 hour



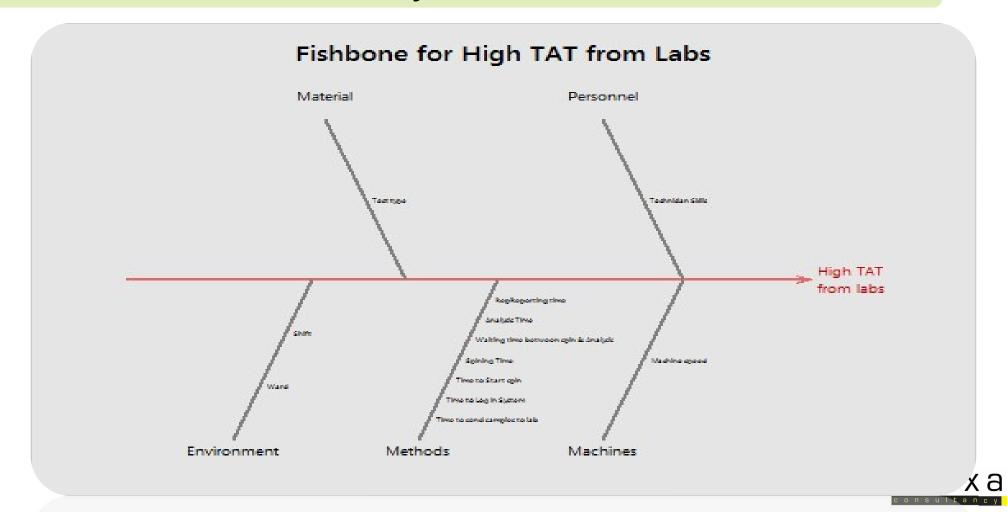
## Data Collection for Potential Causes

Patient N *	Dat(▼	TAT ▼	Time to send blo	Time to Log in Syste 🔻	Time to Start sp	Spining Tin 💌	Waiting time between spin & Analys	Analysis Tin ▼	RepReporting tin •	Technici 💌	Machi <b>▼</b>	Test ty ▼	Special <b>*</b>	Wai▼	Shift <b>▼</b>
2	13-May	138	15	56	14	10	10	30	3	K	1	R,H,B	General	Α	Before 10
3	13-May	62	5	6	9	10	10	20	2	K	1	R,H,B	General	CLINIC	After 10
4	13-May	80	2	3	5	10	10	45	5	K	1	R,H	General	CLINIC	After 10
5	13-May	61	1	4	8	10	7	30	1	K	1	R,H	General	CLINIC	After 10
6	13-May	240	125	11	4	<u>1</u> 0	25	63	2	K	1	R,H,B	General	В	Before 10
7	13-May	49	1	1	3	10	5	25	4	J	1	R,H,B	General	CLINIC	After 10
8	13-May	160	1	1	8	10	10	70	60	J	1	R,H	General	CLINIC	Before 10
9	13-May	155	18	2	35	10	10	75	5	J	1	R,H	General	В	Before 10
10	13-May	262	85	40	45	5	30	55	2	K	1	R,H	General	В	Before 10
11	13-May	97	1	4	10	10	5	65	2	K	1	R,H,B	General	CLINIC	Before 10
12	13-May	66	10	18	2	10	5	20	1	J	1	R,H,B	General	CLINIC	Before 10
13	13-May	172	70	20	30	10	5	36	1	J	1	R,H,B	General	A	Before 10
14	13-May	185	70	21	14	10	10	58	2	J	1	R,H,B	General	Α	Before 10
15	13-May	162	69	22	14	10	10	36	1	K	1	R,H,B	General	Α	Before 10
16	13-May	72	5	4	6	10	5	40	2	K	1	R,H	General	CLINIC	Before 10
17	13-May	198	68	27	26	9	5	62	1	K	1	R,H	General	D	Before 10
18	13-May	96	20	36	14	10	2	13	1	K	1	R,H	General	CLINIC	After 10
20	13-May	176	65	30	12	10	8	48	3	J	1	R,H	General	A	Before 10
21	13-May	54	5	3	7	10	5	22	2	J	1	R,H,B	General	В	Before 10
22	13-May	110	0	6	4	10	15	45	30	J	2	R,H	General	CLINIC	After 10
23	13-May	44	2	10		10	7	22	3	J	2	R,H	General	CLINIC	After 10
24	13-May	70	5	7		15	5	40	5	J	2	R,H,B	General	CLINIC	After 10
25	13-May	161	20	30	10	10	10	78	3	K	2	R,H,B	General	В	Before 10
26	13-May	112	20	20	20	10	11	29	2	K	2	R,H	General	Α	Before 10
27	13-May	82	2	3	10	10	3	52	2	J	2	R,H	General	Α	Before 10
28	13-May	66	2	5	3	13	7	35	1	K	2	R,H	General	CLINIC	Before 10

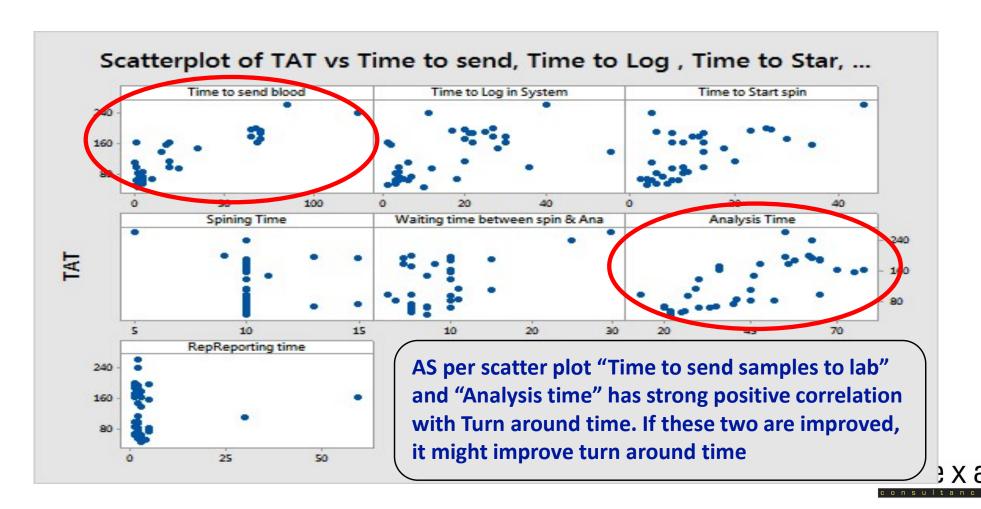
## Current Process – Value Stream Mapping



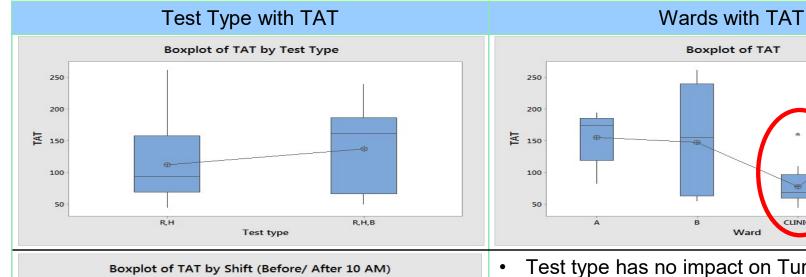
## Potential Causes of Delay

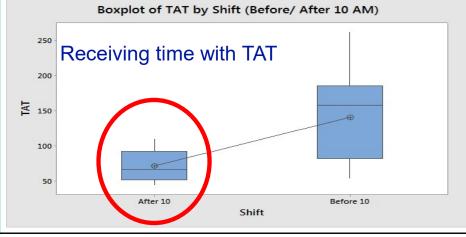


## Root Cause Analysis



## Root Cause Analysis





- Test type has no impact on Turn around time
- Samples received from clinics have less TAT (77 Min) as compared to other wards
- Samples received before 10 AM have significantly high time (166 min) as compare to sample received after 10 Am (56 Min)



## Analysis Summary

Υ	Root cause	Classification	Control
	Delay in receiving samples from lab	Waiting waste	In control
	High Analysis Time	Value Added	Out of control
High TAT from lab	Samples received before 10 AM have high TAT	Wait	In control
	Samples received from clinics and samples collected on the Laboratory have less TAT		Out of control
	15 min lag time after receiving the samples and logging into system	Waiting waste	In control
	10 Mins of lag time after logging into system and spinning the sample	Waiting waste	In control

# Solution (Improvement)

Υ	Root cause	Control	Solution Proposed
	Delay in receiving samples from lab	In control	Nurses to send the samples immediately after extracting the blood through tubes
High TAT from	High Analysis Time	Out of control	-
lab	Samples received before 10 AM have high TAT	In control	Change the shift timing for some staff to 5 AM or do Night shift
	Samples received from clinics and samples collected on the Lab have less TAT	Out of control	-
	15 min lag time after receiving the samples and logging into system	In control	Login to system immediately after receiving the samples by the same person who received the samples





# DIVIAIC

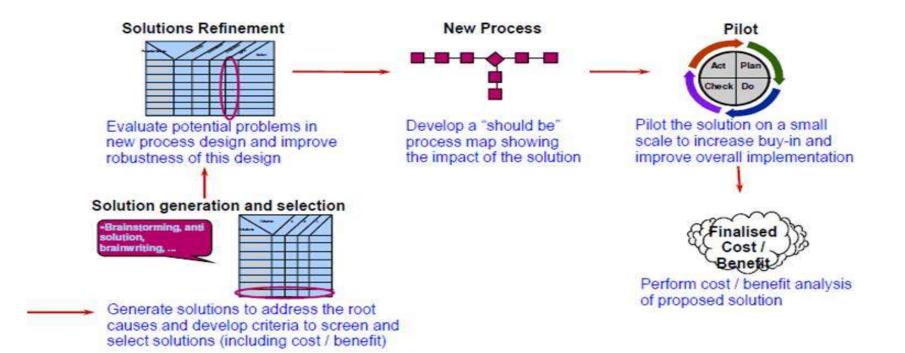
# Improve





### **IMPROVE**

Purpose: To determine new improved process design through idea generation, selection, process design, solution testing, and improvements implementation.



### **DMAIC METHOD OF LEAN SIX SIGMA**





## **Overview**

### **Objectives:**

Determine new improved process design.

### Steps:

- 1. Ideas Generation.
- Prioritize and Select solutions.
- 3. Test Solutions/Implementation.



### **Idea Generation**

### Creativity approaches

- Process benchmarking
  - Compare the performance of an existing process against other companies' "best in class" practices (same market or not)
  - Determine how those companies are organized to deliver these performance levels
- Best practices
  - Use company data
- Brainstorming
  - Brainstorming with post it notes, channeled brainstorming, anti solution, .... etc



### **Brainstorming**

### **Pre-requisites of Brainstorming**

- Purpose of Brainstorming
- Participants (From the process / not from the process)
- Facilitator
- Stationery
- Selection of tool of brainstorming
- Meeting room
- Facilities
- Communication to participants about time, venue, topic in advance



### **Brainstorming**

### Rules of Brainstorming

- Equal opportunity to everyone to participate
- Capture all the ideas (Document)
- Leave your designation and ego along with your shoes outside meeting room
- Non threatening environment to be created
- Ensure that there are no disturbances
- Focus on the topic (Create parting lot)
- Fantasize freely (Do not put breaks on your thoughts)
- Watch your time!
- Defer evaluation (Do not discuss ideas)
- Generate Quantity, do not worry about Quality



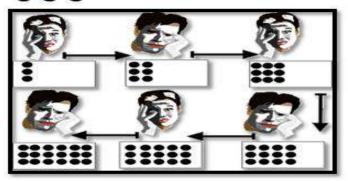
### **Brainstorming**

### Types of Brainstorming

#### **Round Robin**



6-3-5



#### **Anti Solution**

### **List of Anti-Solutions**



- · Put products on the wrong aisles
- · Don't have employees to assist shoppers
- Don't train employees where products belong
- · Move products on an hourly basis
- Train the employees to tell the shopper that "if they don't see it, we don't have it".
- · Don't mark the aisles well









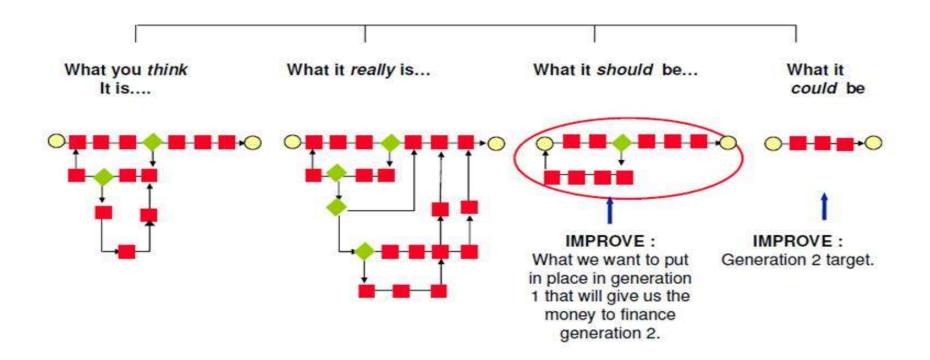








# Continuous Improvement (PDCA)





## Test Solutions/Implementation Benefits of Doing a Pilot

- Improve the solution that meets customer requirements.
- Refine implementation plan.
- Lower risk of failure by identifying and fixing possible problems ahead of time.
- Confirming expected results and relations between predictive parameters and results (Xs on Y).
- 5. Increase opportunities to receive feedback and buy-in.
- Implement the solution earlier and faster for a particular customer segment.

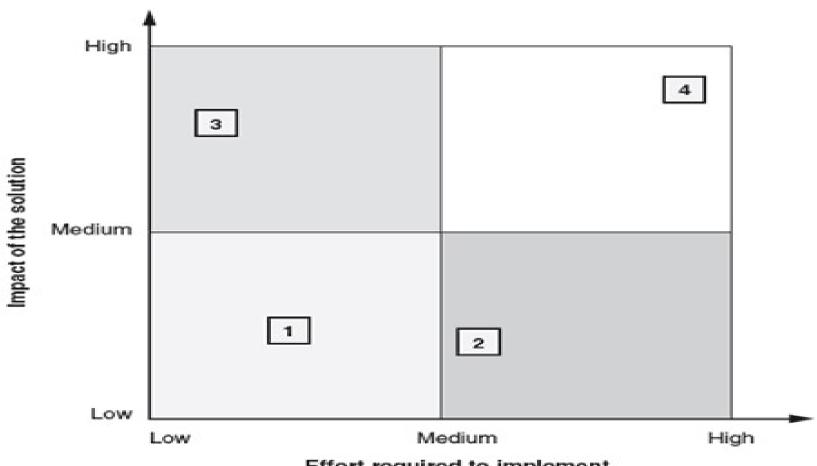
### **Select the Best Solutions**



M	L	K	J	1	Н	G	F	Е	D	С	В	A
#	solution			Team Members Voting (1 - 10)							Average	
1731			1	2	3	4	5	6	7	8	9	
1		Impact										
1.274		Effort										
2		Impact										
1477		Effort										
3		Impact		80	80	80		8)	80			
		Effort										
4		Impact		20		2	8	8	20	20	2	
		Effort				2						
5		Impact										
		Effort										
6		Impact										
		Effort										
7		Impact		) ))	5)	8		8)	2) 2)			
		Effort										
8		Impact					8		2			
		Effort			G G			6	63	0		



### **Select the Solution**

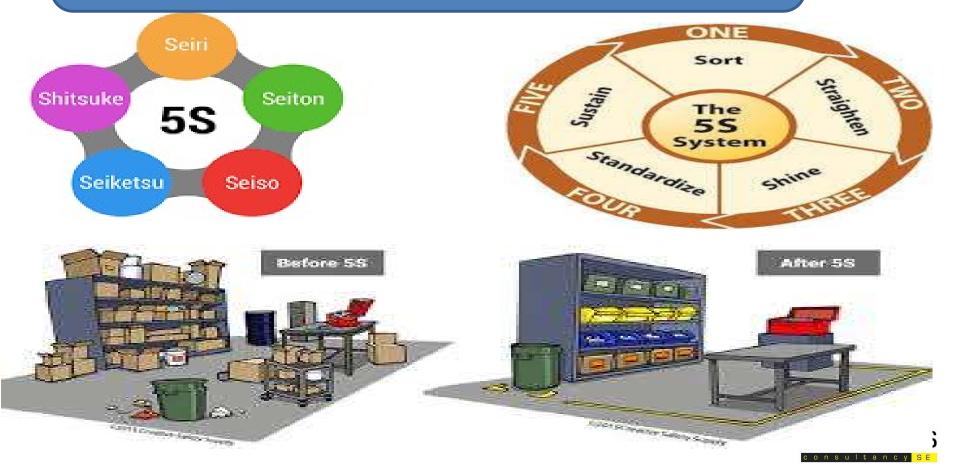


Effort required to implement

### Improvement Methodology

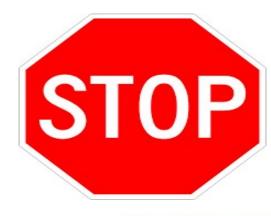


**5 S** 



### Visual Management



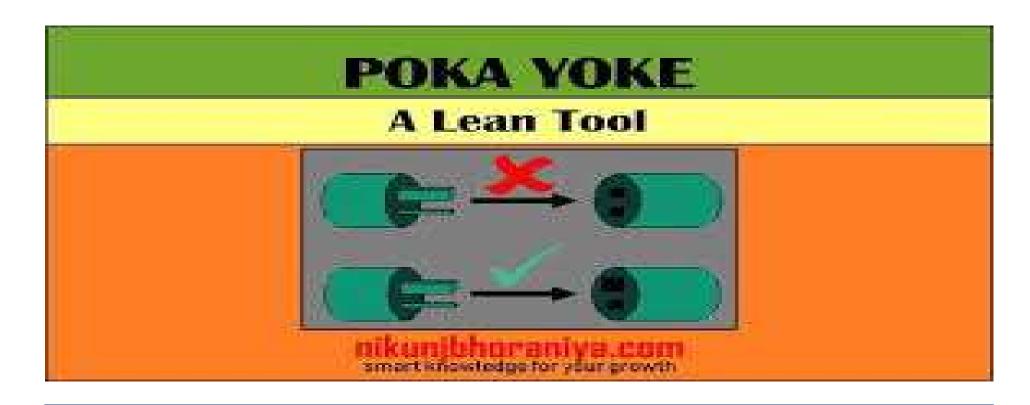












# Poka Yoke Improved quality and customer satisfaction

**Prevent defect occurrence** 

**Cost effective**, Easy to implement









VS



#### Push vs. Pull

### Make all we can just in case.



- Production Approximation
- Anticloated Usage's
- Large Lots
- High Inventories.
- Waster
- Management by Firefighting
- Poor Communication

### Make what's needed when we need it



- Production Precision
- Actual Consumption
- Simuel Lots:
- Low beversories
- Waste Reduction
- Management by Sight
- Better Communication

### Multi Task Employee





The first step in getting started with process improvement is to?	put people in teams	use problem- solving techniques	empowerment	training
is conducted based on the ground rules such as -no idea is a bad idea?	SIPOC	Brainstorming	Brain writing	Antisolution
The primary objective of a process is to achieve?	Efficiency	I ow Cost	Customer Satisfaction	Throughput
Fool proofing (Japanese) ?	PILOTING	Brain storming	Poka Yoke	None of the above
ine purpose of prainsforming is to?	improve processes	satisfy stakeholders	generate ideas	eliminate waste





# DIVIAIC

Control

### Summary

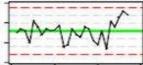


### CONTROL

Purpose:

To ensure improvement effectiveness over time by institutionalisation of the improvement and implementation of ongoing monitoring and reviews.

### Monitoring Plan



Develop a monitoring plan to insures gains are held over the long term

#### Documentation / Standardization

Document the process with process maps & procedures to assure the solution becomes part of daily work

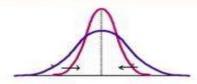
Address appropriate changes to broader systems and structures to institutionalise the improvement

Yellow Belt Training

#### Implementation Plan



Develop a full implementation plan including project and change management elements



#### **Process Capability**

Monitor the process according to plan. Chart data as evidence that process is in control and meeting customer specifications

### Continuous Improvement



- Process ownership to Process Owner (Process Management chart to facilitate transfer)
- Process Owner to held regular process reviews based on dashboards.
- Process Owner to take action when process does not deliver what is expected
- •Process has entered Process Management = Define Measure , www.anexas.net Operate.



### Overview

### Objectives:

Ensure improvement over time.

### Steps:

- Documentation / Standardization / Implementation Plan
- 2. Control Plan

### **Control Chart**

#### **Purpose**

Predict expected product outcome

#### **Advantages**

Predict process out of control and out of specification limits Distinguish between causes of variation

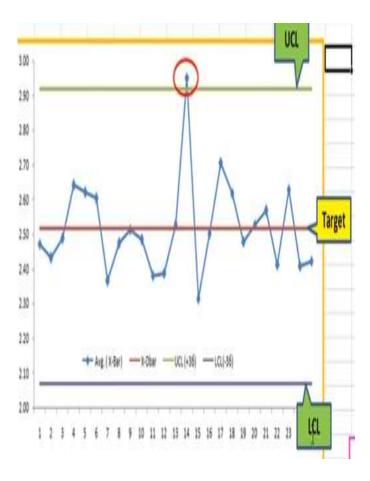
### **How to eliminate Assignable cause variation**

Get timely data
Search for the cause
Change tools to compensate for the special cause

#### **How to eliminate Common Cause Variation**

Don't attempt to explain the difference Reducing Common cause variation usually requires making fundamental changes in your process

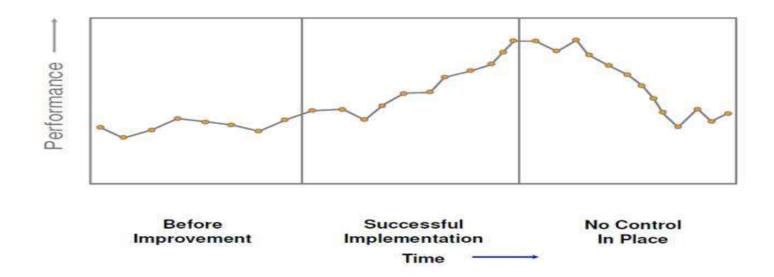






### **Ensure Gains Over Time**

The <u>CONTROL</u> phase naturally leads to <u>Process</u> <u>Management</u> as the purpose of that phase is to deliver the tool set for ongoing management of the process performance by Process Owner.

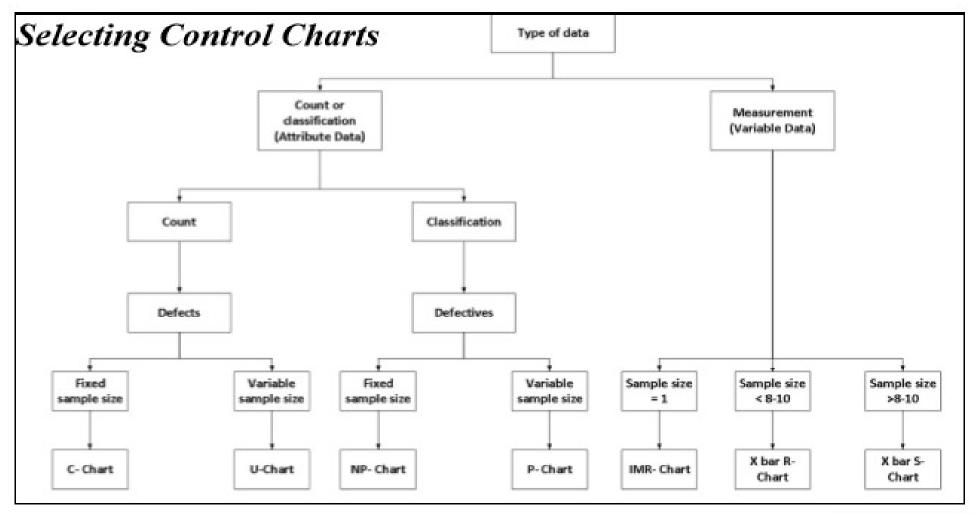




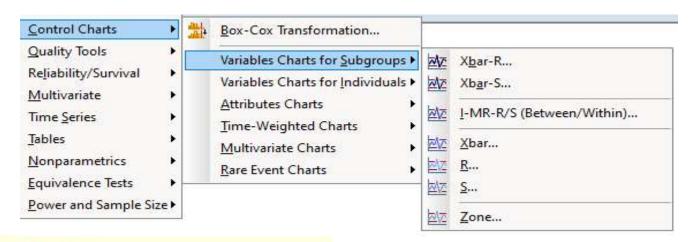
### IMPLEMENTATION PLAN

Document the process with process maps & procedures to assure the solution becomes part of daily work.

WHO	WHAT	WHERE	WHEN







#### Xbar-R

Monitor the mean and the variation (range) of your process when you have continuous data in subgroups. Works best with subgroup sizes of 8 or less.

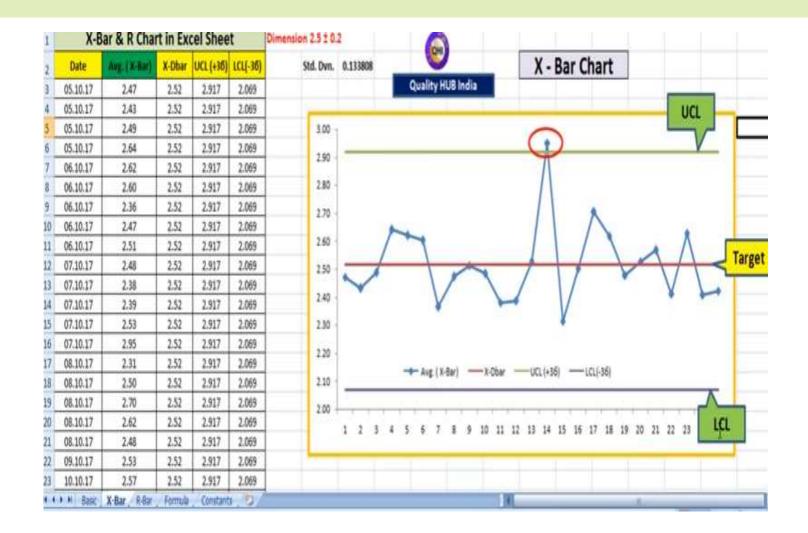
#### Xbar-S

Monitor the mean and the variation (standard deviation) of your process when you have continuous data in subgroups.

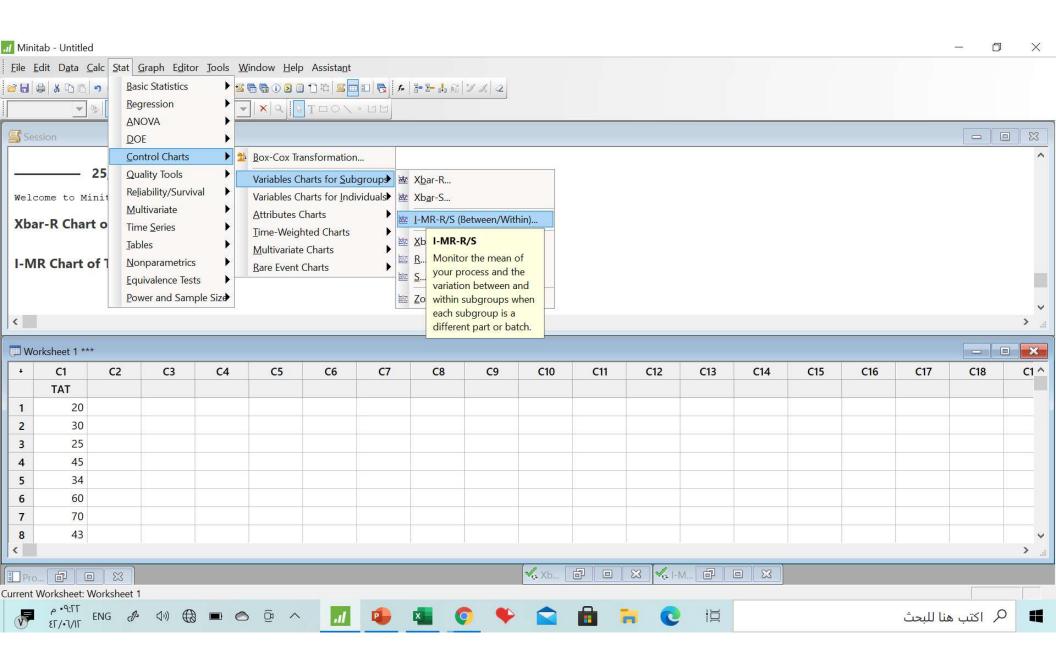
#### I-MR

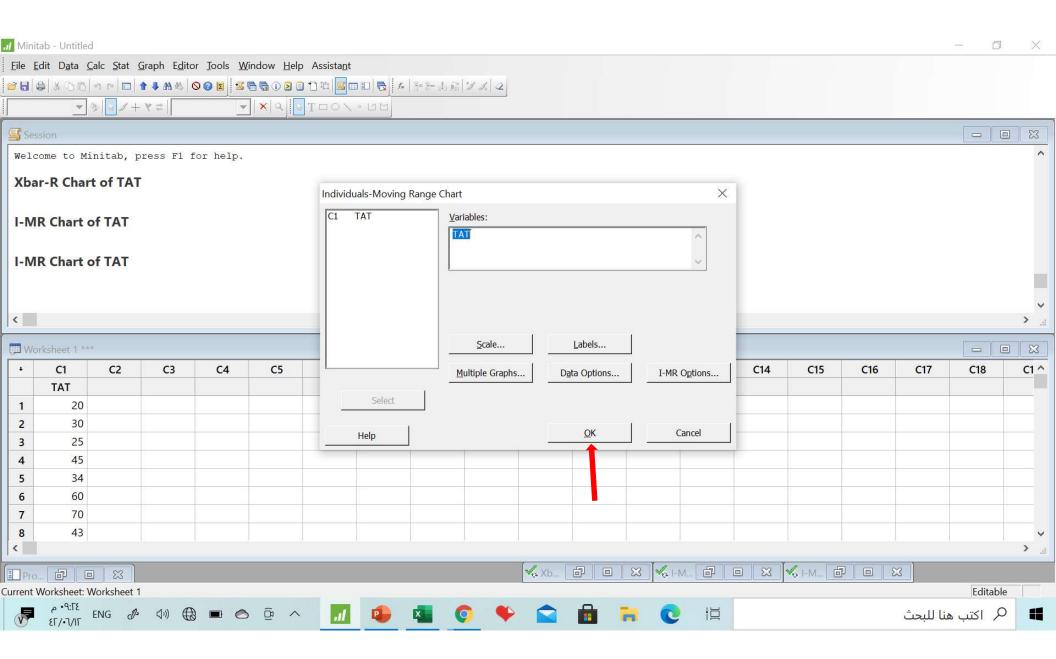
Monitor the mean and the variation (moving range) of your process when you have continuous data that are individual observations not in subgroups.

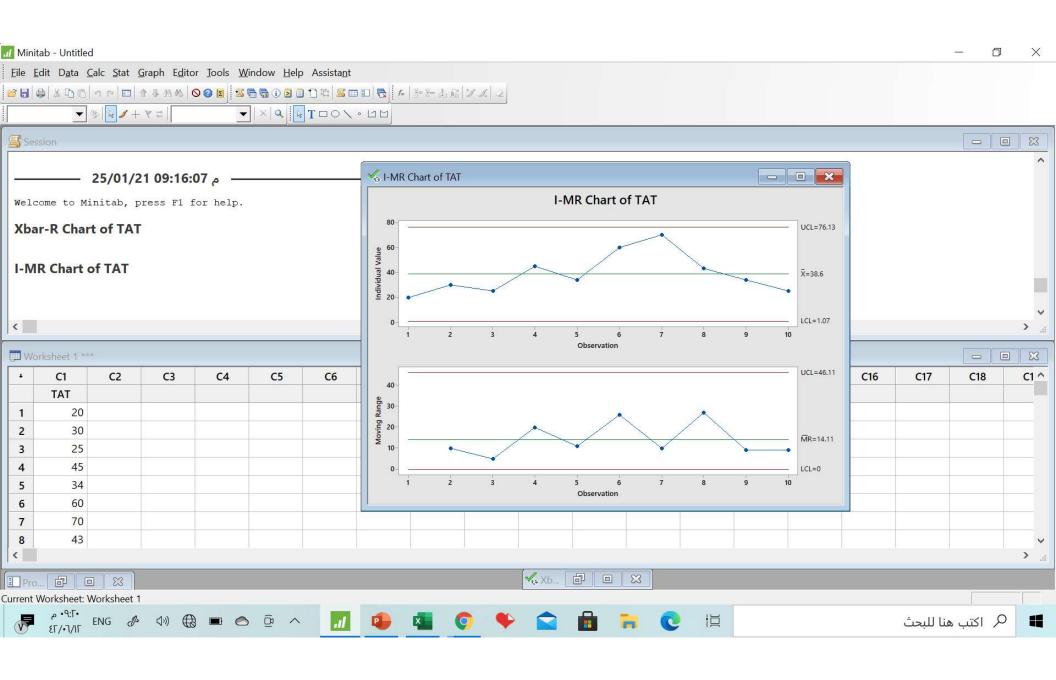












A very useful attribute control chart for plotting the actual number of defects found during an inspection is known as the ?	X-bar and R chart	np chart	p chart	c chart
The prime use of a control chart is to ?	causes of	Detect nonconforming product	The Measure the performance of all quality characteristics of a process	Detect the presence of random variation in the process
A green belt is going to monitor the number of defects on different sized samples. Which of the following control charts would be most appropriate?	u	np	С	p
Your Control Chart shows seven consecutive points or one side of the mean. What does this indicates	The process is -control( within the UCL and LCL)	anneare to ne	The process needs to be checked for special cause	The wrong control chart has been selected
An attribute chart can be represtated by all of the following EXCEPT	P Chart	R Chart	NP Chart	C Chart



## Thanks!

Anexas Europe
Contact us: <a href="mailto:enquiry@anexas.net">enquiry@anexas.net</a>



### **Exam Questions**

QuestionId	Questions	Option 1	Option 2	Option 3	Option 4
1	Which role is not traditionally performed by a green Belt?	Data Gathering	Analysis	Lead Small Projects	Coach and mentor other Six Sigma practitioners
2	The primary factor in the successful implementation of six sigma is to have?	The necessary resources	The support/leadership of top management	Explicit customer requirements	Comprehensive training program
3	What is the relationship of Brainstorming to Cause and Effect Diagrams ?	Both the tools are used only in Control phase	They are completely different tools used in ISO 9000	Cause and Effect can be performed using brainstorming	They are different words for thee concept
4	In a control chart, control limits are ?	analogous to specifications	calculated using sigma value	set by customer or management	none of the above
5	The number one rule of brainstorming that is most frequently violated is ?	wrong technique used	discussion or evaluation of ideas	no participation	scribe writes too slowly
6	The method that attempts to reduce the overall risk on a system is called?	PDCA	FMEA	Cause-and-effect diagrams	Pareto analysis
	A very useful attribute control chart for plotting the actual number of defects found during an inspection is known as the ?	X-bar and R chart	np chart	p chart	c chart
8	The prime use of a control chart is to ?	Detect assignable causes of variation in the process	Detect nonconforming	The Measure the performance of all quality characteristics of a process	Detect the presence of random variation in the process
9	Benchmarking is concerned with finding and comparing organization processes to ?	competitor processes	dissimilar organization processes	other organization processes (at another institution for example)	all of the above

10	In a Pareto Chart, the cumulative frequency percentage line is ?	ascending	descending	vertical	horizontal
11	The median for the following numbers (6, 3, 2, 5, 1, 8,7) is ?	3	4	5	6
12	A green belt is going to monitor the number of defects on different sized samples. Which of the following control charts would be most appropriate?	u	np	С	p
13	What does Six Sigma stand for ?	Six Standards of production from customer point of view		Only six errors in production	The frat house that housed its creator
14	Determine the Mode for the following data set: 2 3 2 1 0 0 4 6 2 1 3 4 4 4 ?	2	0	4	6
15	The central tendency of data set can be represented as ?	mean	mode	median	all of the above
16	RPN in FMEA stands for ?	Random Priority Number	Restricted Priority Number	Risk Priority Number	Relative Priority Number
17	SPC stands for ?	Standard process center	Statistical process control	Standard process control	Statistical process center
18	refers to the category of variables that are least likely responsible for variation in a process, product, or service ?	Vital Causes	Vital Few	Common Causes	Trivial Many
19	The 6 M of Cause and Effect Diagrams include all of the following except?	Methods	Machinery	Money	Measurements
20	The concept of discovering what is the best performance being achieved, whether in your company, by a competitor, or by an entirely different industry is called as ?	SWOT Analysis	Baseline Sigma	ANOVA	Benchmarking <b>e</b> X

21	The problems that can be solved easily and quickly are known in the six sigma hierarchy as	Lurking Variables	Defect	Process Improvement	Low hanging fruits	ĺ
22	CTQ stands for ?	Criticize the quantity	Criticize the quality	Critical to Quantity	Critical to Quality	l
23	Is recipient of a product or service ?	Supplier	Consultant	Employee	Customer	l
24	Fool proofing (Japanese) ?	PILOTING	Brain storming	Poka Yoke	None of the above	1
25		Solve Input Process Owner Customer		Supplier Input Process Output Customer	Supplier Internal Process Owner Customer	ĺ
26	The purpose of brainstorming is to?	improve processes	satisfy stakeholders	generate ideas	eliminate waste	l
27	Cause and Effect Diagrams are also known as?	fishbone diagrams	PDCA	tree diagrams	storyboarding	l
28	When interested in seeing the pattern of data, should be used?	FMEA	histogram	both of the above	none of the above	ĺ
29	Δ henefit of C&F Diagrams is?		91 1	provides a visual of the problem being studied	all of the above	ĺ
30	A flowchart helps to?	understand the scope of a process	identify process steps	identify relationships	all of the above	ſ
31	Which of the following refer to a study of basic statistics?	measure of location	measure of dispersion / spread	both of the above	none of the above	ĺ
32	The primary objective of a process is to achieve?	Efficiency	Low Cost	Customer Satisfaction	Throughput ane	3 X S

33	Quality tools are used to?	broaden thinking	focus on the process and identify issues	both of the above	none of the above
34	The first step to construct a Cause and Effect Diagram is?	identify a problem to be solved	establish category causes		determine how many bones; the diagram will have
35	One characteristic of attributes data is that it is always?	Continuous	Discrete	Expensive to collect	Read from a scale of measurement
36	The Pareto Principle suggests that importance should be placed on?	the vital many	the trivial many	the trivial few	the vital few
37	A common measure of variation is?	mean	mode	median	none of the above
38	In Y=f(x), X represents the of the process and Y the of the process?	Output, Input	Input, Output	Mean, standard Deviation	None of the above
39	Using Six Sigma methodology, a company at 4 sigma would have a failure rate of?	308,000 ppm	233 ppm	6210 ppm	66,807 ppm
40	is conducted based on the ground rules such as -no idea is a bad idea?	SIPOC	Brainstorming	Brain writing	Antisolution
41	People who are directly affected by the project?	Shareholders	Customers	Employees	all of the above
42	is called the father of Six Sigma?	Mike Crichton	Mikel Harry	Michael Dell	Michael Jack
43	The 'first' benefit that flowcharts provide is ?	Identify wasteful steps	Increase understanding of what is taking place		assist with ISO compliance
44	MSA stands for ?	Measurement System Analysis		Management System Attribute	Measurement System Action utel EX a

45	In order for a problem to be solved correctly,which of the following must occur first?	'	Relevant data must be gathered	The measurement system must be validated	The process must be mapped
46	The first step in getting started with process improvement is to?	put people in teams	use problem-solving techniques	empowerment	training
47	Which is not a Lean tool ?	Muda(Waste)	DOE	Mura(Variation)	Mure(Over Burdan )
48	is Deliverable of Define Phase.	Identifying solution	Identifying root causes	Baseline Sigma Level	Project Charter
49	The person who celebrates accomplishments with the team, removes roadblocks, compensates the team efforts, and communicates with management is?	Coach	Champion	Time Keeper	Facilitator
50	is the difference between the largest and the smallest observations .	Average	Standard Deviation	Range	Median
51	If severity =5, Occurrence = 4, Detectability = 2, what is RPN	20	8	10	40
52	MINITAB is a .	Statistical methodology	Quality initiative	Statistical data analysis software	None of the above
53	The expression "Y=f(x)" is best described by	Inputs are a function of the process outputs.	Yield = First Pass X's.	Y is a function of X.	First time Yield is derived from X.
55	Arrange the Six Sigma Process Improvement approach in the correct order: 1) Measure, 2) Define, 3) Control, 4) Improve, 5) Analyze	2,5,1,4,3	1,2,5,4,3	3,2,1,5,1	2,1,5,4,3
56	A process has a mean of 10 and a standard Deviation of 2. What is the tolerance of the process that exhibits the limit of normal variation?	5 to 15	4 to 16	2 to 8	6 to 14
57	A process is in-control and stable. Describe the type of variation that exists in the process	Special Cause variation	Natural Variation	Out-the-ordinary Variation	Non- random Variation
58	Indicate which are the examples of the variable data: 1) Length, 2) Weight, 3) Decision on the coin toss, 4) Dollors, 5) days	1,3,4,5	1,2,4	1,2,4,5	1,4,5 <b>a n</b>

