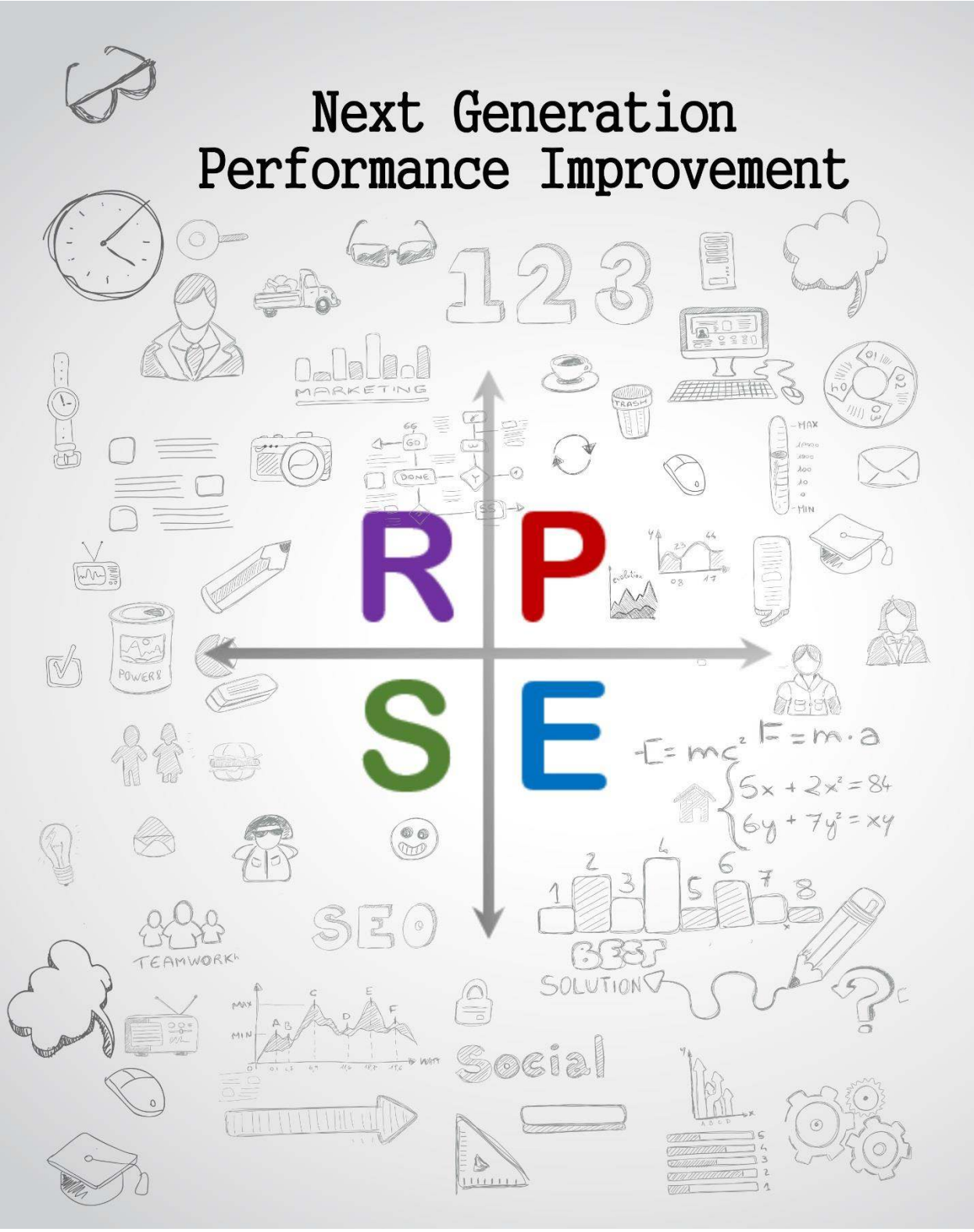
Next Generation Performance Improvement



PRACTICING PERFECTION INSTITUTE

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We highly encourage to share this information with colleagues, friends, and others whose success you care about.

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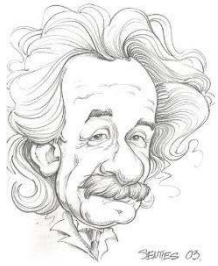
Executive Summary



The current landscape of performance improvement (PI) is hewn with much energy, lots of money being spent, and many smart dedicated people working really hard to make things better.

Unfortunately, stressors remain high. Little (if any) synergy is being achieved in many organizations. And this at a time when external, regulatory, and societal challenges are demanding near 'perfection'.

Two primary symptoms of the current levels of dysfunction exist. As a leader in your organization, you're [very] likely already aware of these:

- A continual need to 'fight fires'
- HR departments spending most of their time and energy serving to protect the company from its workers

In spite of everything we've learned, most organizations still find themselves in an ongoing tug-o-war between priorities, riding a roller coaster of metrics and KPIs. This is because performance improvement, as it has been 'globally' treated up till now, has been primarily based upon…hope.

The significant problems of today simply CANNOT be solved using the same level of thinking that created them.

This Report identifies and details the following:

- A history of how we got here
- Common sense regarding the (4) things EVERY organization seeks
- Latest Research in the area of people performing at work
- The key to achieving BALANCE: How to lower costs while raising performance levels
- An invitation to learn more

Welcome to the Next Generation of Performance Improvement…

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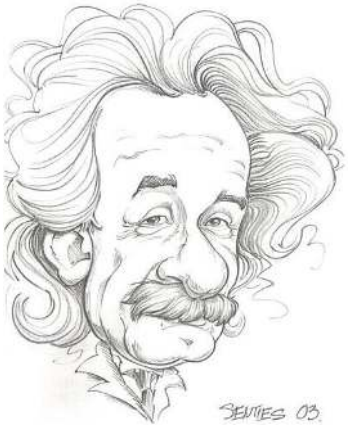


"**The significant problems of our time cannot be solved by the same level of thinking that created them.**"

-Albert Einstein

Overview

Albert Einstein. In addition to solving the mystery of quantum physics (which is still regarded as perhaps the most significant scientific breakthrough…ever), he offered humanity some profound insights.

Ever since I came across this insight about "…*the same level of thinking*…", it's been one of my 'mantras'.

We live (and work) in a time of unprecedented rate of change. In the time it takes you to read this Report, more change will have occurred in the world than happened in an entire year of your great grandparents' lives. 'Old-school' thinking and ways of doing simply no longer work.

You've likely also heard the bit about *insanity* (attributed to Einstein)…

This Report is about leaving 'insanity' behind. It's about being smart; smart in a way that generates [sustainable] difference- difference in attitudes, difference in behaviors, difference in results.

No more platitudes. No more clichés. No more blindly throwing money at challenges and problems based upon hope.

If this is of interest to you, keep reading. If not, you might as well stop right here.

If you're still reading, I anticipate that you're likely frustrated with the status quo, and recognize there simply must be a better approach to improving attitudes, ownership, and results. Or maybe…you simply like to learn new things about improving performance.

Whatever your case, whatever it is that's currently keeping you awake at night, standby.

Whether you're directly responsible for, or simply interested in, improving any type of performance, what you're about to read will rock your world.

My name is Tim Autrey. In this Report, I'm going to specifically…

- Help you understand WHY your current performance improvement efforts are not generating the *sustainable* results you seek (and HOW to dramatically improve your ROI)

- Give you an opportunity to self-assess, creating a visual representation of your current *Performance Culture*, as well as your current *Priority Bias* (which is a very good indicator of where your performance will be in the future if you do nothing to change it)

- Help you see why a Next Generation approach is critical if you truly want to meet milestones, while sustainably hitting all of your metrics and KPIs

Your Biggest Challenge

Because you accessed this report, it's highly likely that you are involved in, or are responsible for, improving performance (i.e., RESULTS) within an organization. As such, it's also likely that you've been to various type(s) of training, been to conferences, come under the auspices of a consultant or two, and have probably even read a book or two on the subject.

I don't know your specific background, role, or position…

- You might be a senior executive, actively seeking for your organization to become (or maintain the status of) 'industry leader'- improving safety, productivity, and reliability while reducing costs. *How can you best BALANCE the need for production with safety and prevention?*

- Perhaps you're a corporate Performance Improvement (PI) leader; maybe a VP or a Director- under the gun to improve metrics and Key Performance Indicators (KPIs). *How can you improve numbers, which to do so SUSTAINABLY requires bringing team members together in the midst of differing perspectives and [seemingly] opposing priorities?*

- Maybe you're a plant or facility manager, wondering, as you go to bed each night, whether you're going to 'get the call'- that [yet another] worker has gotten hurt on the job, or equipment has been damaged due to human error. *How can you possibly avoid being 'called on the carpet' by Corporate regarding your production numbers (and the need to 'hold someone accountable') while placing adequate emphasis on the folks who make your plant run?*

- Or perhaps you're a Safety Lead, sick to death that people continue to get hurt- wondering why workers STILL are not taking personal responsibility for their own safety, let alone the safety of those around them. *How can you possibly promote an environment of "prevention" when workers continue to feel so pressured for production?*

Again, I don't know your background, your role, or your position, BUT I can tell you this…

Whatever your biggest current challenge, operational dilemma, or concern, there IS a simple approach that will produce rapid, substantial, sustainable results while balancing production and prevention…should you choose to take it.

And here's the BEST news…

- it's not 'rocket' science,
- it doesn't require never-ending consulting contracts (in fact, you can do this yourself),
- no new database or software is required,
- it's proven to provide tremendous ROI for every dollar invested, AND
- it's based on science (no more "hope-based" performance improvement)

Sound too good to be true?

- While implementing the approach outlined in this Report, a nuclear power plant achieved a 52% reduction in human errors and safety incidents during a major modification refueling outage (as compared to the previous outage). Further, there were over 1,000 additional contract workers onsite (55% of whom were drafted from the Union halls, and had no prior nuclear power plant experience). The outage was completed on time and under budget.

- An electrical transmission organization in the northeastern US, in the midst of a Billion-dollar capital infrastructure project involving 23 different contract firms, reduced human error and safety incidents by 73.9% by doing what I'm about to show you.

- A 2250-person generation facility cut errors by 72%, while simultaneously witnessing an 80% reduction in union grievances over the 12 months following implementation.

Facts are facts.

In truth, these are just a few of the many success stories this approach has produced over the past decade.

Who am I?

In case you aren't familiar with me, my name is Tim Autrey. I am the creator of an approach to performance improvement known as Practicing Perfection®, author of the best-selling book, *6-Hour Safety Culture*, and Founder of the Practicing Perfection Institute, Inc., where I currently serve as CEO. I am also the Executive Director of the not-for-profit Human Performance Association.

Prior to starting the PPI journey, I spent 20+ years in the US commercial nuclear power industry, where my predominant roles involved reducing risk and minimizing the potential for human error. In 2002, combining my awareness of behavioral psychology with the industry's efforts to reduce human error, I orchestrated a sustained 87.5% reduction in error rate over a 30-month period (including two refueling outages and two operating cycles). Performance at that facility continued to improve after I left. These results were achieved using the same approach I am going to detail for you in this Report.

In 2005, I founded the Practicing Perfection Institute, Inc. (PPI), taking what we had learned, making it simple, and making it available to all industries. Since that time, PPI has had an unrivaled string of successes helping organizations reduce human error and complacency, thereby improving safety, reliability, quality, productivity, efficiency, and…profitability. The emblems of some of the organizations that have utilized and benefited from this approach can be found at the end of this Report.

I've always been a rebel. Just ask my Mom. I love to challenge the status quo. Because of this, what I've said and demonstrated has not always been met with hearty approbation. Like the time following my Keynote as opening speaker for a nuclear executive summit. After my presentation was complete, the Senior VP of Operations for INPO (Institute of Nuclear Power Operations) got up to give his talk, and began by saying, "I think some of the things our previous speaker [Tim Autrey] said were bordering on sacrilege."

Forget dogma. Forget what 'everyone else is doing' (especially when it has PROVEN to only produce marginal or incremental (if any) tangible results). The challenges of today are FAR too demanding to follow the lemming path. They demand a different way of thinking (and doing).

I've never been afraid to say what needs to be said.

All progress begins by telling the truth.

The best professional compliment I ever received during my nuclear career was given to me by a Site Vice President. In the midst of offering me a nice promotion, he said, "You're not like everyone else here. You're different!" I LOVED it!

My 'difference' and the 'departure from the norm' of the approach I'm about to let you in on led to unprecedented success at that facility (and has since quietly been revolutionizing the world of performance improvement).

Before we 'get into it', one more thing- I've never professed to be the 'brightest star in the sky'. What I'm about to show you essentially 'stands on the shoulders' of the brilliant minds who have gone before. I am a *synthesizer*. What I (and the PPI Team) have been successfully able to do is to draw the best from the best, and put it together in a way thus far not achieved by anyone else currently hanging their professional shingle in the performance improvement space.

Furthermore, because I'm not special or exceptionally 'brilliant', you need not be either in order to make what I'm about to show you incredibly effective in your organization. I've discovered that the most profound insights, strategies, and tactics are the simplest, providing, of course, that they actually WORK.

BUT, I have a confession to make…

When we started PPI, we had a vision (which is STILL our vision today):

Event-free, worldwide- one life at a time™

Since the beginning of this journey in 2005, we've had the opportunity to take the Practicing Perfection® approach to Canada, to Europe, to China, to Russia, to South Africa…

We've had a phenomenal string of successes- sustained error reductions of 74.6%, 72.4%, best-ever safety records, best-ever capacity and reliability in a 25-year history. The list goes on and on.

Unfortunately, I have NOT (until now) done a very good job (outside of our client base) of communicating how this simple process generates such phenomenal sustainable results. Furthermore, I have been less-than-stellar in identifying how it impacts and synthesizes ALL of the various "improvement" efforts upon which organizations are STILL spending so much money.

For this I apologize.

But now, with tens of thousands of workers trained and a phenomenal string of successes under our belt, the verdict is in. I am now compelled to tell the story so that all can benefit.

To properly set the stage for why what I'm about to show you is in fact 'Next Generation', I want to briefly run through the history of performance improvement.

The history is important because it is responsible for the current stage upon which we all currently play.

If you hated history in school, don't worry. This is a quick "Cliff's Notes" version.

A BRIEF History

The world of "performance improvement" as we know it had its beginnings more than 200 years ago. Being aware of how all of this evolved will help you to comprehend the incredibly bright possibilities that lie ahead.

Occupational Safety

Occupational Safety, also often referred to as Occupational Health and Safety (OHS) was the first far-reaching performance improvement initiative. Its roots can be traced back to the "Factory Acts" in the United Kingdom in 1802.[i] As the industrial revolution evolved, safety issues were largely responsible for the development and growth of labor movements.

In 1931, Herbert W. Heinrich published *Industrial Accident Prevention: A Scientific Approach*. Based upon his analysis of the databases at the Travelers Insurance Company, Heinrich concluded that roughly 90% of all accidents, injuries, and illnesses were the result of what he called "worker errors." While he was simply analyzing the data he had available, his conclusions regarding worker "culpability" have to this day [unfortunately] helped proliferate the "worker as scapegoat" mentality when something goes wrong.

In 1970, the Occupational Safety and Health Administration (OSHA) came into being in the United States as part of the Occupational Safety and Health Act.

OSHA's mission is to, "assure safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education and assistance"[ii]. It also enforces a variety of *whistleblower* statutes and regulations. Today, most of us are familiar with the OSHA "Illness and Injury Rates" (commonly referred to as the "OSHA Recordable Rates"), which is published regularly for every sector in the US.

In 1978, Dan Petersen wrote *Safety Management: A Human Approach,* wherein he referred to the research and writings of B.F. Skinner, the father of "behavioral analysis". The term "Behavior-Based Safety" (BBS) came into being (the origin of which is also often attributed to Scott Geller). BBS caught on in popularity, and for a time became "the way" relative to worker safety across many industries.

OSHA started the Voluntary Protection Programs (VPP) in 1982, allowing employers to apply for status as "model workplaces", thereby achieving special designation when meeting certain requirements.

Process Safety

Process safety focuses on preventing fires, explosions and accidental releases in chemical process facilities, as well as in other facilities dealing with hazardous materials, such as refineries and oil and gas (onshore and offshore) production installations.

In 2000, OSHA published *Process Safety Management*. Aimed primarily at organizations involved with highly hazardous chemicals, it provides a standard for analysis, required procedures, and mandatory training relative to the safety of associated processes, the health and safety of the public, and the safety of associated workers.

Human Factors

In 1911, Frederick Winslow Taylor, an American mechanical engineer, published *The Principles of Scientific Management.* It detailed the techniques he had discovered for improving efficiency relative to the interface between man and machine. His work was instrumental in the creation and development of the field known as industrial engineering. Frank and Lillian Gilbreth expanded Taylor's methods to develop the "time and motion study", well known in its earliest days for greatly improving bricklayer productivity (from 120 to 350 bricks per hour!).

The term "Human Factors" as it has come to be known in the United States, is generally the study of the interface between human and machine, including psycho-motor aspects, psychological cues, and ergonomics. In other parts of the world, the term is used more globally to encompass an organization's overall efforts to improve the performance of people, including their behaviors.

"Human Performance"

Overt efforts to improve the way human beings 'perform' can be traced back to the 1950s and 60s, emerging from the fields of educational and instructional technology. *Human Performance Technology* (HPT), also referred to as *Performance Improvement*, led to the emergence of Instructional System Design (ISD) in the late 60s and early 70s.

Also referred to as "Human Performance Improvement" (HPI), or "Human Performance Assessment", "HPT" has come to acquire an association with many fields of performance improvement including LEAN, Six Sigma, organization development, instructional technology, and human factors.

In 1990, James Reason published *Human Error*. Based upon his research and that of Jens Rasmussen, this laid much of the groundwork for a focus upon "Human Performance" within the US Nuclear Generation and Airline industries in the early 1990s. As a result of these efforts, both of these industries have seen major reductions of human error, as well as virtual elimination of catastrophic events.

As deployed within the US commercial nuclear power industry, the term "Human Performance" has been pretty much synonymous with "human error reduction." The primary (if not sole) focus of the effort has been to reduce errors and prevent "events" (errors causing significant negative consequence).

In its efforts to disseminate and promote a focus upon the nuclear interpretation of "human performance", the Institute of Nuclear Power Operations (INPO) developed a 'formula' for human performance (HU), which was: HU = B + R. In this formula, "B" stands for Behaviors, while "R" represents Results.

The INPO formula was the initial attempt, on an industry-wide scale, to functionally tie worker behaviors together with corresponding results/outcomes.

As previously indicated, the nuclear industry achieved exceptional results coincident with an acute focus on the reduction of human error. For example,

between 1980 and 2015, plant capacity factors rose from 57% to 92.2%. The industry's Occupational Illness and Injury ("OSHA Recordable") number dropped from 0.38 in 1997 to 0.03 in 2015.[iii]

In September 2010, INPO published a "Significant Operating Experience Report" (document SOER 10-2). In this report, which was titled, "Engaged, Thinking Organizations," INPO cited, "…a number of significant operational events revealed unacceptable weaknesses in important barriers to sustained high levels of nuclear safety."[iv]

In June 2011, INPO published another report, IER 11-3 "Weaknesses in Operator Fundamentals", in which they cited, "…several significant events occurred [in the past 18 months] that highlight weaknesses in the essential knowledge, skills, behaviors, and practices that operating crews need to apply to operate the plant effectively- operator fundamentals."[v]

The US commercial nuclear industry, the most highly regulated industry in the world, achieved tremendous success through a focus on "human performance"; however, it has done so through extensive command and control, and ever-increasing prescriptiveness.

The INPO reports just mentioned reveal the longer-term consequences of 'overly-prescriptive control' of human beings. In addition, the ever-increasing demands placed upon the industry, both by the Regulator and the industry itself, led to near economic non-viability.

The associated "cumulative impact" (i.e., cost) of these burgeoning requirements was cited as the number one concern of Chief Nuclear Officers (CNOs) across the country in 2014. The industry is now seeking to recover from the imposition of numerous requirements adding little or no value.

In 2013, the Practicing Perfection Institute, Inc. (PPI), initiated a new conversation regarding *human performance* by modifying the 'formula', greatly enhancing the depth, scope, and power of its very definition.

The new 'formula' became: HU = W (R +B), where "W" stands for Why, "R" represents Results, and "B" stands for Behaviors.

The new word definition reads as follows:

Human Performance is WHY we do WHAT we do the WAY we do it.

This new understanding finally dug into the 'root' of peoples' performance on the job- the reasons WHY choices are made and specific actions are taken.

In 2014, the international not-for-profit Human Performance Association (HPA) was established with funding by Tim and Suzette Autrey. Its purpose has been to bring together the brightest minds from academia, organization leadership, and frontline practitioners. The intent is to continually learn, develop, and promote next-level holistic thinking in the field of human performance.

"Quality"

If you're from the US, and you've been around for a while, you likely remember how, in the 70s and 80s, Japan was kicking our butts in quality (especially within the auto industry). It was THEN that we started taking Juran and Deming seriously, and "quality" came to America. I still remember those Ford commercials:

Watch Video

"Quality" took off in 1985 when the US Navy coined the term "Total Quality Management" (TQM). It evolved into a set of "tools"[vi] by which to effect improvement:

- Cause and Effect diagrams
- Check sheets
- Control charts
- Histograms
- Pareto Charts
- Scatter Diagrams
- Stratification

Interest in TQM as an academic subject peaked around 1993[vii]. Efforts to standardize TQM were undertaken in Belgium, France, Germany, Turkey, and the UK; however, such attempts were effectively superseded by ISO 9000.

Six Sigma

Six Sigma is a set of tools for process improvement. The intent is to use statistical analyses and the associated lessons learned to produce an accuracy rate in a process or system of six standard deviations (which is where the term comes from). Six standard deviations generate an accuracy rate of 99.99966%.

The concept was first introduced by Bill Smith in 1986[viii], while working as an engineer at Motorola. It was then adopted by Allied Signal, and became well known when Jack Welch made it central to his business strategy at General Electric in 1995. Today it is still widely used in many sectors.

Utilizing many of the tools developed during the "TQM" era, Six Sigma uses primarily empirical statistical methods to identify and remove the causes of 'defects' in a system or process. Organizations employing these methods typically have a 'belted' infrastructure (yellow, green, black) of team members with varying levels of expertise in their use.

Inspired by Deming's "Plan-Do-Check-Act" cycle, a "Six Sigma Project" typically follows a defined set of steps, implemented to achieve specific value targets. Projects aimed at improving existing business processes typically follow the "DMAIC" pattern:

Design – Measure – Analyze – Improve - Control

LEAN

LEAN principles are derived from the Japanese manufacturing industry. The term was first coined by John Krafcik in 1988.[ix] It employs a systematic method for the elimination of waste in a manufacturing system.

The LEAN management philosophy developed mostly from the Toyota Production System (TPS), which was widely referred to in the 1980s as *just-in-time manufacturing*. As such, those involved in LEAN processes use numerous Japanese terms such as, "Muda", "Muri", "Mura", "Heijunka", "Kaizen", "Poke Yoke", etc.

As Toyota grew from a small company to become the world's largest automaker (in 2008)[x], the "seven wastes" that it had identified became the focused targets of others seeking to utilize this performance improvement strategy. The seven wastes include:

- Transport
- Inventory
- Motion
- Waiting
- Overproduction
- Over-Processing
- Defects

As LEAN has evolved, some have begun to acknowledge and address an eighth waste- underutilized personnel.

The approach to LEAN management is often depicted by the following model[xi] (or one very similar to it):

Essentially, LEAN is centered on *making obvious what adds value by reducing everything else*. Its focus on *continuous improvement* breaks down into five basic principles:

1. **Challenge:** the need to challenge ourselves regularly if we are to achieve our goals
2. **Kaizen:** Continuously seeking innovation and evolution- it's never 'good enough'
3. **Genchi Genbutsu:** Getting facts from the source, achieving consensus, making right decisions
4. **Respect:** Building mutual trust and taking responsibility for one another's success
5. **Teamwork:** Developing individuals through team problem-solving

[High] Reliability

In 1987, a conference at the University of Texas brought researchers together to focus attention on "High Reliability Organizations" (HROs). Organizations considered included those using complex integrated technologies while operating in unforgiving social and political environments where the consequences of errors could be catastrophic. Examples of such sectors/industries studied included Air Traffic Control, Nuclear Power Generation, and US Navy Aircraft Carriers.

Organizations deemed "highly reliable" tend to share five characteristics:

- Preoccupation with failure
- Reluctance to simplify operations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise

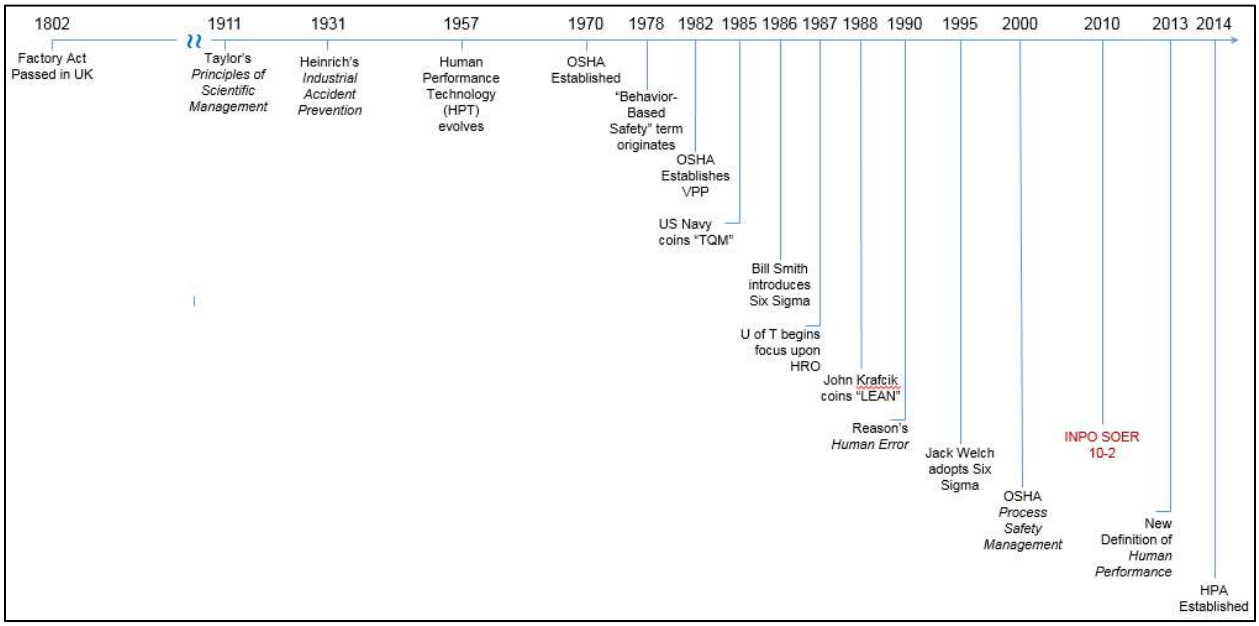
The basic premise of *High Reliability* is that things we do not expect to occur actually happen every day. By being *mindful* as an overall organizational team (vertically and horizontally), an HRO achieves the means to effectively deal with the unexpected in a manner that minimizes consequences.

The concept of turning virtually any organization into one that is "highly reliable" has become a very attractive premise to many. As indicated in the book *Managing the Unexpected,* Karl Weick and Kathleen Sutcliffe identify the need to build a "Mindful Organizational Culture."[xii]:

Performance Improvement Timeline

So what does our history of performance improvement look like if we arrange it on a timeline?

Here you go…



The History of Performance Improvement

You and I have been substantially impacted by the history and outcomes of these efforts. You've likely been directly involved in some of it (as have I), and we've all benefitted. We have safer, more productive, more efficient places in which to work and in which to live.

Cars don't break down.
Luggage doesn't get lost during air travel.
Nuclear reactors don't meltdown

The history of performance improvement has given us an evolving sequence of priorities, each with a specific area of focus. We like to think we've gotten

smarter, and indeed we have. We like to think we've gotten better, and indeed…we have.

Why then, do we still have so much wasted time, energy, and resources?

Why do you STILL feel such frustration and stress when working to fulfill your day-to-day responsibilities?

Why are there STILL so many 'fires to fight'?

The Current State of Affairs

FACT: Over $300 BILLION dollars per year is currently being spent on training and performance improvement efforts, and MUCH of it is WASTED, with very little (if any) ROI

FACT: Organizations are currently spending (on average) more than $1,252 annually per employee on training, and yet 68.5% of the workforce remain either not engaged (or actively disengaged) in their work

FACT: The "Great Divide" in attitudes and perspectives growing in society is promoting "us-vs-them" dysfunction in workplace cultures

With all the years of effort, so much resource, and so many smart people working to improve performance, you think we'd have 'figured it out' by now. Clearly we have a way to go.

The challenges we currently face cannot be solved with the same level of thinking that created them. It's time, as Steve Jobs put it, to THINK DIFFERENT.

REPS

Depending upon the size of your organization, you probably have a Safety Department and a Quality Department. You most likely employ a cadre of people whose jobs encompass or include various PI functions, like the folks with the belts (Six Sigma / LEAN specialists), someone who coordinates or manages error reduction and/or "human performance", and an individual who tracks and trends your metrics and KPIs. You might even have a "Corrective Action" Department, and someone in charge of "self-assessments" (or at least a specialist or two).

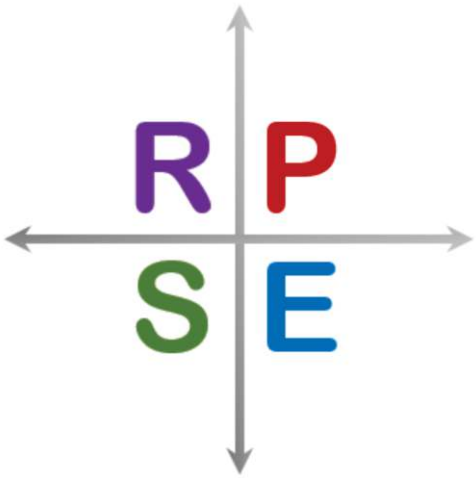
The efforts and focus involved in each of these areas have come into being and have been developed based upon the history of performance improvement, as well as the series of 'best practices' that have reared their heads and grown over time. There are a lot of very smart and dedicated people involved, each with their own priorities, biases, and their own sets of 'tools' with which to solve problems and address challenges.

One of the major problems this creates is a 'siloed' approach to performance improvement.

Think about your company. It's likely that the 'quality' folks rarely (if ever) collaborate with the 'safety' folks. Your 'risk management' department likely has little direct cooperation with your 'belts' seeking to improve efficiency and productivity. If you have a "human performance" person, she is likely predominantly focused on error reduction and after-the-fact investigations, and functions in relative isolation from the other "performance improvement" disciplines.

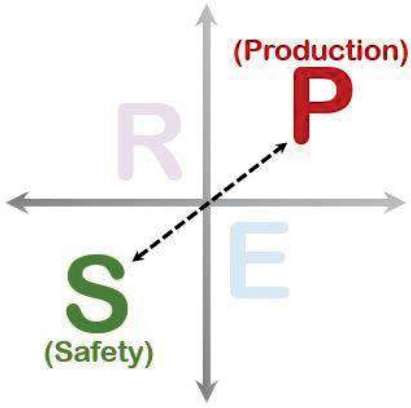
And what about "Human Resources" (HR)? In many cases HR departments have become the 'tail wagging the dog', spending most of their time protecting the company from its people! Senior leaders are frustrated (as you likely know). Workers are pissed off (as you're likely aware). This is another rant for another time, but it is a huge SYMPTOM of our current state of dysfunction.

An effective way of looking at this is to consider that, collectively, your performance improvement efforts are designed to elevate performance in four areas: Reliability, Efficiency, Productivity, and Safety. This 'plays out' as shown in the REPS diagram below.



In order for your organization (or any organization) to be successful, you *must* place appropriate focus in each of these areas. This is where, even with the best of intentions, organizational dysfunction (and the stress it creates) often increases when approaching performance improvement as it has typically been done.

To begin, consider "**S**afety" and "**P**roduction".



From a perspective of direct focus, these priorities are diametrically opposed. It's like a tug-o-war, with one side pulling against the other. Put more emphasis on Production, and Safety tends to be compromised. Pull too much toward the Safety side, and Production schedules can be really tough to meet.

To be fair, you may [initially] want to argue with this. In the 'bigger' picture, many have discovered that there is indeed a highly beneficial correlation between the two (in the longer term). A great example is the story of Paul O'Neill taking the helm of Alcoa in October, 1987. If you're not familiar with that story, you can find it on page 200 in *6-Hour Safety Culture*.

On the surface, however, consider this- the absolute safest thing you and I (or the workers in your organization) can ever do is…nothing. This is because doing anything at all carries with it some level of risk.

Of course, if we do nothing, we have no purpose, we have no revenue, and our organization ceases to exist. Hopefully from this perspective, you can now see how production and safety (prevention) are in direct opposition (as shown in the diagram).

As I make an assumption (which I rarely do) that your organization is doing things to generate revenue, I can tell you as fact- 'safety' is NOT your top priority. So if you are one of those companies out there with "*Safety is our top priority*" still bantering about on your corporate lips, in the words of Dr. Hartley, "STOP IT!"

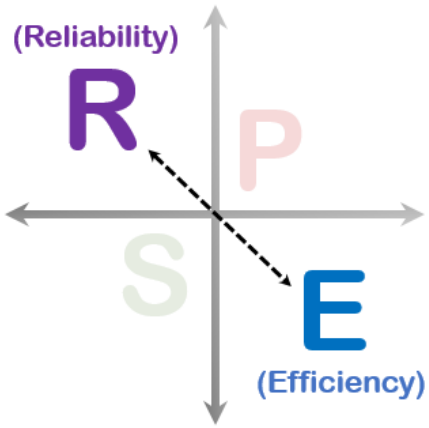
When you say such things, you're causing confusion. When workers hear this, and yet feel a strong sense of 'pressure' to produce (whether real or perceived), it creates confusion. And because of the way the human brain works, confusion automatically generates resistance.

In many organizations today, you have Corporate, the Finance people, the Marketing folks, and the 'belts' all working hard to do everything they can to increase productivity, while the Safety folks are busting their butts to overcome the

resulting perception of time pressure (and the inherent tendency to take more risk and 'cut corners') that this generates.

Things that make you say, "hmmm".

Now, let's look at **R**eliability and **E**fficiency:



Reliability requires stronger, more robust, more failsafe. It needs greater numbers/layers of protection, more redundancy, defense in depth- you get the picture. This is what your designers, your engineers, your risk management folks, and your procedure writers work their tails off to create. The thing is, all of this costs money. Often, LOTS of money (just ask your friendly nuclear executive).

Efficiency, on the other hand, involves faster, cheaper, smaller, simpler- the things that your Six Sigma and LEAN professionals (which I have been affectionately referring to as the 'belts') are often working to achieve.

So now, at the '10,000-foot level', you are being hammered to reduce costs, while ALSO being called on the carpet for metrics/KPIs related to reliability.

And the thing of it is- ALL of these areas (Reliability, Efficiency, Productivity, and Safety) are essential to the success of your efforts and your organization.

What to do…what to do…

Latest Research and the Next Generation of PI

As I mentioned before, I am a *synthesizer*. The success of our company (PPI), and the successes of our Clients have been the direct result of 'standing on the shoulders' of those who have gone before- taking the 'best of the best' from the fields of PI, nuclear "human performance", occupational and process safety, psychology, and neuro-science, and blending them together to create an approach that's never been done before.

Depending upon the business you're in, appropriate tools and disciplines of the professionals involved in the PI arenas discussed thus far are necessary to your success. When properly employed, they SHOULD be adding an amount of tangible value to your organization far beyond their inherent costs. If they are not, they are either not being properly employed, or they should be abandoned. As the wise Chinese philosopher once said, "If you're riding a dead horse, for goodness sake- dismount!"

The BIG question is- HOW can you achieve *synergy* of your efforts to improve performance such that there are no conflicting agendas, no confusion of priorities, and where your facility/organization functions as one coherent team?

What is "Next Generation Performance Improvement"?

You'll find the answer on the next page.

The "Big C"

"Culture eats strategy for breakfast, 'excellence' for lunch, and everything else for dinner."

- Peter Drucker

Culture? Really?

You're likely now thinking, "What the Heck?! I know all about this 'culture' stuff! There are a gazillion books about it. Every other consultant (and his brother) is talking about it. What's 'next generation' about that?"

The greatest management/leadership guru of modern time, Peter Drucker, gave us the ultimate answer [to essentially everything] several years ago: *Culture*.

Unfortunately, the latest research, as well as our experience working with tens of thousands of workers over the past eleven years, clearly indicates that most organizational leaders, managers, and coordinators STILL don't get it.

Most continue to fill their days 'fighting fires' (because they have to). And besides… the whole 'culture thing' seems so abstract- how can you measure it?

Those involved with running organizations, as well as those responsible for improving performance, have therefore tended to stick with what they know- that which can be calculated, touched, and felt. They focus upon facts, figures, metrics, and 'holding people accountable', while doing their best to use the PI 'tools' that history has provided them.

FACT: If you don't manage your culture, your culture will manage you.

When I have the opportunity to speak with leaders in a live environment, I love to ask the question, "How many of you spend most of your work day 'fighting fires'? Without exception virtually every hand in the room is thrust in the air.

How about you?

If you are one who would raise your hand when that question is asked- you are being managed by your culture.

The remedy? It should be obvious. Unfortunately, focusing upon culture transformation is often counterintuitive. After all, you're likely responsible for quarterly reports and monthly KPIs. There are undoubtedly daily metrics being perused by your higher ups. How can you possibly find time to focus on something as abstract as *culture*? Besides, you've likely heard the MYTH: in the world of hope-based performance improvement, its generally accepted that "changing culture is hard and it takes a long time."

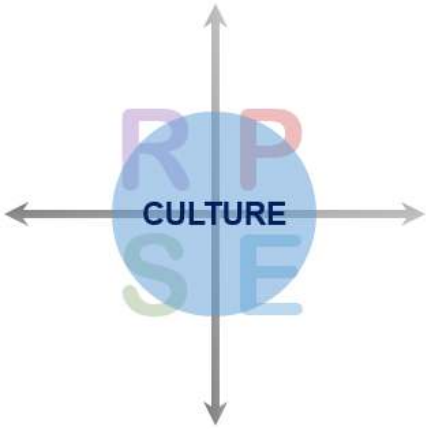
You simply don't have the time, the bandwidth, the energy, or the knowledge.

Relative to things being "counterintuitive", here's what I learned from one of my mentors, Eben Pagan: *The short-term and long-term consequences of the choices you make are typically different, and often opposite.*

You should read that statement again. And perhaps a third time.

It's likely that you're running your organization, your department, your facility, or your area of responsibility primarily with a short-term focus, making short-term decisions! This is the reason why you continue to have so many 'fires' to fight! This is the reason why the various disciplines and PI efforts you have in place are not producing the sustainable results you need.

I'm going to BUST the MYTH about culture change, but before I do, let's go back to the REPS diagram and look at how it is impacted by *culture.*



The best way to explain the impact of *culture* upon your overall efforts toward Reliability, Efficiency, Productivity, and Safety is to tell a story I learned from another of my mentors, Zig Ziglar.

A father was home taking some "me time", wanting to read the latest issue of Forbes magazine, yet, as he attempted to read, his young daughter kept asking him questions. He thought of a solution to his dilemma. Page 42 of the magazine contained a map of the world. He ripped the page out, and tore it into pieces. He handed the pieces to his daughter, saying, "Here's a puzzle for you, Sweetheart. It's a map of the world. See if you can put the puzzle together for me."

Eagerly, she went about her task. Dad figured it would take his daughter quite some time to figure out the puzzle, giving him some time to actually read. In addition, since this was a map of the world, she might learn something in the process. However, within a few minutes, the young girl had completed her task.

"Look, Daddy!" she said, "It's all finished!"

Astonished, Dad responded, "That's great Sweetheart! But, how did you put that map together so quickly?"

"It was easy," she replied. "On the other side was a picture of a man. I just put the man together, and the world came together as well."

Who do you think learned the [real] lesson?

On a personal level, when you get yourself together, your outer world, the people in your life, the circumstances in which you find yourself…all come together as well.

The same thing is true for your organization. When your *culture* comes together, when you achieve proper BALANCE, things synergistically fall into place. No more tug-o-war.

When you get your *culture* right, metrics improve, KPI goals and milestones are met, your organization (and what it does) becomes more Reliable, Efficient, Productive and Safe. Fires begin to put themselves out, and soon, any associated smoke or smoldering dissipates.

People are happier and more fulfilled. Conflicting priorities and agendas diminish and disappear. Your organization begins to function as a solid coherent team.

Sound too good to be true?

It's not. Science, research, and experience have proven this to be VERY doable.

Now for a bit of self-diagnosis…

I would imagine that there's been some head nodding as you've consumed the material in this Report. I would imagine the stressors, the 'fire-fighting', seemingly conflicting priorities, and the sense that you're getting pulled from one side to the other feels rather familiar.

On the next page is a version of the REPS Matrix. If you're reading this as a pdf on a computer, you'll want to print the following page so that you can draw on it. You will also need two pens/pencils of different colors in order to complete this exercise.

Make sure you do this. It'll open your eyes to the present…and to your future.

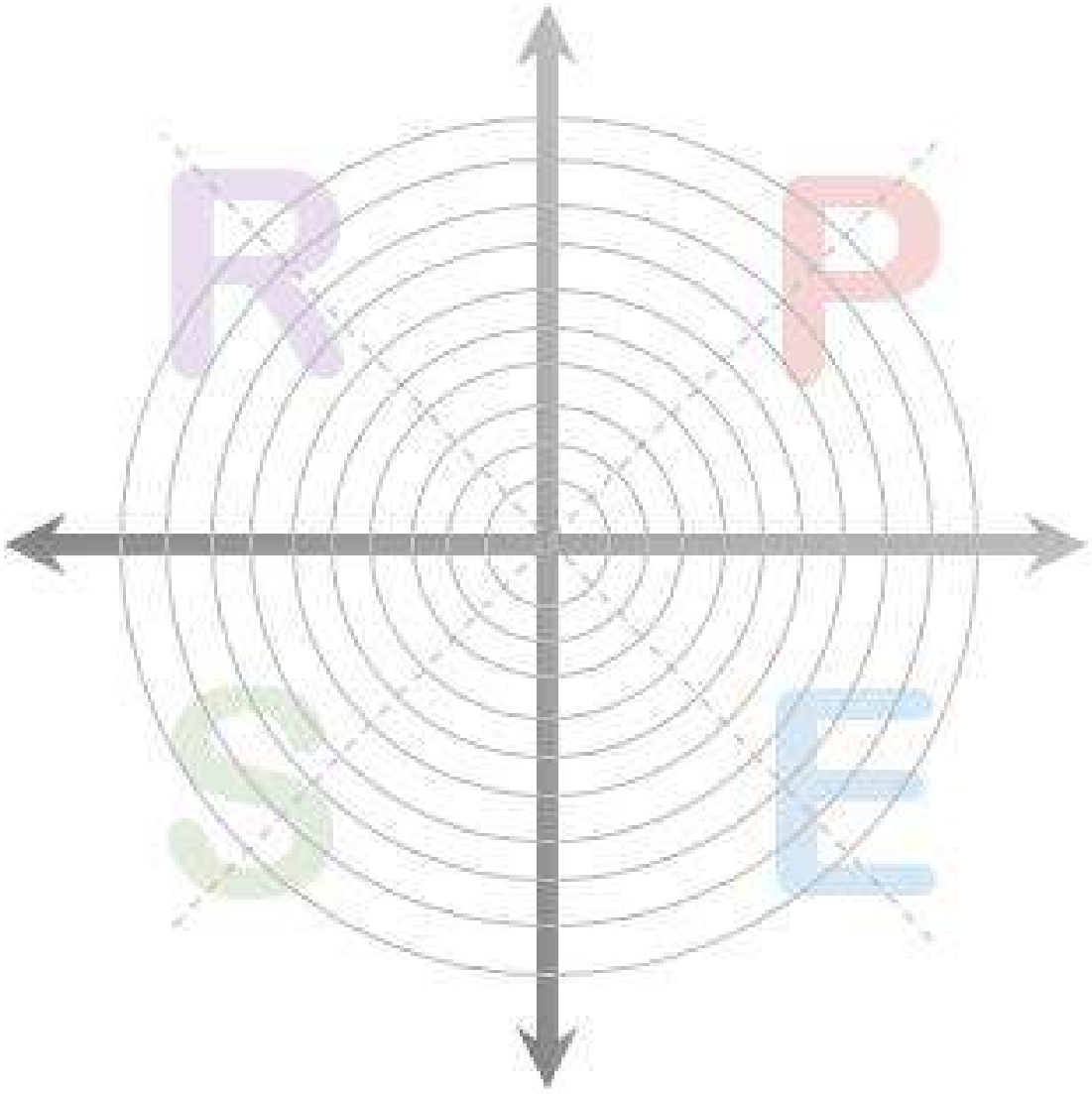
Here's what to do:

1. First, take one of your writing implements, and place a dot along the dashed line in each quadrant relative to your perceived performance in that area (the further from the center, the STRONGER the performance).

2. With that same color pen or pencil, connect the dots. The shape you have just drawn represents your current *Performance Culture*.

3. Now take the pen/pencil of a different color and place a dot along the dashed line in each quadrant that represents the current level of effort (time, energy, resources, and capital) your organization is currently putting forth in each of the four areas.

4. With that same color pen or pencil, connect those dots. The shape you have just drawn represents your current *Priority Bias*.



When you finish, your drawing should look something like the one on the next page (although the shapes and biases may be [quite] different).

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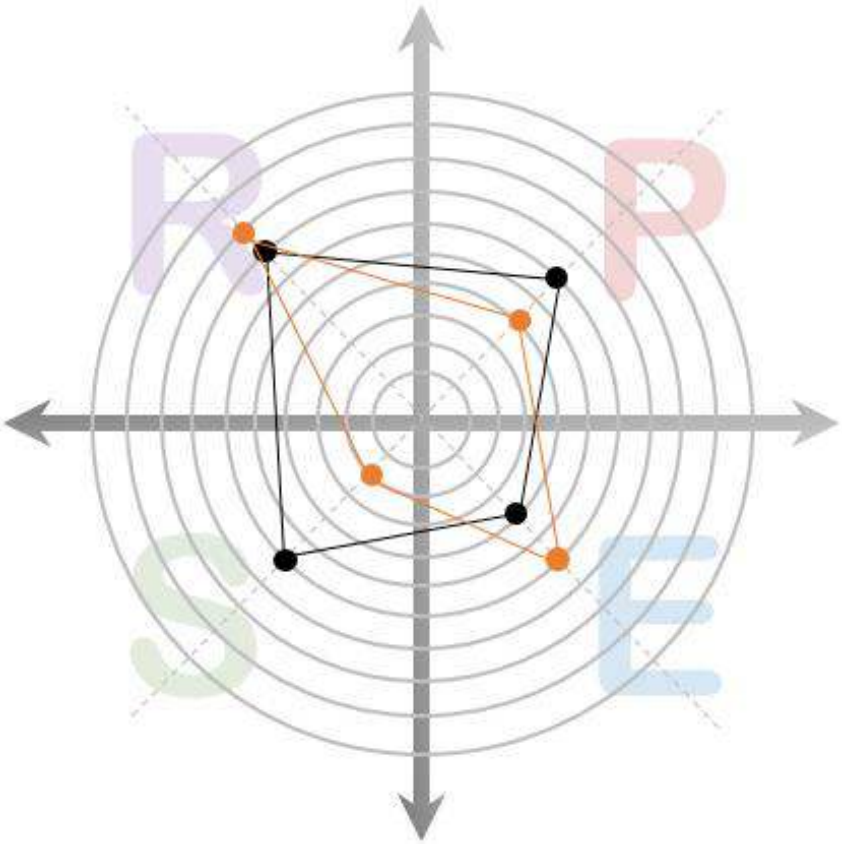

What you have just created:

1. Once you've drawn the first line and connected the dots, the shape within the lines provides a graphical representation of your current ***Performance Culture***. This represents how you are currently performing in each of the areas. In the example above, this is represented by the black line.

   Of course, in this quick assessment, this is your perception, but if you are aware of your 'numbers', your perception is likely fairly accurate.

   In the example above, the black line indicates that this organization is pretty symmetrical and is likely performing relatively well.

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2. The second (orange) line and corresponding shape represents current ***Priority Bias***. If nothing changes, it is highly likely that this represents your future performance.

   In the example, the organization is currently placing more emphasis upon **R**eliability and **E**fficiency. While there is nothing wrong with this, look what's happened in the **S**afety and **P**roduction arenas. This could be a case where the organization feels that these areas are "fixed".

   It's very likely with such low energy being applied to Safety and Productivity, these will become the areas requiring acute focus in the future, as performance in each will likely drop. This is how organizations have tended to live in the mode of '*pendulum performance improvement*', continuously shifting focus from one crisis area to the next. Very costly. Very inefficient. Very dysfunctional.

   I can imagine you're now thinking, "Yeah…in an ideal world! But I have to deal with reality. We can't possibly focus everywhere all the time!"

   In the words of Walt Parazaider, saxophone player for Chicago, off of the *Chicago at Carnegie Hall* album (my very favorite album of all time), "Just keep sittin' there man."

   The best is yet to come.

Before we leave this Exercise, take a look at your matrix and consider the following questions:

a. Do you like what you see?
b. How symmetrical are your shapes? (The more symmetrical your shapes, which in this simple diagram would ideally be a square, centered within the matrix, the more functional your culture/bias.)
c. Do either of your shapes surprise you?
d. Do either of your shapes bother you?

e. What (if anything) do you see that you don't like about your current *Performance Culture*?
f. If you continue with your current *Priority Bias*, where are you likely headed?

The truth is, in spite of the science behind many of the TQM and Six Sigma analysis tools, in spite of the terabytes of data collected in the human performance, corrective action, assessment, and safety arenas, MUCH of the efforts to improve performance over the past decades have simply been based upon…hope.

Further, because of the 'silo' approach used in the performance improvement arena, synergy has not been achieved between the different PI disciplines, resulting in exorbitant costs, incremental (at best) improvement, and the constant urge to adopt another 'program' that promises to take away your pain.

Unless you are an outlier, one of those exceptional organizations who has figured this out, the shapes on your REPS matrix bear witness to what I'm talking about.

The question now is- what are you going to do from here?

CULTURE (Part Deux)

Leaders as entrepreneurs are the architects of culture.[xiii] Make no mistake- culture begins and emanates from the top. In a family, the parents (or dominant parent) pretty much determine the culture. In a community, it's the community leaders. Within your organization, the higher you are on the ladder, the more leveraged your influence upon your culture. So…change it!

Unfortunately, there's that darned old MYTH (changing culture is *hard* and takes a *long* time). It's pervasive. It remains alive and well in business publications, many books, and on the lips of consultants.

Even Edgar Schein, author of *Organizational Culture and Leadership*, and hailed guru of everything 'culture', states, "Culture is hard to change because group members value stability…"[xiv]

The thing is, the "*hard* and *long* thing" is absolutely true…IF you approach culture change the way most organizations have typically approached all performance improvement. Employing efforts designed to "fix" people (and their attitudes) simply doesn't work.

MYTH BUSTED

You CAN transform your culture RAPIDLY using a very simple (yet profound approach).

Remember how I indicated earlier that the approach we've used for the past 11+ years evolved from a synthesis of what previous brilliant PI minds and practitioners, psychologists, and neuro-scientists have discovered and developed? And remember how I indicated that the manner in which we put it together has been unlike anything else 'out there'?

Well as it turns out, this approach, which has typically been implemented by our Clients with an intent of reducing errors and improving safety, absolutely transforms culture.

Using a very simple (yet profound) strategy and set of tactics, it has proven to effect positive culture change, and to do so RAPIDLY. This has resulted in massive positive outcomes for those who have adopted this approach, some of which include:

- Substantial reduction in errors
- Substantial BALANCED improvement in Reliability, Efficiency, Production, and Safety
- Increased levels of commitment, ownership, and personal accountability

- Happier workers (better morale)
- SUSTAINABLE metrics/KPIs/performance improvement

As an example, one of our first flagship success stories is the Limestone Generating Station in Jewett, Texas. At the time, the facility had been operating for just over 25 years. Most of the workers had been there about that long. It is a Bargaining Unit facility. The plant had gone through three mergers/buyouts by other companies. The most recent of which had been the purchase by NRG (now the largest merchant provider in the US). Prior to our assistance with their implementation, they had a horrible safety record, a large amount of contention with the Union, and ongoing attitude fallout from the recent merger. Sound like a challenge?

Six months following implementation of the approach we call Practicing Perfection®, the Senior VP of Operations for NRG paid a visit to Limestone. During his visit he toured the facility, watched operations and maintenance personnel performing tasks, and had one-on-one conversations with a slice of the workforce.

He and I had a phone call scheduled while he was at the plant. During our conversation, he said to me, "Tim, I absolutely cannot believe the amount of positive culture change that has happened at this facility. And it's happened so fast!"

Over the subsequent year, the plant set records in production, capacity, low number of union grievances, and had a flawless safety record (which continued onward to generate a new safety record for the facility).

We're All in This Together

The purpose of this Report has been to introduce you to a new way of thinking- a different way of considering HOW to excel into your future. I trust I have made my case.

In today's global environment we truly are 'all in this together'. I therefore want to give you a few takeaways you can inject into your mindset, sink your teeth into, and begin to take action upon.

Concept → Strategy →Tactics

This figure should give you plenty to think about. Based upon the results you achieved when you identified your current *Performance Culture* and *Priority Bias*, you should be able to consider some actions you can begin taking immediately.

CONCEPT

I trust you are a believer that Culture determines results. Further on in this Report I'm giving you a link to a FREE video learning series, where you will learn specifics on HOW to transform your culture. I hope you'll take advantage of that.

In the meantime, here are some general guidelines relative to the TYPE of *informed mindful Culture* you should be seeking:

- A *reporting culture*, where trust levels are such that team members openly and willingly share successes and non-successes

- A *just culture*, where "acceptable" and "unacceptable" behaviors are universally embraced, punishment never occurs when errors result from *acceptable* behaviors, and when something goes wrong *reasons* are sought (NOT scapegoats)

- A *flexible culture* that provides maximum team member autonomy, fostering individual discretion and creative make-things-better energies (rather than uniformity and conformity)

- A *learning culture* which fosters openness and provides opportunities and a climate where team members are encouraged to share their thoughts and knowledge

STRATEGY

Recognize that the *human performance*, the combined actions, interactions, and accepted 'norms' of your team members is what creates your culture.

Adopt and embrace the new definition of Human Performance:

Human Performance is WHY we do WHAT we do the WAY we do it.

Recognize that the 'root', the core, the power for transformation, within this understanding lies in the WHY. The goal is to get to the point where team members are doing the right things for the right reasons (even when no one is watching) because they WANT to.

In the video series, I'm going to show you HOW to do just that.

TACTICS

THINK Different, involves expanding team member *context* (rather than simply providing more *content*). It involves tapping into (and leveraging) the intrinsic human need to…matter; to make a difference.

DO Different™, involves the use of very simple tools and processes during team member interactions, when making choices and decisions, and when performing tasks. This is where the RESULTS are generated.

I could obviously write an entire text describing this part of the process. But by now, I would imagine that you're tired of reading (and I KNOW I'm tired of writing!).

So, instead of detailing more specifics in print, I have decided to talk with you directly in a three-part video series that you can access for…FREE.

As I mentioned earlier, we're all in this together, and… I'm hoping to redeem myself a bit for taking so long to SHARE this information!

You can access the video series using the url in the box below.

You can access the video series here:

https://ppiweb.leadpages.co/next-gen-pi-access/

CONCLUSION

The pathway to get where you want to go begins with your next step. I trust you gained some insight from this Report that you can put to use. I also trust that you'll watch and consume the "HOW TO" information in the video series I've prepared for you.

I'd hate for you to not be able to take advantage of the information and insight that this approach has to offer.

To access the 3-part video series, go here: https://ppiweb.leadpages.co/next-gen-pi-access/

Following, there is some suggested additional reading, as well as a representation of some of the inspired organizations who have been Clients of PPI.

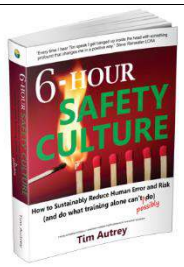
What our world is currently craving is inspired leadership- men and women who are not afraid to take the lead in a new order of things for the benefit of all. I trust, since you have read this to the end, this is YOU, and that in some small way, I might have helped you in your quest.

Thanks for all you are doing to help make our world a better and safer place,

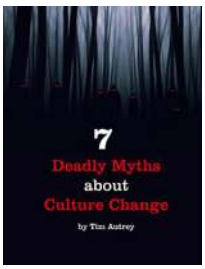
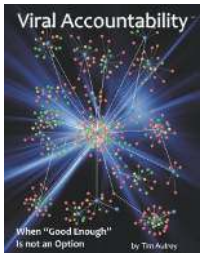
Tim Autrey, Founder/CEO
Practicing Perfection Institute, Inc.

P.S. If you found value in this Report, I'd really appreciate it if you'd offer your comments on the Download page (https://www.ppiweb.net/resources/special-reports/reps/) You can also use this to ask any questions you might have. I'll be happy to answer them.

Recommended Additional Reading

	*6-Hour Safety Culture: How to Sustainably Reduce Human Error and Risk (and do what training alone can't (possibly) do)* by Tim Autrey

PPI Special Reports:

	7 Deadly Myths About Culture Change
	Viral Accountability®: When 'Good Enough' is NOT an Option

Some of PPI's Clients…

[i] Hutchins, B L; Harrison, A (1911). *A history of factory legislation by ; Published 1911* (2nd ed.). Westminster: P S King & Son. Retrieved 30 June 2015.

[ii] https://www.osha.gov/about.html

[iii] http://nei.org/Knowledge-Center/Nuclear-Statistics/US-Nuclear-Power-Plants/

[iv] Significant Operating Experience Report (SOER) 10-2; Institute of Nuclear Power Operations; September 7, 2010.

[v] INPO Event Report (IER) 11-3; Institute of Nuclear Power Operations; June 15, 2011

[vi] *Imai, Masaaki (1986), Kaizen (Ky'zen), the Key to Japan's Competitive Success (1 ed.), New York: Random House, pp. 239–240,ISBN 9780394551869, OCLC 13010323, The seven statistical tools used for such analytical problem-solving are: 1. Pareto diagrams [...] 2. Cause-and-effect diagrams [...] 3. Histograms [...] 4. Control charts [...] 5. Scatter diagrams [...] 6. Graphs [...] 7. Checksheets.*

[vii] Martínez-Lorente, Angel R.; Dewhurst, Frank; Dale, Barrie G. (1998), "Total Quality Management: Origins and Evolution of the Term",*The TQM Magazine*, Bingley, United Kingdom: MCB University Publishers Ltd, vol. 10 no. 5, pp. 378–386, doi:10.1108/09544789810231261

[viii] https://web.archive.org/web/20051106025733/http://www.motorola.com/content/0,,3079,00.html

[ix] Krafcik, John F. (1988). "Triumph of the lean production system".*Sloan Management Review*. **30** (1): 41–52.

[x] http://marketrealist.com/2016/05/toyota-became-worlds-largest-automaker/

[xi] By Laurensvanlieshout from nl, CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=1851969

[xii] Managing the Unexpected: Resilient Performance in an Age of Uncertainty; Karl E. Weick and Kathleen M. Sutcliffe; Jossey-Bass © 2007; Chapter 6 "Organizational Culture: Institutionalizing Mindfulness"

[xiii] Organizational Culture and Leadership; Edgar Schein; 4th Edition; 2010 John Wiley & Sons, Inc.

[xiv] Organizational Culture and Leadership; Edgar Schein; 4th Edition; 2010 John Wiley & Sons, Inc.; page 16