

4 Types of Problems

Coaching Problem Solving &
Developing People Toyota Style



Learning Session Outline

- Background
- 4 Types of Problem Situations
 - Type 1 – Troubleshooting
 - Type 2 – Gap from Standard
 - Type 3 – Target State
 - Type 4 – Innovation
- Situational Leadership & Development
- Summary

Background - Lean / Toyota



Toyota Kamigo
Overhead



Kamigo
Entrance



Taiichi
Ohno



Precision & Machine
Intensive

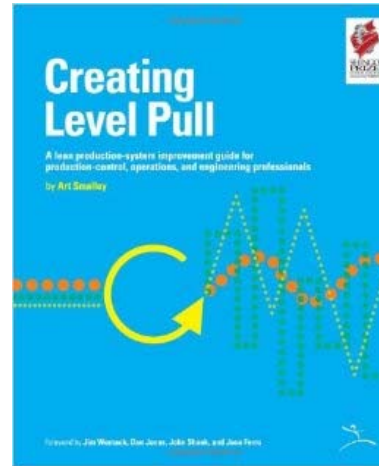
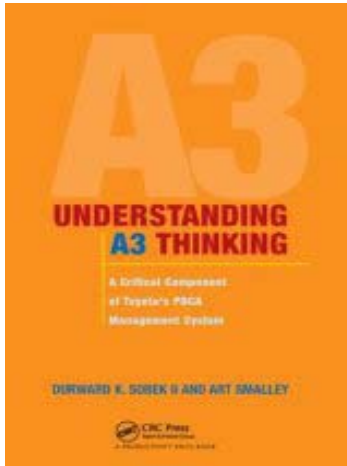


Lower Volume &
Higher Mix

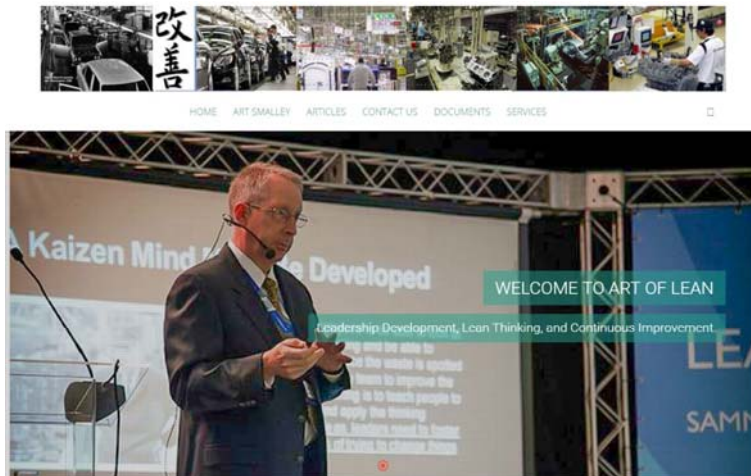


High Volume &
Lower Mix

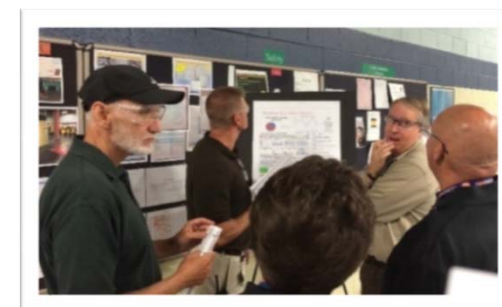
Other Background - Work



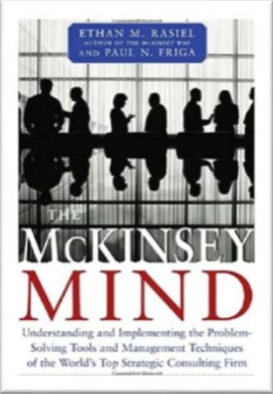
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Leadership Development, Lean Thinking, and Continuous Improvement.



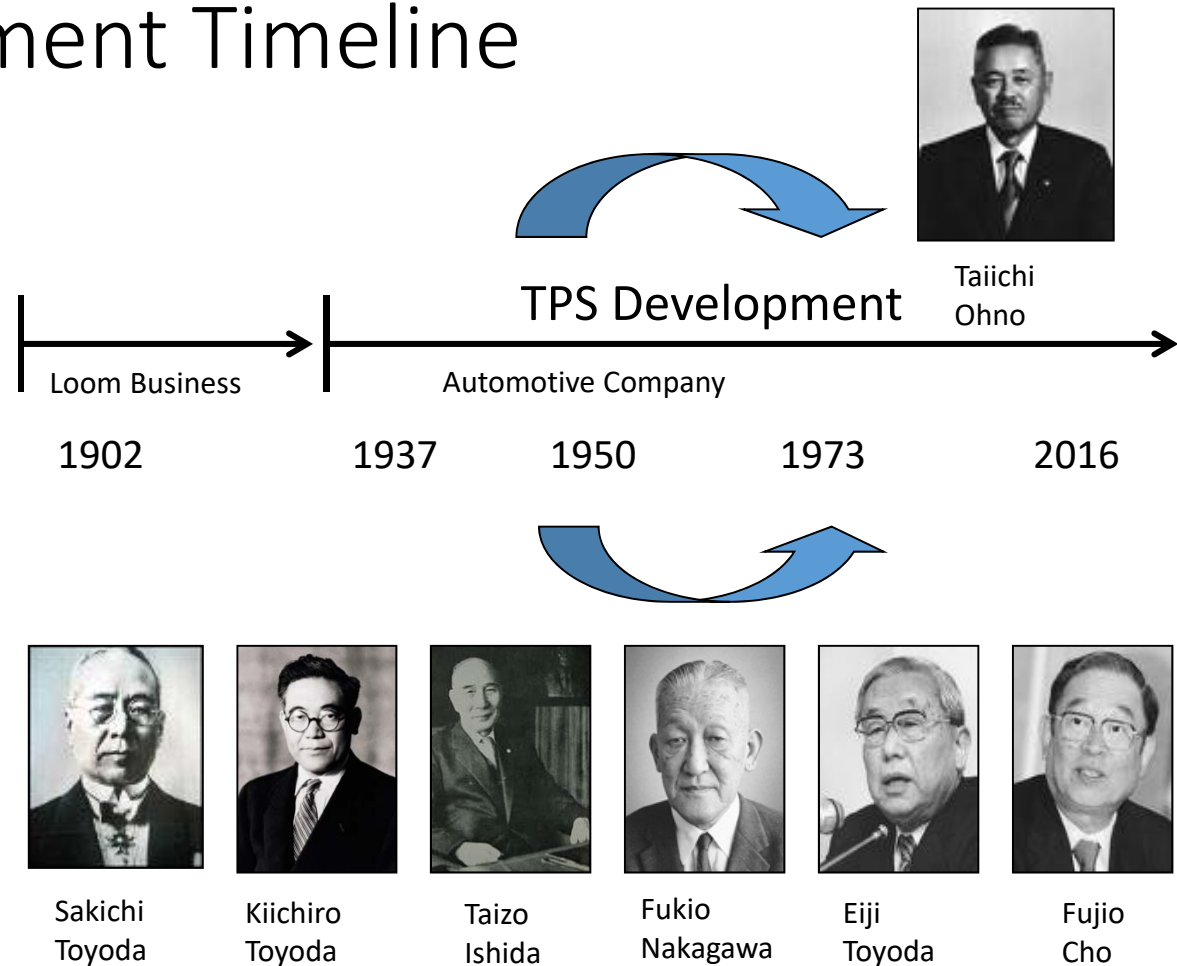
Other Background - Stuff



TPS Development Timeline

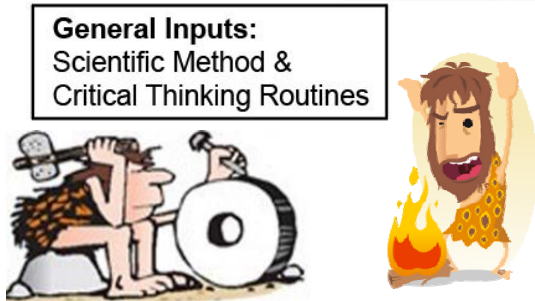
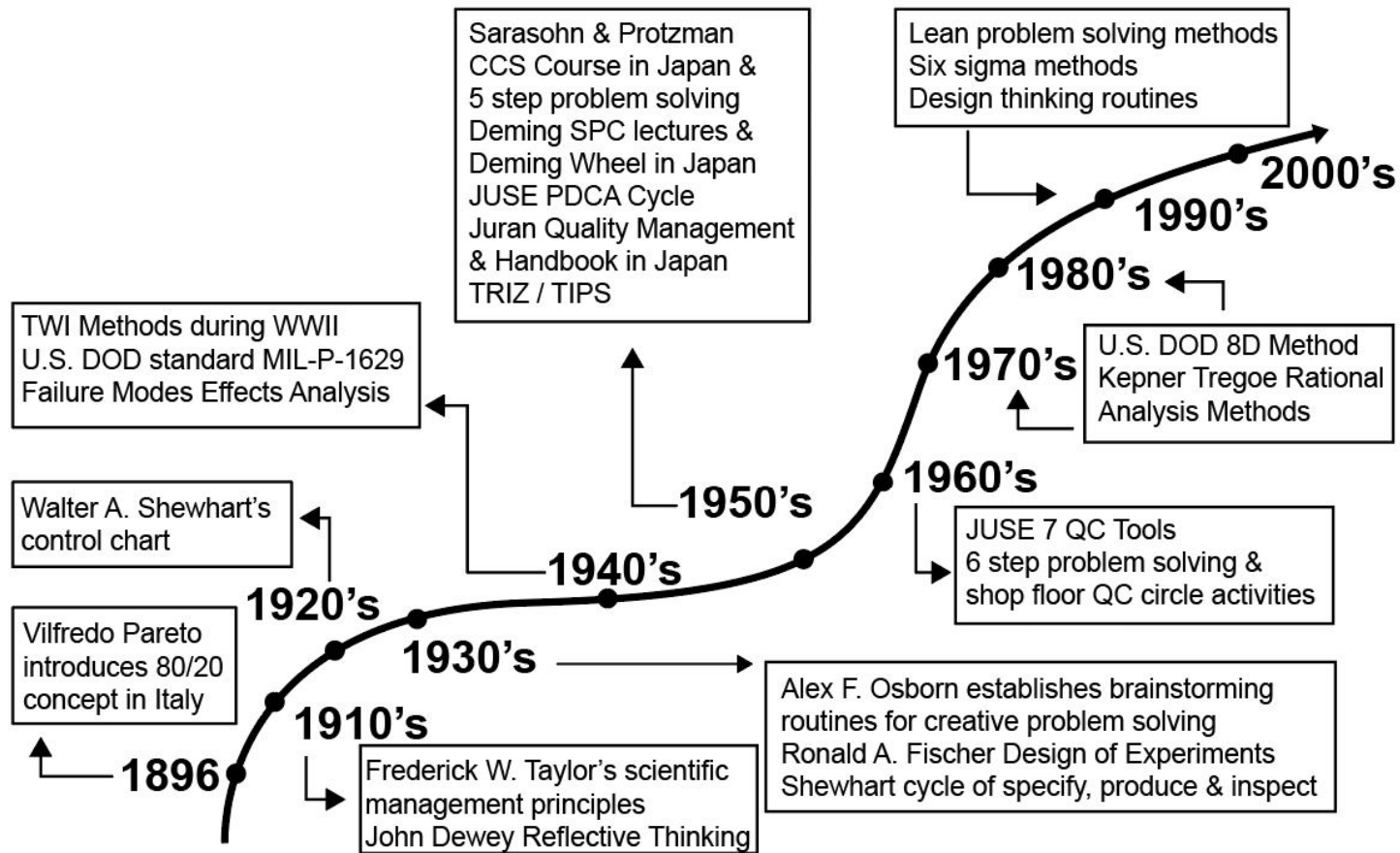
Western Influences:

- Mass Production & moving conveyor lines
- Scientific Principles Of Management
- Standardization Of Parts
- Many Others....

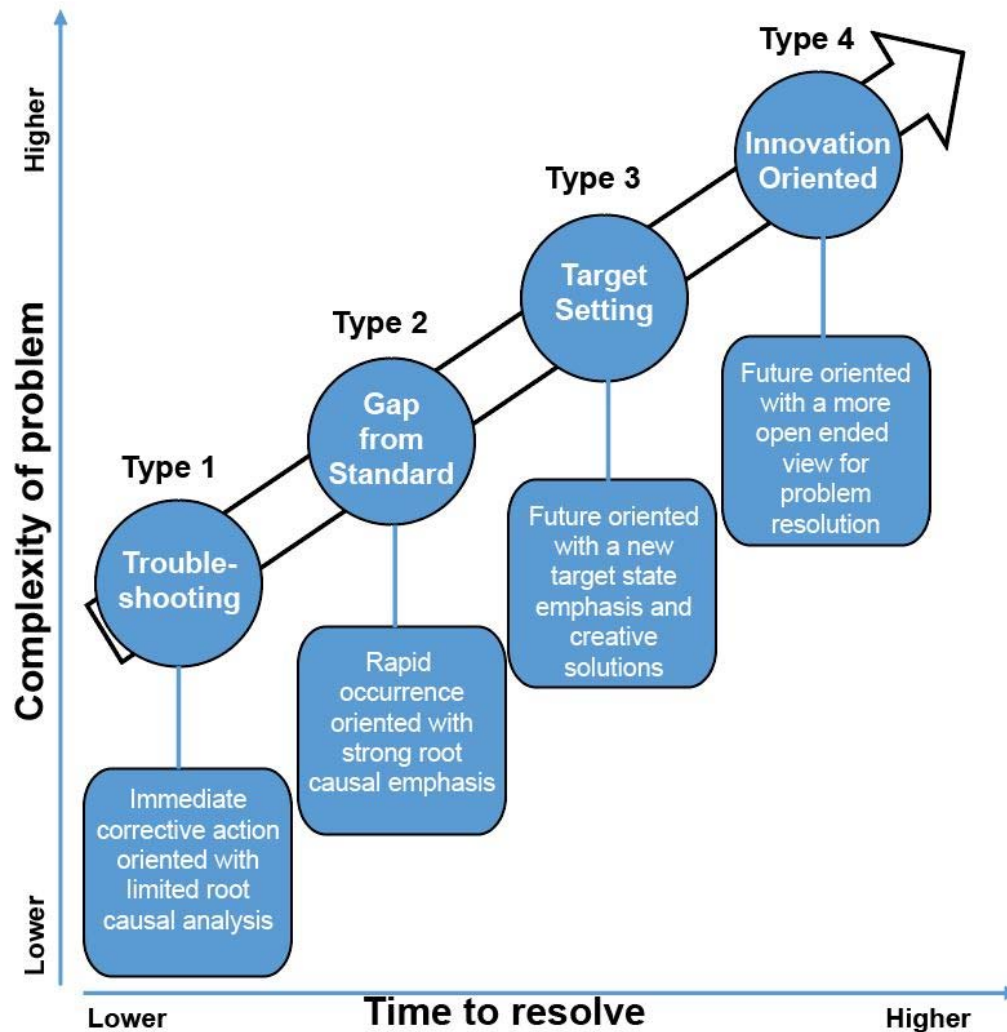


Various parties and key individuals involved over a long period of time

20th Century & Problem Solving



4 Types of Problem Situations



4 Types & Benkei Analogy

Benkei



7 QC Tools

1. Data Collection / Check sheets
2. Cause-and-effect diagram
3. Flow charts
4. Histogram
5. Pareto chart
6. Control chart
7. Scatter diagram

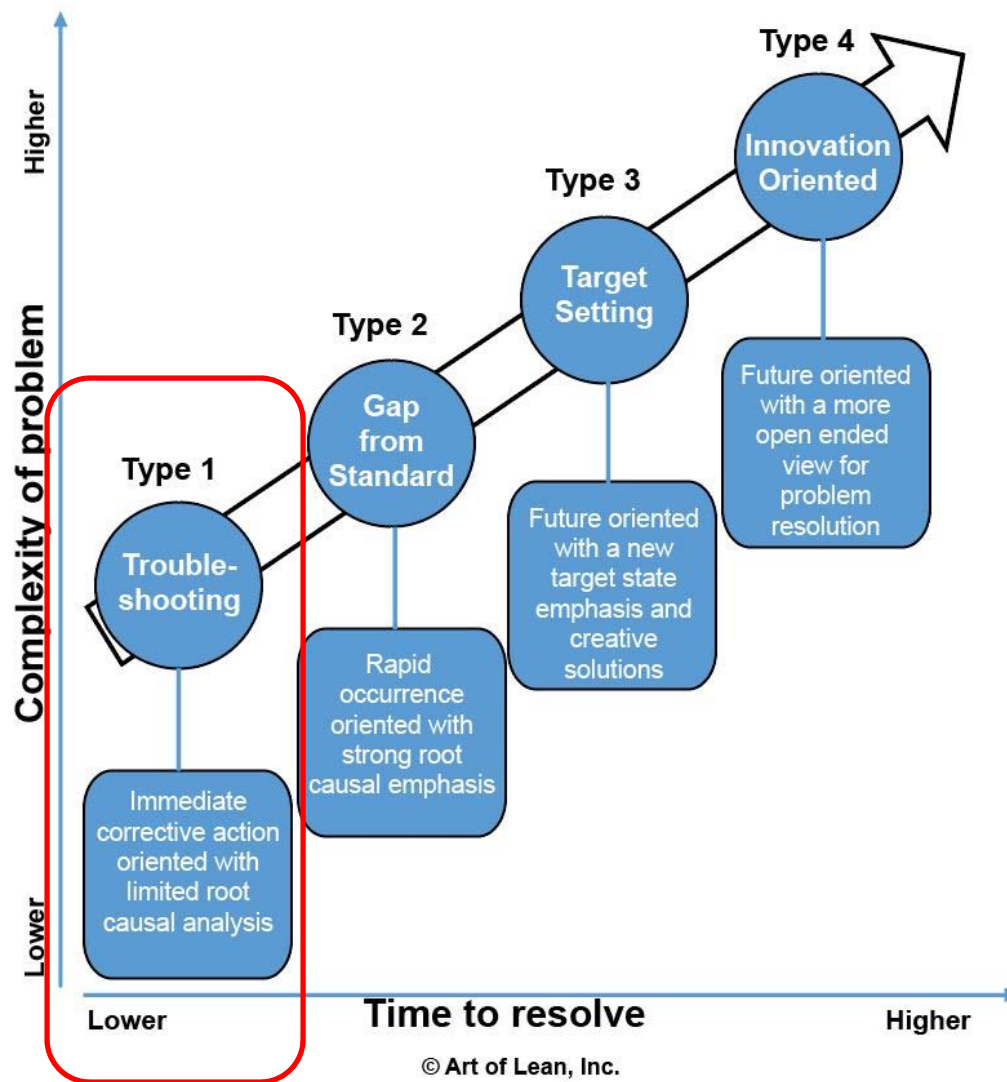
Kaoru Ishikawa



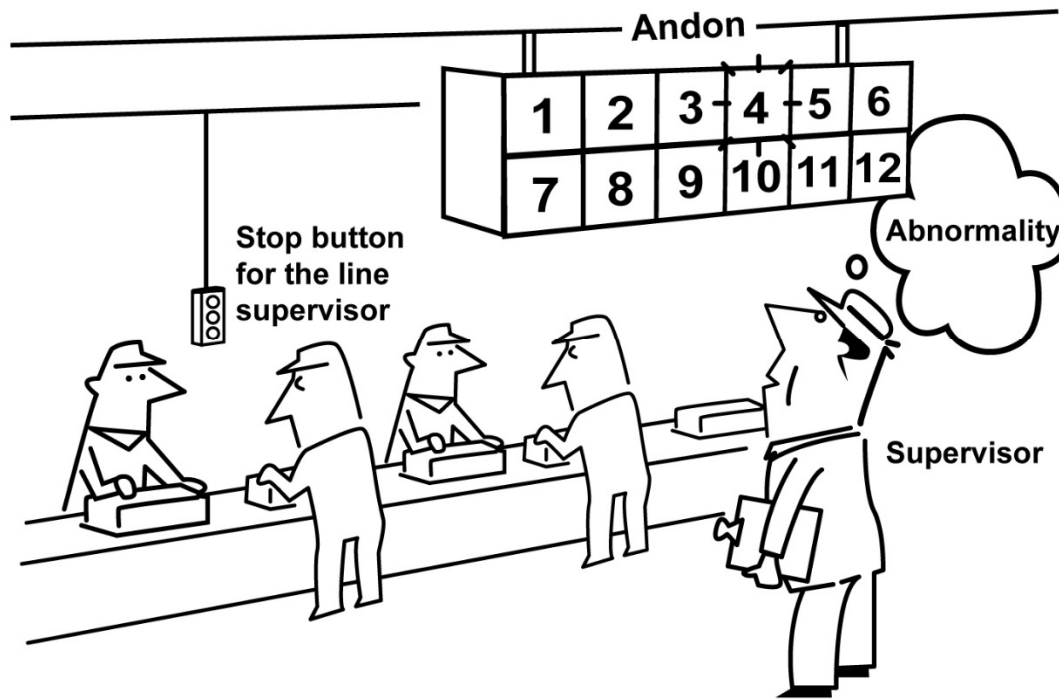
The term "7 QC tools" is named after the seven tools of Musashibo Benkei the famous warrior monk. Benkei owned seven weapons which he used to win all his battles. Similarly from my own experience you will find that you will be able to solve 95% of the problems you face if you properly use the 7 QC tools.

Professor Emeritus
University of Tokyo

4 Types of Problem Situations

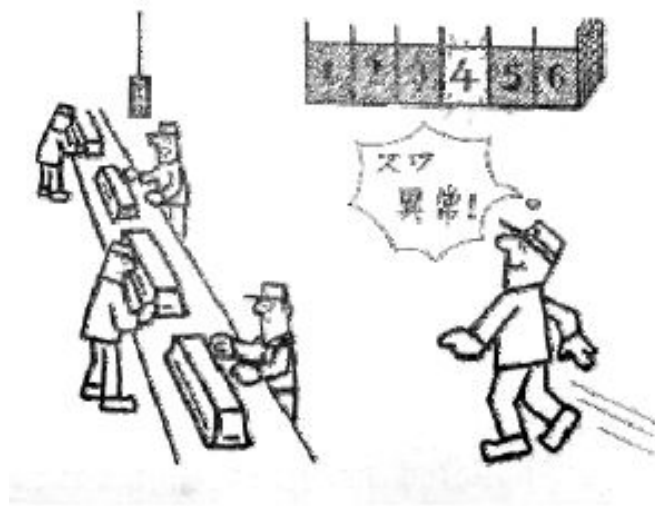


Type 1 – Troubleshooting



**Condition based trigger
Either human or machine**

Toyota Supervisor Image



Rapid response to problems and abnormal conditions by production

- Team Member
- Team Leader
- Group Leader
- Manager
- Plant Manager

“All Mighty” Supervisor Image

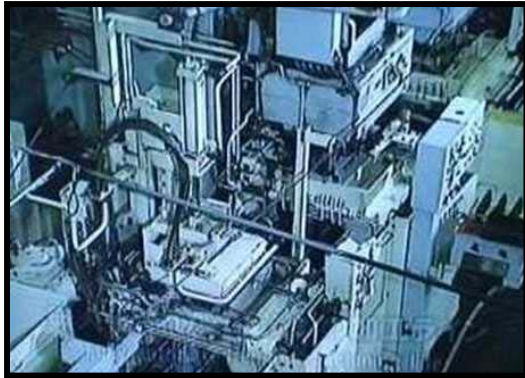
1. Safety
2. Job Ability
3. Team Leadership
4. Kaizen Skills / Problem Solving
5. Technical Knowledge
6. Human Relations

Daily Meeting & 4C's



Start of 8 hour shift
Daily performance trend
Major problem communication
Departmental coordination
Priority alignment & clarification
Hop topics, etc.

Andon Response Example



1. Automated process cycling normally



2. Mechanical probe detects broken cutting tool and stops the machine



3. Probe signals an “andon” board for visual display



4. The operator **immediately takes corrective action** and confirms good products to the following process

Type 1 – Troubleshooting

Production Analysis Board

Line/Cell Name:		Team Leader:		Date:		
Quantity Required:		Takt Time:		Shift:		
				Num of Operator:		
Time	Hourly		Cumulative		Problem/Causes	Sign-off
	Plan	Actual	Plan	Actual		
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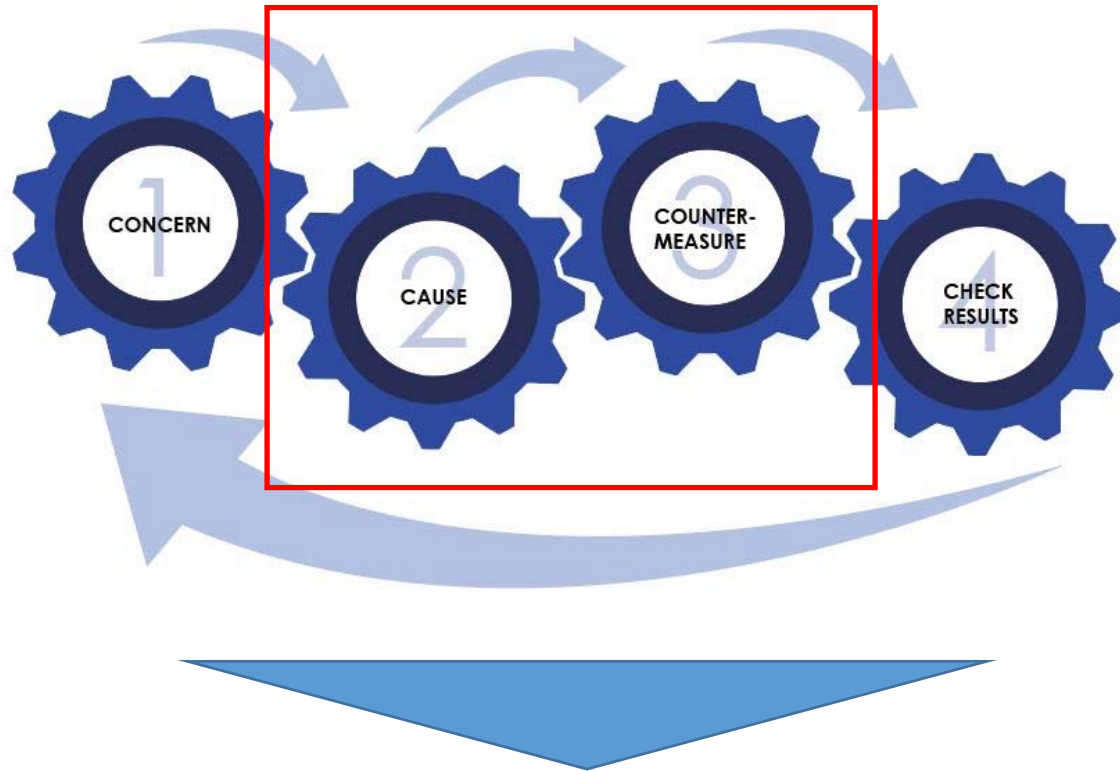
Rapid Problem Solving

- Concern
- Cause
- Countermeasure
- Check



Time & quantity based triggers
Reviewed hourly by supervisor

4 C's Thinking



Minimal (if any) documentation involved. No A3's.
Mainly discussion, thinking, rapid action & follow up.

4C's Example

- Concern: Machine cycle time is 4 seconds slow
- Cause: Bearing shaft is worn
- Countermeasure: Replace the bearing shaft
- Check: Machine cycle time is back to normal



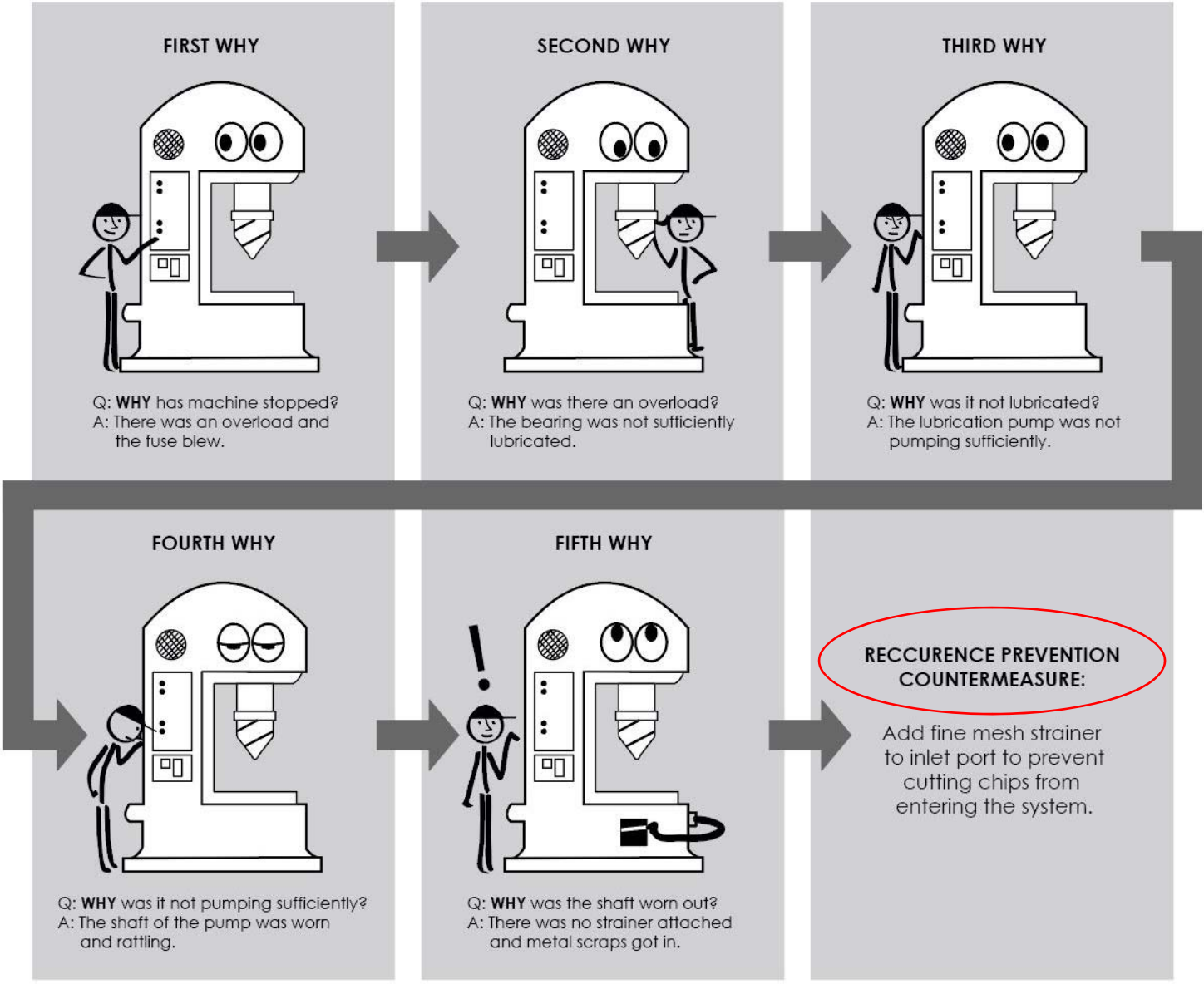
What is almost always the weak point?

“5 Why” Thinking is Critical

Situation: A machine tool has stopped working halting production.

- 1) “Why did the machine stop working?”
 - “Because the machine overloaded blowing the fuse in the control panel.”
- 2) “Why did the overload condition result?”
 - “Because there was insufficient lubrication to the spindle bearing.”
- 3) “Why was there insufficient spindle bearing lubrication?”
 - “Because there was insufficient lubrication drawn up by the pump.”
- 4) “Why was there insufficient lubrication draw from the pump?”
 - “Because the pump shaft was worn and rattling.”
- 5) “Why was the pump shaft worn?”
 - “Because there was no strainer on the lubrication device inlet port, and small metal cutting chips entered the system causing damage.”

Key Point is also the Countermeasure!



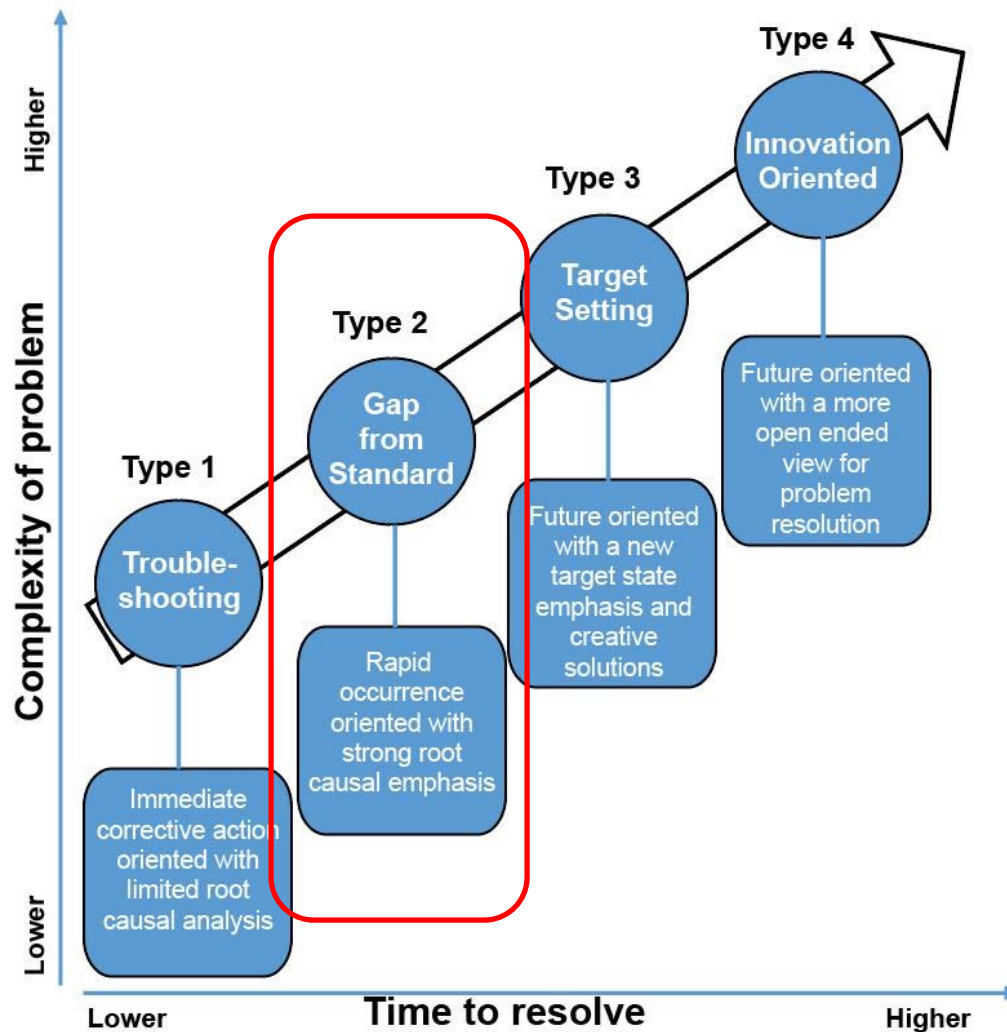
Summary Slide

- Troubleshooting is part of life and lean
- Developing good troubleshooting skills in lead personnel is part of TPS
- Reactive work is sometimes needed to “gain” time to do the correct proactive work to permanently fix the problem
- For lean to function you must have adequate time and condition based triggers to signal abnormalities
- First line supervision must respond immediately and problems must escalate up the management chain by some form of protocol
- 4C’s are good for verbal problem solving routines. Not everything is a Six Sigma project or an A3 report!

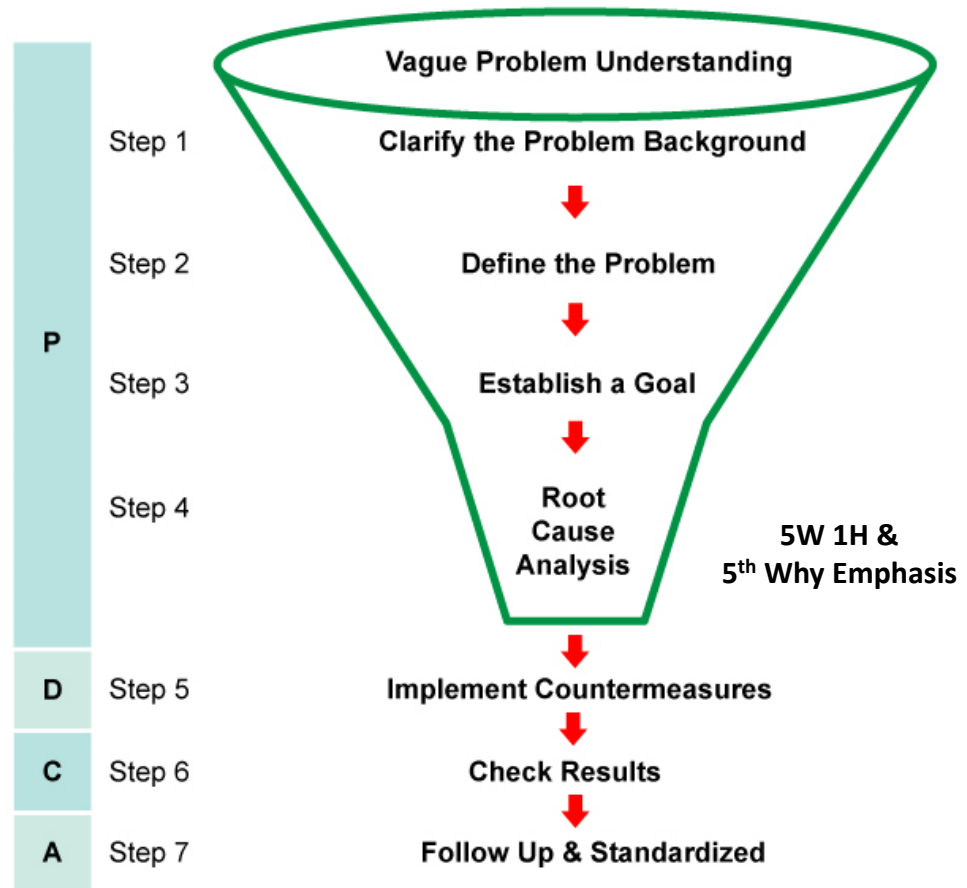
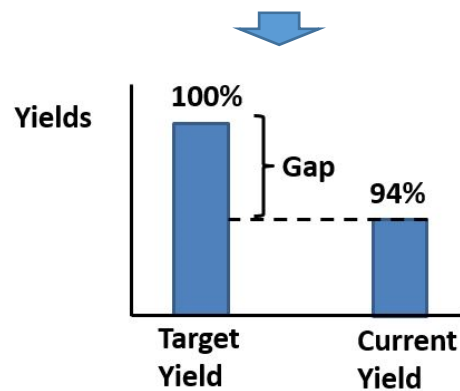
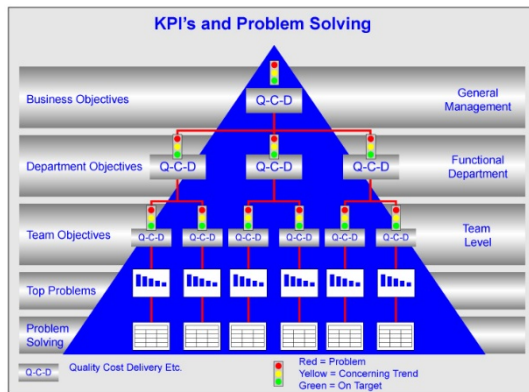
Homework Exercise

- Select a critical process or area for observation
- Clarify the goal (minute/hour/shift/day)
- Monitor closely by observation for xx hours (tbd)
- Set time and condition signals
- Catch all the minor problems / concerns
 - 4C's Thinking
- Evaluate how well it is going
- What needs to be improved

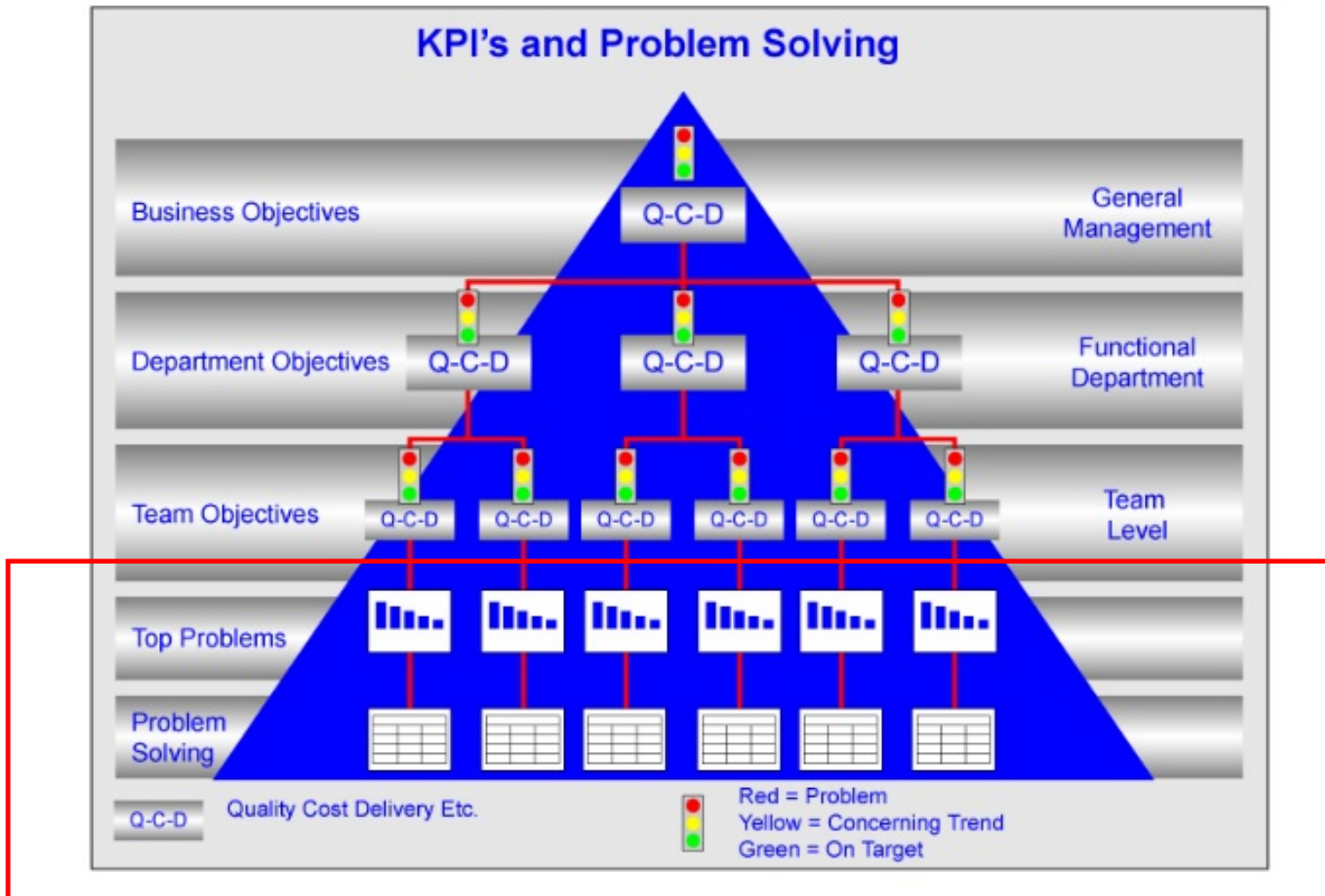
4 Types of Problem Situations



Type 2 – Gap from Standard



KPI's & Problem Solving



Daily Meeting & Type 2 Problems



- Start of 8 hour shift
- Daily performance trend
- Major problem communication
- Departmental coordination
- Priority alignment & clarification
- Hop topics, etc.
- May or may not have problem type A3's posted here

Shop Floor Management Board

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PLAN																																																																																																				
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Problem Solving Report / A3

Problem Background		Countermeasures	
Problem Definition			
Goal		Check Results	
Root Cause Analysis		Follow Up & Standardize	

Clarify the Problem Background

CLARIFYING THE PROBLEM BACKGROUND

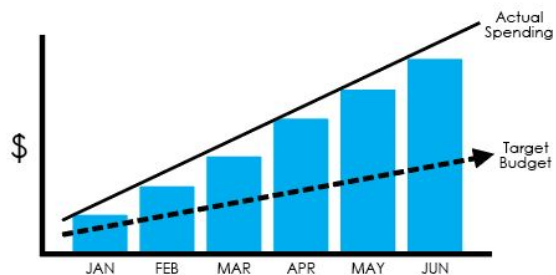
RELEVANT INFORMATION

- Historical Information
- Key Terms
- Framing Data
- Links to Annual Plan
- Etc.

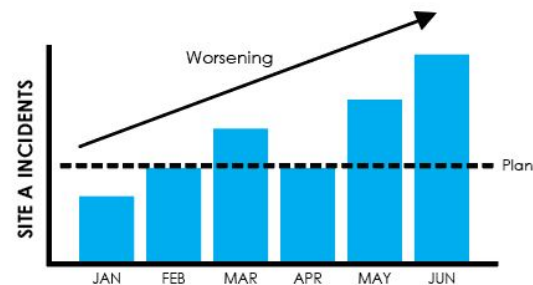
IMPORTANCE



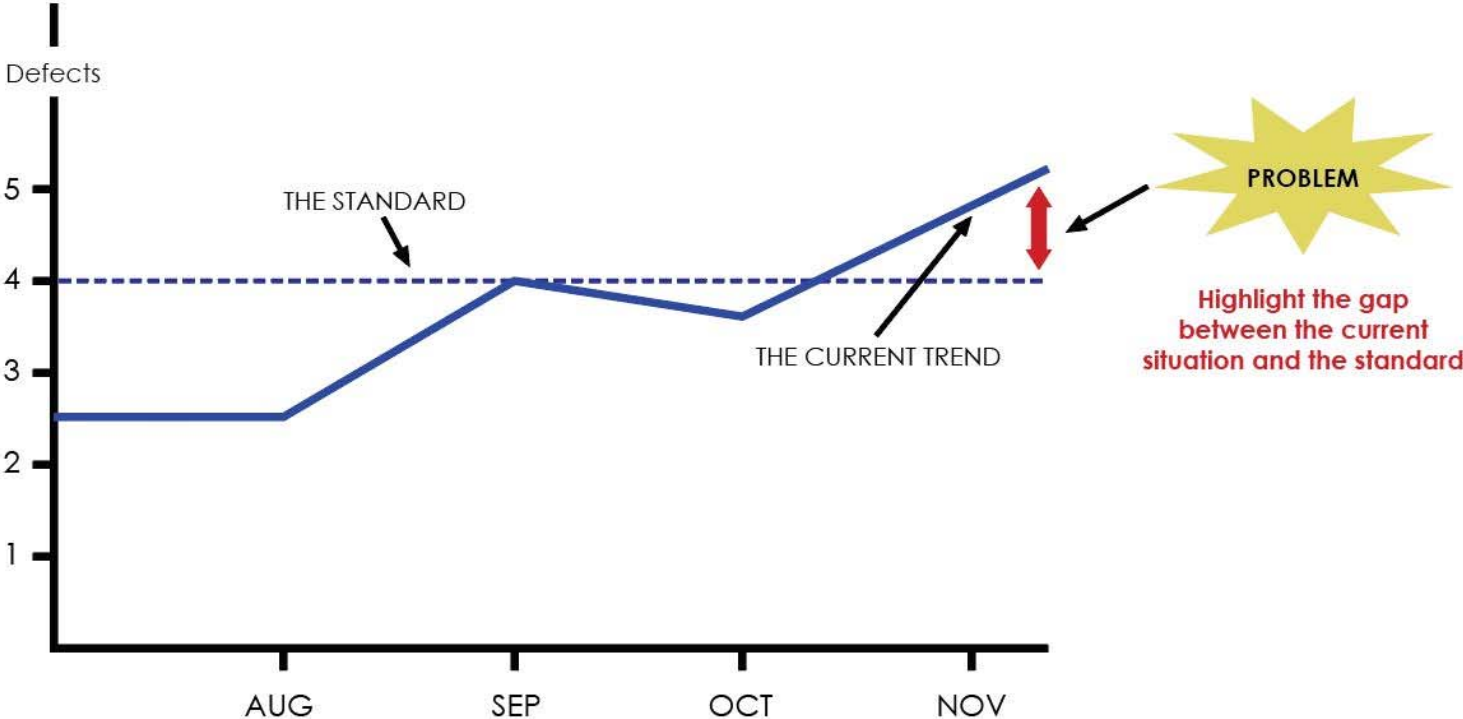
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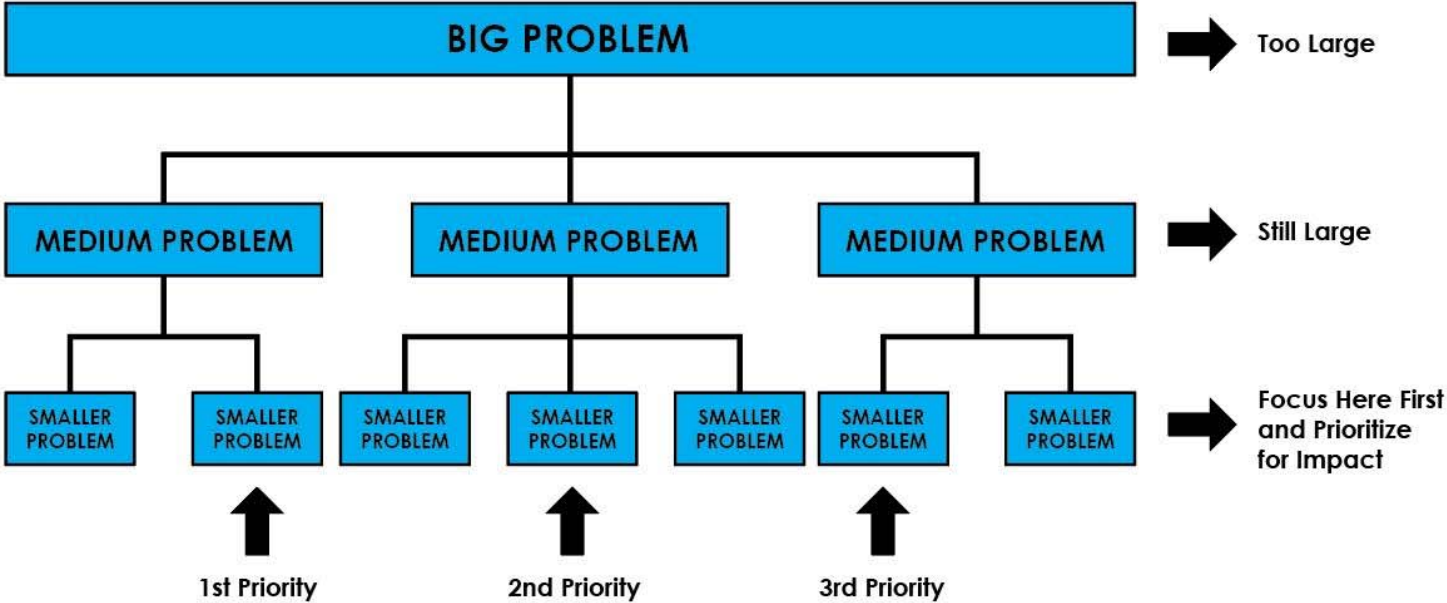
TREND



Define the Problem



Define the Problem



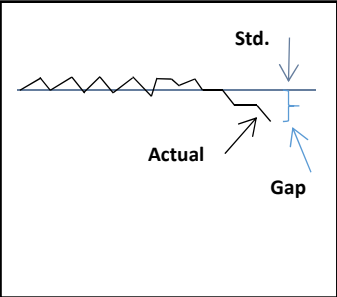
Problem Investigation



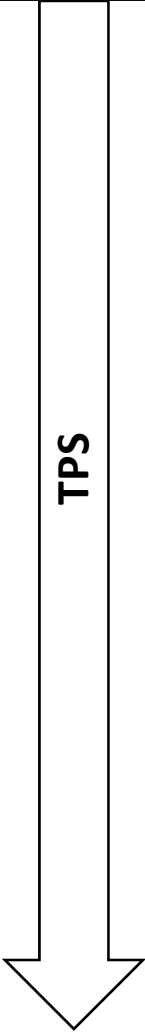
A. Immediate abnormality signal



B. Go to actual machine and see status

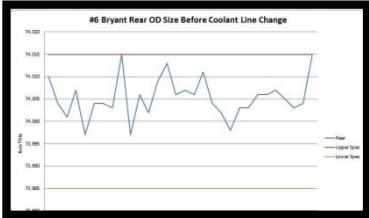


C. Ascertain actual problem situation

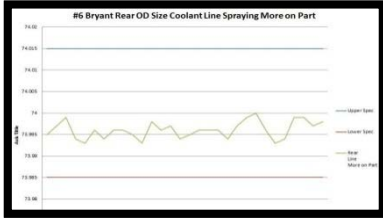


D. Problem Investigation Sequence

1. Measure actual dimensional extent of problem
2. Look for obvious contamination or abnormalities
3. True and re-dress grinding wheel and observe status
4. Check actual grinding wheel (check "pores")
5. Confirm actual (not theoretical) stock removal
6. Send part to QC Mat'l lab for hardness and HT depth check
7. Check actual cutting conditions
 - Wheel RPM
 - Feed Rate, Depth of Cut, etc.
 - SFPM
8. Confirm status of datum features
9. Measure spindle run out
10. Coolant check
 - Flow rate / pressure
 - Nozzle condition and direction
 - Temperature
 - Concentration



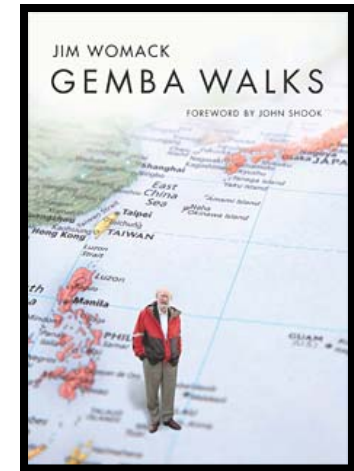
Cpk 1.15



Cpk 2.33

Dig Deeper! 8G's

- Genba 現場 Actual Place
- Genjyou 現状 Actual Condition
- Genchi 現地 Actual Location
- Genbutsu 現物 Actual Object
- Genjitsu 現実 Actual Facts
- Genji 現時 Actual Time
- Genpō 現法 Actual Method
- Genin 現因 Actual Cause

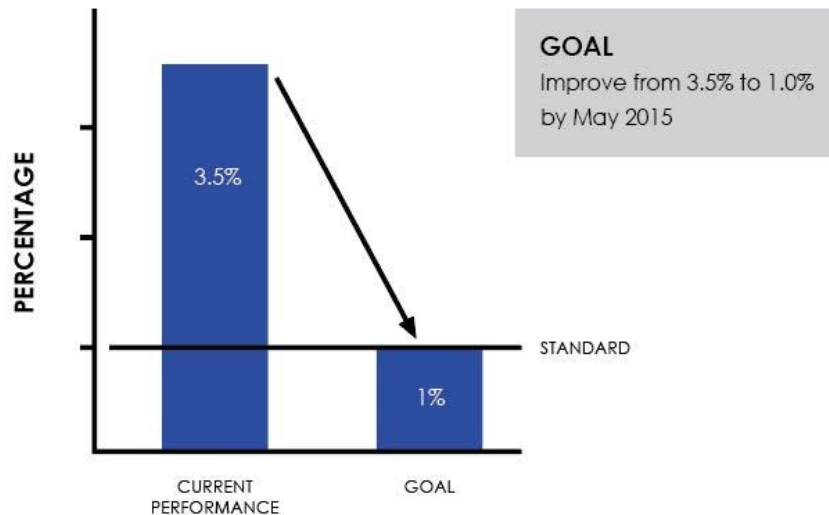


現地現物
Genchi Genbutsu - "Go and See"

Dig Deeper! Plain English

5W 1H	Level 1	Level 2	Level 3	Level 4	Level 5
Who?	Site	Department	Group	Team	Individual
When?	Day	Shift	Hour	Minute	Actual instant of occurrence
Where?	General area	Specific production line level	Specific process	Actual location in the process	Actual point of occurrence
What?	Occurrence	Symptom	Broad problem	Categorical problem	Specific problem
Why?	1st cause	2nd cause	3rd cause	4th cause	5th cause
How / How much?	Non-conformance issue	Dimensional variation	Above standard allowed	Comparison to actual Standard	Gap from actual standard: e.g., .001 mm

Set a Goal



3 Factors

From what level?

To what level?

By when?

SMART

Specific?

Measurable?

Attainable?

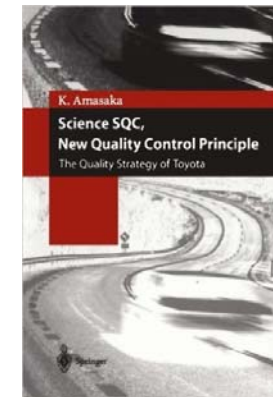
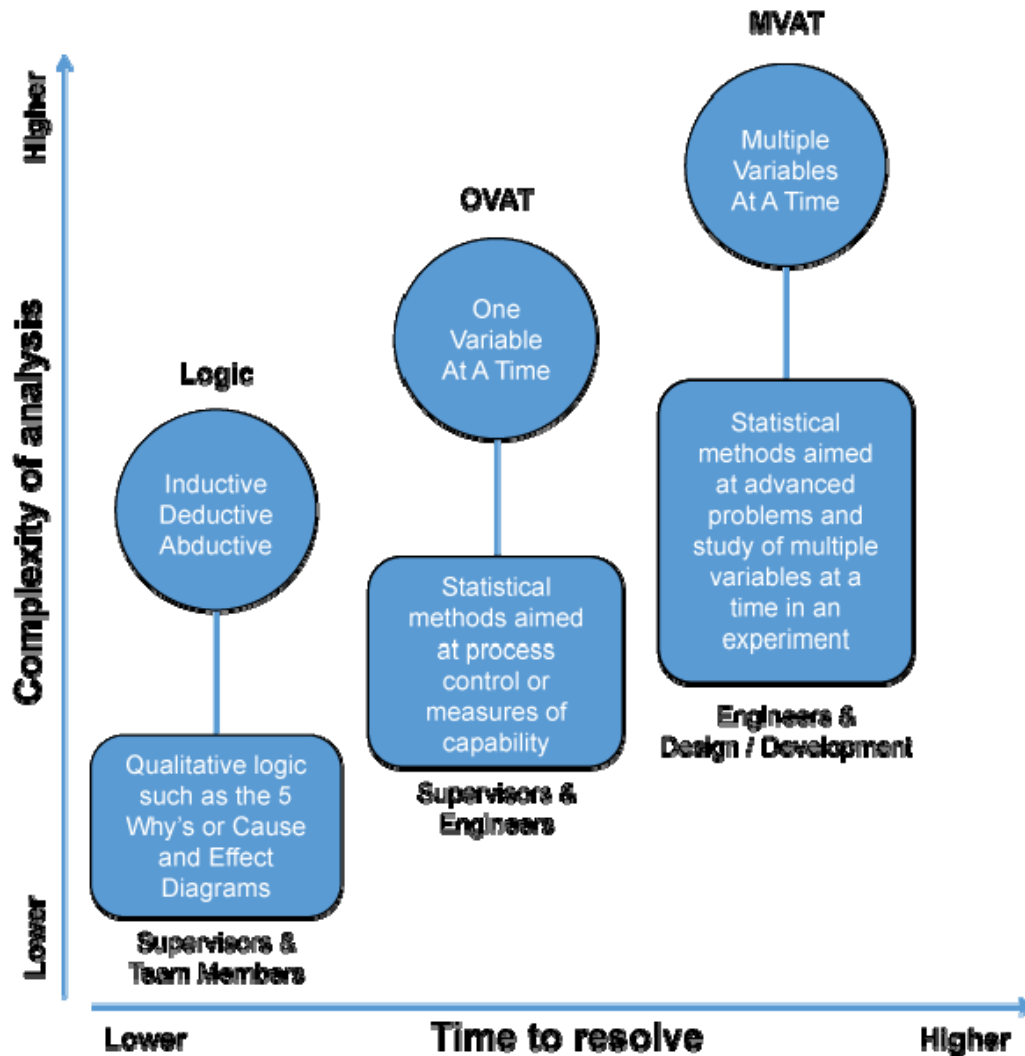
Relevant / Realistic?

Time bound?

Poor examples include:

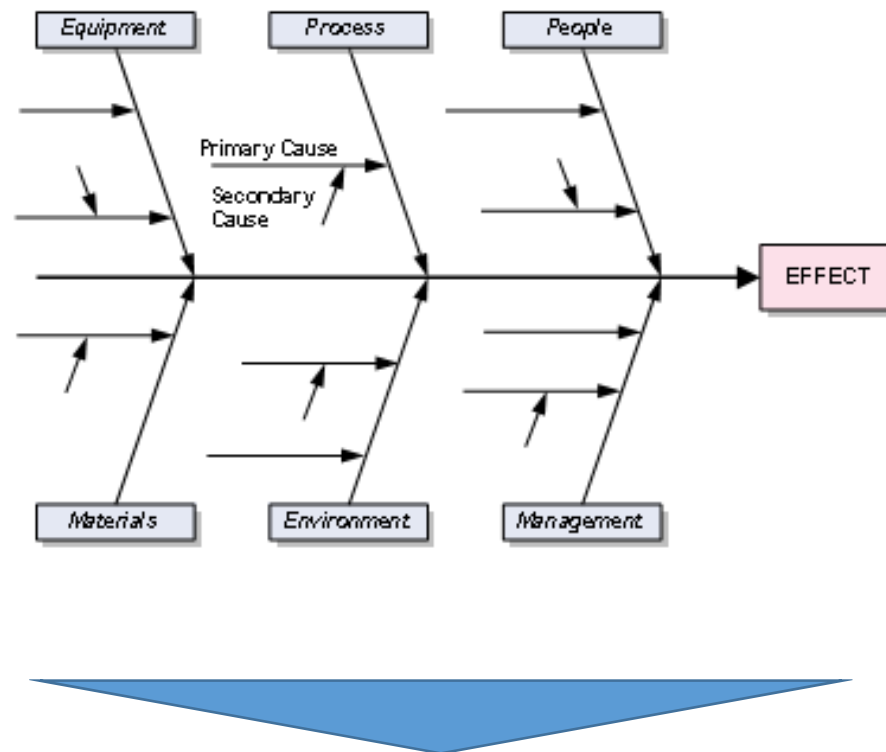
- 1) Find the root cause! (This is the next step of the process)
- 2) Implement lean tools like 5S or Standardize Work, etc. (This is an action item)
- 3) Train the employee (This is jumping to conclusions)

Analyze the Problem



Right type for the right problem...

Logic Based - Fishbone



Fishbone is the common name for a structured Cause & Effect diagram

You do not “brainstorm” a fishbone

Distinguish between critical thinking and creative thinking

Simply writing down random opinions = Wishbone diagram

Logic Based – 5 Why

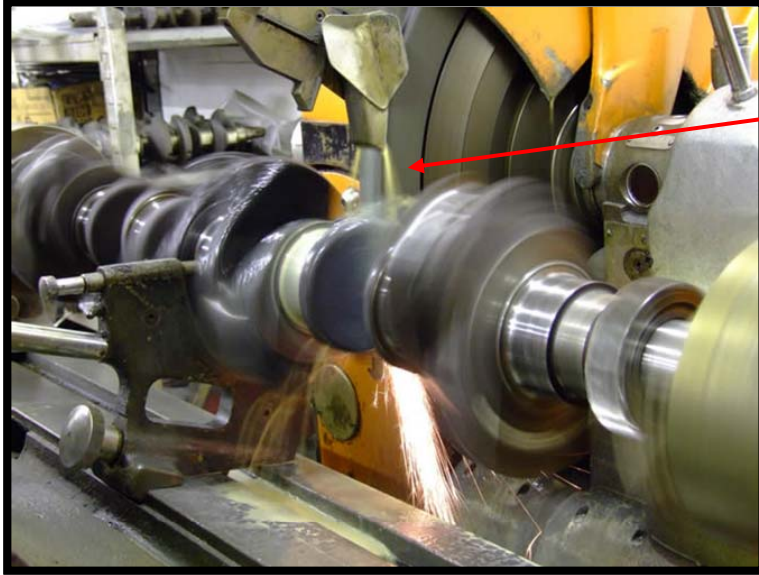
Situation: A machine has stopped working halting production.

- 1) **“Why did the machine stop working?”**
 - **“Because the machine overloaded blowing the fuse in the control panel.”**
- 2) **“Why did the overload condition result?”**
 - **“Because there was insufficient lubrication to the spindle bearing.”**
- 3) **“Why was there insufficient spindle bearing lubrication?”**
 - **“Because there was insufficient lubrication drawn up by the pump.”**
- 4) **“Why was there insufficient lubrication draw from the pump?”**
 - **“Because the pump shaft was worn and rattling.”**
- 5) **“Why was the pump shaft worn?”**
 - **“Because there was no strainer on the lubrication device inlet port, and small metal cutting chips entered the system causing damage.”**



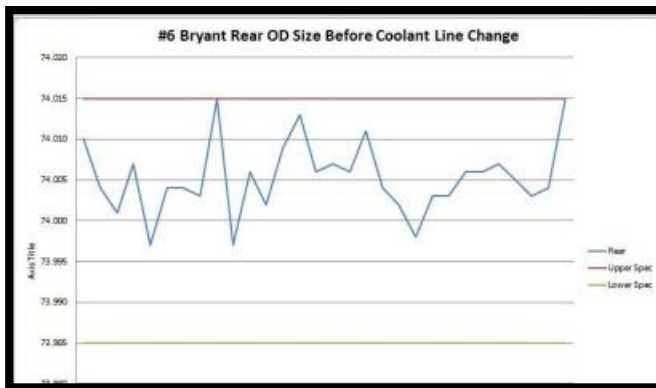
Note deeper causes exist!!!!
However here at this level a quick,
inexpensive, and effective
countermeasure can be established

OVAT

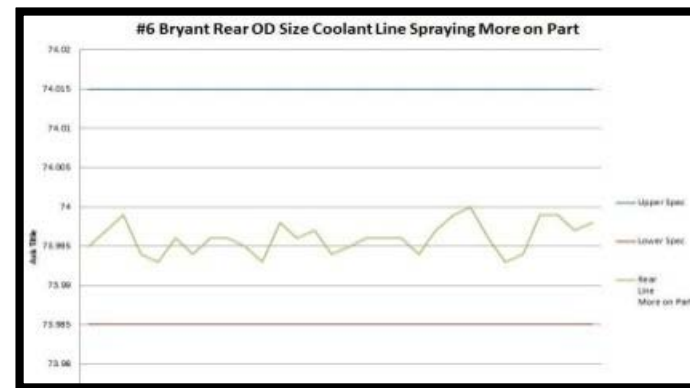


Simple case of inadequate coolant flow to the part due to a blocked / damaged coolant line.

One variable (coolant flow) cause the entire problem....

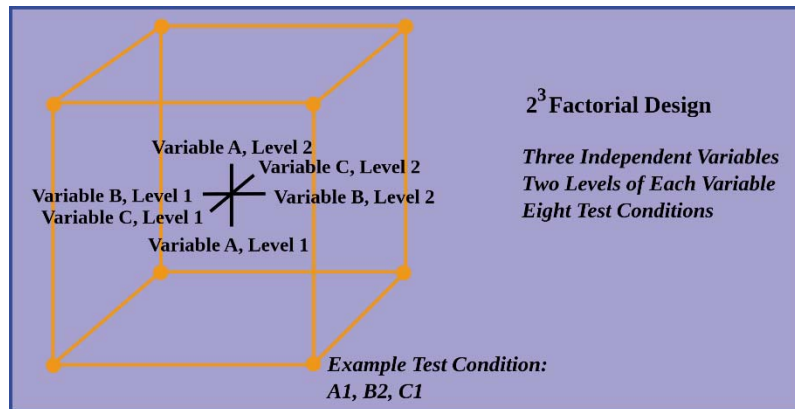


Before Cpk 1.15



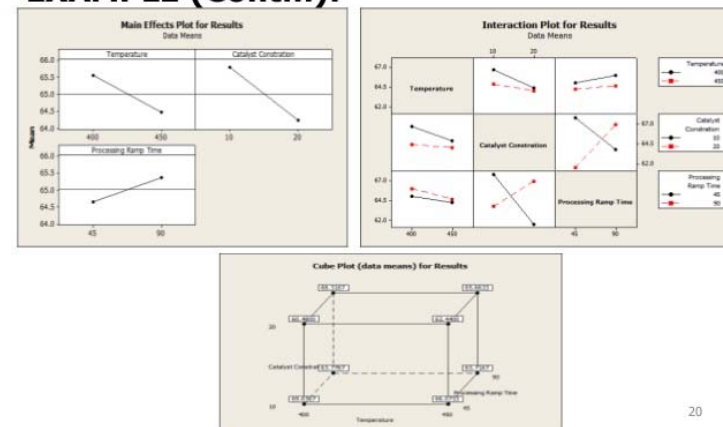
After Cpk 2.33

MVAT



2³ FACTORIAL EXPERIMENTAL DESIGN

EXAMPLE (Cont...):



20

Complex case of multiple independent variables

- Temperature
- Pressure
- Processing time
- Etc.

Basic OTD Case & Multiple Factors

- Inventory amount
- Order entry system
- Lead time to produce
- Material storage
- Production schedule
- Set up time
- Production execution

Key Points in RCA

Area of emphasis	Key Points
Analytical	Break it down to the proper level for study. No one technique is always best.
Quantitative / Qualitative	Measure and organize carefully in order to understand relationships.
Detailed	Get the facts using 8G's or 5W 2H to the proper level for the problem in question.

Establish Countermeasures

ADMINISTRATION	DETECTION	PREVENTION
<ul style="list-style-type: none">• Examples include increasing inspection duties, adding training or altering work instructions for the operator.• These controls are generally weak and mainly acceptable as temporary short term countermeasures.	<ul style="list-style-type: none">• Examples include any instances of sensors or alarms used to signal that an abnormality has occurred in the product or process and stops the defect from moving downstream. Mistake or error proofing in the process.• These controls are stronger in nature and contain defects internally better than administrative ones.	<ul style="list-style-type: none">• Examples include creative usage of techniques to prevent the defect or abnormality from occurring in the product or process. Or elimination of the underlying condition or potential.• These controls either alone or in conjunction with detection for the strongest type of defect control.

Weaker



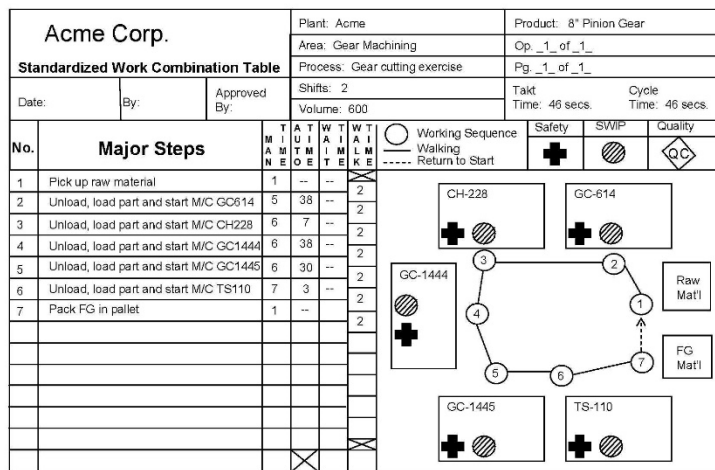
Stronger



Select countermeasures which are most likely the prevent recurrence of the problem. Training and inspection are not satisfactory countermeasures.

Administration Countermeasures

Standardized Work Chart



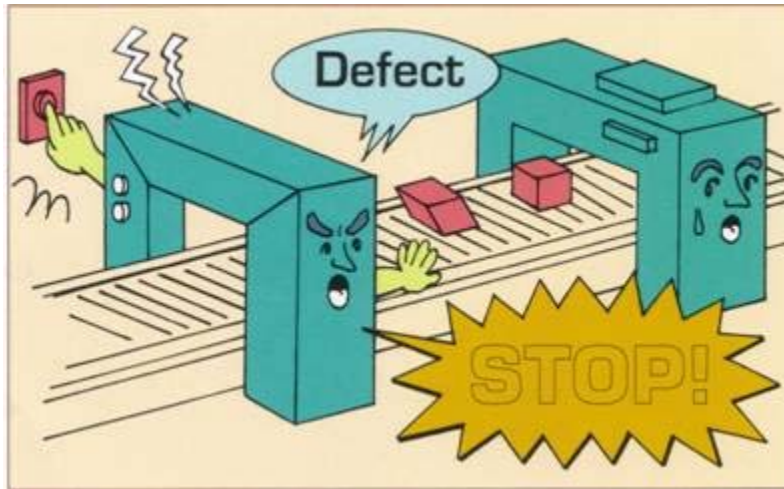
Slide 4-7

Examples of Administrative C/M

Standardized Work / Work Instructions
 Inspection Frequency or Method
 Training and Communication

Detection Countermeasures

Jidoka concept



Automatically stop the process at any detection of a defect or abnormal condition

Examples of Detection C/M

Error proofing

Sensors (Mechanical, Electrical, Optical, etc.)

In-process auto measurement

Immediate post process auto measurement

Prevention Countermeasures

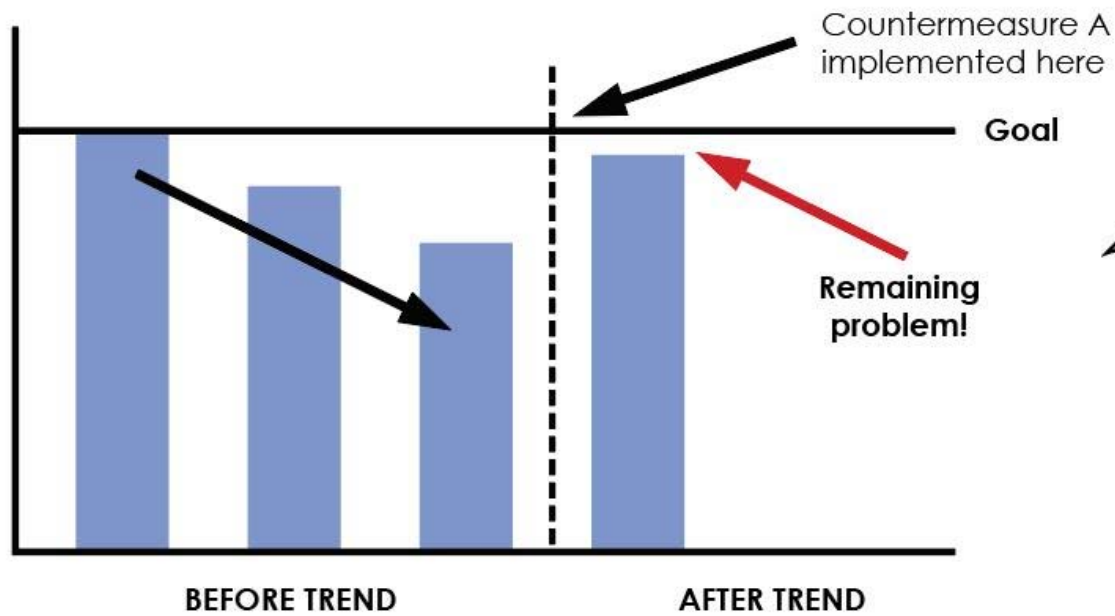


3 Stages of Prevention

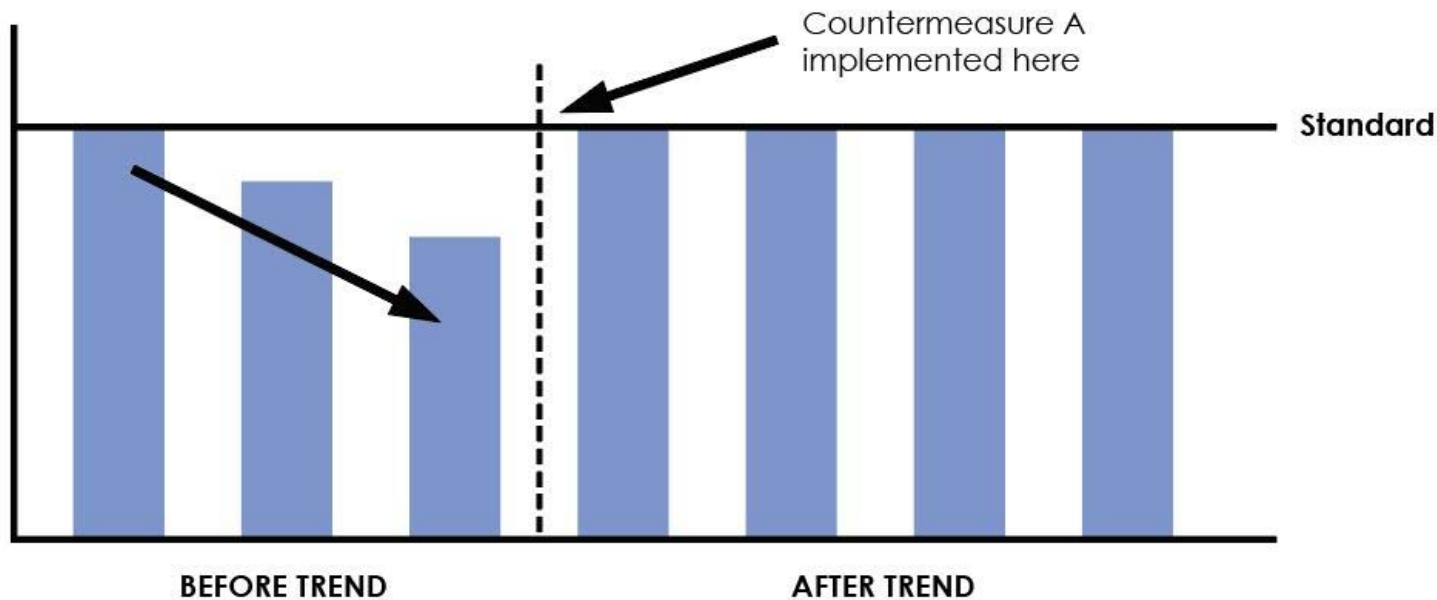
STAGE OF PREVENTION	PRIMARY	SECONDARY	TERTIARY
STAGE OF DISEASE	NONE (YET)	IMMINENT	ESTABLISHED
PRIMARY OBJECTIVE	DISEASE AVOIDANCE	EARLY DETECTION	MINIMIZE DAMAGE
INTERVENTION TOOLS	HEALTH RISK ASSESSMENT HEALTH/WELLNESS PORTAL SELF-CARE BOOK/CLASSES LIFESTYLE COACHING EXERCISE PROGRAMMING HEALTH EDUCATION	BIOMETRIC SCREENING CVD SCREENING CONSUMERISM CLASSES COMPLIANCE PROGRAM NURSE HELP LINE	ON-SITE MEDICAL CARE PREDICTIVE CARE MGMT. LARGE CASE MGMT. MATERNITY MGMT. UTILIZATION MGMT.



Check Results

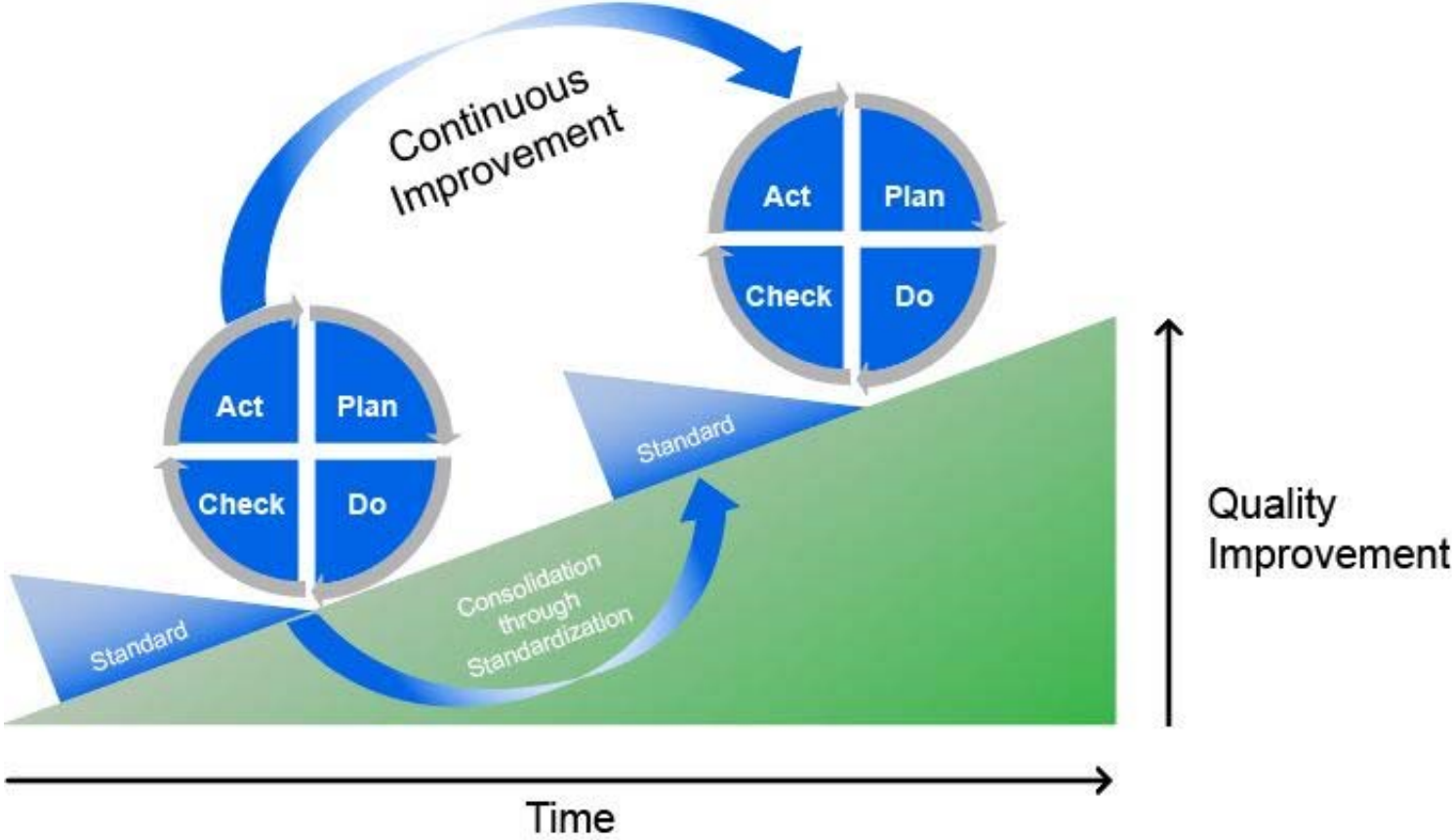


Check Results

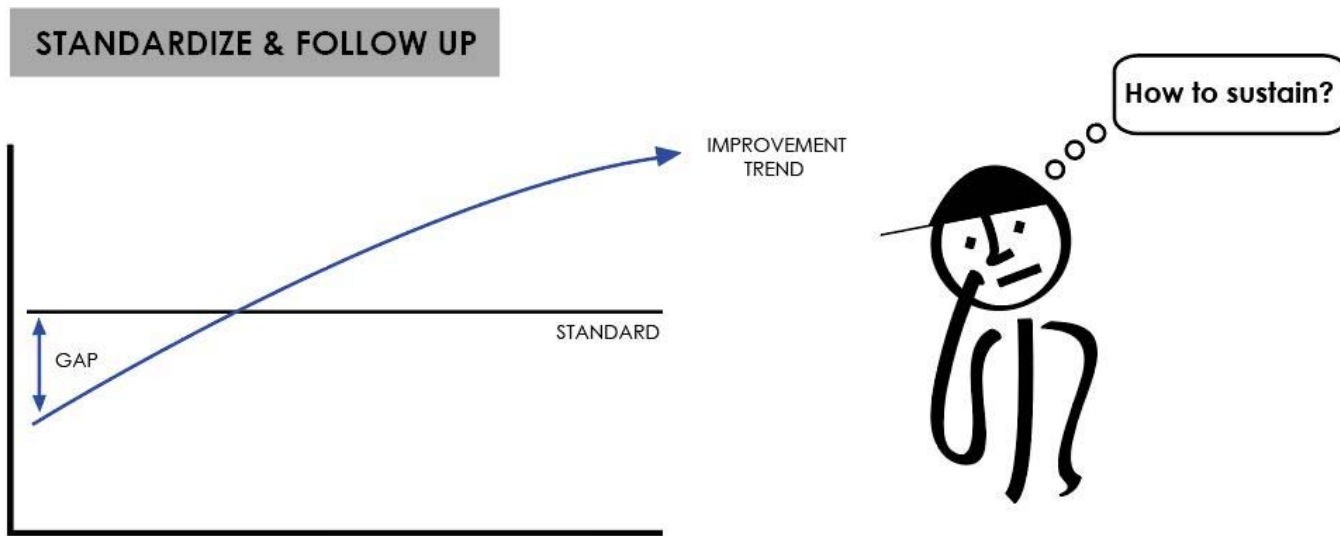


Note: Do not fall into the mistake of checking the completion of action items. That is not the same thing as checking whether or not you have accomplished the goal!

Follow Up & Standardize

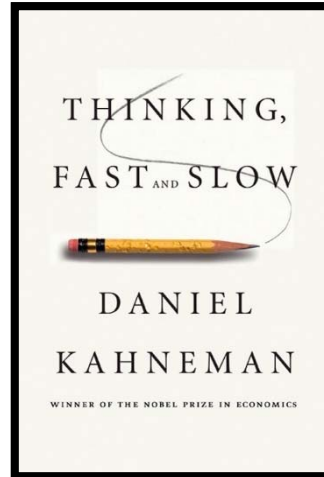
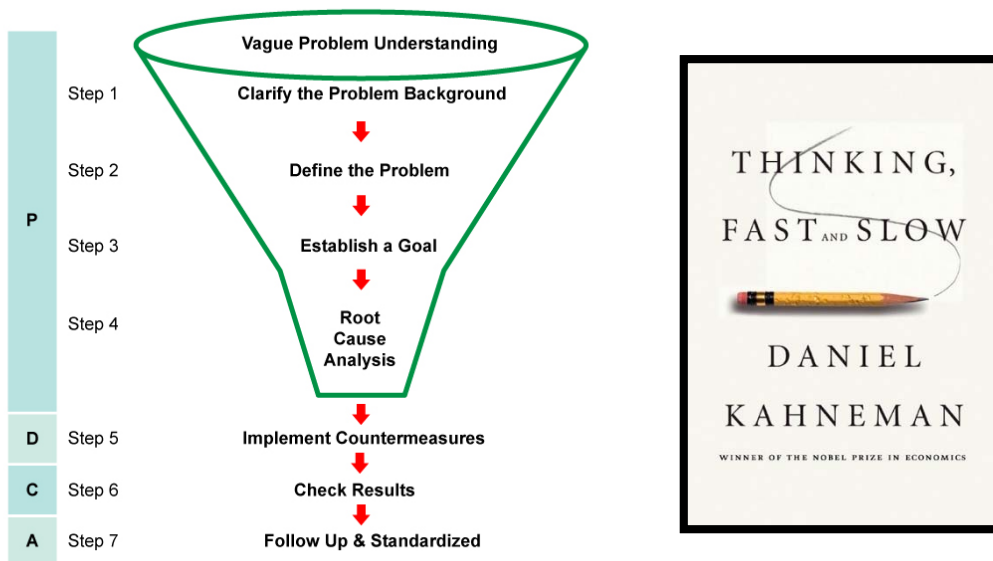


Follow Up & Standardize



WORK INSTRUCTIONS	FORMS	CHECKLISTS	AUDITS
SPARE PARTS	TRAINING	COMMUNICATION	MANUALS

Type 2 Summary

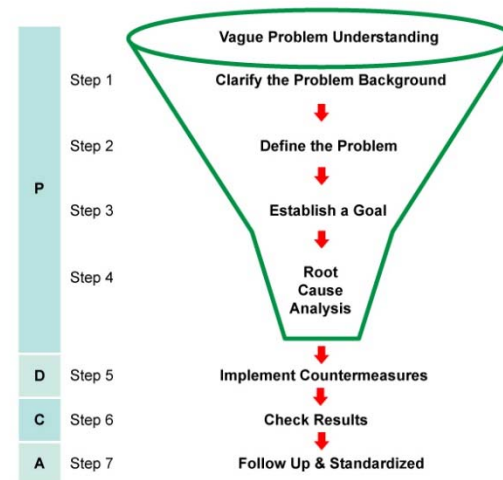


Type 1 Troubleshooting is about rapid action and response to the abnormal condition...an analogy is thinking fast.

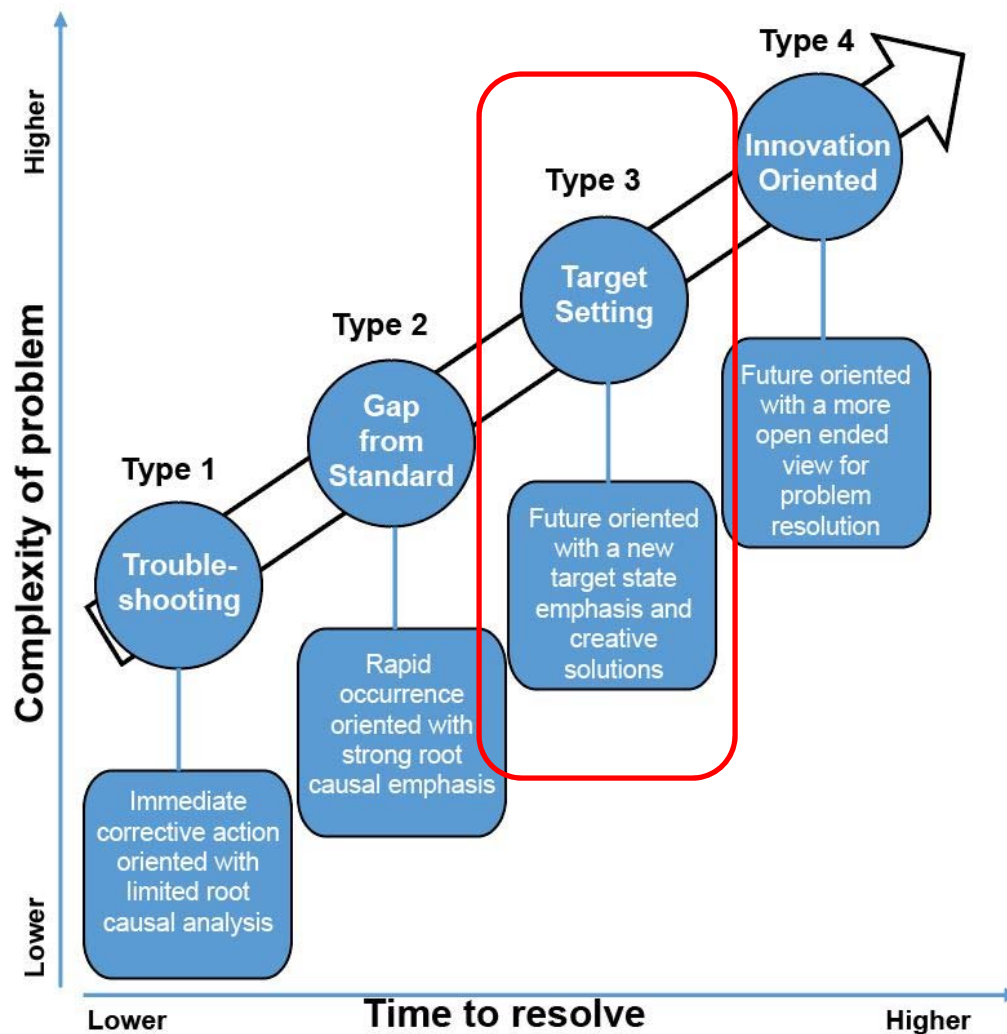
Type 2 Gap from standard problem solving is about being more deliberate and slowing down to consider what is the **real problem** or **root cause**...an analogy is thinking slow.

Homework Exercise

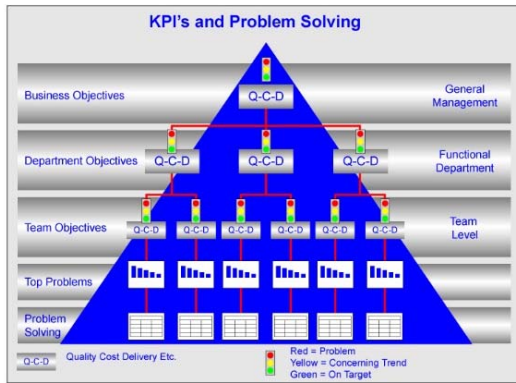
- Pick a problem that involves a gap from standard involving a KPI, or the annual performance plan.
- Execute Basic Steps
 1. Problem Background
 2. Problem Definition
 3. Set a Goal
 4. Root Cause Analysis
 5. Countermeasures
 6. Check Results
 7. Standardize & Follow Up



4 Types of Problem Situations

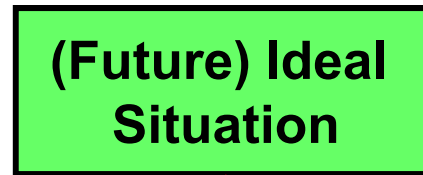


Type 3 – Target State

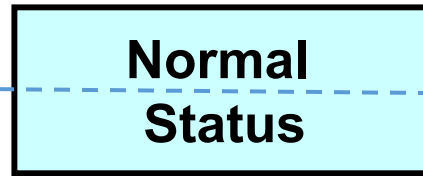
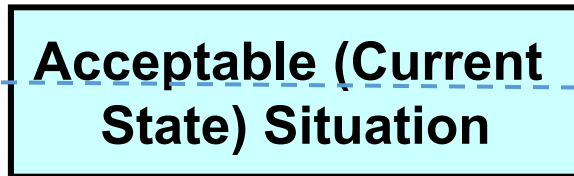
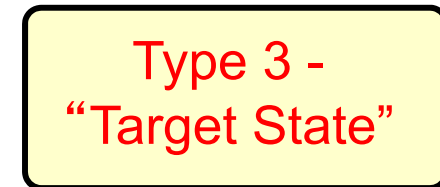
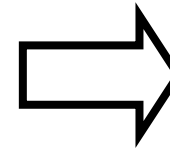


Kaizen Methods

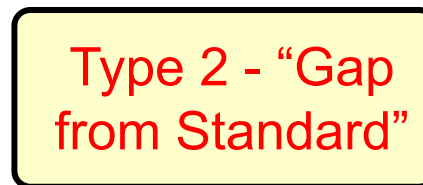
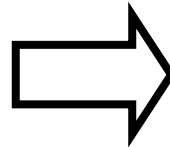
改善方法



GAP



GAP

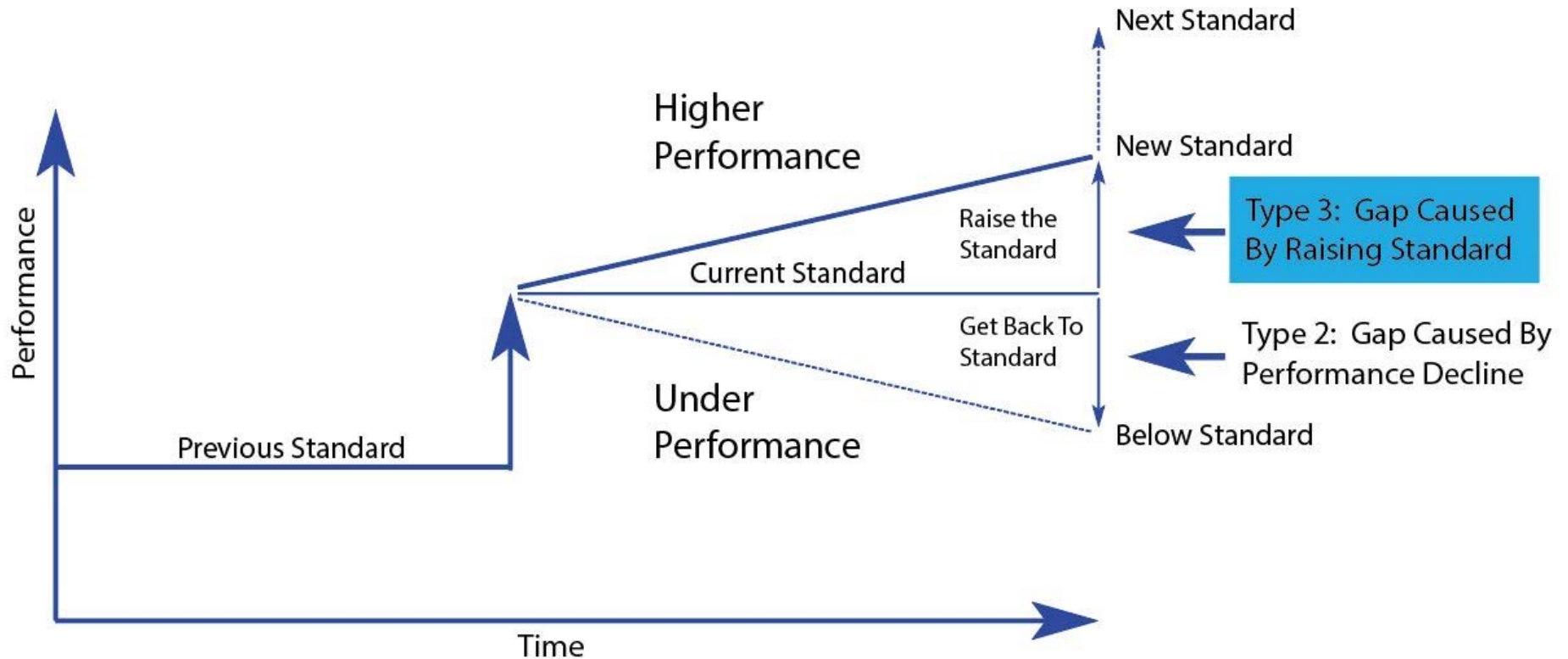


問題解決

Problem Solving



Type 3 – Raise the Bar



Two Types of Thinking

TWO KINDS OF THINKING

Critical Thinking

- analytic
- convergent
- vertical
- probability
- judgment
- focused
- objective
- answer
- left brain
- verbal
- linear
- reasoning
- yes but



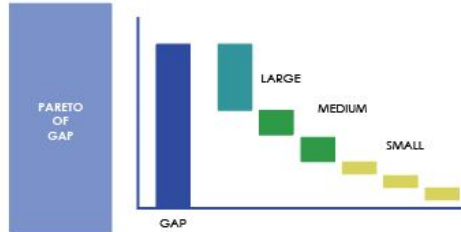
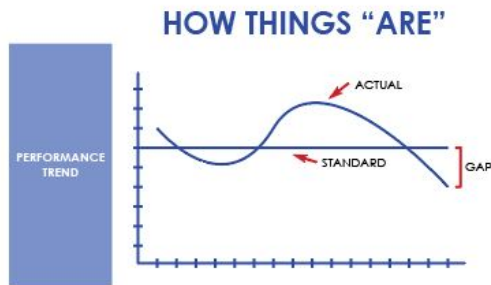
Creative Thinking

- generative
- divergent
- lateral
- possibility
- suspended judgment
- diffuse
- subjective
- an answer
- right brain
- visual
- associative
- richness, novelty
- yes and

Target State Concept (Time Frame)

KEY PERFORMANCE INDICATORS

Type 2 Problems & Gap From Standard



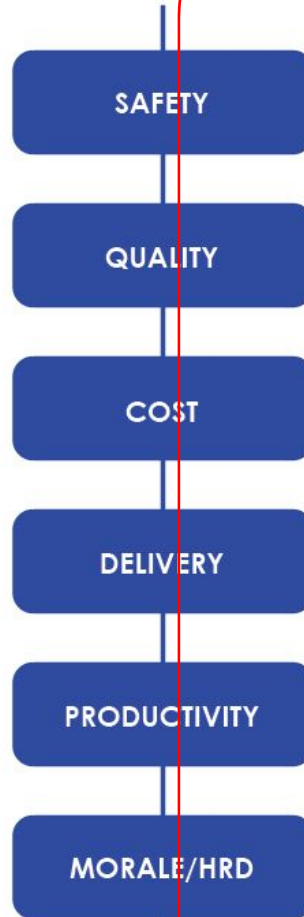
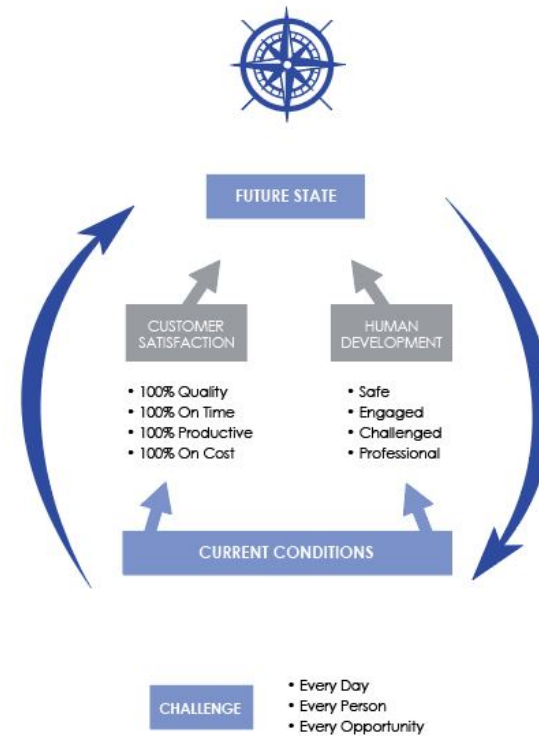
PROBLEM SOLVE TOP 3-5 CONTINUALLY

A3

- Problem Background
- Problem Definition
- Goal
- Root Cause Analysis
- Countermeasure
- Check Results
- Follow Up & Standardize

Type 3 Problems & Target State Setting

HOW THINGS "SHOULD BE"



Last Year Last Quarter Last Month Last Week Yesterday Right Now Tomorrow Next Week Next Month Next Quarter Next Year

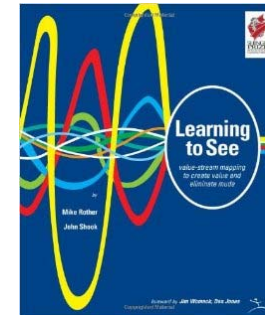
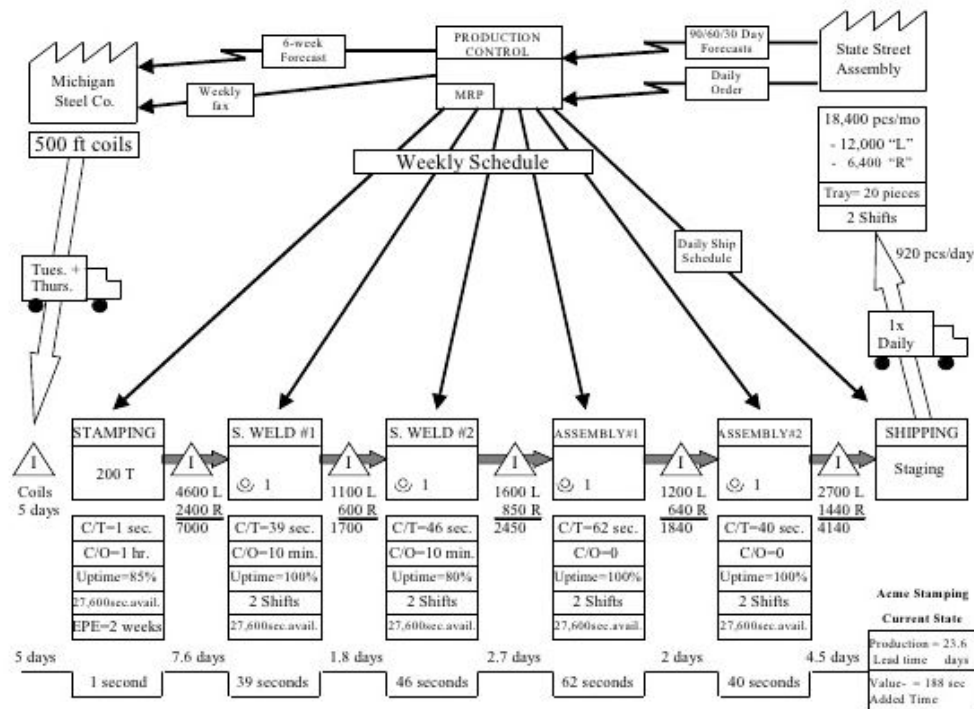
You Can Target State Anything!

- Products
- Processes
- Services
- Sports
- Metrics



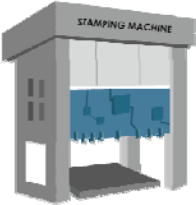
But you have to think
and not just copy...

Value Stream Example



Multiple process flow depiction with emphasis on lead time reduction

Process Example SMED Example



Dedicated Press
Part A



Dedicated Press
Part B

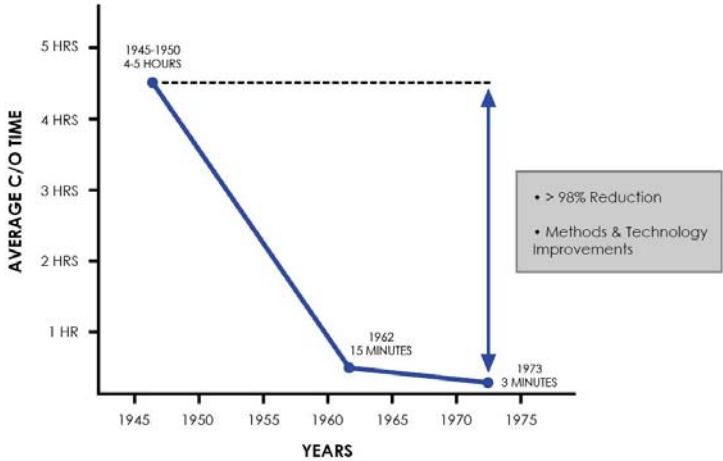


Dedicated Press
Part C



3 Dedicated Machines
No Flexibility
Each 30% Utilization
Make lots of inventory!

TOYOTA'S SET UP REDUCTION TIMELINE

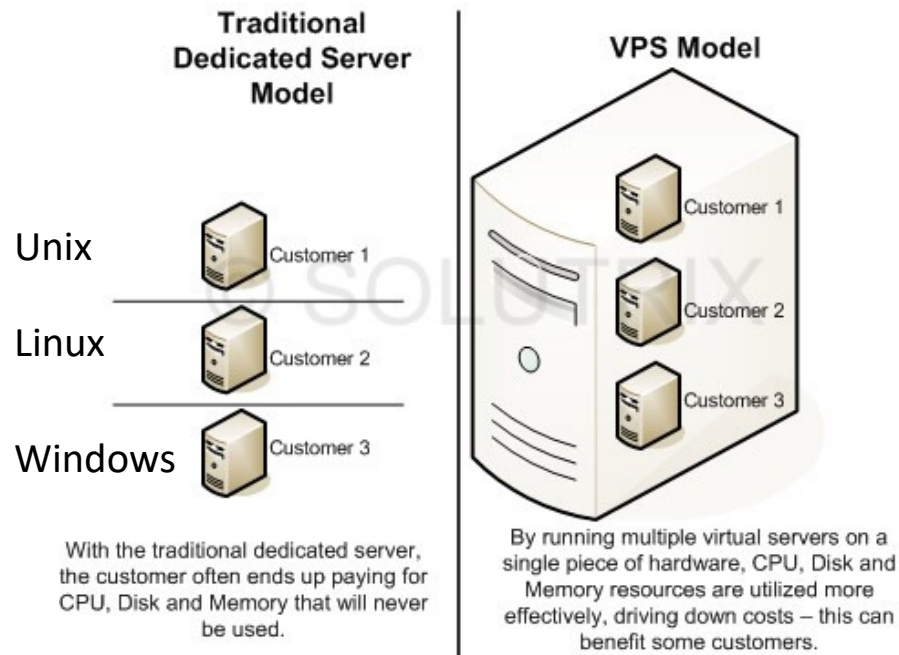


Flexible Press
Parts A, B, & C



1 Machine / 3+ Tools
Change Over Flexibility
90% Utilization
Run more JIT style

Software Example



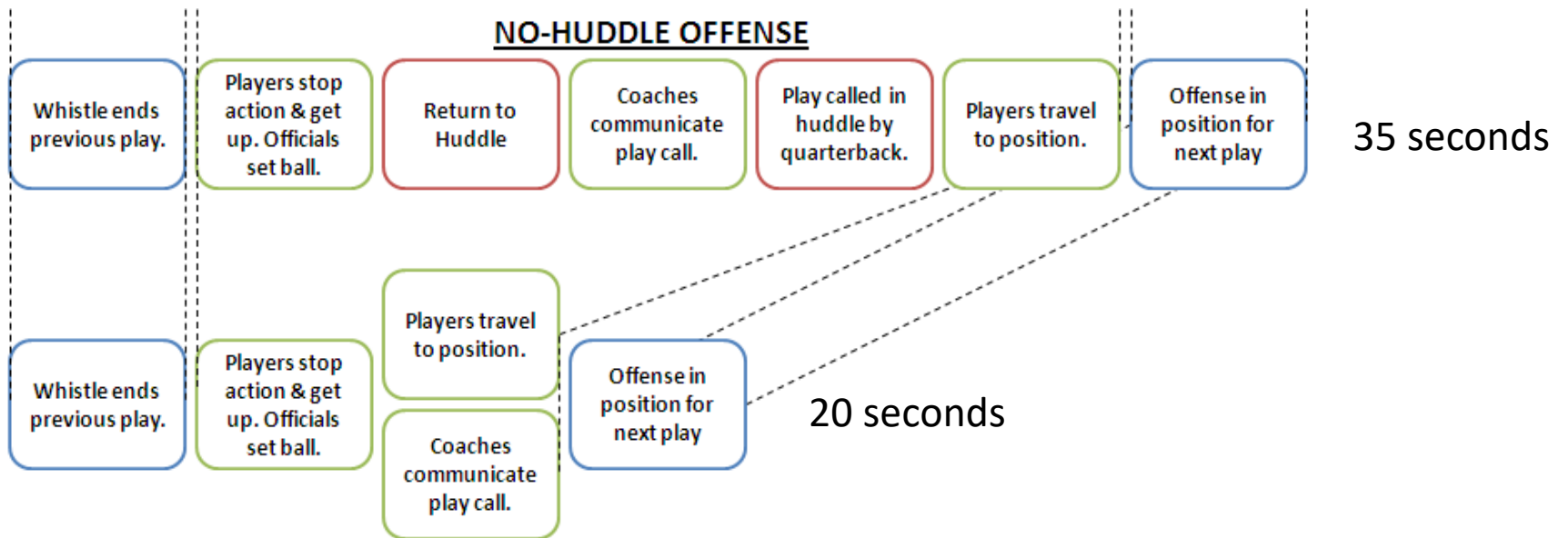
3 Dedicated Servers
Each 30% utilized
No flexibility
Stranded resources

1 Virtual Server
Now 90% utilized
Flexibility
Less waste

Same basic principle as SMED in die exchange...

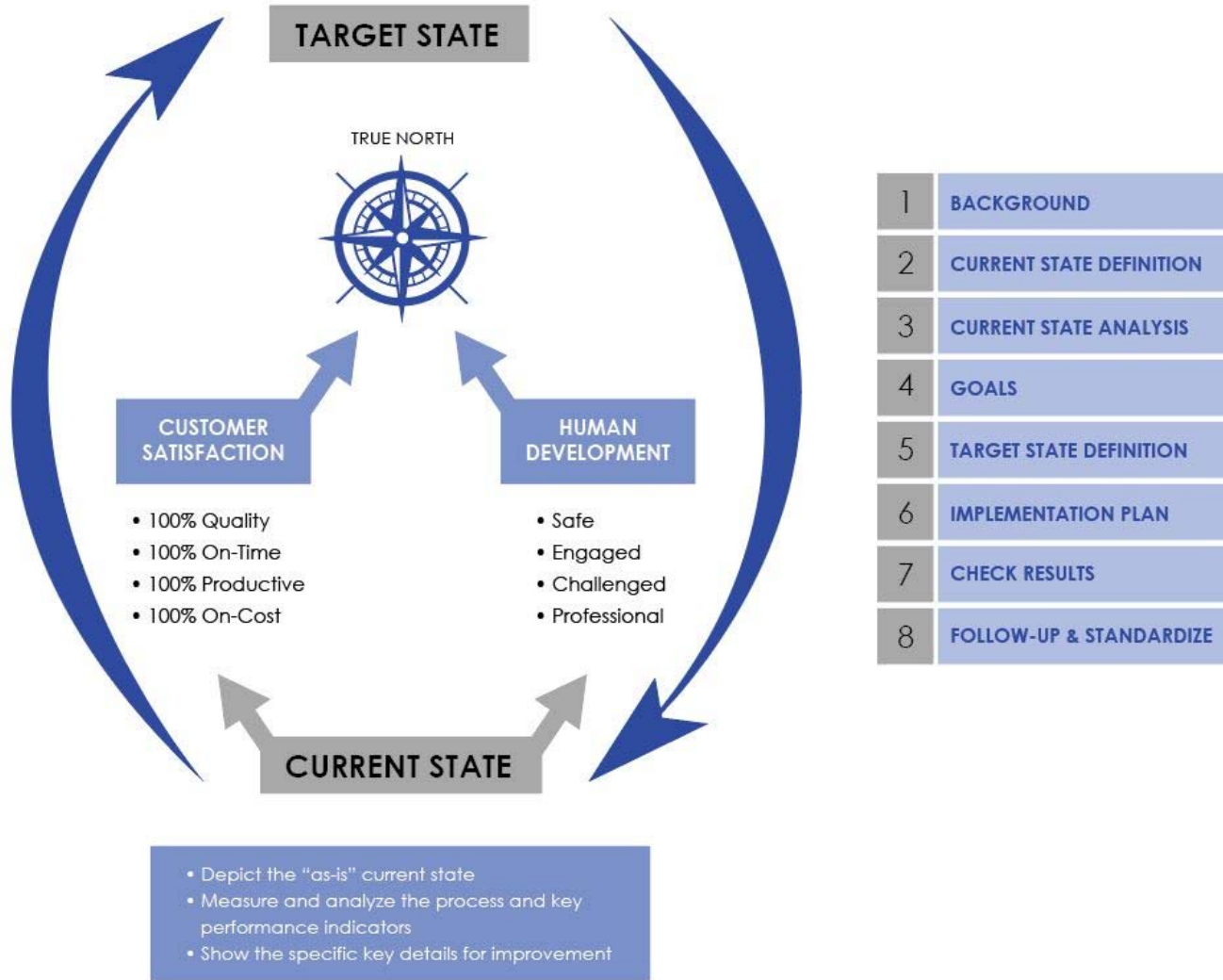
Key here is not the time change over aspect but the software ability to act and host multiple server types...

Sports Example



Also teams now run as many different plays as possible from one basic formation. SMED for sports.

Target State Improvement Steps

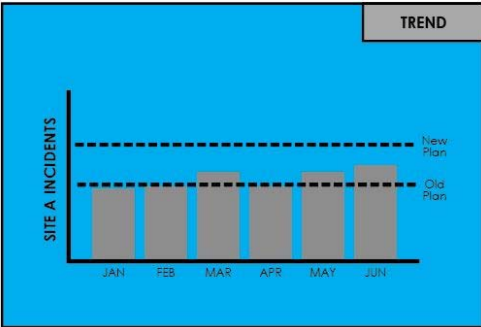
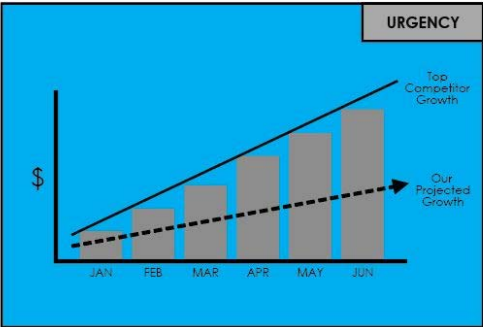
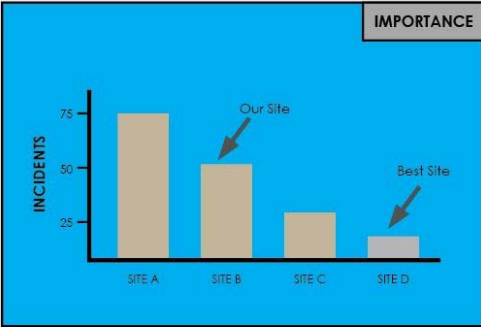


Background Situation

CLARIFYING THE SITUATION BACKGROUND

RELEVANT INFORMATION

- Historical Information
- Key Terms
- Framing Data
- Links to Annual Plan
- Etc.



Generic Example

Purpose:
Provide context
Bigger picture
Relevant information
Logic for next sections

Current State Definition



Dedicated Press
Part A, B, C



Dedicated Press
Part D, E, F



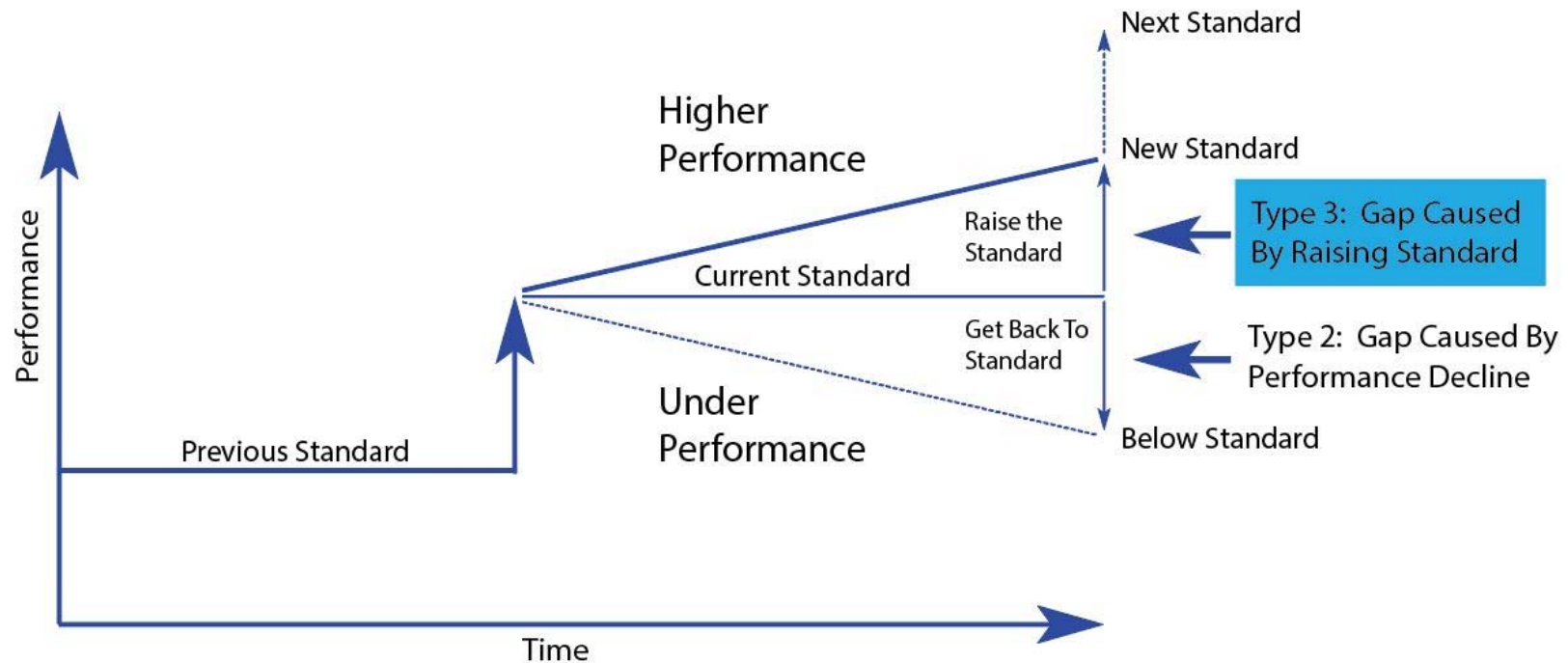
Dedicated Press
Part G, H, I

- Zero safety incidents
- 100% On-Time Delivery
- <1% Scrap
- Satisfied customers
- No major problems...

...However

- 3 Dedicated Machines
- Each 30% Utilization
- Minimal Flexibility
- 3 Underutilized Operators
- 75 Minute Changeover

Goal Setting



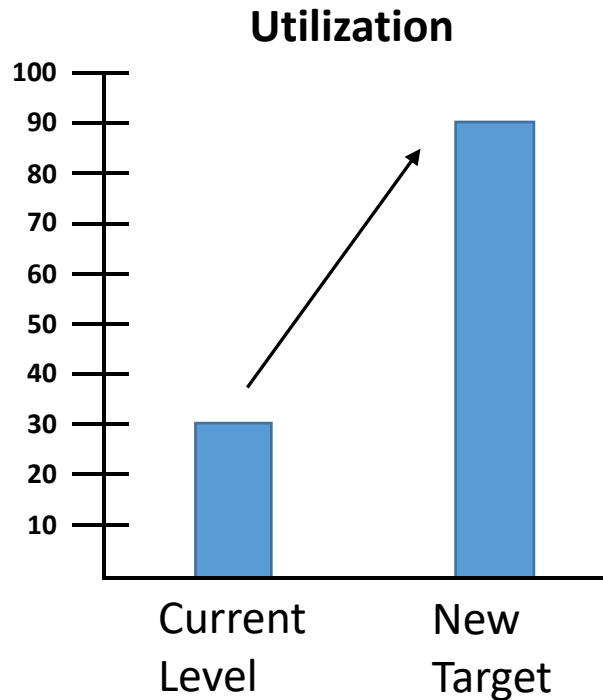
3 Consideration Points:

- From What Level
- To What Level
- By When

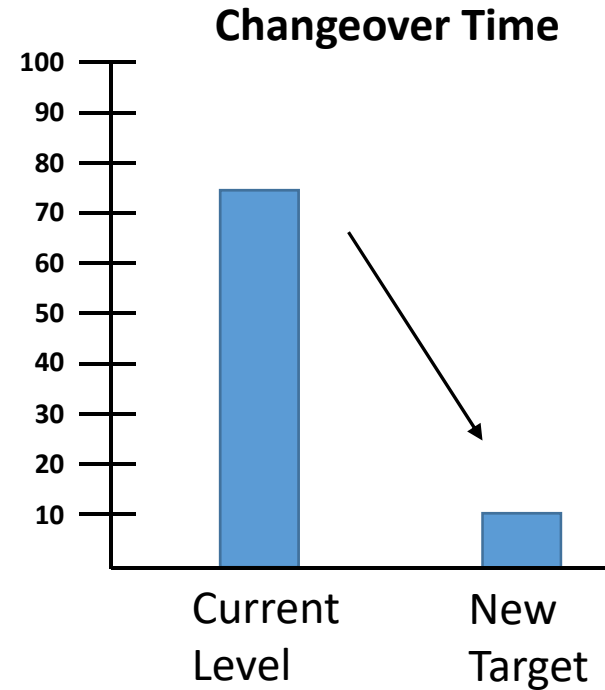
SMART Concept:

- Specific
- Measurable
- Actionable
- Relevant / Realistic
- Time Bound

Goal Setting



Improve utilization
From 30% to 90%
By July 15th, 2016



Reduce Set Up Time
From 75 Minutes to 10 Minutes
By July 15th, 2016

Current State Analysis



Dedicated Press
Part A, B, C



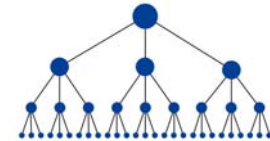
Dedicated Press
Part D, E, F



Dedicated Press
Part G, H, I



Analysis – Break it down



Quantify – Measure



Detail – Get specific facts



Two Types of Thinking

TWO KINDS OF THINKING

Critical Thinking

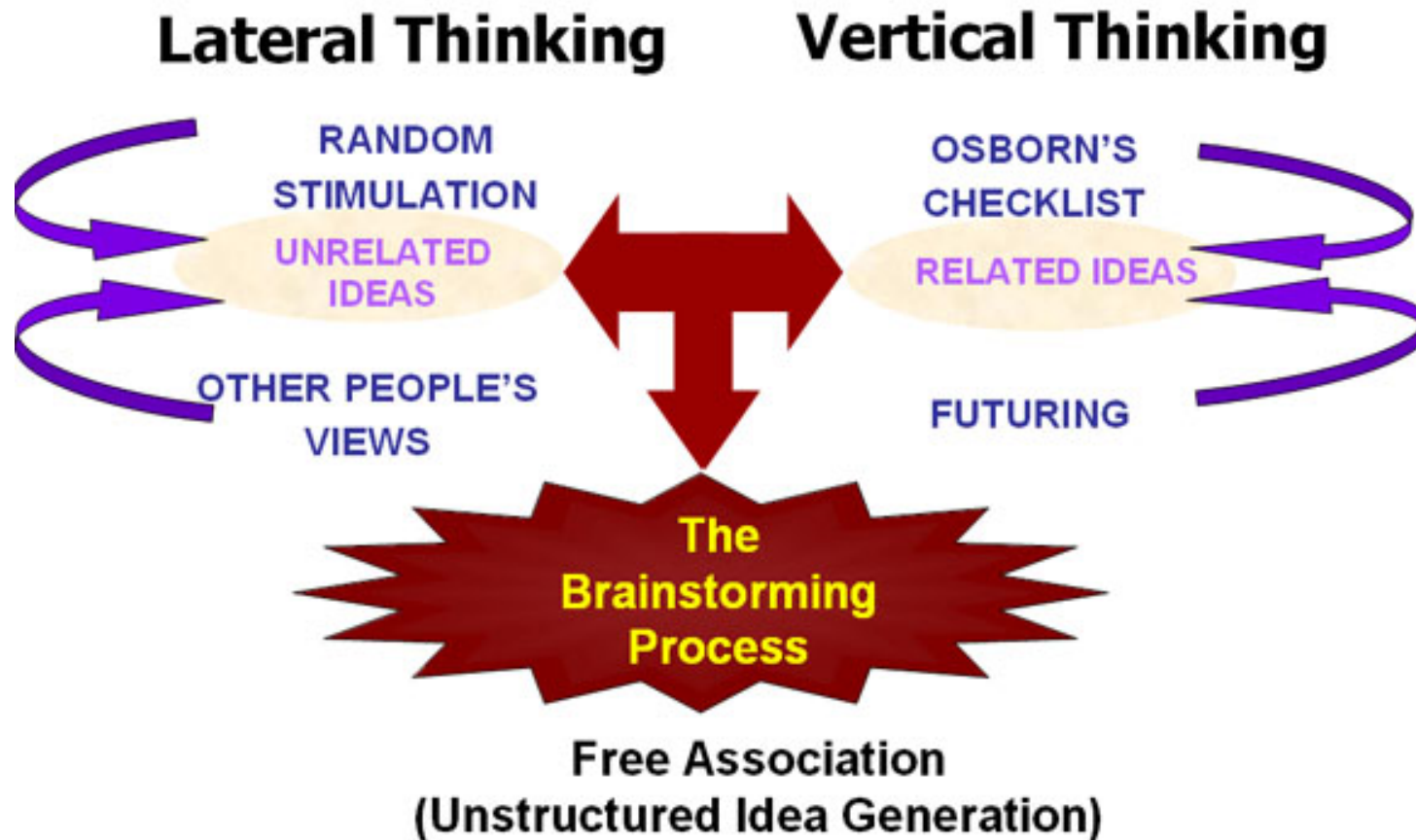
- analytic
- convergent
- vertical
- probability
- judgment
- focused
- objective
- answer
- left brain
- verbal
- linear
- reasoning
- yes but



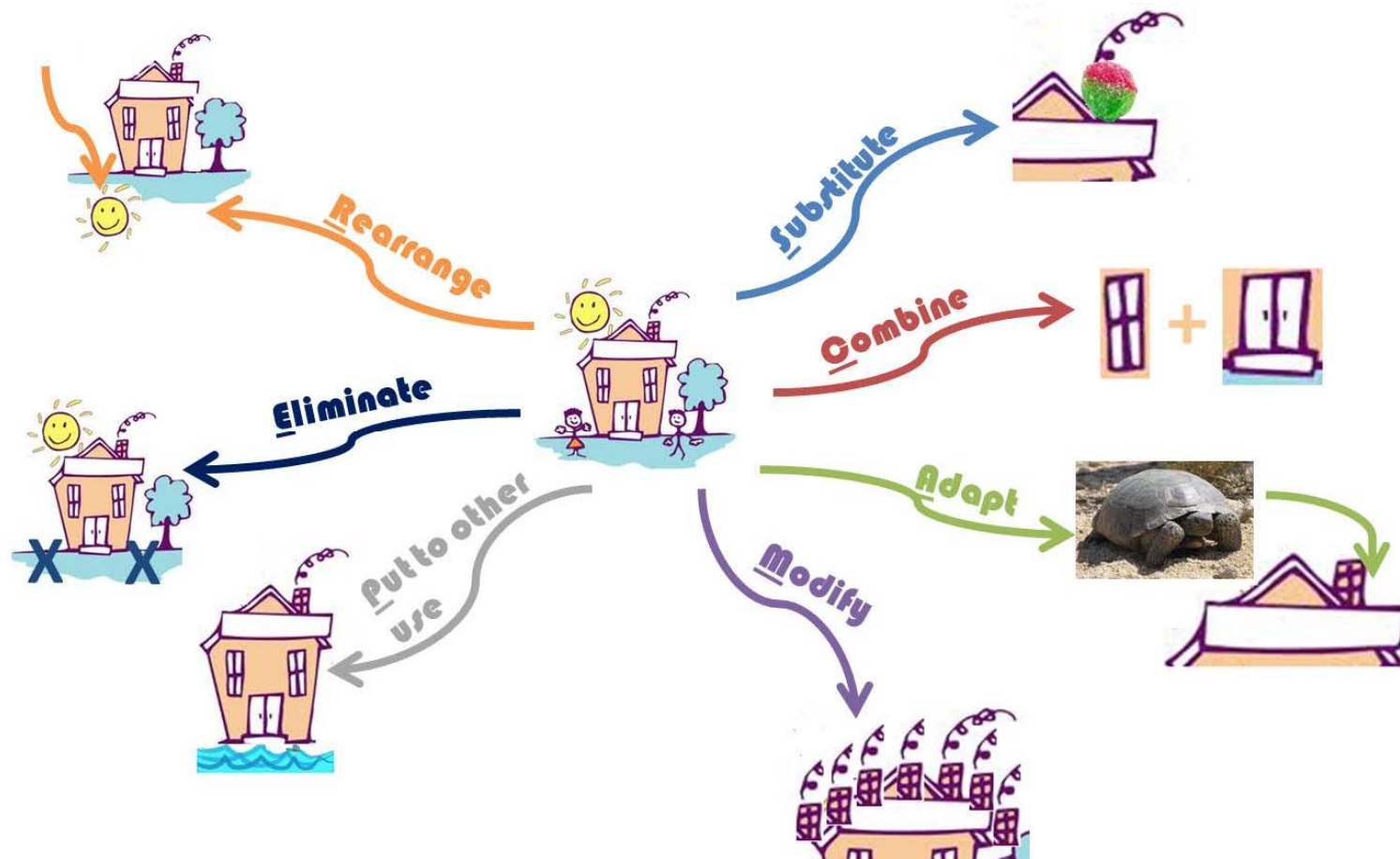
Creative Thinking

- generative
- divergent
- lateral
- possibility
- suspended judgment
- diffuse
- subjective
- an answer
- right brain
- visual
- associative
- richness, novelty
- yes and

Idea Generation



Osborn / SCAMPER Checklist



Scamper Questions

Item	Meaning	Example Questions
S	Substitute	What can you use instead? What components could change?
C	Combine	What can you add or put together? What can be combined into one?
A	Adapt	What can meet other needs? What can this also possible do?
M	Modify / Magnify / Minimize	What if you alter in some fashion? What if you make it larger? What if you make it smaller or lighter?
P	Put to other uses	What other uses might this serve? How might it benefit somewhere else?
E	Eliminate	What can be eliminated or taken away? What can be omitted?
R	Reverse / Rearrange	What if something was rearranged? What if something was reversed?

Others concepts to consider:

Simplify?

Error proof?

Standardize?

Synchronize?

Lighter?

Faster?

Efficient?

5W & 1H Improvement Q's

THE 5W & 1H QUESTIONS OF IMPROVEMENT

WHO?

1. Who does the work?
2. Who is doing it?
3. Who should be doing it?
4. Who else can do it?
5. Who else should do it?
6. Who is doing it with any form of waste, overburden, or inefficiency?

WHAT?

1. What is the purpose or need?
2. What is actually being done?
3. What should be done?
4. What else can be done?
5. What else should be done?
6. What is being done with any form of waste, overburden, or inefficiency?

WHERE?

1. Where is the work to be done?
2. Where is it actually done?
3. Where should it be done?
4. Where else can it be done?
5. Where else should it be done?
6. Where is there any form of waste, overburden, or inefficiency?

WHEN?

1. When is the work to be done?
2. When is it actually done?
3. When should it be done?
4. What other time can it be done?
5. What other time should it be done?
6. When is there any form of waste, overburden, or inefficiency?

WHY?

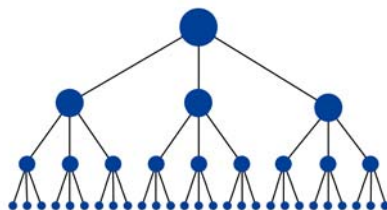
1. Why is it done this way?
2. Why is it actually done this way?
3. Why should it be done?
4. Why do it then at all?
5. Why do it that way and not another way?
6. Why is there any form of waste, overburden, or inefficiency in the process?

HOW?

1. How is the work to be done?
2. How is it actually done?
3. How should it be done?
4. How else can it be done?
5. How to eliminate, combine, rearrange or simplify?
6. How to better improve any form of waste, overburden, or inefficiency in the process?

Set Up Reduction Time Analysis

PRODUCT LINE NAME		SET UP REDUCTION WORKSHEET							
PRODUCTION PART NAME		(Work element analysis, time study, problem identification sheet)							
PROCESS NAME		MACHINE NAME			PART NUMBER				
NO.	MAIN SET UP (WORK ELEMENTS)	TIME STUDY			CATEGORY		IMPROVEMENT POINT	IMPROVEMENT IDEA	
		START	END	TOTAL	INT.	EXT.			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									



Analyze



Quantify



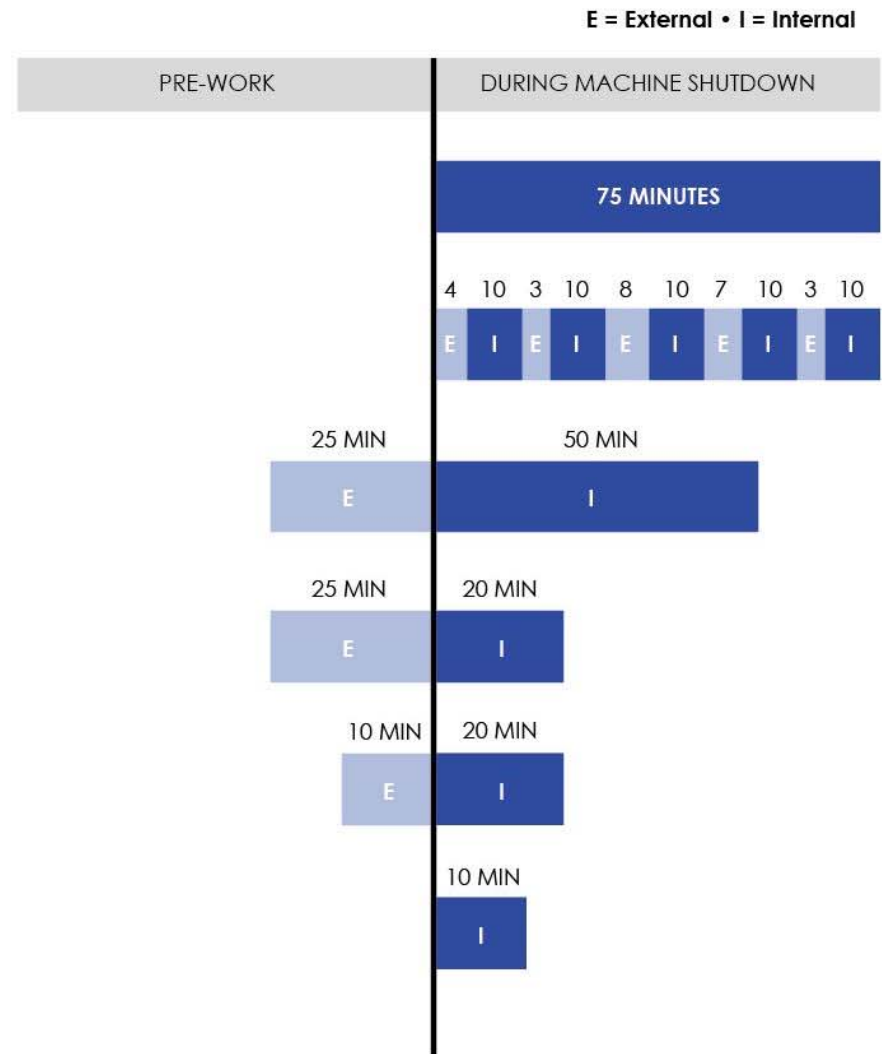
**Pay Attention
To The Details**

Details

Set Up Reduction Time Analysis

METHODS: CHANGEOVER REDUCTION STEPS

- 1** Measure total time required for changeover. Video tape is best.
- 2** Identify internal versus external elements and calculate individual times
- 3** Take the external elements and make sure they are done before the machine stops
- 4** Reduce and eliminate the internal elements (i.e. adjustments & fastener items in particular)
- 5** Reduce the time required for external elements
- 6** Standardize and improve the new procedure over time



Target State Definition



From:

Dedicated Press
Part A, B, C



Dedicated Press
Part D, E, F



Dedicated Press
Part G, H, I



To:



Flexible Press
Parts A, B, C, D, E, F, G, H, I
On Demand / Any Sequence



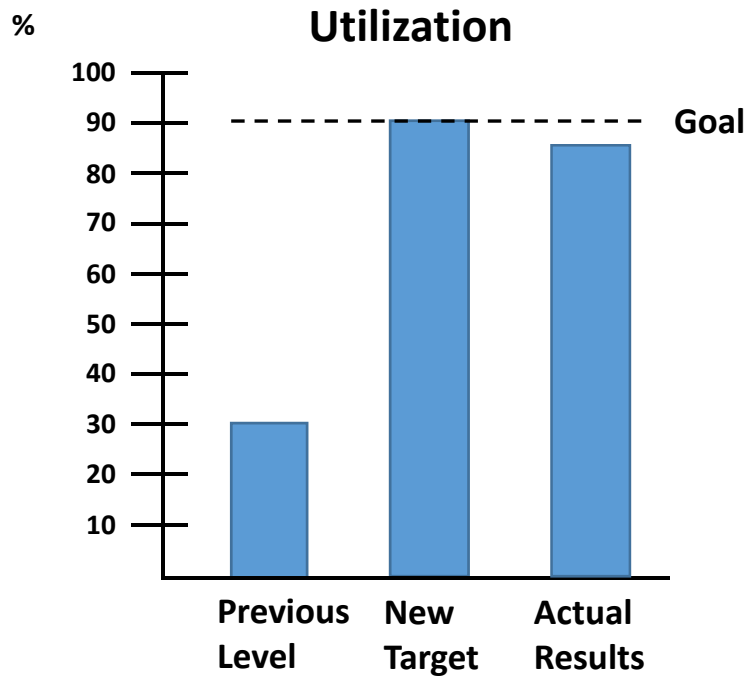
3 Dedicated Machines
3 Operators
No Flexibility
Each 30% Utilization
75 Minute C/O

1 Machine / 9+ Tools
1 Operator
Change Over Flexibility
90% Utilization
10 Minute C/O

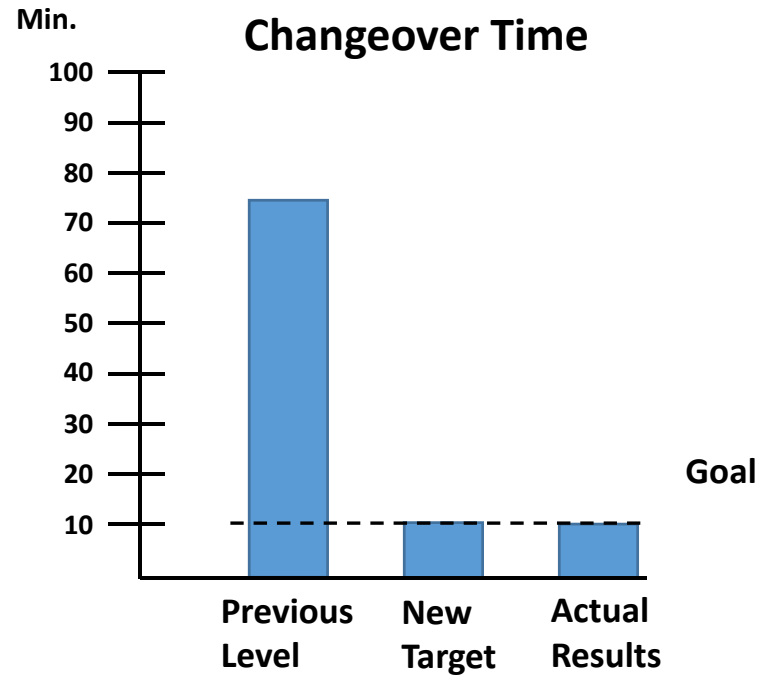
Implementation Plan

What Item	Who's Responsible	Due Date	Expected Outcome	Status Review (June 25 th IPR)
Eliminate bolts & switch to clamps	Tom M.	June 20 th	Time savings of 28 minutes	Complete. First trial showed 9 minute gain.
Preheat dies	Jeff R.	June 16 th	Time savings of 22 minutes First part quality	Complete. First trial showed 10 minute gain.
Standardize hoses, manifold connectors, & quick disconnect	Kathy L.	June 25 th	Time savings of 8 minutes	Complete. First trial showed 11 minute gain.
Create set up cart & 5S tool board	Tom M.	June 22 nd	Time saving of 7 minutes	Complete. First trial showed 5 minute gain.
Alignment aids for die insertion	Jeff R.	June 16 th	Work simplification & visual management	Confirmed easier die insertion.
Create new work instructions	Kathy L.	June 26 th	Training document	Not complete yet.
Train all operators across 3 shifts	Kathy L.	June 30 th	Same result each shift	Pending completion of new work instruction.

Check Results



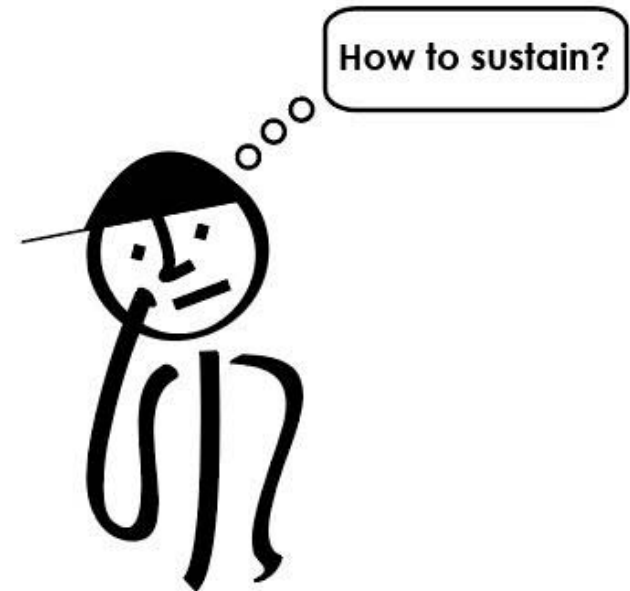
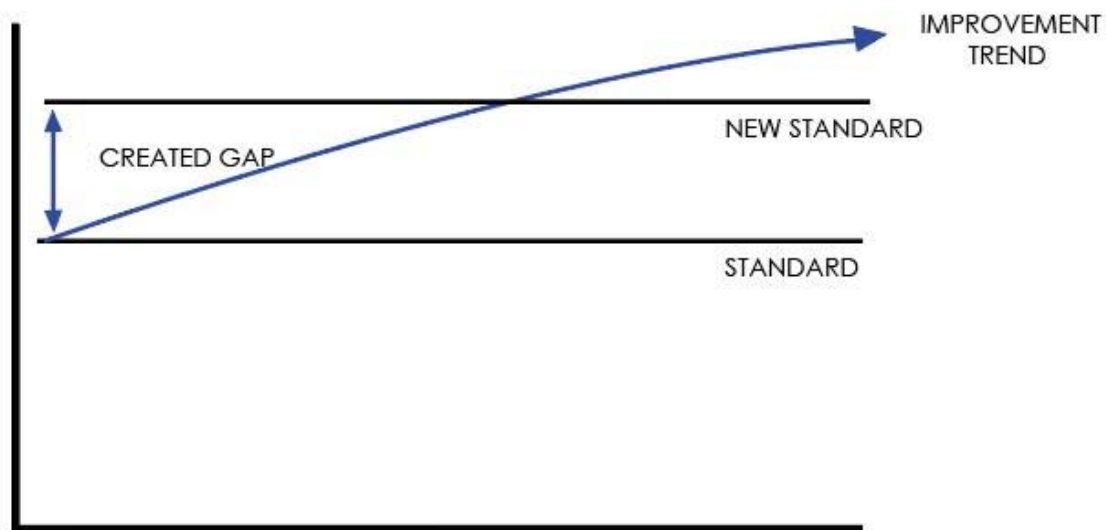
Did not achieve goal yet.
Small gap or problem remains.
Follow up & resolve



Successfully achieved goal.
Will focus on sustainment.
Follow up & sustain

Follow Up & Standardize

STANDARDIZE & FOLLOW UP



WORK
INSTRUCTIONS

FORMS

CHECKLISTS

AUDITS

SPARE PARTS

TRAINING

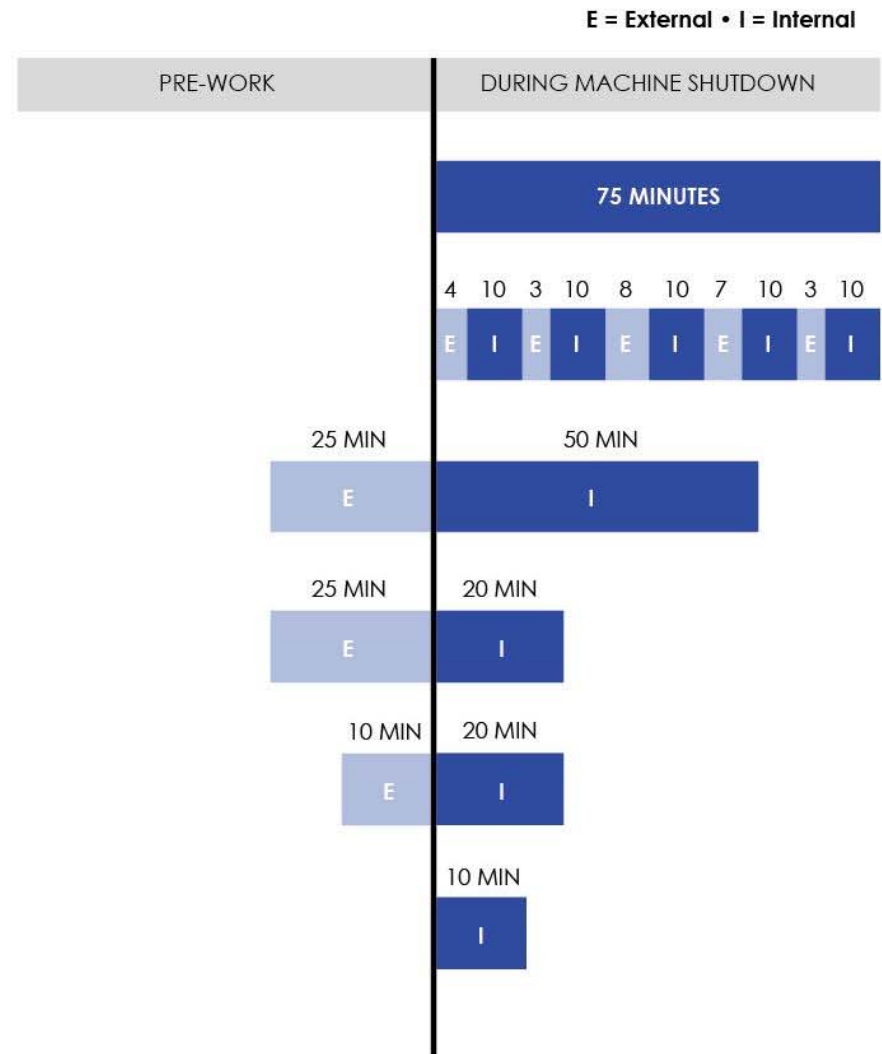
COMMUNICATION

MANUALS

Set Up Reduction

METHODS: CHANGEOVER REDUCTION STEPS

- 1 Measure total time required for changeover. Video tape is best.
- 2 Identify internal versus external elements and calculate individual times
- 3 Take the external elements and make sure they are done before the machine stops
- 4 Reduce and eliminate the internal elements (i.e. adjustments & fastener items in particular)
- 5 Reduce the time required for external elements
- 6 Standardize and improve the new procedure over time

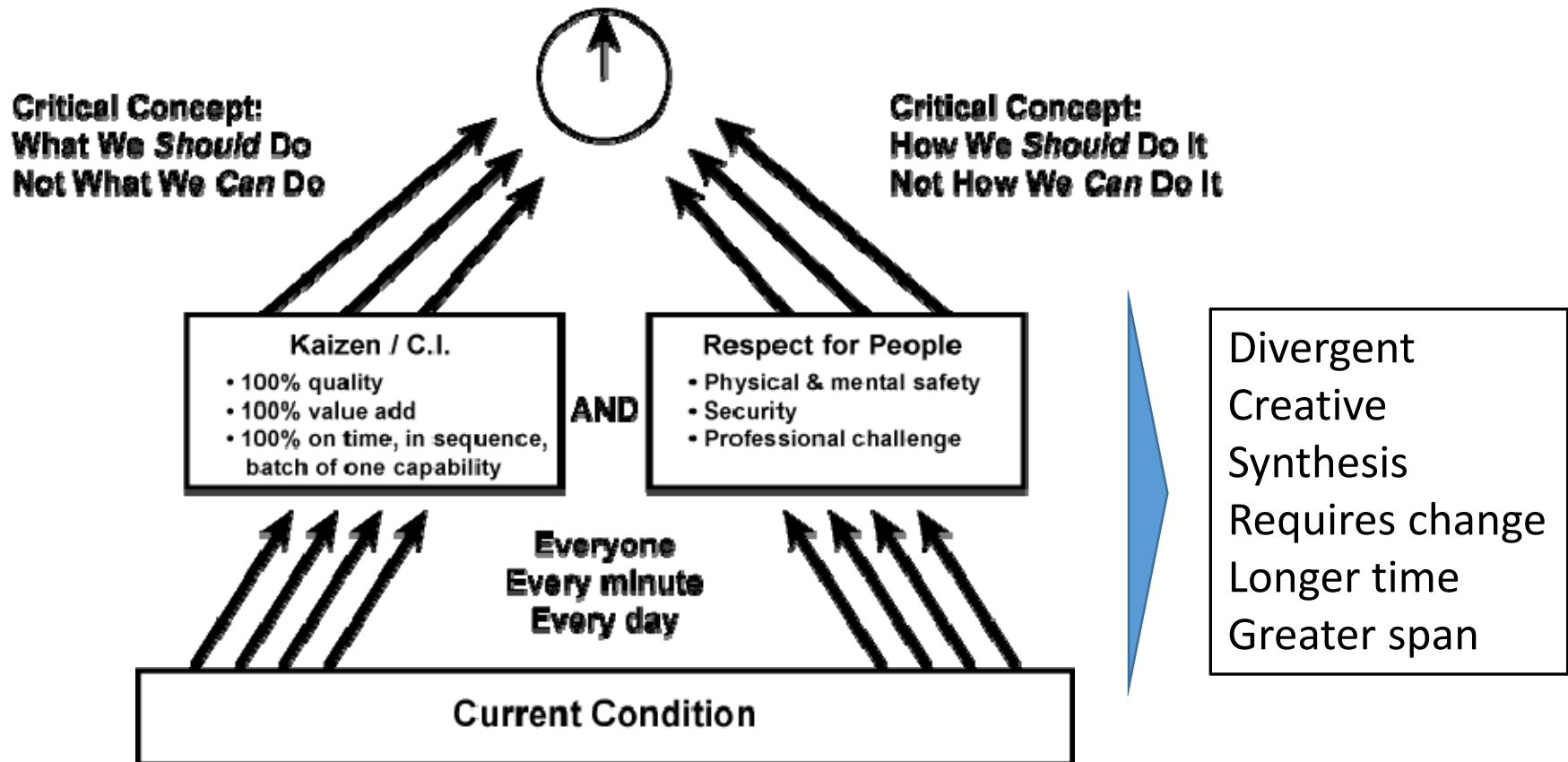


Type 3 Summary

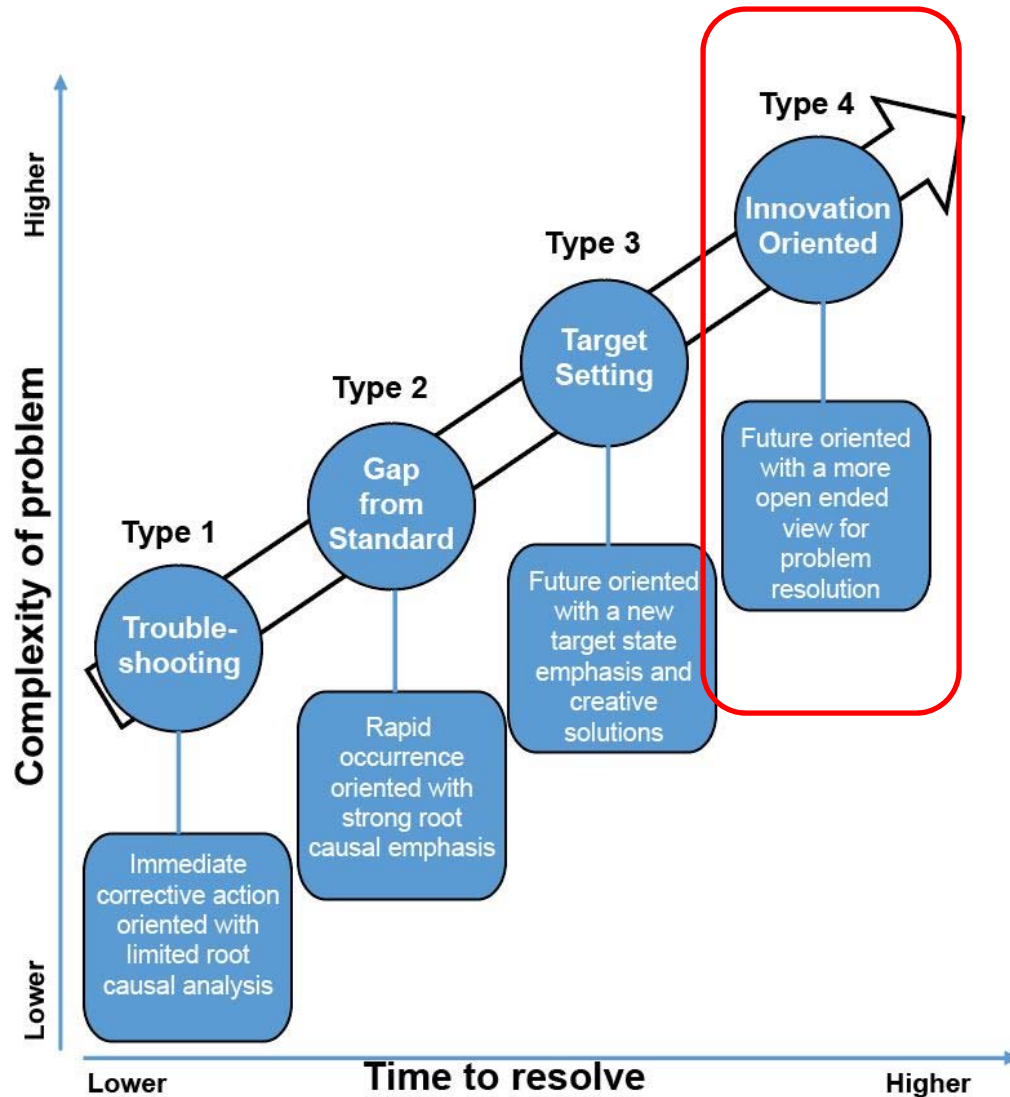
- Type 1 & 2 Problem Solving: Defense
- Type 3 & 4 Problem Solving: Offense
- Type 3 Key Success Factors
 - Challenge, Courage, & Creativity
 - Openness to exploration
 - PDCA Loop iteration
 - Rapid experimentation
 - Learning by doing
- Good luck on your improvement journey!

Type 3 – Target State Summary

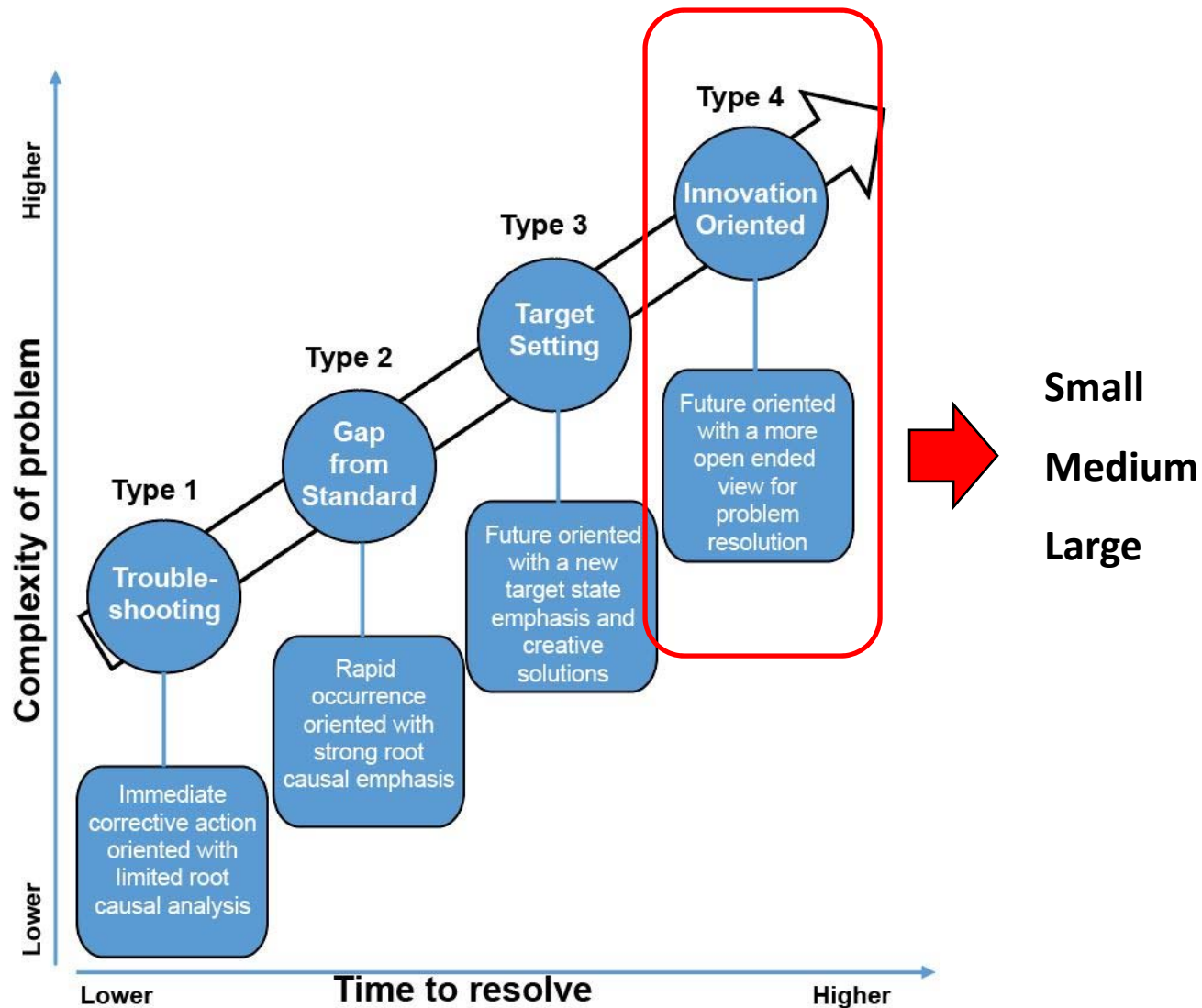
Arubeki Sugata / Ideal State



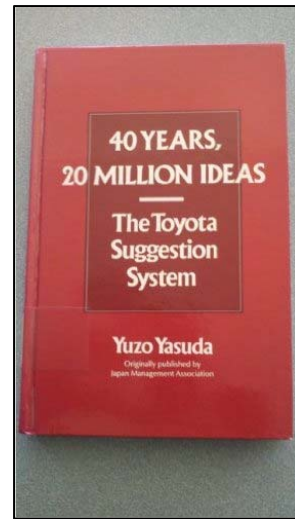
4 Types of Problem Situations



4 Types of Problem Situations



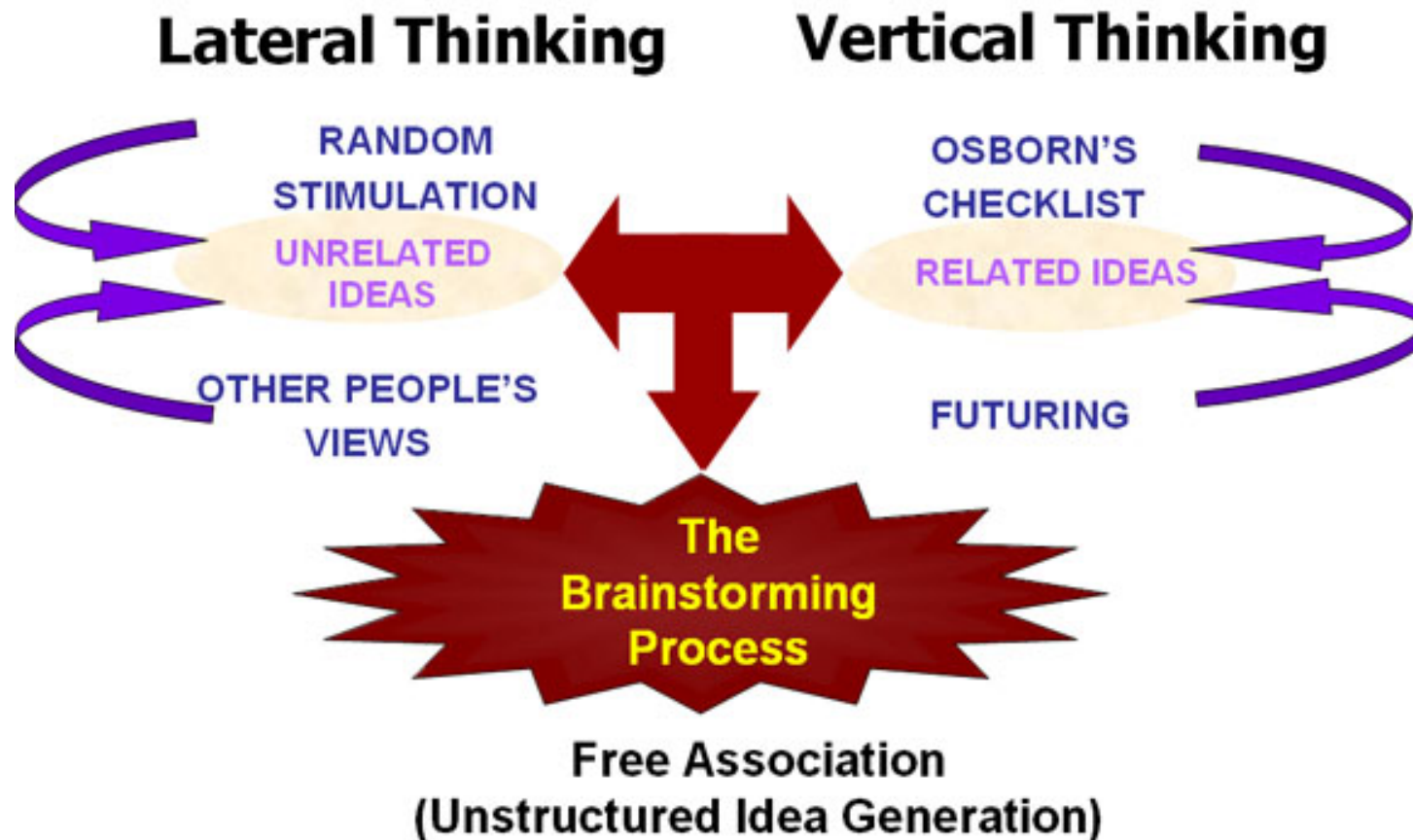
Toyota Suggestion System 1951



The system was introduced by Managing Director Eiji Toyoda in 1951 when it became clear during the post Second World War economic recovery that Toyota's production facilities needed improvement. Toyoda took the idea of TCISS (the creative ideas suggestion system) from a Ford Motor Company plant which he had visited in July 1950.

Although the TCISS offered incentives to employees, the real value of the system was that it provided motivation to employees by focusing on their skills and creativity. The TCISS systemized the practices that had been customary since the time of Toyota Motor Corporation founder Kiichiro Toyoda: respecting opinions from production and sales and conducting spontaneous on-site inspections while simultaneously inviting suggestions for improvements.

Lateral and Vertical Thinking



Brainstorming

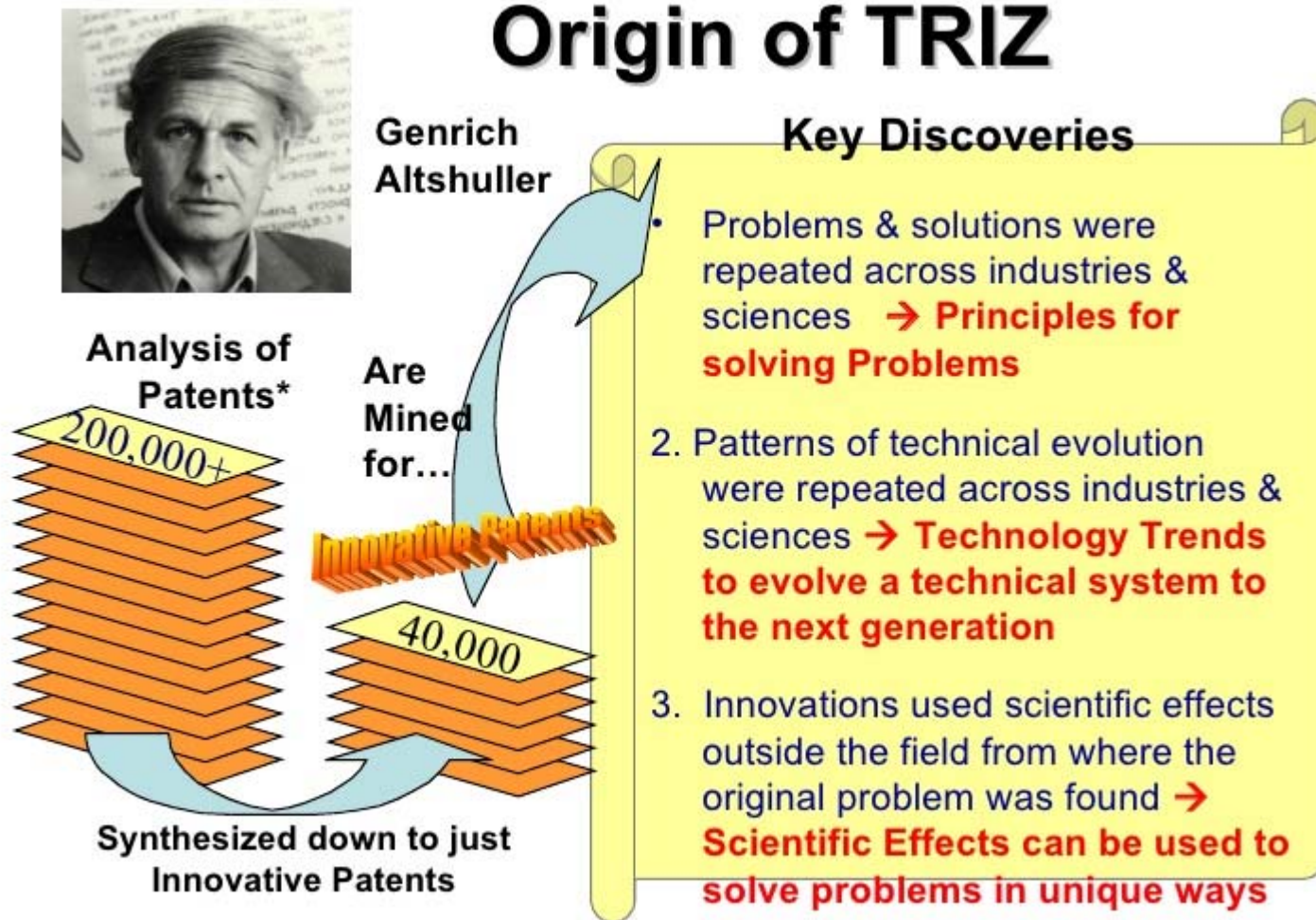


Brainstorming is a group creativity technique by which efforts are made to find a conclusion for a specific problem by gathering a list of ideas spontaneously contributed by its members. The term was popularized by Alex Faickney Osborn in the 1953 book *Applied Imagination*.

Four Rules:

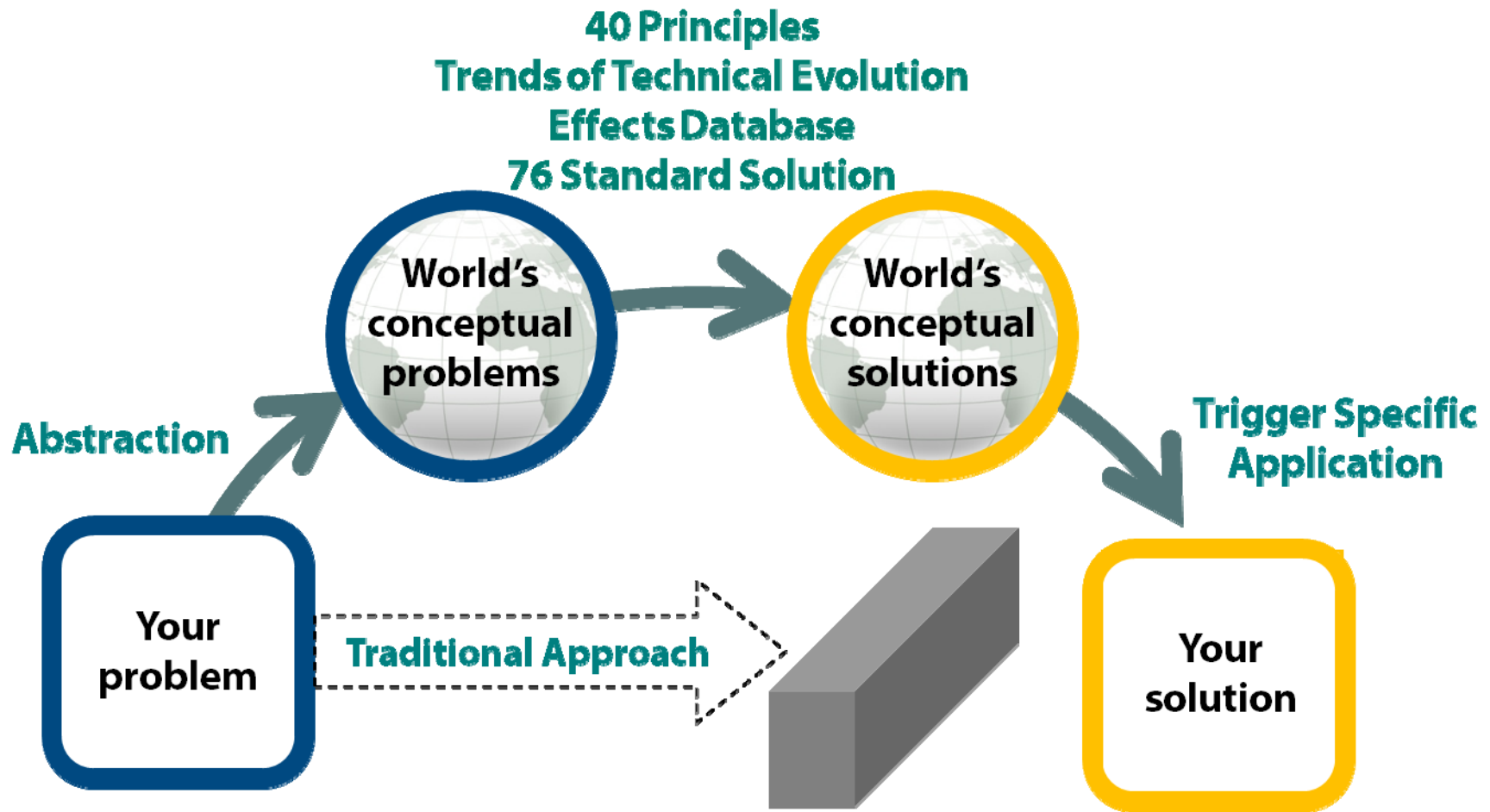
- 1) Seek quantity
- 2) Suspect judgement
- 3) Free association / wild ideas
- 4) Combine and improve ideas

TRIZ / TIPS



* Today, the followers of Altshuller have analyzed / investigated over 2,800,000 patents

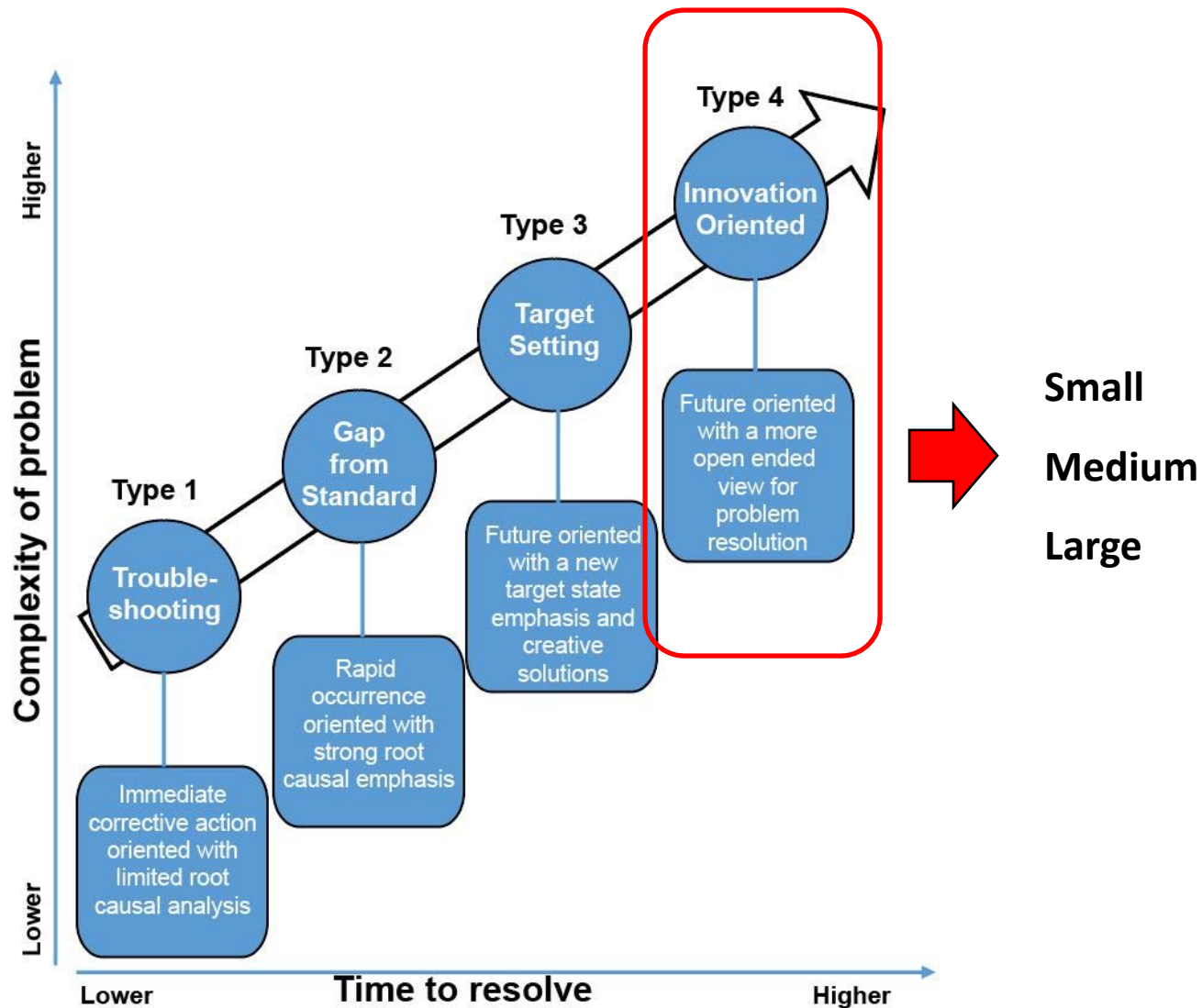
TRIZ / TIPS



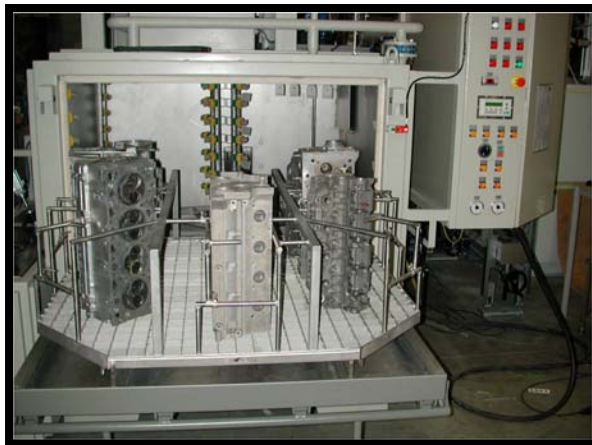
TRIZ / TIPS

 <p>1 Segmentation</p>	 <p>2 Taking Out</p>	 <p>3 Local Quality</p>	 <p>4 Asymmetry</p>	 <p>5 Merging</p>	 <p>6 Universality</p>	 <p>7 Nesting</p>	 <p>8 Anti-weight</p>
 <p>9 Preliminary Anti-action</p>	 <p>10 Preliminary Action</p>	 <p>11 Beforehand Cushioning</p>	 <p>12 Equipotentiality</p>	 <p>13 Inversion</p>	 <p>14 Spheroidality</p>	 <p>15 Dynamics</p>	 <p>16 Partial or Excessive Actions</p>
 <p>17 Another Dimension</p>	 <p>18 Oscillation</p>	 <p>19 Periodic Action</p>	 <p>20 Continuity of Useful Action</p>	 <p>21 Skipping</p>	 <p>22 Convert Harm into Benefit</p>	 <p>23 Feedback</p>	 <p>24 Intermediary</p>
 <p>25 Self-service</p>	 <p>26 Copying</p>	 <p>27 Cheap, disposable objects</p>	 <p>28 Mechanics Substitution</p>	 <p>29 Pneumatics and Hydraulics</p>	 <p>30 Flexible shells or thin films</p>	 <p>31 Porous Materials</p>	 <p>32 Color Changes</p>
 <p>33 Homogeneity</p>	 <p>34 Discarding and recovering</p>	 <p>35 Parameter change</p>	 <p>36 Phase transformation</p>	 <p>37 Thermal expansion</p>	 <p>38 Use strong oxidizers</p>	 <p>39 Inert environment</p>	 <p>40 Composite materials</p>

4 Types of Problem Situations



Washer Process Innovation



Entry View

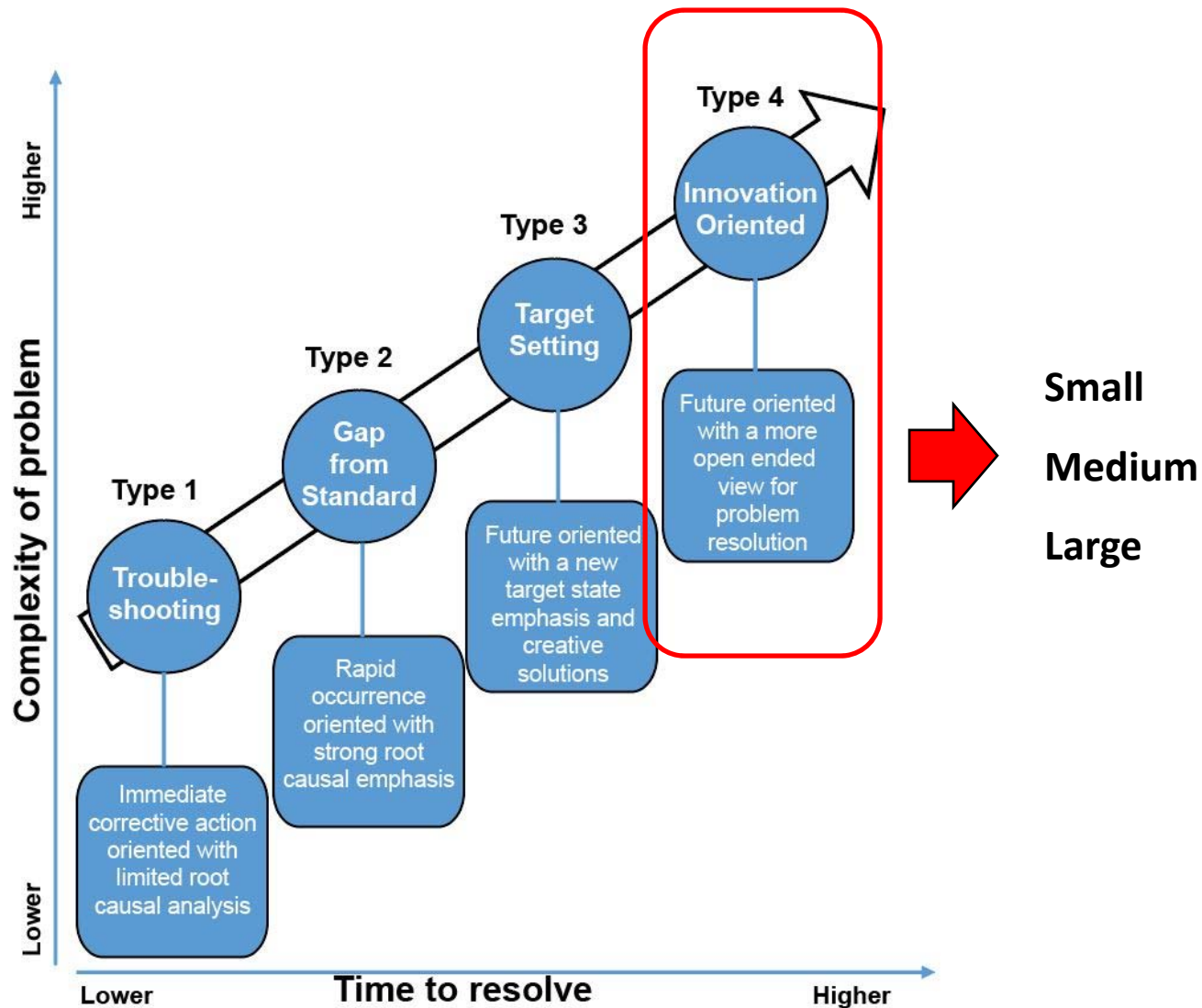


Front View

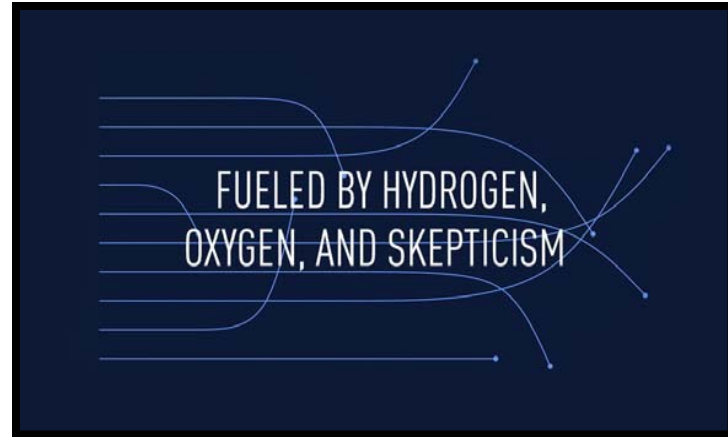
Employee Improvement Idea

- “It occurred to me that the thought of putting the cylinder head through a large box shaped industrial washer was inherently a bad idea...blasting it from the outside with dozens of high pressure nozzles only pushed some cutting chips, dirt, and contaminants father into the holes and ports, etc.”
- “It also occurred to me that just dunking the cylinder head into a series of 55 gallon sized dunk tanks via a robotic arm would work better. Plunging action into the tank with an agitator style of motion would drop the chips and contaminants out with less time, energy, cost, maintenance, and higher end quality...”

4 Types of Problem Situations



Prius, Lexus, & Mirai

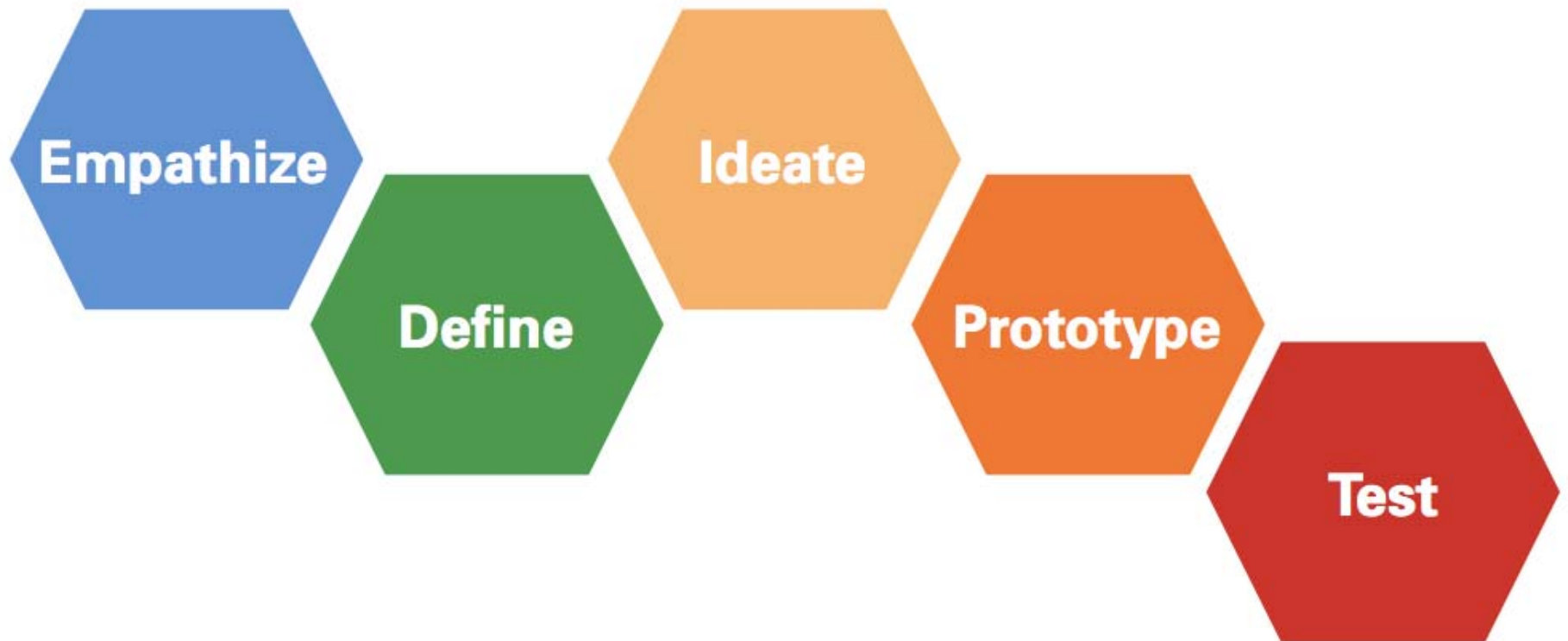


Type 4 – Vision / Innovation

		How you?		
CONFIGURATION	Profit Model	Make money	Gillette, Hiltl	
	Network	Connect with others to create value	UPS, GSK, Toshiba	
	Structure	Align your talent and assets	Mc Do, FabIndia	
	Process	Use Superior methods to do your work	Zara Ikea	
OFFERING	Product Performance	Employ distinguish features and functionality	Dyson, Mars, Inuit	
	Product System	Create complementary products and services	Microsoft, Scion	
EXPERIENCE	Service	Support and enhance the value of your offering	Zappos, Car Glass, Sysco	
	Channel	Deliver your offering to your customers and users	Nespresso Amazon	
	Brand	Represent your offering and business	Intel, Virgin	
	Customer Engagement	Foster interaction	Apple Foursquare	

Doblin: 10 Types of Innovation: The Discipline of Building Breakthroughs

Design Thinking



Three Phases of Design Thinking

**Extreme
Empathy**

**Extreme
Experimentation**

Understand

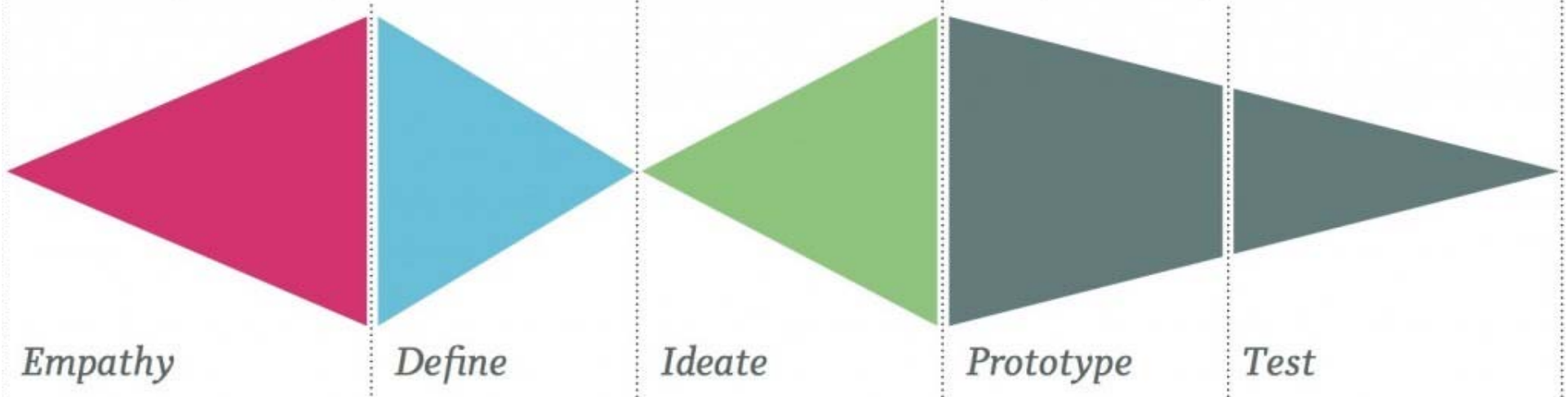
Understanding ends in *Insight*.

Create

Creation ends in *ideas*.

Deliver

Delivery ends in *reality*.



Lean Learning Loops

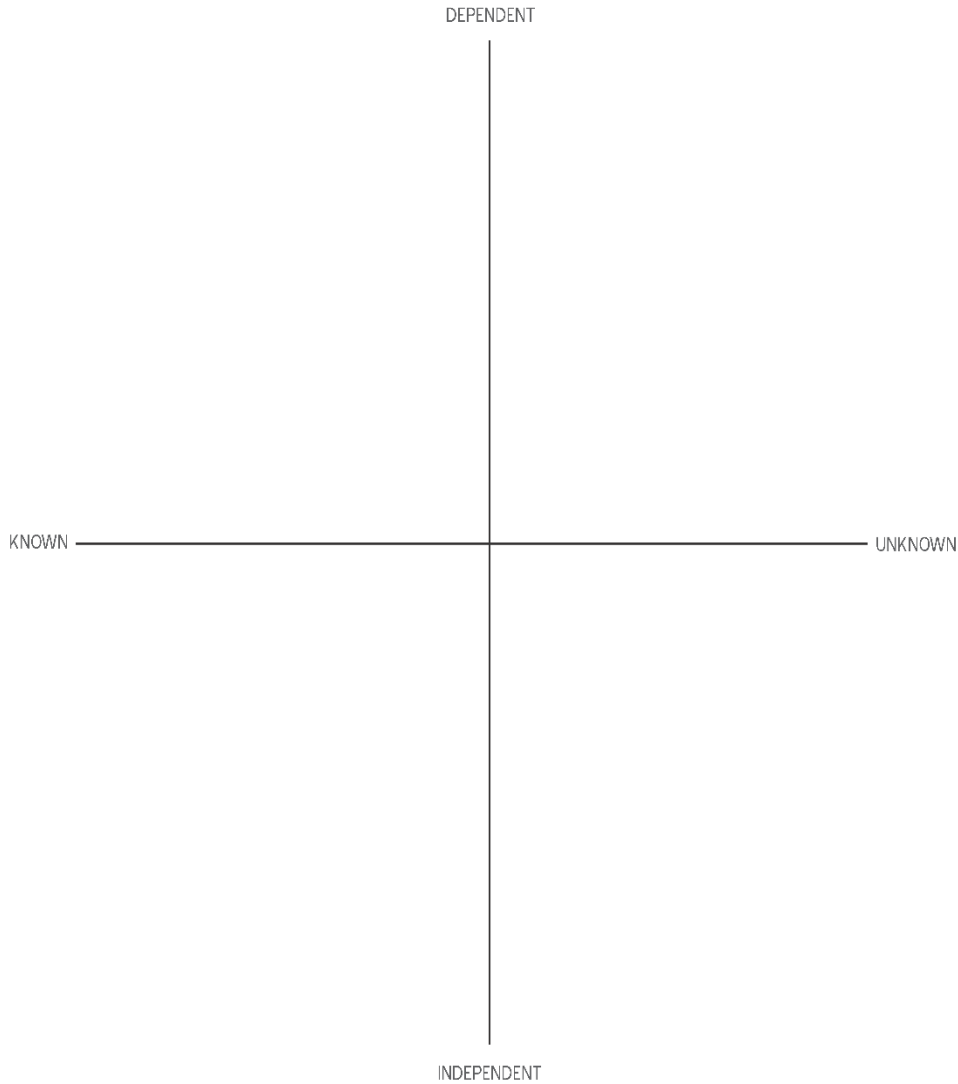
winning aspiration

playing space

business challenge

winning solution

What Must Be True?



1. GUESS

What are the riskiest elements of our solution – the potential barriers to success?

Loop 1 Loop 2 Loop 3

Condition

what condition are we most worried might not be true?

what condition are we most worried might not be true?

what condition are we most worried might not be true?

Concern

why is it so worrisome?

why is it so worrisome?

why is it so worrisome?



2. TEST

What simple, fast, and frugal experiment can we run to test our "what must be true" beliefs... our conditions for success?

What minimally viable prototype can we build to elicit actual customer behavior?

What measurable result can we use to gauge the validity of our hypothesis?

Objective

what is it that we must learn?

what is it that we must learn?

what is it that we must learn?

Hypothesis

what is our testable belief? (i.e. "if we do X, Y will happen")

what is our testable belief? (i.e. "if we do X, Y will happen")

what is our testable belief? (i.e. "if we do X, Y will happen")

Prototype (MVP)

how will we test our hypothesis?

how will we test our hypothesis?

how will we test our hypothesis?

Impact

what target measure will be our standard of proof?

what target measure will be our standard of proof?

what target measure will be our standard of proof?



3. Learn

How well did our experiment work?

What key insights did we gain?

What will be our next iteration?

Results

what actually happened?

what actually happened?

what actually happened?

Explanation

what explains the results, if different from expected?

what explains the results, if different from expected?

what explains the results, if different from expected?

Insights

what was our biggest surprise? what new things did we learn?

what was our biggest surprise? what new things did we learn?

what was our biggest surprise? what new things did we learn?

Decision

what is our next iteration: kill, pivot, or persevere?

what is our next iteration: kill, pivot, or persevere?

what is our next iteration: kill, pivot, or persevere?

5 Why Example Revisited

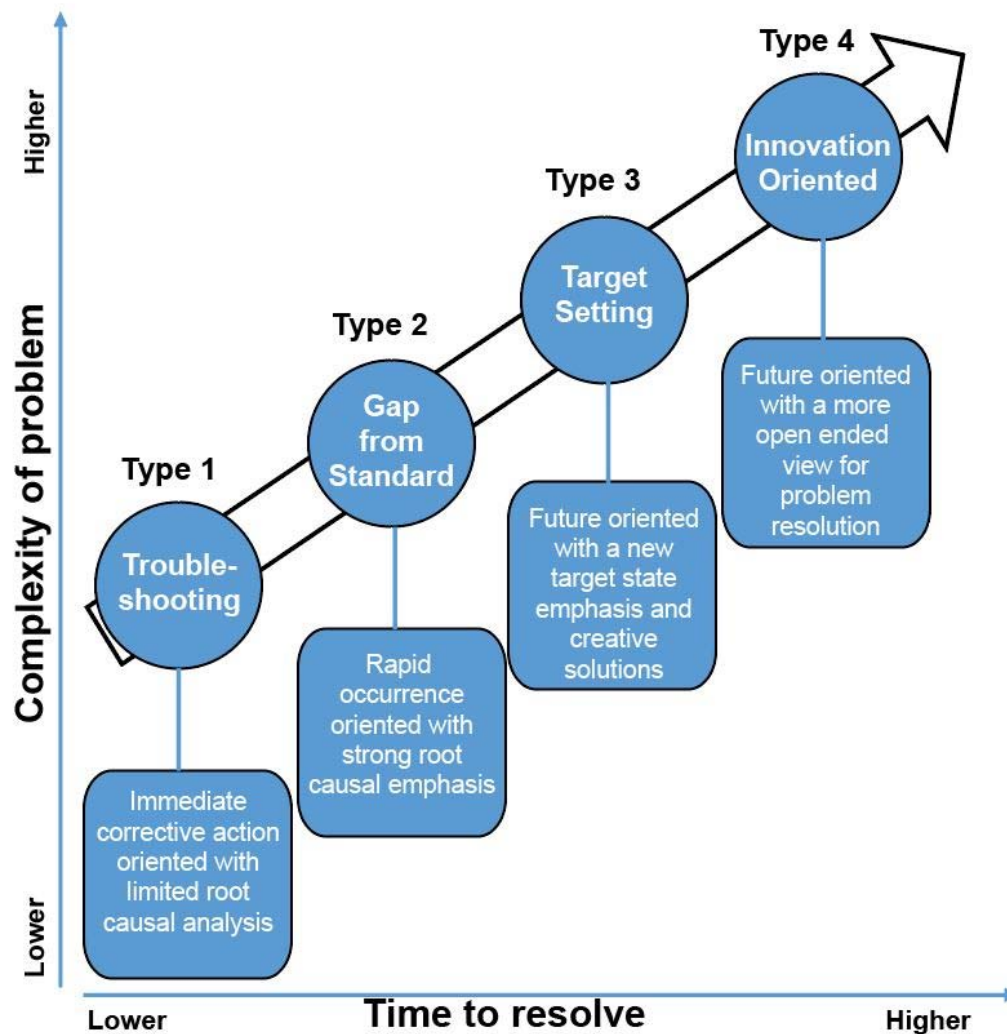
Situation: A machine tool has stopped working halting production.

- 1) “Why did the machine stop working?”
 - “Because the machine overloaded blowing the fuse in the control panel.”
- 2) “Why did the overload condition result?”
 - “Because there was insufficient lubrication to the spindle bearing.”
- 3) “Why was there insufficient spindle bearing lubrication?”
 - “Because there was insufficient lubrication drawn up by the pump.”
- 4) “Why was there insufficient lubrication draw by the pump?”
 - “Because the pump shaft was worn and rattling.”
- 5) “Why was the pump shaft worn?”
 - “Because there was no strainer on the lubrication device inlet port, and small metal cutting chips entered the system causing damage.”

5 Why Revisited

- **Type 1** - Troubleshoot cutting chips by daily cleaning and maintenance of the machine for immediate relief.
- **Type 2** – Put the strainer on the inlet port in the previous example for recurrence prevention.
- **Type 3** – Evacuate the cutting chip better by breaking the cutting chips smaller, with better coolant systems, chip breakers, and better tooling conditions. Also improve machine guards and tank covers for a more creative solution.
- **Type 4** – Tooling innovation, chip formation optimization, cutting condition innovation, washer process redesign, and upstream die casting optimization for process innovation. Material and product innovation are also possible angles.

4 Types of Problem Situations



4 Types & Benkei Analogy

Benkei



Kaoru Ishikawa



The term "7 QC tools" is named after the seven tools of Musashibo Benkei the famous warrior monk. Benkei owned seven weapons which he used to win all his battles. Similarly from my own experience you will find that you will be able to solve 95% of the problems you face if you properly use the 7 QC tools.

Professor Emeritus
University of Tokyo

Baka / バカ / 馬鹿

馬鹿の一つ覚え
[ばかのひとつおぼえ,
baka no hitotsu-oboe

A fool remembers only
one thing

A fool knows only one way
of doing things

Session Summary

- Benkei versus Baka analogy and be careful of experts who only know one way
- Each type has a different cadence and focal point
- Learning by doing is key for all four types
- Reflection after doing is key as well. However you can't just "think" your way to improvement
- Problem solving, innovation and improvement require perspiration and willingness to fail more than once

Appendix