



Reducing Human Error

The IT Maintenance Division of a global bank was experiencing reliability issues with fixes, patches and upgrades, despite the Engineers being indoctrinated into the ITIL Service Management framework.

Our Consultant established that, despite the validation procedures, errors were being reported and the same errors often recurred, albeit with different Engineers. We also identified that the errors were not due to particular hardware or software failures, so they must be down to human error.

On further investigation, we were able to categorise the nature of the errors as 'slips & lapses', 'decision-making' and 'sequencing'. So we instigated some focused workshops with teams of Engineers and set about reviewing existing procedures (Scripts) under the facilitation and structured questioning of the Consultant.

Checklists were created but the emphasis was placed on outcomes rather than inputs, creating Pause Points at key stages where 'evidence' played a significant role. Engineers were soon able to recognise that 'outcomes' provided the link to identifying what is 'critical to quality'. This was a term they were familiar with, having attended Six Sigma programmes, yet none had seen the link to existing scripts and procedures.

Outcomes now drive the inputs rather than the other way round, and recurring errors have been prevented. Moreso, the client estimated that as much as £180,000 was saved over the next year by avoiding re-work alone across three Teams and numerous locations let alone the consequential impact of previously unreliable systems and mobile communication on the Trading and Investment Bank activities.