Human & Organizational Performance: (HOP)
A Path to Improvement for All Organizations

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GOAL: Provide an introduction to human & organizational performance (HOP) that will, in turn, create an appetite for you to learn more about HOP, and motivate you to begin, or engage in, your organization’s HOP journey.

SESSION OVERVIEW:
• What is Human & Organizational Performance (HOP)?
• 6 Key HOP Principles
• Why HOP?
• Who Should Implement HOP?
• Starting Your HOP Journey
• Recommended Reading List for Continued Learning
Human & Organizational Performance (HOP)

• An Individual

• Working within the organizational system

• To meet expectations set by leaders.
What is HOP?

Human and organizational performance (HOP) is a risk-based OPERATING PHILOSOPHY which recognizes that ERROR is part of the human condition and that an organization's PROCESSES AND SYSTEMS greatly influence employee actions and choices, and consequently, their likelihood of success.
HOP is *not* a program...

...it is an **OPERATING PHILOSOPHY**

HOP provides a new way of looking at work, people, and the systems in which people get work done.
HOP

is more than Human Error Management

Design of Physical Systems, Organizational Systems & Processes, and Culture

Human Factors

+ Organizational Psychology
Principles of Human & Organizational Performance

1. People are fallible, and even the best make mistakes
2. Workers are masters at adaptive problem solving
3. Context drives worker actions and behaviors
4. Leadership’s response to failure matters
5. Blame Fixes Nothing
6. Improvement happens through learning
HOP Principle 1:

People are fallible, and even the best make mistakes.
ERROR is NORMAL

is NOT a choice
How many times does the uppercase or lowercase letter “F” appear in the following sentence?

Finished files are the result of years of scientific study combined with the experience of many years.
“Mistakes arise directly from the way the mind handles information, not through stupidity or carelessness.”

- Edward de Bono PhD
HOP Principle 1: People are fallible and even the best make mistakes.

- BAD things don’t just happen to “BAD” people / employees!!
- Who makes the most mistakes / errors?
- The more experienced employees are better able to RECOVER from their mistakes.
- As work gets more complex, the number and complexity of errors increase
ERROR is NOT a choice.

Mistakes & Errors ≠ Violations
HOP Principle 2:

Workers are MASTERS at adaptive problem solving
WHAT IS HAPPENING?
• Adaptions
• Adjustments
• Work-arounds
• Problem Solving
• Tweaking
• Fine-Tuning
• Goal Trade-Offs

The Black Line – “Work-as-Envisioned or Planned”
The Blue Line - “Work-as-Done”

Normally Successful!
Work Changes Every Day

• All work environments are dynamic
• We expect (pay) workers to get the job done
• Workers are experts at [complex] adaptive problem solving
• Procedures are always underspecified
• Planners are not smarter than workers
• Workers are the “Masters of the Blue Line”, the heroes of our workplaces
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OPERATIONAL RISK ACCUMULATION
HOP Principle 3:

Context --> ORGANIZATIONAL PROCESSES, VALUES & INCENTIVES, AND OPERATIONAL SYSTEMS -->

drives worker actions and behaviors.
“People do not operate in a vacuum, where they can decide and act all-powerfully. To err or not to err is not a choice. Instead, people’s work is subject to and constrained by multiple factors.”

— Sidney Dekker
Local Rationality

People do things that

make sense to them at the time,

under the existing circumstances

(expectations, goals, resources, mindset, culture...),

otherwise, they would not do them!
CONTEXT

- Requirements, Expectations, and Feedback: 35%
- Tools, Resources, and Job-site Conditions: 29%
- Incentives & Disincentives: 11%
- Knowledge and Skills: 11%
- Capacity and Readiness: 8%
- Personal Motives, Expectations, and Preferences: 6%
Organizational Processes

“Workplaces and organizations are easier to manage than the minds of individual workers. You cannot change the human condition, but you can change the conditions under which people work.”

— Dr. James Reason
HOP Principle 4:

Leadership’s response to FAILURE matters.
How does your organization respond to FAILURE?

Crime & Punishment
(Blame, Shame, & Retrain)

or

Diagnose & Treat
(Learn First, then Act)
WHY do you perform an incident investigation after an accident?
The Black Line – “Work-as-Envisioned or Planned”
The Blue Line – “Work-as-Done”

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Responding to an Event

• Hindsight bias is always a factor in event investigations.

• Your perspective, by definition, does not allow you to see the worker’s perspective.

• The fact that you are investigating an event arms you with information that the workers did not have!
The Challenge:

Not to let *post-event hindsight* bias our judgment of the *pre-event context*.
HOP Principle 5:

Blame fixes *nothing*!
BLAME

Blame SILENCES communications

Blame CUTS OFF access to information

Blame IMPEDES learning

Blame STIFLES improvement efforts
You can EITHER

Blame & Punish

or

Learn & Improve

You CANNOT do BOTH!!
HOP Principle 6:

Improvement happens through learning.
“In a world of change, the learners shall inherit the earth, while the learned shall find themselves perfectly suited for a world that no longer exists.”

- Eric Hoffer
Building a Learning Culture: A Learning Organization

• Learn from EVENTS, NORMAL WORK AND SUCCESSES
• Learning is integrated into all stages and aspects of work
• Learning happens at all levels of the organization
• LISTENING is required in order to learn; listening is a skill and takes practice
• Learn first, then improve - -> otherwise you might just have made things worse!
• Top organizations are obsessed with learning!
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Discussion Overview

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WHY HOP?

- Fatal & Serious Injury Prevention
- Enriched Employee Engagement
- Operational Excellence
  - ↑ Work Quality
  - ↑ System Reliability
  - ↑ Productivity

The broader the integration of HOP (H&S, Environment, Engineering, Quality, Finance, etc.) the broader and greater the benefits will be.
HOP & FSII Prevention

- This is a deliberate change in strategy
- Because Error is NORMAL --> Plan for failure
- Build in the capacity to FAIL SAFELY
HOP Case Study
Medical Supplies Manufacturing Facility

- Facility introduced to HOP
- 1 Year into HOP Journey
- 2 Years into HOP Journey

- SCOT at 73%
  Backlog at 2.0MM
- SCOT at 79%
  Backlog at 2.5 MM
- SCOT at 95%
  Backlog at 0.2 MM

SCOT = Shipped Complete On Time
WHO Should Implement HOP?

EVERYONE!
STARTING YOUR HOP JOURNEY

- **Event Reporting** and **Response**
- **Blue Line Reviews**

Integration

Deployment
STARTING YOUR HOP JOURNEY

EVENT REPORTING & RESPONSE

1. Shift thinking from WHY → HOW
2. Train those who receive reports of failures in HOP Principles
3. Build “time to learn” into event response process
4. Eliminate automatic discipline
5. Update language
   • Replace “INVESTIGATION” with “EVENT REVIEW” or “EVENT LEARNING”
   • Replace “WITNESS” with “INTERVIEWEE”
   • Replace “EVIDENCE” with “FACTS”, “DATA” and “INFORMATION”
STARTING YOUR HOP JOURNEY

BLUE LINE REVIEWS

• Did anything in your work surprise you today?
• Tell me about the last time you had to adapt or veer from the job instructions?
• What is the worst thing that could happen in your job? What can be done to ensure this never happens?
• What is the best and worst part(s) of your job or this task?
• If you had a $1MM, what would you change about your job?
• Is there anything I can do to improve your job?
Recommended Reading

- *Pre-Accident Investigations: An Introduction to Organizational Safety*, by Todd Conklin
- *The 5 Principles of Human Performance: A Contemporary Update of the Building Blocks of Human Performance for the New View of Safety*, by Todd Conklin
- *Risk-based Thinking: Managing the Uncertainty of Human Error in Operations*, by Tony Muschara
- *Disastrous Decisions: The Human and Organisational Causes of the Gulf of Mexico Blowout*, by Andrew Hopkins
HOP is a 
JOURNEY

ENJOY THE RIDE!

Not a DESTINATION
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