

FMEA Approach of Lean Six Sixma Implementation: Estimating the Value of COPQ

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Abstract

Lean and Six Sixma are a comprehensive concept in business systems. The strength of this concept is that it is able to provide tangible results for the company, so it requires implementation and measurable evaluation steps. The implementation step of Lean Six Sixma must use two approaches, is a Lean approach to eliminate waste processes and reduce variations in products. This article discusses the changes resulting from the implementation of Lean Six Sixma because there are differences in the cost of quality between the conditions before and after the implementation. Cost of Poor Quality (COPQ) is the cost due to defects in processes, products, and services. COPQ is defined as the costs that must be incurred to resolve failures and damage in the process. The measurement method used to estimate the value of CPOQ requires initial measurements. The constraint faced in this estimation was that there was no measure available at the start of the project. To overcome these limitations, we use a weighted risk approach based on potential failures to calculate the costs of the ongoing process. Furthermore, the paper also presents the steps in Lean Six Sixma. In addition, the evaluation mechanism uses Lean Six Sixma with the FMEA approach to COPQ.

Keywords: Lean , Six Sixma, COPQ, FMEA

1. INTRODUCTION

Lean Six Sixma is a comprehensive concept in business systems. The lean concept comes from the Toyota management system concept which was developed and expanded, while the Six Sixma concept comes from the Motorola management system concept. The strength of the two concepts is synergized into Lean Six Sixma (Antony et al., 2017; Aboelmaged, 2010).

In order for Lean Six Sixma to be able to provide tangible results for the company, it requires implementation steps and measurable evaluation. The implementation steps for Lean Six Sixma must use two approaches. A lean approach to eliminating processes from waste and Six Sixma to reduce variation in products (Hill et al., 2017; Petrusch & Vaccaro, 2019; Harry & Schroeder, 2000).

One of the changes resulting from the implementation of Lean Six Sixma, there is a difference in the cost of quality which explains the conditions before and after the implementation. Cost of Poor Quality (COPQ) is the cost resulting from 'defects' on a process, product, or service. COPQ is also defined as the costs that must be incurred to deal with failure and damage in the process. Many methods are used to estimate the value of CPOQ because all of them require initial measurements (Prashar, 2014).

The constraint faced in estimating COPQ was that no measure was available at the start of the project. To overcome these limitations, we need to present a weighted risk approach from potential failures to calculate the cost of processes that are running in a company.

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2. LITERATURE REVIEW

2.1. Theory of Lean

Lean as a business philosophy that is based on minimizing the use of various resources (including time) in various company activities. Lean focuses on identifying and eliminating non-value added activities in the design, production, or operation and supply chain management that are directly related to customers. Lean creates a self-sustaining culture by emphasizing the 5-S concept. This system will generate motivation for workers to always work effectively and efficiently. Lean thinking distills the lean approach into 5 main perspectives (Čiarnienė & Vienažindienė, 2012; Womack & Jones, 2005).

First, value is needed to identify product value from a customer perspective, where customers want products with superior quality, competitive prices, and on-time delivery. Second, the value stream as a process mapping which includes all the steps needed to design an order, produce goods or products and look for non-added value activities. Third, it is necessary to create a value flow, because various activities that provide added value are arranged into a continuous flow and eliminate non-added value activities. Fourth, organizing a pulled system so that materials, information, and products flow smoothly and efficiently along the value stream. Fifth, the perfection stage is aimed at continuous improvement, so that the waste that occurs can be completely eliminated from the existing process (Holden, 2010).

2.2. Six Sigma Approach

Six Sigma is a quality management system that is always oriented to customer satisfaction with a Six Sigma quality level target measurement. Six Sigma (σ) is a symbol that describes the distribution or distribution of the process mean value (standard deviation). This Six Sigma value is used as a measuring tool to show the performance of a process. The Six Sigma process with a normal distribution allows the average value to shift 1.5 Six Sigmas from the quality target specification (T) value desired by the customer (Ganguly, 2012; Dutta & Jaipuria, 2020; Schroeder, 2008).

There are five basic steps or steps in implementing the Six Sigma strategy, i.e. Define-Measure-Analyze-Improve-Control (DMAIC). From the stages, it is a recurring part and forms a cycle of quality improvement for Six Sigma. The DMAIC cycle is presented in Figure 1.

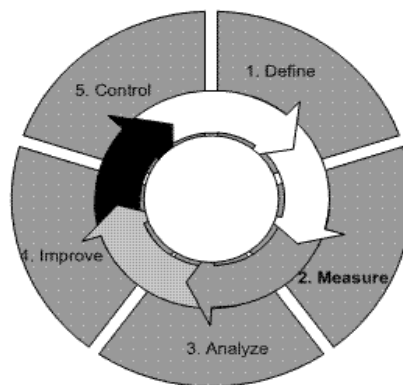


Figure 1: DMAIC cycle
Source: Pande et al. (2000)

Six Sigma as a quality program is also a tool for problem-solving. Six Sigma emphasizes methodically and systematically which will result in a breakthrough in quality improvement. This systematic methodology is generic, so it can be applied in both the manufacturing and service industries. Six Sigma is also said to be a process-focused method and defect prevention. Prevention of defects is done by reducing

the variation in each process by using statistical techniques that are generally known (Snee, 2004; Montgomery & Woodall, 2008).

The benefits of implementing Six Sixma are different for each company concerned, depending on the business they are running. Typically, this approach will lead to improvements in cost reduction, productivity improvements, market share growth, customer retention, reduced cycle times, defect reduction, and product or service development. Judging from the tools used, Six Sixma is quite broad. Figure 2 shows the commonly used methods of Six Sixma (Hammer & Goding, 2001; Raisinghani et al., 2005; Ghaleb et al., 2004).

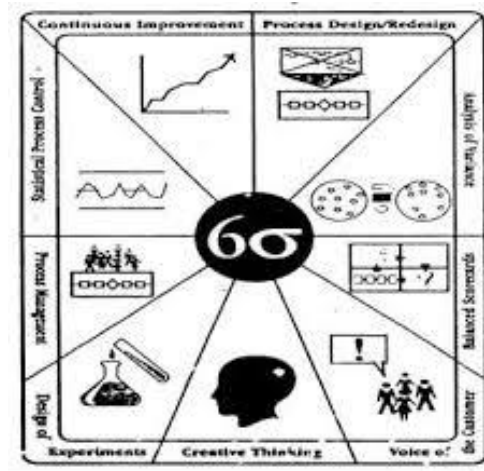


Figure 2: Six Sixma with its tools
 Source: Brue (2002)

Efforts to improve towards the Six Sixma target can be done with the DMAIC methodology with several stages. Formally define process improvement goals consistent with customer demands or needs and company strategy. Measure current process performance so that it can be compared with the target set. Perform process mapping and collect data related to key performance indicators. Analyze the causal relationship of various studied factors to determine the dominant factors that need to be controlled. Optimizing the process using analysis such as DeSixn of Experiment (DOE), to determine and control the optimum process conditions. Controlling the process continues to improve process capabilities towards the Six Sixma target (Rahman et al., 2017; Kusnadi & Yudoko, 2016).

Table 1: Sixma level values

Specification limits	Percent	Defective (ppm)
$\pm 1\sigma$	30.23	697.700
$\pm 2\sigma$	69.13	308.700
$\pm 3\sigma$	93.32	66.810
$\pm 4\sigma$	99.38	6.210
$\pm 5\sigma$	99.98	233
$\pm 6\sigma$	99.99	3.4

Source: Harry & Schroeder (2000)

In general, the successful implementation of the Six Sixma concept is measured by the Sixma value achieved. This value is an interpretation of the number of errors that occur per one million units. The higher the Sixma value achieved, the better the industrial process performance is. Table 1 presents the Six Sixma quality level, which is the quality level where the process with a 6s spread of the average process still meets the specified specification limit. At this quality level, there are only 3.4 defects resulting from 1000,000 defects (defects per million opportunities).

Table 2: The relevance of Sixma Level, DPMO and COPQ

Sixma level	DPMO (criteria)	% COPQ of sales value
1	697,700 (highly uncompetitive)	Can not be calculated
2	308,700 (Indonesian industry average)	Can not be calculated
3	66,810	25% - 40%
4	6,210 (USA industry average)	15% - 25%
5	233 (Japanese industrial average)	5% - 15%
6	3.4 (world class industry)	< 1%

Source: Gaspersz (2002)

Quality improvement as a result of implementing Lean Six Sixma along with achieving the Sixma level can be measured based on the percentage of COPQ to sales value (see Table 2).

2.3. Cost of Poor Quality (COPQ)

COPQ is the cost due to defects in processes, products, and services. COPQ is the initial financial analysis that resulted in the implementation of the Lean Six Sixma project. COPQ is also a cost that must be incurred to resolve failures and damage in the process. Costs incurred are influenced by 4 factors such as the probability of each failure occurring, how serious the condition will be if a failure occurs, provisions for finding the cause of errors, and the cost of handling one failure (Troy & Schein, 1995).

Many methods are used to estimate CPOQ values and all require initial measurement. The constraint faced in estimating COPQ was that no measure was available at the start of the project. However, an approach can be used to calculate the cost of an ongoing process using the weighted risk of potential failures. One of them is by using FMEA (Moen, 1998; Krishnan, 2006; Giakatis et al., 2001; Ghobadian et al., 1994).

3. MEASUREMENTS

3.1. Failure Mode and Effect Analysis (FMEA)

Failure Mode and Effect Analysis (FMEA) is a method that functions to show problems that may arise in a system, because it can cause the system to be unable to produce the desired output and then determine countermeasures (before the problem occurs). Thus, problems in the production process that affect product quality can be reduced, so they will be eliminated by themselves. Basically, the FMEA program wants to know 3 things which include the potential causes of failure of the product during its life cycle, the effect of these failures, and the level of criticality of the effect of failure on product function (Ben-Daya, 2009; Wang et al., 2017).

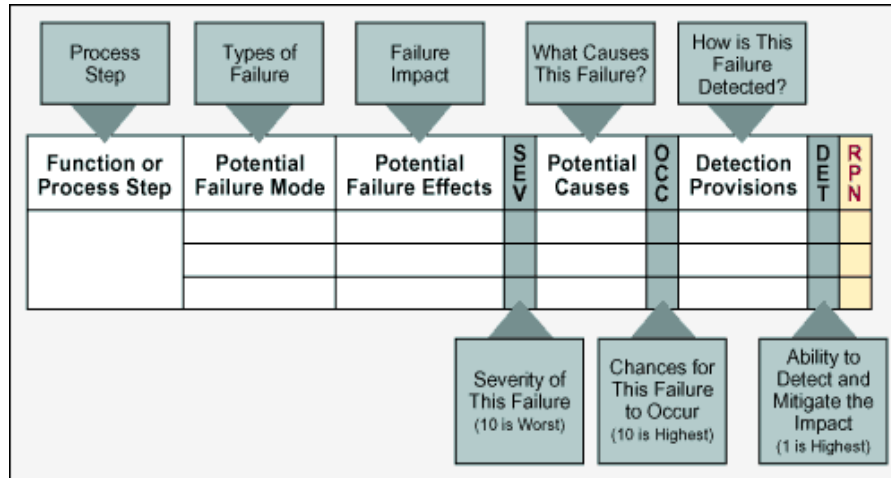


Figure 3: FMEA worksheet
 Source: Schneider (1996)

Figure 3 shows the FMEA worksheet which consists of an estimate of the potential failure that may arise in the system, the estimated effect of the problem on the product (effect), determining the cause of each failure, and determining the priority order of troubleshooting based on the frequency and degree of failure (George, 2002).

3.2. Lean Six Sixma Implementation and Evaluation DeSixn

FMEA is carried out in the measure (analyze) phase and control on the project DMAIC, to provide the basis for estimating COPQ. The use of FMEA in estimating COPQ is carried out in the following steps:

Step 1: Identify potential causes of failure using the input-output diagram and transfer it to the FMEA worksheet. Use a cause-and-effect matrix, to ensure that all types of failure are included in the COPQ analysis. Enter only the controlled input (factor), this is important because the costs for uncontrolled factors cannot be calculated with certainty.

Step 2: After inputting input, review with the team to ensure all potential failures have been identified. Include every possible failure. If there is a risk of failure, the team must identify it and include the potential cost of failure in the COPQ calculation.

Step 3: Calculate risk priorities for all potential failures using FMEA. Calculate the value of risk priority number (RPN) by considering the value of severity, occurrence, and detection.

$$Risk\ Priority\ Number = Severity \times Occurrence \times Detection$$

Where: Severity is the ranking of the severity of the failure mode effect for customers, Occurrence is the ranking of the causes of the failure mode during product use, and detection is the ranking of the current control system capable of detecting the occurrence of failure mode and preventing it from reaching the customer.

Step 4: Use team input and all available estimation tools. Then, calculate the Average Cost to Resolve (ACR) for each potential cause of failure. ACR is calculated as the product of the estimated time to solve the problem (Estimated Effort Hours to Resolve = EHR) and the average.

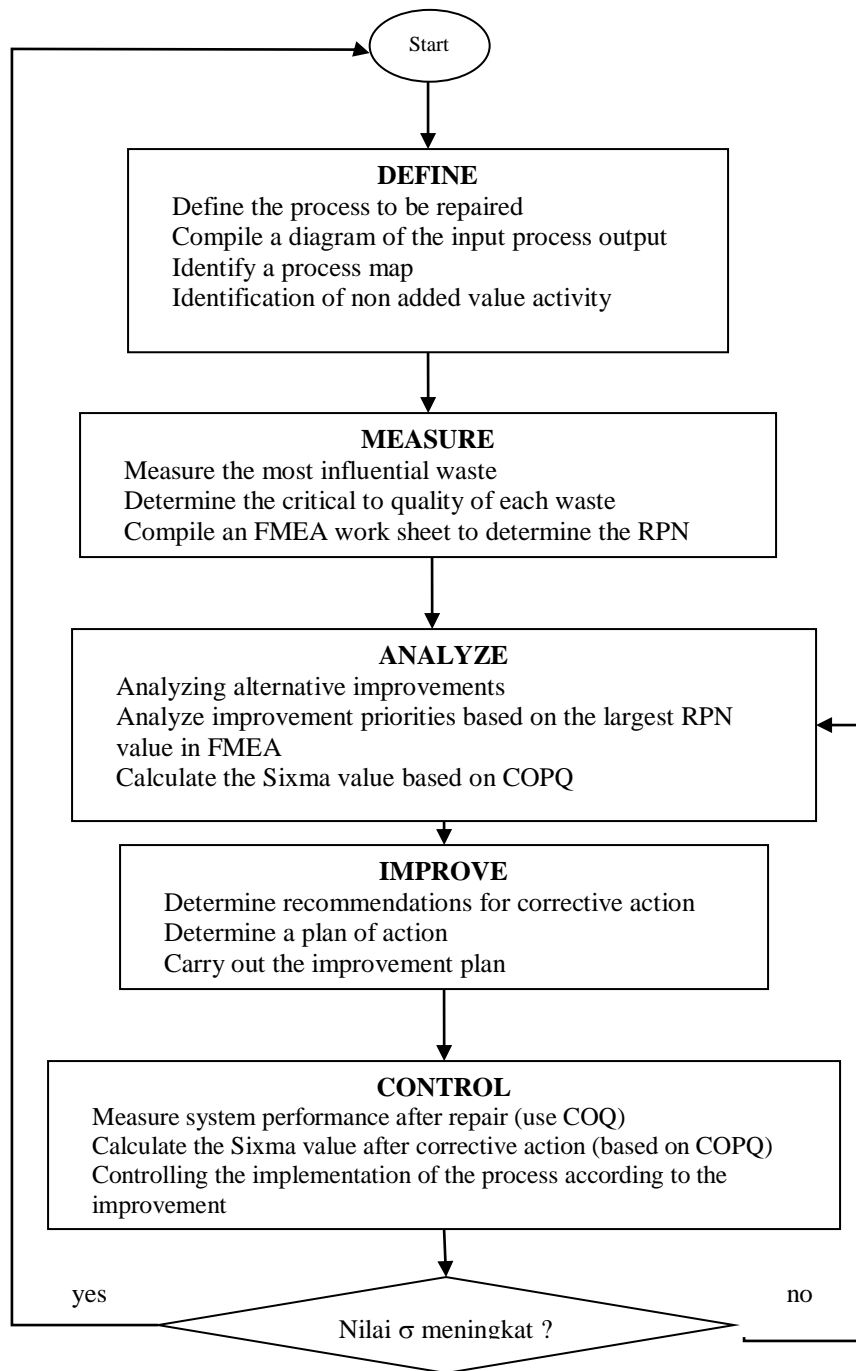


Figure 4: Lean Six Sixma procedure flow chart

The hourly completion cost (ACH) is estimated here using a 90% -95% confidence level.

$$ACR_i = EHR_i \times ACH_i$$

Where: ACR_i is the average cost to solve problem i , EHR_i is the time needed to solve the problem i , ACH_i is the average cost per hour to solve problem i , and i is 1 to n (n total number of failures).

Step 5: Calculate the average cost required to solve a random problem, using the weighted average of the time to solve the problem. Weighting uses the risk priority for each failure.

$$\text{Weighted Average Cost to Resolve (WACR)} = [\text{Sum of } (RPN_i \times ACR_i) / \text{Sum of } (RPN_i)]$$

Step 6: Calculate the COPQ of the project by multiplying the WACR by the case reduction target during the project.

$$COPQ = WACR \times \text{Reduction in Events Due to the Project}$$

4. RESULT AND DISCUSSIONS

The Six Sixma team at Bank "X" was tasked with reducing the number of failed transactions resulting from 400 cases to 300 cases per month. No data was collected in the past either on cases or their measurements. However, team members can find out what caused the failure. In the absence of measurements, the team attempted to estimate the COPQ. The financial estimate related to the calculation of troubleshooting time is an important parameter to validate the results of this improvement project. As a solution, the team will use a risk prioritization approach with FMEA to estimate the COPQ. There are 2 steps taken by the team through define and measure.

This project is carried out to improve the service process at a bank, aiming to reduce customer queuing time by making improvements to service speed and factors that can reduce queues. Inputs from the service process are employee skills, transaction procedure computer systems, and transaction forms. The resulting output is in the form of customer service time (5 ± 2 minutes), the transaction value per month is Rp. 250 million \pm 10 million, and customer satisfaction on a scale of 8-10. The customer service process is as shown in Figure 5. Based on the value stream mapping, it is known that 55% of all activities are value-added activity, 20% are necessary but non-added activity and 25% are non-added activity. The existence of non-added activities results in ineffective bank performance and efficiency.

From the process map, the biggest waste identified in this activity is waiting for the result of rework. From the input-output process, the causes of waste are identified. Furthermore, written in the FMEA worksheet. The steps are as follows:

Step 1: The team uses the input-output diagram to identify all potential causes of failure. Four causes were identified and imported into the FMEA tool. The four causes are employee skills, computer systems, transaction procedures, and transaction forms

Step 2: Next, the team meets to brainstorm and identify other causes. From this brainstorming, one main cause would be identified (damaged ATM), so that the cause was identified with a total of 5 cases.

Step 3: Calculating the RNP for the five causes of failure using FMEA tools.

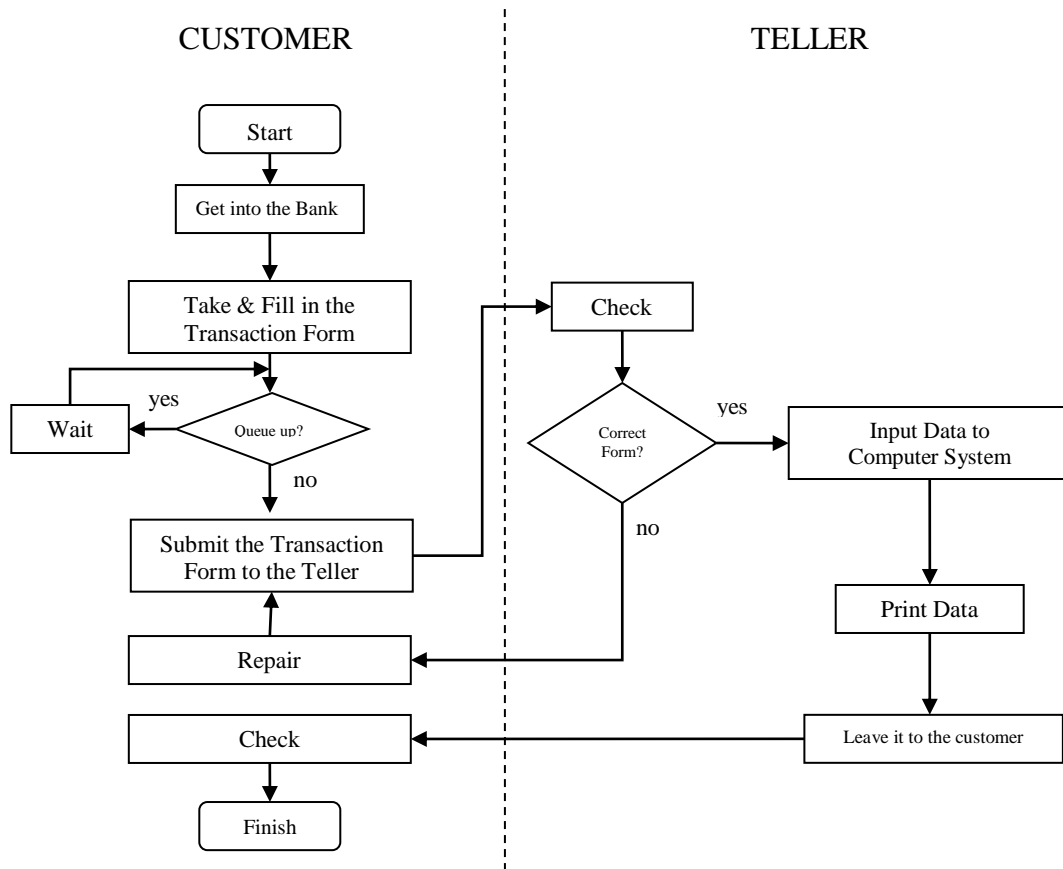


Figure 5: Process flow

Step 4: Then, the team reviews each cause of failure and calculates the average cost of dealing with the failure caused by that factor. Here, it takes an estimate of the problem-solving time and the average cost per unit of time.

Table 3: RPN calculation

Potential causes	Severity	Occurence	Detection	RPN
Employee skills	7	5	0.2	7.0
Computer system	5	5	0.5	12.5
Transaction procedure	6	9	0.8	43.2
Transaction form	8	9	0.8	57.6
ATM has broken	4	5	0.3	6.0

Source: Own tabulations

Step 5: Use the estimated average cost per case to calculate the weighted average weight estimate for solving the problem (WACR).

$$\begin{aligned}
 \text{Weighted Average Cost to Resolve (WACR)} &= (RPN \times ACR) / RPN \\
 &= Rp.19,990,000 / 126.3 = Rp. 158,274
 \end{aligned}$$

Table 4: COPQ calculation

Potential causes	RPN	Effort Hours to Resolve (hours)	Average Cost Per Hour (Rp.000)	Average Cost to Resolve (Rp.000)	RPN x ACR
Employee skills	7.0	1	50	50	350
Computer system	12.5	4	100	400	5,000
Transaction procedure	43.2	1	50	50	2,160
Transaction form	57.6	1	50	50	2,880
Weather	6.0	16	100	1,600	9,600
Total	126.3	23	350	2,150	19,990

Source: Own tabulations

Notes: Effort Hours to Resolve (EHR), Average Cost per Hour (ACH), Average Cost to Resolve (ACR).

Step 6: Finally, COPQ is estimated by multiplying the cost of resolving failures by the potential occurrence of failures per year.

$$COPQ \text{ (annualized)} = [Sum \text{ of } (RPN_i \times ACR_i) / Sum \text{ of } (RPN_i)] \times \text{Annual Reduction in Events}$$

The estimated occurrence of this failure is 400 cases per month, so that in 1 year as many as 4,800 cases per year.

$$COPQ \text{ in 1 year} = Rp. 158,274 \times 4,800 = Rp. 759,715,200$$

So, if there are 400 failures per month (4,800 per year), the COPQ that occurs is Rp. 759,715,200. When compared with the transaction value per year is Rp. 250 million x 12 = Rp. 3 billion, then this COPQ reaches 25.32%. Based on Table 2, this value indicates the Sixma level 3.

To improve services, there are 4 alternative corrective actions that are considered by conducting training to improve employee skills, changing the computerized system, improving transaction procedures, and improving transaction forms. From the FMEA worksheet, it can be seen that the transaction form has the highest RPN value, so it is classified as an alternative improvement that has the highest priority to be implemented. The bank management targets this year to be able to reduce the occurrence of delays in service from 400 cases to 200 cases. Therefore, the COPQ value and the Sixma value will be analyzed in this condition. From the calculation, the COPQ value is Rp. 379,857,482 or 12.66% of the annual sales value, so as to achieve the Sixma value of 4.

Improvements are made in accordance with alternative improvements that have the highest RPN value, namely improvement of the transformation form.

If the implementation has been carried out, it is necessary to take control measures to ensure the implementation of improvements in accordance with the provisions. Apart from that, the COPQ value and the Sixma value were also calculated to find out whether the method was able to improve the quality of the process. The calculation process uses the FMEA approach.

Several empirical studies conducted by Ridwan & Noche (2014), Sörqvist (1997), and Edgeman & Bigio (2004) have supported the findings in this article, that FMEA is a structured approach, so this calculation is relatively easy to do. Accuracy and ability to know the relationship (dependency) of each case and its severity, will result in COPQ estimates close to the actual value.

5. CONCLUSIONS

The combination of the Lean Thinking and Six Sixma approaches will produce a quality process in a fast time and at low cost, because the two work together. Six Sixma produces quality products, so it will spur

lean speed to minimize rework time. On the other hand, lean speed has helped Six Sixma in producing quality products because it is driven by the experimental process and the learning process quickly.

The successful implementation of Six Sixma can be seen from the number of costs resulting from the production of poor quality products (COPQ). The lower the COPQ value, it shows that the process needs a relatively small cost of handling failure. This means that the process is able to produce good quality products and the achievement of the Sixma level by higher processes.

If the Six Sixma project team calculates the COPQ value at the measuring stage, then the FMEA approach will be very helpful because this approach objectively estimates COPQ which is constrained by the absence of past data and available measurement systems.

REFERENCES

- Aboelmaged, M. G. (2010). Six Sixma quality: a structured review and implications for future research. *International Journal of Quality & Reliability Management*, 27(3), 268-317. <https://doi.org/10.1108/02656711011023294>
- Antony, J., Snee, R., & Hoerl, R. (2017). Lean Six Sixma: yesterday, today and tomorrow. *International Journal of Quality & Reliability Management*, 34(7), 1073-1093. <https://doi.org/10.1108/IJQRM-03-2016-0035>
- Ben-Daya, M. (2009). Failure Mode and Effect Analysis. In: Ben-Daya M., Duffuaa S., Raouf A., Knezevic J., Ait-Kadi D. (eds) *Handbook of Maintenance Management and Engineering*. London: Springer. https://doi.org/10.1007/978-1-84882-472-0_4
- Brue, G. (2002). *Six Sixma for Manager*. Jakarta: Canary.
- Čiarnienė, R., & Vienažindienė, M. (2012). Lean manufacturing: Theory and practice. *Economics and Management*, 17(2), 726-732. <https://doi.org/10.5755/j01.em.17.2.2205>
- Dutta, S., & Jaipuria, S. (2020). Reducing packaging material defects in beverage production line using Six Sixma methodology. *International Journal of Six Sixma and Competitive Advantage*, 12(1), 59-82. <https://doi.org/10.1504/IJSSCA.2020.107477>
- Edgeman, R., & Bigio, D. (2004). Six Sixma as Metaphor: Heresy or Holy Writ?. *Quality Progress*, 37(1), 25-30.
- Ghaleb, A. A., El-Sharief, M. A., & El-Sebaie, M. G. (2014). Study of Tools, Techniques and Factors used in Lean Six Sixma. *International Journal of Scientific & Engineering Research*, 5(12), 1652-1658.
- Ganguly, K. (2012). Improvement process for rolling mill through the DMAIC Six Sixma approach. *International Journal for Quality Research*, 6(3), 221-231.
- Gaspersz, V. (2002). *Total Quality Management*. Jakarta: Gramedia.
- George, M. L. (2002). *Lean Six Sixma: Combining Six Sixma Quality with Lean Speed*. New York: Mc-Graw Hill.
- Ghobadian, A., Speller, S., & Jones, M. (1994). Service Quality: Concepts and Models. *International Journal of Quality & Reliability Management*, 11(9), 43-66. <https://doi.org/10.1108/02656719410074297>
- Giakatis, G., Enkawa, T., & Washitani, K. (2001). Hidden quality costs and the distinction between quality cost and quality loss. *Total Quality Management*, 12(2), 179-190. <http://dx.doi.org/10.1080/09544120120011406>
- Harry, M., & Schroeder, R. (2000). *Six Sixma: The Breakthrough Management Strategy Revolutionizing the World's Top Corporations*. New York: Doubleday.
- Hill, J., Thomas, A. J., Mason-Jones, R. K., & El-Kateb, S. (2018). The implementation of a Lean Six Sixma framework to enhance operational performance in an MRO facility. *Production & Manufacturing Research*, 6(1), 26-48. <https://doi.org/10.1080/21693277.2017.1417179>
- Hammer, M., & Goding, J. (2001). Putting Six Sixma in perspective. *Quality*, 40(10), 58-62.
- Holden, R. J. (2011). Lean Thinking in emergency departments: a critical review. *Annals of Emergency Medicine*, 57(3), 265-278. <https://doi.org/10.1016/j.annemergmed.2010.08.001>
- Kusnadi, A., & Yudoko, K. (2016). Contractor Work Preparation Process Improvement Using Lean Six Sixma. *The South East Asian Journal of Management*, 10(1), 1-29. <https://doi.org/10.21002/seam.v10i1.5781>
- Krishnan, S. K. (2006). Increasing the visibility of hidden failure costs. *Measuring Business Excellence*, 10(4), 77-101. <https://doi.org/10.1108/13683040610719290>

- Moen, R. M. (1998). New quality cost model used as a top management tool. *The TQM Magazine*, 10(5), 334-341. <https://doi.org/10.1108/09544789810231216>
- Montgomery, D. C., & Woodall, W. H. (2008). An Overview of Six Sixma. *International Statistical Review*, 76(3), 329-346.
- Pande, P. S., Neuman, R. P., & Cavanagh, R. R. (2000). *The Six Sixma way*. New York: McGraw-Hill.
- Petrusch, A., & Vaccaro, G. L. (2019). Attributes valued by students in higher education services: a lean perspective. *International Journal of Lean Six Sixma*, 19(4), 862-882. <https://doi.org/10.1108/IJLSS-07-2018-0062>
- Prashar, A. (2014). Adoption of Six Sixma DMAIC to reduce cost of poor quality. *International Journal of Productivity and Performance Management*, 63(1), 103-126. <https://doi.org/10.1108/IJPPM-01-2013-0018>
- Rahman, A., Shaju, S. U., Sarkar, S. K., et al. (2017). A Case Study of Six Sixma Define-Measure-Analyze-Improve-Control (DMAIC) Methodology in Garment Sector. *Independent Journal of Management & Production*, 8(4), 1309-1323. <https://doi.org/10.14807/ijmp.v8i4.650>
- Raisinghani, M. S., Ette, H., Pierce, R., et al. (2005). Six Sixma: concepts, tools, and applications. *Industrial Management & Data Systems*, 105(4), 491-505. <https://doi.org/10.1108/02635570510592389>
- Ridwan, A., & Noche, B. (2014). Analyzing Process Capability Indices (PCI) and Cost of Poor Quality (COPQ) to Improve Performance of Supply Chain in Port. *The Hamburg International Conference of Logistics (HICL)*. Hamburg, Germany.
- Schneider, H. (1996). Failure Mode and Effect Analysis: FMEA From Theory to Execution. *Technometrics*, 38(1), 80. <https://doi.org/10.1080/00401706.1996.10484424>
- Schroedera, R. G., Linderman, K., Liedtke, C., & Choo, A. S. (2008). *Journal of Operations Management*, 26(4), 536-554. <https://doi.org/10.1016/j.jom.2007.06.007>
- Snee, R. (2004). Six Sixma: The evolution of 100 years of business improvement methodology. *International Journal of Six Sixma and Competitive Advantage*, 1(1), 1-20. <https://10.1504/IJSSCA.2004.005274>
- Sörqvist, L. (1997). EFFECTIVE METHODS for measuring the cost of poor quality. *Measuring Business Excellence*, 1(2), 50-53. <https://doi.org/10.1108/eb025484>
- Troy, K., & Schein, L. (1995). The quality culture: manufacturing versus services. *Managing Service Quality: An International Journal*, 5(3), 45-47. <https://doi.org/10.1108/09604529510796403>
- Wang, Z., You, J., Liu, H., & Wu, S. (2017). Failure Mode and Effect Analysis using Soft Set Theory and COPRAS Method. *International Journal of Computational Intelligence Systems*, 10(1), 1002-1015. <https://doi.org/10.2991/ijcis.2017.10.1.67>
- Womack, J. P., & Jones, D. T. (2005). Lean consumption. *Harvard Business Review*, 83(3), 58-68. <https://doi.org/10.1049/me:20050411>