March-2020

Newsletter

Indian Society for Quality

ISQ salutes healthcare staff, police force and all those who are putting relentless efforts to keep us safe during the crisis.

"Follow social distancing, lock down and be socially responsible citizen."

BE SAFE AND STAY HEALTHY! WE WILL GET THROUGH THIS!!

Contents

Contents	Page
Editorial message by Mr.. Ved Prakash, Chief Editor	2
"Vignettes from Ram"	3-4
Role of Quality Function In Manufacturing Organization Mr. Ved Prakash	5-6
Proactive Approach to Achieve Defect Free Product Mr.. Mahesh Hegde	7-13
ISQ News, upcoming National and International events in Quality	14-16
Welcome to the new members of ISQ family	16

ISQ Quality for Prosperity

Newsletter

Indian Society for Quality

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Dear Readers,

It`s my pleasure once again to present you with **1st Quarter ISQ Newsletter** as promised.

First of all, let me **wish you a happy, healthy and prosperous 2020!**

Health wish is most appropriate in view of the ongoing COVID-19 pandemonium world over.

Won`t be wrong to say that 2020 has started on an unpleasant note for the social health as well as business and economy for the whole world. Though India seems to be better off as of now in terms of cases reported and fatalities inflicted but we need to keep our fingers crossed and pray that situation does not deteriorate.

Wish for a fast recovery to normalcy!

Hope for a robust growth 2nd Quarter onwards in current fiscal, Auto sector one of the major engines of growth is expected to turn around that time having overcome pangs of BS VI transition.

ISQ is making rapid progress in its journey to become a vibrant professional body with regional chapters taking shape - actively adding membership, planning host of events as you will read in this issue.

I would call upon the readers to contribute their thoughts on topics relevant to Quality specifically and Business in general, we would be delighted to publish all deserving articles in our future publications.

We are creating a dedicated email account viz. newsletter@isqnet.org to interact with our readers. Please be generous in sharing with us your feedback, views on how to make the Newsletter more interesting, informative and effective. I believe without feedback from you all it would not be an interactive forum that we intend it to morph into.

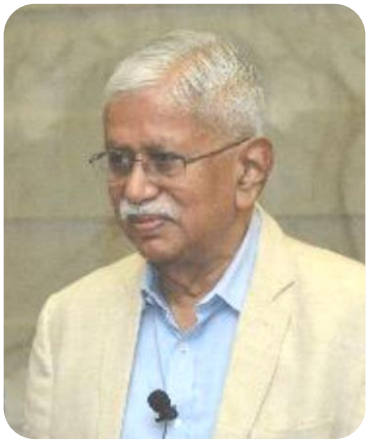
In this issue, we bring you our serial “Vignettes from Mr. Ram” with a few other articles, including one from me. My articles attempts to address a perennial question about the role of Quality which many CEOs and business Owners often seek from senior Quality executives in their respective organizations and even from consultants.

I must thank you for encouraging the efforts of our editorial team for publishing 2019 last Quarter Newsletter, we received many appreciations. Thanks for your patronship!

Enjoy reading!

Ved Parkash

'Vignettes from Ram'



Overcoming Typical Troubles in Daily Management

Recently, two colleagues independently shared their thoughts with me about their experiences while implementing Daily Management (DM). Their descriptions made me think about my own encounters. Since many organizations have similar problems, I wondered if we should re-examine the system we promote and the way we teach it.

DM begins with establishing role clarity. What is my job; what are my objectives; what are the measures (KPI) and how are these operationally defined? Consistent with the idea of Standardize-Do-Check-Act (SDCA) cycle, some of these KPI should arise from system manuals or Management System Charts (MSC) for quality, NPD etc.

How are the KPI to be stratified for ready investigation?
What is the current status of the measures?
How are the KPI deployed down the hierarchy?
How are targets fixed?

In some companies DM is meant to only maintain a level, not improve it. The target is a horizontal line. In others, improvement too is part of DM, and Policy Management takes up the strategic challenges for a particular year. As mediocre targets can derail progress, a TQM company should develop the habit of setting tough goals even under DM.

Then there is the question of whether there is a plan for achieving the target. Not infrequently, the target is mistakenly considered the plan. A 4W-1H plan is not made, not realizing that if a target can be achieved without a plan, it could have been achieved before.

Now the question of standards turns up. Apart from system level manuals, operating procedures (SOP) are of central importance in DM, as the regular tasks needed to accomplish objectives should be standardized. The first element in a SOP ought to be its objective. What will be achieved if the SOP is followed?

In my experience such an objective is not stated at all in many standards. Then of course the SOP should be such as to produce the desired results when followed. Most companies fail this test too, writing up perfunctory steps to merely satisfy auditors. Visiting India in the 1990s, Prof. Tsuda would say that a good standard is one which, if not followed, would lead to a predictable failure in results!

Contd.,

Now we head to the check-act part. Is the target being met? If not, is the gap big enough to necessitate action? What is the basis for deciding whether to act or not? Some have instituted the so-called 'barbaric' (not statistical) limits, often formula-based. Judgment is required in these cases. Even a small gap that persists period after period should warrant investigation. For a particular period, however, only a 'large' gap, a spike or a known trouble might merit countermeasures.

At this point things fall apart in most organizations. Stratified data, organized as run charts or control charts, are seldom made available. Abnormalities – special cause situations – are therefore not spotted. Actions are either of the knee-jerk kind – responding to an event – or those suitable for common cause or chronic situations. Special causes may be rooted in standards that are weak or are not followed, or in changes elsewhere in the system. If abnormalities are not present, the question is whether the plan is being followed. Is it effective?

So, two types of charts are required for effective check-act: charts comparing target with results, and time series charts. The exact method should be tailored to each type of KPI. For example, morning meetings on the floor to discuss yesterday's problems are customary, and each defective, breakdown or incident gets analysed. A better practice is to classify problems as chronic and sporadic (or new), and act immediately on the latter. But is yesterday's production shortfall or surplus a common-cause variation or is it abnormal? An Individuals chart of daily variance can answer this question. And help shorten, or even abolish morning meetings.

In the 1980s, Hewlett Packard framed its 'Business Fundamentals Table' - not unlike a table of KPI as part of DM. These are objectives which must be achieved each year to keep the business going. DM is about clarifying roles, formulating objectives and KPI, setting challenging targets, making plans, following and revising standards and plans and acting on gaps such as to keep the company competitive and produce desired outcomes at all times.

About the Author:

Mr. N. Ramanathan is a senior counsellor and advisor of TQM. He is a Mechanical Engineer with Masters from IIM, Ahmedabad (1969) with 50 years of experience in industry, and in teaching and counselling. Ram has received awards internationally for his work, as well as receiving the Dronacharya Award in 2018 by ISQ for his contributions to teaching and counselling on quality. Ram has been associated with twelve successful Deming Prize challenges, and has taught and advised Ashok Leyland, Ceat, SRF, Indus Towers, JSW, Mahindra group of companies, Tata Quality management Services, Tata Steel, and other organizations.

Role of Quality Function In Manufacturing Organization

by Ved Parkash, Chief Editor ISQ

Primary Functions of Quality can be divided into following :

1. Control - Typically in down stream activities. Implies inspection / verification / validation and authority for final say.
2. Collaborate – Typically in upstream activities. Implies collaboration in defining products specs, developing robust processes for inhouse activities, validate robust processes are in place for outsourced parts / subsystems / systems and services. It may be emphasised that ownership remains with respective functional heads.
3. Facilitate - Typically Business Objectives / Goals. Primary ownership remains with respective functional heads. Differs from collaboration in the sense that it is more of advisory / coaching in nature and not a deeper level engagement as in collaboration.

1. Control

- Customer interface – Understanding customer expectations / customer pain and address for customer delight. Manage Recalls , if any.
- Custodian of Specs – i.e. Ensure Products are made as intended – PDI / Final Inspection at Part level , Sub-assy level and Product level. Legal / Regulatory compliance
- Consistency in Products – i.e. All Products perform equally – Process variation contained. Minimize variation in processes i.e. Ensure Process documentation compliance.
- Products/ Parts / Services outsourced meet intended Specs / Contract intent.
- Ensure all measurements / sensing are calibrated – Calibration / Lab compliance.
- Ensure reasonable Traceability for focussed action in case something goes wrong.
- Provide Expertise in Analysis / Investigation to eradicate defects.
- Deviation management.
- Authority to approve any deviations in Products and Processes – inputs may be required on highly technical matters from PD / SMEs in the organization.
- Disposition of nonconforming materials.

2. Collaborate

- Product Development – Evolving of Specs from Customer expectations, testing and validation of Design Intents.
- Production Processes – Selection of Process and Equipment / Machinery. Establishment of robust processes and Validate their capabilities.
- Sourcing – Selection of appropriate sources , verification of selected manufacturing processes (Q, C, D) and validate processes for mass production
- Developing and Implementing QMS
- Engaged Employees – Personnel Policies and Culture
- Continuous improvement – Deploy PDCA

3. Facilitate

- Organizational vision and mission with the documentation of a QMS
- Evolve Quality Policy and guidelines
- Roadmap for achieving organizational aspirations
- Define Systems / Business Processes and continual improvement relevant for business scenario.
- Evolve requisite and functionally optimum and effective Organization structure
- Strategies for Business objectives – Top line and Bottom line
- Risk assessment and addressal – strategy & process
- CSR initiatives

About the author

Mr Ved Parkash is a Graduate Engineer (Mech) from NIT Kurukshetra ; 1978 graduated. He got his training in Quality Management and Lean Manufacturing from AOTS ,Japan and SQC from Indian Statistical Institute.

He had long on the job training in Mitsubishi Motors Japan, and Honda Motors Japan. He has over 41 years of experience in Auto Industry - 2 Wheelers , 4 Wheelers , Multi Axle , Specialty Vehicles. Superannuated in 2015 from Ashok Leyland as Head Quality and TQM spearheading Deming implementation initiative, Business Excellence advisor to Hinduja Foundries the Sr VP Quality and Engg with Surin Automotive .Currently working as Advisor Quality with Ather Energy – a 2-Wheeler EV startup company.

He is a Faculty with IMTMA on Quality and Manufacturing. He was ISQ Annual Conference Director in 2017 and now Bengaluru Chapter President.

Proactive Approach to Achieve Defect Free Product

Mahesh Hegde Counsellor TQM
“magicmahesh@gmail.com”

1. Need for Proactive Approach

It is easy to say "DO RIGHT FIRST TIME", but to practice is a hard nut to crack if you do not know what tools and methods to follow. Mostly people are busy in solving problems and quickly fixing abnormalities. The trouble with doing right first time is, nobody appreciates how difficult it was. For example, if there is a "FIRE" and someone extinguishes the fire, he will be treated as "HERO" and "REWARDED" even though it is only for overcoming the effect of fire. Whereas for someone ensuring "NO FIRE" by identifying and eliminating possible reasons of fire, there is "NO REWARD" although it is a proactive approach. Similarly in organizations mostly people are busy in solving today's problem which is immediately rewarded and they don't find time to do future oriented work which is beneficial in long term. Achieving defect free product proactively, can help to save everyone’s time on problem solving at later stage, minimizes cost of poor quality and most importantly improves customer satisfaction resulting into better brand value

2. Tools and Methods to Achieve Defect Free Product

This article is focused on effective usage of few techniques like Human Error Prevention, Process FMEA, SOPs, Proactive usage of DOE. Defects are generated if something goes wrong in the process. Unless we control the process it is not possible to achieve defect free product. Process control could be error proofing, process audit, preventive maintenance, start-up checklists, operator training and skill evaluation, fixture design, etc. Table-1 shows how to arrive at process controls.

Table 1. Defect Prevention Philosophy and Proactive Tools

Philosophy		Tools and Method
Step-1	**Understand the Process** Macro to micro level sequence of activities within each process, expected outcomes, sources of variations, etc.	**Process Flow Diagram** Dividing operation into elements Linkage of product characteristics with process characteristics and incoming source of variations.
Step-2	**Identify Failure Modes & Causes** What can go wrong? Why it can go wrong (cause)? What is the risk involved?	**Process FMEA** Error Identification checklist (16 Errors), Master Ishikawa Diagram, Cause Analysis Table, Past Trouble Data Base (PTDB), Why-Why Analysis, 13 Error Prevention Principles
Step-3	**Define How to Control** What to control? When to control? How to control? How much to control? Who has to control?	**Control Plan (QCPC)** Product & process parameters to be controlled, specifications, measurement techniques & frequency, control methods & reaction plan.
Step-4	**Achieve Defect free Product** Control the process to achieve defect free product.	**Apply Control Methods** Error proofing, SOP, operator training and skill evaluation, control charts, first piece approval, fixture design, functional testing, etc.

Unfortunately, most of the automotive industry have only increased the paper work without meeting the real intent of Advanced Product Quality Planning(APQP) and Part Approval Process. It can be attributed to lack of importance given by senior management on proactive approach, poor understanding of tools & techniques, focusing on satisfying auditor with documentation rather than intending to achieve real benefit, poor cross functional team work, fire-fighting to meet development deadline etc. Very few have used it effectively to come up with 1000s of proactive actions by using these tools.

3. Why Operator Errors?

Many why-why analysis ends with operator error which is difficult to tackle because of some beliefs like – “to error is human”, “with operators defects are bound to come”, “only solution for human error is training”, etc. There is a need to go deeper into why does an operator make error, what would be an appropriate solution?

I don't Know, so I do mistakes. 20% of human errors attributed to lack of knowledge. Education: Operator makes mistake in spite of having documented SOPs. If operator does not know "what to do?"

and "how to do?" then it is related to operator "Knowledge" It requires education. It can be provided by classroom session, through pictures, videos, etc. If operator does not know place to keep rejected part, we cannot expect him to follow. Education is needed in spite of SOP display. ▫ I know, but I don't have skill, so I do mistakes. 15% errors are attributed to skill Training: Operator makes mistake in spite of having knowledge. It is due to lack of skill. The skill level needed varies from job to job. For example skill needed to perform CO2 welding or Spot welding may be much higher than skill needed to perform operation of "Sticker Pasting".

Can anyone learn swimming by reading book? One cannot attain skill by listening or reading. To develop skill one needs practice. Putting unskilled manpower on job and not having close monitoring of their work till operator attains skill can lead to problems. Even in case of temporary operator, depending on the nature of operation required knowledge and skill must be provided before putting them on job. Organization should have facility to develop such skills and evaluate skill level. Skill development can happen in 2 stages - a) Dexterity Training b) On the job Training. Dexterity training includes training on basic skills. For example person working in assembly shop is required to have basic skill of tightening. It includes picking exact number of bolts without counting, pre-tightening, straight and angular tightening etc are needed as a part of basic skill. Person doing visual inspection may require skill to move his eye in specific path on the product with specific speed. Person doing manual painting may require to have skill to move hand in specific speed, maintain distance of spray gun and part, method to operate spray gun etc. Develop basic skill using dexterity.

I have Skill, but I cannot follow SOP. 25% errors are attributed to motivation.

I cannot follow SOP because it is difficult. If SOPs are difficult to follow, look for simplification of methods without compromising its effectiveness. Provide some tools, fixtures to simplify.

I cannot follow SOP because I don't want to follow.

Motivation: Operator makes mistake in spite of having skill. For example, if operator has to verify Pokayoke daily before staring, he may do few days. When he notices that there is no problem for many

4. Method to determine possible Human Errors proactively and to find solutions

Step1: Write operation steps /elements) and identify all possible human errors using 16 error checklist developed by Dr. Nakajo as shown in Table 2.

Step 2: Include all errors in FMEA, analyse risk and prioritize where control is needed.

Step 3: Generate Multiple solutions using 5 main principles (13 sub principles) of Human error prevention method of Dr. Nakajo. (Not part of this article)

Step 4: Prioritize solutions and implement.

Human Error Identification: Note only 4 are shown out of 16 errors are shown below in table 2.

16 Error Checklist	Activities within Operation						
	1.Pick up the plastic part	2.Mount part on the fixture	3.Pick up the foam & remove adhesive tape sticker	4. Paste foam on part. Repeat step 3 and 4 to paste more foams	5. Pick up the roller and move roller on the foam with pressure	6. Remove part from the fixture	7. Self check& keep in the bin
(1) Omission		- Forgot to mount on fixture - Forgot to clamp	Forgot to pick up the foam		Forgot to apply roller		Forgot to check
(2) Excessive/ Insufficient Repetition				Adding less number of foams	Excessive or insufficient application of roller		
(3) Wrong Order			Wrong foam picking sequence	Wrong pasting sequence			
(4) Early/Late Execution				Late pasting after sticker removal			

Common mistakes in doing process FMEAs are – focusing too much on RPN, spending time on discussing SOD numbers rather than identifying possible causes and possible controls, not able to distinguish between failure modes, causes & effects, missing of various failure modes/causes, etc.

The Quality of FMEA is determined by "depth of identification of causes" and "extent of new controls identified through FMEA". This can be ensured by using drawings (for what is expected and what is not expected), PTDB, Technical Knowledge, Master Ishikawa diagram. Rams or Tree Diagram. Rams for each failure mode. Separately looking for controls on failure mode and each cause, Usage of Cause Analysis Table to identify need for SOPs or other standards and adherence to standard, Why-Why analysis to identify control at sub cause level, 13 principles for human errors

Controls on Failure Mode and Causes are shown below in table 3.

	Detection of Failure mode	Detection of cause	Prevention of cause
Purpose	**Protect Customer** (Does not stop generation)	**Give early feedback to process.** Take action before defect occurs	**Reduce the possibility occurrence of cause.** Hence occurrence of defects
Examples	*"Cracked tubes automatically falls into rejection bin".* Customer protected.	Example: Checking Coolant Concentration (cause) at defined frequency reduces occurrence of variation in finish (Failure mode)	Example: For Less strength "wrong roller selection" is cause. Sub-cause is operator could not distinguish rollers. Control identified is colour coding

5. Setting process parameters at optimum level using Design of Experiments

Unplanned way of taking trials and decisions just by looking at numbers rather than analysing using statistical methods can lead to error inference. Method of changing one parameter at a time, which was considered to be best till 1940s, is proved to have several limitations and gives a false feeling of reaching optimum. These process parameters will become part of control plan / process sheet and people will ensure that it is being followed. Today we have better methods to set process at optimum level. Taking the input from technical knowledge and defining must be maintained factors, experimental factors and noise factors helps to have better experimental planning. It is possible to select type of experiment like full factorial, fractional factorial, Orthogonal array, mixture design or response surface methods. With these techniques it is possible to set the process at optimum level input.

6. Making a best-in-class SOP

SOP is the "current best way" or "best known way". We need to analyse the operation and find out best known way considering safety, quality, ergonomics, speed, cost etc. Generally people end up making SOPs which contains only WHAT to do rather than HOW to do. For example writing "pickup the component" is only WHAT part. Some good practices of SOP includes below points.

- Involvement: Sr. Operator, Supervisor, Production Engineer are involved in SOP preparation.
- Method to prepare: Studying operation at GEMBA (work place) using pre-analysis sheets, considering inputs from FMEA, Considering NVAs, balancing of cycle time, motion economy principles, ergonomics, safety, quality and finding "best way" to do the job through detailed analysis at micro level is needed.
- Revisions: Constantly reviewed and revised. Learning from troubles and improvement through Kaizen leads to SOP revision. Whenever there is problem, SOP is referred, adherence checked. Daily Management leads to revision of SOPs. New key points are added in SOP and operators are trained on revision.
- Adherence check: System to evaluate adherence through observation at GEMBA on routine basis using defined checklist and necessary actions taken to fill the gaps.
- Training through demonstration: Document is used to train operator through 3 step learning - I DO, WE DO, YOU DO. Supervisor is able to perform job as per SOP. He trains operator through demonstrations, explains all key points. Checks whether operator is able to do in same way.
- How to Do: Main steps are identified with what to do. How to do contains complete details including all the movements.

- Key points: Key points are highlighted and Consequence of not following key points are mentioned. Operator is made to "memorize" key points & consequences.
- Time: Standard time to perform operation is defined for man, machine and adherence is verified.
- Visuals: Necessary photographs/ drawings are attached to explain main steps, key points, reasons for key points.
- Safety points: What are the PPE to be used? What are the care to be taken to ensure safety?
- Setting: How to set the operation? Depending on the type of the product, how to select process parameters, how to ensure that setting is correct etc
- Shift Start up: While starting the operation, what are things to be done, what are the points to be checked, etc are linked with SOP. It can be linked to JH activities of TPM (CLITA)
- Anomalies : Include "what to do" whenever there are anomalies.
- Self Check: I produce, I check. Self check points addressed in SOP.

7. Failure can lead to success, if we learn from it :

We keep doing same mistakes and keep solving them again and again. Each problem presents an opportunity for lessons to learn. Success lays in learning from these failures and preventing them in future. It requires a strong system to capture all past troubles from different sources like design, testing, process development, internal defects, customer complaints, warranty, abnormalities in production, breakdown etc. Some of the companies have implemented excellent system of capturing "Past Trouble Data Base" or in short PTDB which contains all trouble history, why it happened, lessons learnt. People who solve these problems keep updating PTDB which is referred for upcoming process development. All troubles (100%) of the company troubles should go to PTDB and feedback to new process should be 100%. It should provide input to Process FMEA. This will ensure that we will not do the same mistake again.

8. Conclusion:

It is rightly said by William A. Foster “Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skilful execution; it represents the wise choice of many alternatives”. This paper was aimed at drawing attention towards importance of proactive approach.

References: Prof. Takeshi Nakajo and Prof.Hitoshi Kume, "The principles of fool proofing and these application in manufacturing"

About the author

Mr.. Mahesh Hegde is a passionate trainer and TQM counsellor. He is training & handholding organizations in India and overseas in their “Journey of Excellence.” He has formed LearnEx Consulting in the year 2017. Mr.. Mahesh is an ASQ certified Six Sigma Black Belt. He has trained more than 10,000 people & facilitated more than 1500 chronic problems in last 14 years of consulting experience. Projects mentored by him include more than 200 tools and won various awards. He has trained top leaders of organizations on TQM practices. His structured way of “Daily Management, Dexterity, FMEAs, SOPs etc.” have been implemented in companies in India and overseas. He has integrated number of proactive tools for achieving “First time Right” & developed unique way of preparing process FMEAs. It include human error prevention techniques of Dr.Nakajo, Past Trouble Data base, Master Ishikawa, Cause analysis table etc. Mr.. Mahesh was leading flagship program “Post Graduate Diploma in Quality Management” Of Mahindra Institute of Quality and got learning from eminent faculty members including Dr.Kume, Dr.Washio, Dr.Nakajo, Mr..N.Mr.. Ramanathan. He is trained by “Renault Nissan Institute” of France on System Production Renault (SPR). He is lead auditor for ISO/TS16949 and facilitated many companies for QMS.

Mr.Mahesh has presented number of technical papers at various places including in International Conference in Quality - Japan, Asian Network of Quality, Alucast, NIQR and has been key note speaker in various quality forums.

Newsletter

Indian Society for Quality

Thank you for overwhelming support and making **16th Annual Conference 2019** a grand success.

Block your dates.

ISQ is happy to announce

17th Annual Conference 2020

Date: 11th and 12th December, 2020 | Venue: Taj Yeshwantpur, Bengaluru

For updates visit www.isqnet.org and www.isqconference.org

Theme: Quality for Sustainable Development

(Social, economic and environmental)

The serious pandemic of Covid- 19 across the globe has led to cancellation of many national and international events without any exception to Quality Organisations. Travel is being advised against and social distancing is being recommended to all.

ISQ is compelled to defer the date of the program **CEO through TQM**, a 2.5 day seminar program for senior management designed and delivered by Mr. N. Mr. Ramanathan on pro-bono basis at NCR.

This was the 3rd in the series of programs which was planned from 16th to 18th April 2020 at Crowne Plaza Gurgaon.

4th seminar program of **CEO through TQM** will be also planned in 2020 which will be announced later.

Coming up….

TOPS Convention, a contest of team oriented problem solving projects for supervisors at Gurugram, Pune and Bengaluru. ISQ will also monitor the situation as the world does and announce the dates of these Programs once normalcy is restored.

Symposium:

For the first time, a Symposium will be planned at regional level by ISQ at Bengaluru in October 2020. It will an opportunity to present papers on Quality based study/ research and showcase the hard work done in the field of Quality. It is expected that 50% each of academia and industries will be participating. An opportunity to promote industry institute interaction and promote Quality domain at the grass root.

Knowledge sharing sessions

For the benefit of members of ISQ and quality fraternity, the chapters will initiate quarterly knowledge sharing sessions from the best in class organisations who have internalised quality and TQM.

International News:

ANQ board meeting:

As a member organisation of Asian Network for Quality, ISQ will be hosting the ANQ board meeting on 8th and 9th April 2020. The face to face meeting had to be converted to teleconferencing because of the covid-19.

ANQ Congress 2020 Seoul, Korea

The 18th Asian Network for Quality (ANQ) Congress will be held in Seoul, Korea on 19th to 23rd October 2020. The theme is "New Quality & New Responsibility".

Though dates are not reviewed yet, the Covid-19 situation is being cautiously observed by the Seoul team on feasibility to adhere to the dates. As of now, the important tentative dates of the Congress are shown below:

Call for Paper

- Deadline for Abstract Submission: **April 2020**
- Deadline for Full Paper Submission: **May 2020**
- Venus: Korea Chamber of Commerce and Industry (KCCI), Grand Hall and Seminar rooms in basement 2nd floor, 39 Sejong-daero, Sogong-dong Jung-gu, Seoul, South Korea.
- Please look for announcement from Seoul ……

International events mentioned below were cancelled due to the coronavirus pandemic declared by the WHO .

15th June 2020	:	**EOQ Global workshop - Cancelled**
June 16 -17, 2020	:	**64th EOQ Scientific & Business Congress 2020 on** Effective Education & Quality Management- Key Factor for Success at Belgrade, Serbia **-Cancelled** For updates visit www.eoq.org
May 2020	:	**ASQ 2020 World Conference on Quality** schedule for May 2020 in Columbus OH, USA. Cancelled
May 2020	:	The IAQ (International Academy for Quality) also cancelled their meeting in May 2020 to be held in Columbus.

Quality innovation award:

Your organisation Indian Society for Quality has become national partner from India for the Quality Innovation award. The award is currently organised by Finnish Quality Association.
The Quality Innovation Award is an annual, international competition that enables innovators to

- get professional assessment for their innovation
- benchmark their innovation against others
- increase the visibility of their innovation

All together this helps to increase the competitiveness of each participating country.

Coming up….

Assessment process

For more details on the award, key dates visit www.qualityinnovation.org

Membership:

We welcome the newly joined members of ISQ in the year 2020.

Life members:

Mr. Kishor Mr. Ramchandra Naik	Mahindra & Mahindra Farm Equipment Sector, Zaheerabad	Sr. GM, Plant Head,
Mr. Prakash G.	Toyota Kirloskar Auto Parts Pvt Ltd , Bengaluru	GM- Manufacturing
Mr. Kannan Rajagopalan Srinivasan	JayKay Associates	Director
Mr. Chandra Mouli S.	SEG Automotive Pvt Ltd, Bengaluru	Sr. GM Quality
Mr. V. Prakash	Sartorius Stedim India Pvt Ltd Bengaluru	Manager QA
Mr. Manohar Sethpalani	CEAT LTD, Mumbai	Head QBM (TQM/B E)

General Members (April 2020 to March 2021)

Mr. Rakesh Chandrakant Kulthe	Aster Technologies, Pune	QMS Executive
Mr. Panduranga B.	SEG Automotive India Pvt Ltd	Manager
Mr. S. R. Ithal	SEG Automotive India Pvt Ltd	Manager Purchase Quality
Mr. B. S. Venkatesh	Consultant Mfg & Business development	Self employed
Mr. Mahaveer Kumar Jain	J K Tyre & Industries Ltd	Vice President- Corp (QA & QMS)

Welcome to 231 participants in 16th annual conference 2019 and CEO through TQM Pune who are awarded membership (April 2020 to March 2021) on a complimentary basis.
For those whose membership will be ending on 31st March 2020, it is time to renew membership .

ISQ look forward to you to introduce professionals with passion for quality, align with its objectives willing to contribute; as members of ISQ.
Download membership form at https://www.isqnet.org/wp-content/uploads/2017/06/Individual-Membereship-form-New.pdf