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AES SYSTEMS THINKING FRAMEWORK

THE SCALE WORKBOOK

Improve one core workflow without weakening governance, safety or accountability.

EDUCATION & HEALTH

One workflow | Five lenses | One 30-day improvement

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SEE THE WORK	CLARIFY THE SYSTEM	IMPROVE WITH EVIDENCE
Actual workflow	Ownership and decisions	30-day experiment

01 EFFORT-DRIVEN VS SYSTEM-DRIVEN GROWTH

Choose one recurring workflow; do not turn this into a whole-organization review.

Education and health institutions often protect important controls through approvals and verification. Inefficiency grows when the same information is checked repeatedly, documents move through offices without a clear decision, or teams accept long queues as unavoidable. SCALE helps leaders retain necessary safeguards while making routine work clearer, faster and easier to manage.

EFFORT-DRIVEN GROWTH

Results depend on extra effort, memory, personal rescue and repeated chasing. Growth adds strain because the workflow itself is not dependable.

- Staff visit several offices to secure routine approvals.
- The same request details are written into multiple registers or systems.
- Queues grow because work waits for a named person rather than a defined role.
- Employees call or walk documents through the process to keep them moving.
- Managers intervene repeatedly to resolve ordinary exceptions.
- Progress is difficult to see until a delay or shortage becomes urgent.

SYSTEM-DRIVEN GROWTH

The workflow makes the result repeatable: ownership, decisions, information, controls and learning work together even when pressure increases.

- Each required check has a documented purpose and one accountable owner.
- Routine requests follow one visible path with clear service times.
- Information is captured once and reused by authorized teams.
- Decision limits distinguish routine approval from genuine escalation.
- Backups can continue the work using current records and instructions.
- Delays, rework and exceptions are reviewed and used to improve the workflow.

SELECT THE WORKFLOW

Choose the process causing the most repeated delay, rework, complaint, dependency or confusion.

ORGANIZATION

REVIEWER / TEAM

REVIEW DATE

CURRENT WORKFLOW OWNER

WORKFLOW SELECTED *Name one request-to-result process.*

RECURRING PAIN *What keeps happening, and who feels the effect?*

START EVENT

COMPLETED RESULT

RUNNING EXAMPLE

Operational supplies: purchase request to supplier payment

02

REVIEW THE WORKFLOW THROUGH SCALE

Write one evidence-based observation for each lens.

S — SEE THE WHOLE WORKFLOW

Map the work from request to result, including the informal steps.

PRACTICAL QUESTION

What actually happens, not what the policy says should happen?

Use: Where does the request actually travel from need to payment? | Where does it wait, return or get recorded again? | Which informal calls, visits or workarounds keep it moving?

YOUR OBSERVATION / EVIDENCE

C — CLARIFY OUTCOMES AND OWNERSHIP

Define the expected result, owner, backup, decision rights, and escalation limits.

PRACTICAL QUESTION

Who owns the result and what can they decide without waiting?

Use: Who owns the result from request to completed payment? | What can each role decide without waiting? | Who acts when the owner or approver is absent?

YOUR OBSERVATION / EVIDENCE

A — ALIGN PEOPLE, PROCESS, INFORMATION, AND TOOLS

Remove conflicting instructions, duplicate records, unnecessary handovers, and tool gaps.

PRACTICAL QUESTION

Do the roles, workflow, data, and technology support the same outcome?

Use: Is the same information captured more than once? | Do roles, records and tools support one shared outcome? | Which handover can be simplified without removing a necessary control?

YOUR OBSERVATION / EVIDENCE

L — LEARN FROM FEEDBACK AND EXCEPTIONS

Review delays, rework, complaints, quality failures, and unusual cases.

PRACTICAL QUESTION

What is the process teaching us, and what should change?

Use: Which delays, returns or complaints recur most often? | What do unusual cases reveal about the normal process? | Who reviews the evidence and agrees what will change?

YOUR OBSERVATION / EVIDENCE

E — EXPAND ONLY AFTER THE CORE WORKS

Standardize the improved method, train the team, then add volume, people, branches, or technology.

PRACTICAL QUESTION

Are we scaling a reliable process or multiplying confusion?

Use: Has the improved workflow worked reliably for 30 days? | Can another trained person follow it without informal guidance? | What must be standardized before adding volume or technology?

YOUR OBSERVATION / EVIDENCE

03

TEST DEPENDENCY, AUTHORITY AND RELIABILITY

A strong average does not cancel a critical dependency.

DEPENDENCY RED FLAGS

- ☐ A request stops when one experienced employee or approver is absent.
- ☐ Critical instructions or status information exist only in someone's memory or inbox.
- ☐ Only one person can access a required register, system or approval function.
- ☐ Procurement, receiving and finance rely on different records of the same request.
- ☐ Staff must personally chase documents because no one can see the next owner.
- ☐ An urgent operational need routinely requires senior rescue to move through the process.

DECISION-RIGHTS CHECK

- What decision must be made at this step?
- Which role should make it during normal operations?
- What may that role approve, correct or reject without further permission?
- Which value, risk or policy threshold requires escalation?

END-TO-END OWNER

ROUTINE AUTHORITY / LIMIT

BACKUP AND ESCALATION TRIGGER

RATE THE CURRENT WORKFLOW: 1 = FRAGILE, 5 = SYSTEM-DRIVEN

Use consistent evidence, not the best recent case.

VISIBILITY	1: Teams cannot see the current status, next owner or reason for delay. 5: Authorized teams can see every request, its evidence, status, next action and service time.	1	2	3	4	5
CONSISTENCY	1: The route and requirements change by person, office or urgency. 5: Comparable requests follow one defined route, with controlled exceptions.	1	2	3	4	5
OWNERSHIP	1: Departments complete their own step but no one owns the final result. 5: One accountable owner monitors the end-to-end outcome and each step has a clear role.	1	2	3	4	5
RESILIENCE	1: Absence, leave or system access held by one person stops the workflow. 5: Authorized backups can continue the work using current instructions and accessible records.	1	2	3	4	5
LEARNING	1: Delays and returned requests are resolved individually and then forgotten. 5: The institution reviews patterns, tests changes and updates the standard method.	1	2	3	4	5

TOTAL / 25	AVERAGE / 5	INTERPRETATION

21-25	System-driven / scale-ready
17-20	Generally reliable
13-16	Developing system
9-12	Effort-dependent
5-8	Fragile / critical

WHAT THE AVERAGE MEANS

The average is the total divided by five. It shows the typical reliability of this workflow across the five factors: 1.0 is person-dependent and fragile; 3.0 is developing; 5.0 is consistently system-driven.

RED-FLAG OVERRIDE

If any red flag is selected, act on that exposure even when the total score is high. The interpretation will display + RED FLAG.

04 CHOOSE ONE 30-DAY IMPROVEMENT

Use a controlled experiment: one root cause, one owner, one measure and one review date.

WHAT TO PUT IN THESE FIELDS

- Focus: the recurring failure or root cause to improve.
- Change: the smallest practical system change to test.
- Measure: the number or evidence that will show whether it worked.
- Review: adopt, adjust or stop based on Day 30 evidence.

IMPROVEMENT FOCUS / ROOT CAUSE

OWNER AND BACKUP

CHANGE / EXPERIMENT *What will be different in the workflow?*

BASELINE *Current evidence*

30-DAY TARGET *Desired evidence*

MEASURE AND DATA SOURCE

SECTOR EXAMPLE

Focus: Reduce repeated checking and invisible waiting in routine operational-supply requests.

Change: Pilot one request reference, a shared status log, defined approval limits and a backup for each critical decision.

Measure: Median request-to-order time; percentage returned for missing information; percentage completed within the agreed service time.

WEEKLY CHECKPOINTS

WEEK 1	WEEK 2	WEEK 3	WEEK 4

DAY 30 EVIDENCE AND DECISION *Adopt, adjust or stop - and why.*

SAVE YOUR WORK, THEN CHOOSE THE NEXT STEP

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