

LEADING FOR VALUE

Making it easier for good people
to do good work

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Leading for Value

Five disciplines for making it easier
for good people to do good work



01 KNOW WHAT MATTERS

Clarity before activity



02 LEARN TO SEE

Understand the work before
diagnosing the problem



03 FIX THE SYSTEM

Before you blame the person



04 DESIGN FOR VALUE

Make good work easier to do



05 CREATE RHYTHM

Build improvement into the way
the organisation works

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INTRODUCTION

Leading for Value

Good People Can't Compensate for Broken Systems Forever

I have spent much of my career working with organisations full of good people trying incredibly hard to do good work.

Nurses who run all day and miss lunch.

Managers carrying problems in their heads because nobody else quite knows how the system works.

Frontline teams developing workarounds because the formal process doesn't match the reality of the work.

Leaders moving from one urgent issue to another, trying to keep everything moving.

Quality and risk teams producing more reports, more actions and more assurance — while wondering whether any of it is actually making the organisation safer or better.

I've been one of those people too.

For a long time, I thought being a good leader meant knowing the answer, working hard, solving problems and helping other people get things done.

Over the years, I learned something quite different.

Good people can't compensate for broken systems forever.

Eventually, the system wins.

People become exhausted. Things get missed. Workarounds become normal. Risks become harder to see. Customers feel the consequences. And when something finally goes wrong, organisations can be remarkably quick to look for the person who failed.

I've spent more than three decades working across health and human services, as a nurse, executive, Board director, leader and consultant.

Different sectors. Different organisations. Different problems.

But I keep seeing the same patterns.

And I keep coming back to the same question:

How do we make it easier for good people to do good work?

That question has shaped much of my life's work.

I Didn't Start Out Thinking About Systems

I trained as a nurse.

Like many professionals, I learned to value expertise. You studied, gained experience and became increasingly good at knowing what to do.

Then I began learning about LEAN and continuous improvement, and it challenged much of what I thought leadership was.

I had to learn to stop arriving with the answer.
To go and see.

To listen to the people doing the work.
To understand the problem before trying to fix it.
To distinguish between activity and value.

And perhaps hardest of all, to become comfortable saying:

"I don't know yet."

Once I learned to see work as a system, I couldn't unsee it. I began noticing the unnecessary steps people took every day. The processes everyone worked around. The policies that said one thing while the work required another. The meetings where data was reported but nothing changed. The recurring incidents attributed to human error without anyone asking why the system made that error possible. The capable people carrying organisations through sheer effort.

And I became fascinated by what happened when we changed the system instead of asking the people within it to try harder.

This Isn't Really a Book About LEAN

LEAN has profoundly influenced the way I think and work.

You'll see its principles throughout this book — going to the Gemba, understanding value, reducing waste, standard work, continuous improvement and respect for people.

But this isn't a LEAN textbook. It isn't a book about tools. It's about what I have learned from applying those ideas in real organisations, alongside what I've learned through leadership, nursing, risk, quality, governance and organisational dynamics.

Most of the lessons in these pages came from work that was messy.

Sometimes we got extraordinary results.

Sometimes we thought we'd solved the problem and discovered another one.

Sometimes I got things wrong.

And some of the hardest lessons came from seeing organisations return to old habits even after we'd shown there was another way.

That's why I no longer think operational excellence is something you achieve through a transformation program.

It is something you practise.

Every day.

Leading for Value

For me, value is bigger than efficiency.

Of course resources matter. Productivity matters. Waste matters. Organisations need to be sustainable.

But particularly in human services, value also lives in the experience of people. The patient who doesn't spend unnecessary hours waiting for cancer treatment.

The resident who is safer because someone looked beyond the incident report and understood what actually happened.

The employee who can say, "This process isn't working," without fearing that they will become the problem.

The frontline team that has enough clarity, capability and agency to improve its own work.

And the leader who can see what is really happening in the organisation early enough to do something about it.

That's what I mean by **leading for value**.

It requires us to know what matters.

To learn to see.

To fix systems before blaming people.

To design work around value.

And to create the operational rhythm that keeps all of it alive.

An Invitation to Look Differently

This book isn't a prescription for the perfect organisation.

I don't believe one exists.

It is an invitation to look differently at the organisation you already have. As you read, think about your own workplace. Where are good people compensating for poor systems? What has become unnecessarily difficult? Which problems keep returning? What does everyone believe they already understand?

Where are people frightened to tell you what's really happening?

What are your customers experiencing that your dashboard can't show you?

And what would continue to work if the person currently holding it all together left tomorrow?

You don't need to answer all of those questions at once.

Start by becoming curious.

Because in my experience, the moment we stop asking “Who is the problem?” and start asking “What is happening in the system around them?”, we begin to see very different possibilities.

And that is where better work begins.

01

KNOW WHAT MATTERS

Clarity before activity

If everything is important, nothing is.

I've walked into organisations where everyone is working incredibly hard.

Calendars are full. Executive meetings run over. Project lists grow. New initiatives are launched before old ones are finished. People move from one urgent issue to the next, often without enough time to stop and ask whether all that activity is actually taking the organisation where it wants to go.

There is no shortage of effort.
What's often missing is clarity.

At two different organisations, I was involved in mapping all the projects and initiatives underway across the business. In both cases, we identified more than 200 active projects.

Two hundred.

They hadn't arrived there because people were careless or incompetent. Quite the opposite. They were full of committed, capable people trying to make things better. The problem was that there was no effective mechanism for deciding which work mattered most.

New projects were added, but very little was stopped. Different parts of the organisation had different priorities. The loudest or most urgent issue could quickly find its way to the top of the list. Leaders were trying to balance strategy, stakeholder expectations, operational pressures and the priorities of their own portfolios.

Eventually, everything became important.

Purpose Is a Decision-Making Tool

Most organisations have a purpose. They have strategic plans, values, annual priorities and beautifully designed documents explaining what they want to achieve. But having a purpose and using purpose to run the organisation are very different things.

Purpose should be a filter.

It should help leaders decide:

Does this work move us towards what matters? If it does, prioritise it. If it doesn't, there should be a very good reason for doing it.

That sounds simple. In practice, it requires discipline — particularly the discipline to stop doing things.

One of the most powerful questions a leadership team can ask isn't:
What else should we be doing? It's:

What are we prepared to stop?

That is where strategy becomes real.

From Strategy to True North

I've also seen what happens when organisations get this right. In two organisations, we used Hoshin Kanri — strategy deployment — to create a much clearer connection between organisational purpose and the work happening every day.

We identified just five key measures of success.

Not twenty.

Not a dashboard so crowded that nobody could tell what mattered.

Five.

Those measures became our True North.

They created a common language across the organisation. Teams could see how their work connected to organisational priorities. Leaders had a clearer basis for making decisions. Projects and improvement work could be tested against what we were actually trying to achieve.

Strategy stopped being something discussed periodically by executives and the Board and became something visible in day-to-day work.

The difference was significant.

People weren't being asked to work harder. They were being given greater clarity about where to put their effort.

That clarity also changed conversations.

Instead of every function competing to prove that its work was important, there was something bigger to align around. Decisions became less dependent on personalities, hierarchy and who could argue their case most convincingly.

The system helped make the priorities visible.

That is what True North should do.

It isn't another framework to put on a wall.

It is a way of answering, every day:

What matters here?

How does this work contribute to it?

And what are we doing that no longer does?

Because operational excellence doesn't begin with doing more.

It begins with knowing what matters.

What This Looks Like in Practice

Lack of clarity has a cost.

You see it in project overload, competing priorities and teams working hard on things that have little connection to the outcomes the organisation is trying to achieve.

You see it when the same people are pulled into every new initiative because they are capable and reliable. Eventually, those people become exhausted — not because they aren't resilient, but because the organisation has failed to make choices.

You see it in executive teams too. Priorities are agreed, but new work keeps finding its way in. Decisions are made in meetings but aren't consistently translated into action. Strategy becomes something reviewed periodically rather than something used to guide everyday decisions.

This is where leaders need to create discipline around purpose.

Not another layer of reporting. Not another planning day.

A regular rhythm for asking:

- What are we trying to achieve?
- What are we currently doing to achieve it?
- What is creating value?
- What is consuming effort without moving us forward?
- What has changed?
- What do we need to stop?

These conversations need to happen regularly enough that priorities don't quietly multiply again.

A Question for Your Next Executive Meeting

Put your current projects, initiatives and major pieces of work on the table.

Then ask:

If we could only deliver five of these exceptionally well, which five would make the greatest difference to the people we serve and the organisation we are trying to build?

The answer will tell you a great deal about your True North.

The harder conversation is what you are prepared to do with everything else.

Because clarity isn't demonstrated by what you say is important.

It's demonstrated by what you are willing to stop.

02

LEARN TO SEE

The hardest thing I had to learn

Of all the things I have learned about leadership and operational excellence, this was probably the hardest:

I had to learn not to know.

That did not come naturally.

I had built my career on expertise. I was a nurse. I had technical knowledge, experience and judgement. Like many professionals, part of my identity — and part of my value — came from knowing what to do.

Then I moved into a role where I had very little technical expertise.

I found it deeply uncomfortable.

I remember repeatedly asking my manager, “**Just tell me what to do.**”

She wouldn't.

Instead, she asked me questions.

How do you know?

And then, even more uncomfortably:

Do you really know?

At the time, those questions could drive me mad.

I wanted the answer. She wanted me to learn how to find it.

She invested in my development. I began formal LEAN training, worked with a coach and learned how to observe systems rather than immediately diagnose them. I had to complete my own A3 problem-solving work. I couldn't hand the analysis to someone else and wait for the answer.

I had to go and see.

More importantly, I had to listen.

And slowly I began to understand that my job as a leader wasn't to walk into the room and prove that I was the smartest person in it.

My job was to create the conditions in which we could understand the problem together.

Shedding the Technical Ego

I now see technical ego everywhere.

And I understand it, because I had to shed plenty of my own.

Professional expertise is hard won. Nurses, doctors, teachers, educators, social workers, accountants, engineers and other specialists spend years building knowledge and experience. That expertise matters.

But expertise can also become a trap.

The more experienced we become, the easier it is to walk into a problem already believing we know what is causing it.

We stop asking.

We start telling.

We listen for confirmation rather than understanding.

And sometimes we become so attached to our professional expertise that we dismiss insight from anyone who doesn't share our background.

What would you know? You haven't done this work.

I've encountered versions of that throughout my career, but I've felt it particularly strongly when working outside my original professional world.

I am not a teacher.

I am not an early childhood educator.

I cannot tell an educator how to teach a four-year-old, and nor should I.

But I don't need to be an early childhood educator to recognise a system that relies on people remembering too many things, a process with unnecessary steps, unclear accountability, unmanaged risk, duplicated work, poor escalation or staff running all day just to keep the system together.

In healthcare, I could use my nursing background as a bridge. I understood the feeling of being the nurse who ran all day, worked through lunch and went home exhausted — while still knowing there had to be a better way.

Outside healthcare, I have had to learn to build that bridge differently. And perhaps that has reinforced the lesson.

I don't need to be the expert in the work.

The people doing the work are the experts in the work.

My job is to help them see the system around it.

The People Closest to the Work Usually Know More Than We Think

One of the most common mistakes leaders make is trying to understand work from too far away.

We look at dashboards. Read incident reports. Review policies. Discuss performance at executive meetings.

All of those things have their place.

But none of them is the work.

If you want to understand why something keeps going wrong, you have to get close enough to see what actually happens.

Talk to the person doing it.

Watch the process.

Ask where it gets difficult.

Ask what they do when the standard process doesn't work.

Ask what they have learned to work around.

And then resist the urge to explain to them why they're wrong.

That last part matters.

Because going to the frontline with your diagnosis already formed isn't "going to see."

It's going to confirm what you already believe.

Learning to see requires something much harder:

the willingness to discover that you might be wrong.

When You Go Looking for a Person and Find a System

One of the clearest examples of this came when I was approached to undertake a process review following a serious incident.

Even during the initial interview and project briefing, I could sense that there was already a view about what had happened — and who was responsible.

I remember being very clear about what I would, and wouldn't, do.

"I won't be looking for who made the error. I'll be looking at what caused the error." I explained the 4Ms — Man, Method, Machine and Mode — and that while the person is one possible source of failure, experience had taught me that it is very rarely where I should start.

If they wanted someone to confirm who was at fault, I probably wasn't the right consultant. I wasn't entirely sure I would get the work.

I did.

By the time I arrived, however, some of the staff involved had already received first warnings. The prevailing explanation was that the incident had been caused by complacency.

That created an immediate tension. The organisation had already reached a conclusion. I was only just beginning the inquiry. So I did what I had said I would do.

I went to see.

I sat with the people doing the work and we mapped the process together, step by step. What was supposed to happen? What actually happened? Where were the decision points? What information was available? Where could an error occur? What did people do when the process didn't work as intended?

And as we mapped the work, the story began to change.

What had looked from a distance like complacency looked very different when we got close to the work. There were vulnerabilities in the process. There were opportunities for error. And there were things the workforce understood about how the work actually happened that simply weren't visible from an executive office or an incident report.

Then staff began saying things that have stayed with me:

“This is the first time anyone has asked us.”

“We’ve known this for years.”

The organisation had been looking for a person who had failed.
The people doing the work were showing us **a system that could fail.**

Those are two very different things.

The 4Ms

One of the disciplines I use when something goes wrong is to look broadly at the possible causes before settling on an explanation.

I learned to consider the **4Ms — Man, Method, Machine and Mode.**

Is this genuinely about the person?

Or is there something about the method — the way the work has been designed?
Is the equipment, technology or environment contributing?

Is there something about the way the system is operating that makes failure more likely?

The language may be old, but the discipline behind it remains useful:

Don't start with the person. Start with the system.

Because once a leader decides that somebody is careless, complacent or simply “the problem”, everything they see afterwards can become evidence supporting that conclusion.

That is precisely when leaders most need to become curious.

We'd Been Here Before

What made this experience particularly striking was that it wasn't the first time I had seen this happen in the same organisation.

During an earlier incident, there had again been a strong view that an individual was responsible. Someone came perilously close to losing their job.

But when we mapped the process, the vulnerabilities became clear.

The system had created opportunities for the error to occur. That earlier experience should have changed how the organisation approached the next incident.

It didn't.

When another incident later occurred at a different site, the organisation again reverted to what it knew.

Warnings were issued.

Conclusions were reached.

Nobody had gone to see.

That was an important lesson for me too.

Doing a process review is relatively easy. Changing the way leaders think is much harder.

You can map a process and fix a problem.

But unless leaders learn to resist certainty, challenge their own assumptions and listen to the people closest to the work, the organisation will eventually return to blame.

Operational excellence requires more than improvement tools. It requires leaders who are willing to say:

“I don't know yet. Let's go and find out.”

Learning to See Is a Leadership Discipline

Learning to see sounds simple.

It isn't.

It asks leaders to resist some of the very things we are often rewarded for — certainty, speed, expertise and having the answer.

For me, it comes down to four disciplines:

Go and see.

Get close enough to understand what is actually happening.

Ask before you tell.

The people doing the work usually know things about the system that you don't.

Listen without defending.

If someone tells you the process isn't working, resist the urge to explain why it should.

Don't diagnose until you understand.

Your first explanation may be right. Be prepared to discover that it isn't.

A Question Worth Asking

Think about a problem in your organisation that everyone believes they understand.

Then ask:

When was the last time someone actually went to the people doing the work and asked them what they see?

You might be surprised by what they already know.

03

FIX THE SYSTEM BEFORE YOU BLAME THE PERSON

Good People Need Good
Systems

If you can't explain the problem without blaming a person, you probably don't understand the system yet.

Something goes wrong and very quickly the conversation turns to the person.

Who did it?

Who didn't follow the process?

Who needs more training?

Who needs performance management?

Sometimes individual performance genuinely is the problem. People have responsibilities. Professional standards matter. Accountability matters.

But before I conclude that somebody has failed the organisation, I want to know whether the organisation has failed them.

When I hear someone described as a "problem employee", I become curious.

What exactly are they being asked to do?

Are expectations clear?

Is there a workable standard process?

Have they been taught it?

Do they have the time, information, tools and authority they need?

Are different managers giving them different instructions?

And perhaps most importantly:

Could a reasonable person succeed consistently in the system we've designed?

Because good people are remarkably good at compensating for poor systems. They create workarounds. They remember the unwritten extra step. They know who to ring when the formal process doesn't work. They stay late. They build spreadsheets beside the official system. They carry knowledge in their heads.

And because the work keeps getting done, the organisation can mistake human effort for a functioning system. Eventually someone leaves, gets sick, makes a mistake or simply runs out of capacity. Then the fragility becomes visible.

And too often, the person standing there when it finally breaks gets blamed.

That's why I believe we need to understand the system before we move to individual accountability.

Support Before Accountability

Systems thinking is sometimes misunderstood as being soft on performance. I don't see it that way at all. Quite the opposite. A well-designed system makes accountability clearer.

If I have clearly explained what is expected of you, provided a workable process, made sure you have the capability and tools you need, created feedback loops and coached you when things aren't working, then we can have a much more honest conversation about performance.

The question becomes:

Can't they do it — or won't they do it?

Those are very different problems. I learned this through experience.

I once inherited a direct report who had already developed a reputation as a “problem employee”. She had been passed between managers and there was a long history around her performance. I didn't want to inherit everybody else's conclusion about her.

So I tried to reset the relationship.

I worked on clarity. We agreed small goals. I coached. I followed up. I tried to understand what was getting in the way rather than beginning from the assumption that she was the problem. But over time, something became clear.

She would agree to things in conversation, but her actions didn't consistently follow. Eventually I had to confront the question I had deliberately avoided answering too early:

Was this a person who couldn't succeed in the system — or someone who was choosing not to?

In this case, the process of support and coaching brought clarity. She ultimately chose to leave. I don't regard that as a failure of systems thinking.

I regard it as the point of it. We had tested the system around the person before reaching a conclusion about the person.

That matters.

Because accountability without support is blame.
But support without accountability isn't leadership either.

From Police to Partners

I once inherited a quality team with an image problem.

They were known as the **quality police**.

And, to be fair, the way the function had been designed almost guaranteed it.

Quality arrived when something had gone wrong. They checked compliance. They asked for evidence. They quoted policies. They identified gaps. Education was frequently prescribed as the solution.

People didn't necessarily see Quality as a team that could help them.

They saw Quality coming and wondered what they had done wrong. I loved working with that team, because once we began looking at a different way of working, you could almost feel the weight coming off them.

They didn't want to be the police either.

We started redefining what their role was actually there to achieve.

Were they there to catch people doing the wrong thing?

Or were they there to help the organisation understand why things went wrong and build systems that made good outcomes more likely?

That distinction changed everything.

Quality Should Be an Enabling Function

We taught the team to go to the Gemba — to where the work actually happened.

They learned to ask rather than tell.

Instead of beginning with:

“Why didn't you follow the procedure?”

they could begin with:

“Talk me through what happened.”

Instead of automatically recommending more education, they learned to ask whether lack of knowledge was actually the problem.

Instead of investigating from a desk, they went to see.

I remember one investigation following a resident fall in aged care.

The old approach might have been to review the incident report, check whether staff had complied with the relevant policy and determine whether additional education was required.

This time, the quality team went to the floor.

They spoke with the resident.

They spoke with the staff.

They looked at the environment.

They examined how the work was actually being done.

They didn't find a villain.

They found a systems issue.

And because they understood the system, they could do something useful about it.

That team went on to facilitate process redesign and improvement work. Their relationship with the organisation changed. They became people that operational teams could work **with**, rather than a function they feared being reported **to**.

They became partners in improvement.

And they loved it.

If People Are Afraid of Quality, Quality Has a Problem

That experience fundamentally shaped the way I have designed quality, risk and improvement functions ever since.

Whether I have been an executive or a consultant, I have wanted these functions to be enabling functions.

Because think about what we ask people to tell them.

We ask people to report incidents.

To disclose errors.

To identify risks.

To tell us when a process isn't working.

To admit when they have developed a workaround.

To raise concerns about practices that may have existed for years.

To tell us things that may be uncomfortable for their manager — or for the organisation itself — to hear.

And then we wonder why people don't speak up when the function receiving that information feels punitive.

If people are afraid to tell Quality what is really happening, how can the organisation possibly learn?

Psychological safety doesn't mean lowering standards or removing accountability. It means people can say:

"I made a mistake."

"This process doesn't work."

"We've been working around this for months."

"I'm worried about this."

"I don't understand."

without believing that speaking honestly will automatically make them the problem. That is not soft leadership.

It is how organisations learn.

You Cannot Improve What People Are Afraid to Tell You

This is why I believe quality, risk and assurance functions have to think carefully about the experience they create.

Their authority shouldn't come from being feared.

It should come from being useful.

People should involve them early — before the incident, before the complaint, before the regulator arrives — because they know they will help make the system stronger.

That doesn't mean ignoring poor practice. It doesn't mean there are no consequences when someone knowingly or repeatedly behaves outside reasonable expectations.

It means we don't confuse **accountability with blame**.

We make it safe to tell the truth first.

Then we work out what the truth is telling us about the system.

Because the moment people become frightened to tell Quality what's really happening, the organisation hasn't reduced its risk.

It has simply made the risk harder to see.

04

DESIGN FOR VALUE

This is where it began for me

There are some experiences in your career that fundamentally change the way you see work.

For me, one of those experiences happened in an oncology service.

The problem seemed obvious.
Patients were waiting too long.

A patient might arrive at 9am expecting a treatment journey of around four hours and still be there six hours later. These were people receiving cancer treatment. They were already carrying enough uncertainty and discomfort without spending unnecessary hours waiting because our systems weren't working.

The staff were struggling too.

Nurses were rushing between competing demands. Sick leave was high. Overtime was high. Agency use had reached 126 hours a month. The team was exhausted and frustrated. From the outside, it would have been easy to conclude that the service needed more resources.

More nurses.
More pressure on performance.
More KPIs.
More reminders to move patients through quickly.
But that wasn't what changed the service.
What changed it was learning to see the work differently.

Stop Pushing People. Start Designing the Work.

A manager I had the privilege of leading embraced our LEAN training and began looking at the service as a system.
She didn't begin by asking people to work faster.

She watched.
She listened.
She involved the staff doing the work.
She mapped the patient journey from beginning to end.

She looked at where patients waited, where information stalled, where staff were interrupted, where pharmacy created bottlenecks and where unnecessary steps had become embedded simply because that was how things had always been done.

Importantly, patients were brought into the conversation too. The team began distinguishing between activity and value.

What actually mattered to the patient?

Which steps genuinely contributed to safe, effective treatment?

Which existed because the organisation needed them?

Which added no value at all?

And what could be redesigned so that the work flowed better for everyone?

That was when I began to really understand something that has shaped my work ever since:

You can get extraordinary results without asking people to work harder.

Sometimes the greatest improvement comes from making the work easier to do well.

The Results Followed the System

The changes were significant.

Agency staff hours fell by **56%**, from 126 hours a month to 55.

Where previously 60% of patients waited more than 30 minutes, **95% were now commencing treatment within 10 minutes.**

Daily capacity increased from **57 patients to 77.**

Sick leave fell by **40%.**

Overtime fell by **85%.**

Patient satisfaction reached the **98th percentile.**

Those numbers matter.

But what mattered to me was what they represented.

Patients spent less of an already difficult day waiting unnecessarily.

Staff weren't running harder to achieve the improvement.

The system was carrying more of the load.

That distinction has stayed with me.

Because organisations often try to improve performance by putting pressure on people.

When demand increases, we ask people to do more.

When something is late, we ask them to move faster.

When an error occurs, we retrain them.

When performance drops, we introduce another KPI.
When staff become exhausted, we talk about resilience.
But eventually there is nowhere left to push.
Sometimes the problem isn't the effort being put into the system.

It's the system itself.

Standard Work Is Not About Turning People Into Robots

This is where the idea of standardisation can make people uncomfortable.

Particularly in human services.

People hear “standard work” and imagine rigid processes that ignore professional judgement, individual needs and the complexity of caring for human beings.

That's not what I mean.

Standardisation should remove unnecessary ambiguity from the things that don't need to be different, so people have more capacity for the things that do. A nurse shouldn't need to invent a new way to access routine information every shift. An educator shouldn't have to rely on memory to know which administrative steps need completing.

A support worker shouldn't need to know which particular person to call because the formal escalation process doesn't work.

Professional judgement is precious.

We shouldn't waste it navigating poorly designed systems.

Good standard work creates a stable foundation.

It makes expectations visible.

It reduces unnecessary variation.

It makes it easier to teach new people.

It helps us see when something has gone wrong.

And, importantly, it gives us something we can improve.

Design With the People Who Experience the Work

There is another lesson from oncology that I have carried into every improvement project since.

You cannot design good work entirely from an office.

The people doing the work need to be involved.

And so do the people receiving it.

This sounds obvious, particularly in organisations that describe themselves as customer-centred, person-centred or child-centred. Yet I have sat in countless rooms where services are being redesigned without a single customer, patient, resident, client or frontline worker involved.

We assume we know what matters to them.

That's dangerous.

Because we can't define value solely from the perspective of the person designing the service. We have to understand it through the experience of the person receiving it.

And sometimes they will tell you something you weren't expecting.

I've learned that operational excellence isn't about making every process faster. It is about designing work so that it delivers what matters, removes what doesn't, respects the people doing it and creates the best possible experience for the person receiving it.

Efficiency matters.

But efficiency without value can simply help us do the wrong thing faster.

When the Numbers Aren't the Whole Story

One of the most important lessons I learned about improvement came at a time when we had every reason to feel proud of what we'd achieved.

We had redesigned flow through an emergency department.

Waiting had reduced. Bottlenecks had been addressed. The operational measures were improving.

But something else had changed too.

The staff were happier.

They had been involved in redesigning their own daily work. They had been listened to. Their knowledge of the system had been valued, and instead of having change done to them, they had helped create it.

I remember staff literally doing little dances as the results started coming through.

Their engagement results shifted dramatically. A team that had previously described a culture of blame was now reporting a very different experience of their workplace. Their lives at work were better because of improvements they had helped design.

That mattered enormously to me. We had improved flow for patients, but we'd also demonstrated something I've seen repeatedly since:

When people are genuinely involved in improving their own work, improvement itself can become energising.

Then we listened to the patients. And they gave us our next lesson. The feedback wasn't primarily about waiting.

Patients talked about the coldness of the environment. They talked about rushed interactions and how they felt while moving through the service.

I remember the staff laughing when we heard some of that feedback. It wasn't dismissive laughter.

It was more: **"Oops. We missed that."**

We had become so focused on solving one set of problems that we'd needed reminding to check in with the other important people in the picture.

And what I loved was that the team didn't react defensively.

They wanted to know more.
They had caught the improvement bug.

Improvement Changes the Way People See Work

Something happens when people experience improvement rather than having it imposed upon them.

They start noticing things.

Once they've solved one problem, they begin looking for the next one.

What else isn't working?

What else could be easier?

What are our patients telling us?

What are we putting up with simply because we've always done it this way?

The people who once felt blamed by the system can become the people actively trying to make the system better.

That's when continuous improvement stops being a project and starts becoming part of the culture.

The leader's job changes too.

You don't need to generate every improvement idea.

You need to create an environment where people are curious enough, safe enough and empowered enough to keep finding them.

The Customer Experience Is Richer Than Any Number

The patient feedback also taught us not to become seduced by our own success.

Our operational data was good.

Our staff experience had improved.

Those things were real and worth celebrating.

But they weren't the whole story.

A wait time can tell me how long someone waited. It can't necessarily tell me what that wait felt like. An engagement score can tell me whether the workforce experience is changing. It can't replace sitting with staff and hearing what has made their working day better. A satisfaction score can show a trend.

It can't reproduce the experience of the patient who felt frightened, cold, rushed or genuinely cared for.

The customer experience is richer than any number.

That's why quantitative data and lived experience belong together.

We need the measures.

But we also need the voices behind them.

And sometimes those voices will tell us that something we thought we'd solved still needs work.

That's not failure. **That's improvement.**

Don't Rest on Your Laurels

There is no point at which an organisation gets to say:

"We're excellent now. We're done."

We aim for excellence.

We aim for zero harm.

We design the best systems we can.

We measure them.

We listen.

And then we adjust. Again and again.

Because once people really understand improvement, they don't need to be persuaded to look for the next opportunity. They start asking the question themselves: "What could we do better tomorrow?"

That's when you know something has really changed.

A Question for Your Leadership Team

Think about a process in your organisation that people regularly complain about. Not the person you think is causing the problem. The **process**.

Then ask:

When was the last time we watched this work from beginning to end with the people who actually do it — and the people who experience it?

If the answer is "we haven't", don't redesign it yet.

Go and see.

Because before you can improve a system, you need to understand whose value it is supposed to create.

05

CREATE RHYTHM

Make Improvement Survive

The real test of improvement is what is still happening after the consultant leaves.

I've spent a lot of my career being brought into organisations to fix things.

Sometimes the problem is obvious. Sometimes it takes time to understand what is really going on.

We diagnose.

We map.

We redesign.

We clarify roles.

We identify risks.

We develop frameworks.

We agree actions.

And often, organisations do this work very well.

The problem comes next.

Who makes sure it keeps happening?

This is where I see so much good improvement work unravel.

Not because the diagnosis was wrong.

Not because people didn't support the change.

And not necessarily because the organisation lacked capability.

It unravelled because nobody built the operational rhythm that would make the new way of working part of everyday business.

Organisations Need a Heartbeat

Good organisations have a rhythm. You can feel it.

People know what gets reviewed, when it gets reviewed and why. Leaders don't need a crisis to remind them to look at risk. Audit actions don't disappear into spreadsheets until somebody asks for an update six months later. Compliance obligations aren't considered only when the regulator arrives.

Performance data isn't produced simply because the Board needs a report. Improvement actions aren't launched and forgotten.

There is a heartbeat to the organisation.

See. Understand. Act. Review. Learn. Adjust.

Then do it again.

That rhythm creates visibility.

And visibility allows leaders to lead before problems become crises.

What Rhythm looks like in Practice

Operational rhythm doesn't need to be complicated. It might mean frontline teams looking at yesterday's performance and today's risks.

Managers reviewing trends, incidents, complaints and workforce pressures regularly enough to act before they become crises.

Executives reviewing strategic priorities, enterprise risks, compliance obligations, audit actions and improvement work through an agreed cycle — not whenever someone remembers.

Boards receiving information that shows not just what happened, but what is changing, what sits outside appetite and what management is doing about it.

And across all of those levels, there is a clear line of sight:

What matters? What are we seeing? What are we doing? Is it working?

That's rhythm.

It isn't about creating more meetings.

In fact, good rhythm should reduce unnecessary meetings and reporting because everyone knows where information belongs, when decisions will be made and who is accountable for following through.

Data Should Help You Run the Organisation

Organisations collect extraordinary amounts of data.

Incidents; Complaints; Workforce measures; Customer feedback.

Financial results.

Audit findings.

Risk indicators.

Compliance data.

Operational performance.

The problem is rarely a shortage of information. The problem is turning information into useful intelligence.

I've sat through plenty of meetings where pages of data are presented and almost nothing happens as a result. The numbers are reported. Everyone nods. The meeting moves on. That's not an operating rhythm.

Useful data should provoke a conversation.

What is this telling us?

Is something changing?

Where is the variation?

What are we worried about?

What do we need to understand better?

What are we going to do about it?

And then, critically: **Did what we did actually work?**

That's the difference between reporting performance and managing it.

Discipline Creates Freedom

The word discipline can sound rigid. I see it differently. Disciplined organisations don't have to constantly reinvent how they manage themselves.

They know that risks will be reviewed.

They know obligations will be checked.

They know audit findings will be followed through.

They know improvement actions will come back for review.

They know who owns what.

They know when something needs to escalate.

That creates confidence. It also creates space. When the basics are managed through a predictable rhythm, leaders have more capacity to think, improve and respond to what is genuinely new. Without that rhythm, everything competes for attention. The urgent crowds out the important.

Actions accumulate.

Risks quietly change.

Commitments are forgotten.

And eventually somebody discovers that an issue everyone thought was being managed... wasn't.

Improvement Works in Cycles

Continuous improvement doesn't mean constantly changing things. It means creating regular opportunities to learn.

Plan, Try something, Look at what happened, Adjust, Standardise what works, Then look again.

Very few organisational problems are solved perfectly on the first attempt.

A process redesign may solve one bottleneck and expose another. A new control may reduce one risk but create unnecessary work somewhere else. The workforce may tell us that the new process looks wonderful on paper but is difficult to use in practice. None of that means the improvement failed.

It means the organisation is learning.

The danger comes when we implement something and stop looking.

Governance Should Create Movement, Not Paper

This is particularly important in risk, compliance and assurance. These functions can create enormous amounts of organisational activity without necessarily creating much organisational value.

A risk register that is updated once a year isn't managing risk.

An audit action that remains open for eighteen months isn't creating assurance.

A compliance register that nobody uses to make decisions isn't creating compliance.

A dashboard nobody interrogates isn't creating visibility.

And a committee that receives reports but doesn't cause anything to happen isn't governance.

A framework without a rhythm is just a document.

The question I keep coming back to is:

What does this information cause us to do?

If the answer is nothing, we need to question why we are collecting it. Good governance should create movement. It should surface what matters, make ownership clear, prompt decisions and create follow-through.

Build the Rhythm Before You Leave

This is something I think about particularly when I work as a consultant. I don't want an organisation to become dependent on me. If the improvement only works while I am in the room, I haven't finished the job. The work needs to become theirs.

That means leaving behind more than a report or a redesigned process. It means helping build the rhythm that will sustain it.

Who will review this?

How often?

What information will they need?

Where will actions be tracked?

How will we know whether the change is working?

What happens when performance moves outside what we expected?

Who needs to know?

When do we stop, learn and adjust?

Those questions aren't the exciting part of transformation.

They're the part that makes transformation stick.

From Firefighting to Rhythm

You can usually tell when an organisation doesn't have an effective operating rhythm.

Everything feels urgent.

The same issues keep returning.

Actions remain open.

Meetings are crowded with updates but short on decisions. People create parallel spreadsheets because they don't trust the formal systems. Leaders discover risks through incidents rather than through monitoring.

Boards ask questions that trigger frantic searches for information.

And improvement becomes something the organisation does to itself every few years when things have become painful enough.

It doesn't have to operate that way.

A good rhythm doesn't eliminate surprises.

It gives the organisation a better chance of seeing them coming.

A good rhythm doesn't eliminate surprises. It gives the organisation a better chance of seeing them coming. It creates regular moments to look up from the daily work and ask:

What is happening?

What are we learning?

What needs our attention now?

And what are we going to do next?

FutureProof the System

For me, this is where operational excellence becomes sustainable.

Know what matters.

Learn to see.

Make it safe for people to tell you what's really happening.

Fix systems before blaming people.

Design work around value.

Then create the rhythm that keeps all of it alive.

Because organisations don't become excellent through one extraordinary piece of work. They become excellent through thousands of ordinary disciplines, repeated consistently.

The risk review that happens when it should.

The audit action that is actually closed.

The customer feedback that changes a process.

The team that reviews yesterday's problem and improves tomorrow's work.

The leader who asks one more question before accepting a reassuring number.

The organisation that learns, adjusts and keeps going.

That's rhythm.

And once it becomes part of the way an organisation operates, improvement no longer depends on the consultant, the enthusiastic executive or the latest transformation program.

It becomes how the organisation works.

CONCLUSION

Leading for Value

Build what you want to lead

When I think about the organisations I have worked in over the years, the ones that have stayed with me are not necessarily the ones with the best strategies, the biggest transformation programs or the most sophisticated systems.

They are the places where something genuinely changed for people.

A patient spent less of an already difficult day waiting for treatment.
A nurse stopped running from one broken process to another.
A quality team discovered they could be partners rather than police.
Staff who had felt blamed became involved in redesigning their own work — and started looking for the next thing they could improve.
Leaders learned to ask before assuming.

People felt safe enough to say, **“This isn't working.”**

Those things matter. They are also what operational excellence looks like to me.

Excellence Is Not Perfection

I don't believe there is such a thing as the perfect organisation.

There will always be risk.
People will make mistakes.
Systems will fail.
Demand will change.
Customers will tell us something we hadn't considered.
And even our best improvements will eventually need improving.

The goal isn't perfection. The goal is to build an organisation capable of **seeing, learning and responding.**

An organisation that doesn't hide its problems.

An organisation where people don't have to compensate for poor systems simply to get through the day.

An organisation where leaders are curious enough to discover that their first explanation might be wrong.

And an organisation disciplined enough to keep looking after the excitement of the latest improvement has passed.

That is why operational excellence is never finished.

We aim for excellence.

We aim for zero harm.

And then we keep learning.

Leadership Creates the Conditions

Over time, I've come to believe that leadership is less about having the answer and much more about creating the conditions in which the organisation can find it.

Clarity about what matters.

Curiosity about what is really happening.

Psychological safety for people to tell us the truth.

Systems that make good work easier to do.

Measures that help us understand whether things are getting better.

And a disciplined rhythm that keeps the organisation learning.

None of those things is particularly glamorous.

But together, they create something powerful.

They create an organisation that doesn't need heroics to function.

Respect the People Doing the Work

If there is one principle underneath everything in this book, it is this:

Respect the people doing the work.

That doesn't mean avoiding accountability.

It doesn't mean accepting poor performance.

And it certainly doesn't mean lowering standards.

It means recognising that when good people repeatedly struggle, we should be curious about the system around them.

It means asking the workforce what they know before designing a solution for them. It means making it safe for people to tell us about mistakes, workarounds and risks before those things become incidents.

It means designing work so that professional judgement is used where it adds value – rather than being wasted navigating unnecessary complexity.

And it means remembering that the people receiving our services get to tell us what value feels like to them.

Start With What You Can See

If you've recognised your organisation somewhere in these pages, don't try to fix everything tomorrow. Go and look at one thing. Find the process everyone complains about. Look at the recurring incident nobody seems able to prevent.

Ask why the same audit action is still open.

Sit with the team everyone describes as difficult.

Talk to the customer whose experience isn't showing up in your dashboard.

Ask the workforce what makes it unnecessarily hard to do a good job.

And listen.

You may discover that the organisation doesn't need people to try harder. It needs the system around them to work better.

That's where I'd start.

Because better organisations aren't built through slogans, heroics or another burst of activity.

They are built deliberately.

One problem understood.

One system improved.

One voice heard.

One disciplined cycle at a time.

That's leading for value.

About Clare Jennings



Clare Jennings is the founder and Director of FutureProof Consultants.

For more than three decades, Clare has worked across health and human services as a nurse, executive, Board director, consultant and improvement leader.

Her work has spanned operational excellence, quality and safety, risk, governance, organisational change and service improvement — but the thread connecting it has remained remarkably consistent:

How do we make it easier for good people to do good work?

Clare brings together systems thinking, LEAN improvement principles and organisational dynamics to help leaders understand what is really happening inside their organisations — and turn that understanding into practical change.

She is particularly interested in the space between strategy and everyday work: where good intentions meet complicated systems, competing priorities, regulatory requirements and the realities of delivering care.

Her approach is practical, curious and grounded in respect for the people doing the work. She believes sustainable improvement doesn't come from asking people to work harder. It comes from creating clearer priorities, better systems, greater visibility and an operating rhythm that allows organisations to keep learning.

Clare holds a Master of Nursing and a Master of Organisational Dynamics and is a graduate of the Australian Institute of Company Directors.

About FutureProof Consultants



FutureProof Consultants helps health and human services organisations turn complexity into clearer, safer and more sustainable ways of working. Through FutureProof, I work with leaders and teams who know something isn't working as well as it should — but need help seeing the whole system, understanding what is getting in the way and deciding what to do next.

That might mean clarifying priorities, redesigning a struggling process, strengthening risk and governance systems, improving quality and assurance, responding to recurring incidents, or creating the operational rhythm needed to make improvement stick. My approach is grounded in the principles explored throughout this book:

Know what matters.

Learn to see.

Fix the system before you blame the person.

Design for value.

Create rhythm.

FutureProof doesn't arrive with a generic solution. I go to the work. I listen to the people who understand it. I use data alongside lived experience. I make problems visible and work with organisations to design practical solutions that can survive long after the consulting engagement ends. Because the goal isn't to make an organisation dependent on a consultant.

It's to leave it stronger than I found it.

Ready to look at your organisation differently?

If something in *Leading for Value* has made you recognise a problem in your own organisation — a process that isn't working, a risk that keeps returning, a team under pressure or simply too much effort for too little value — I'd be very happy to have a conversation.

Clare Jennings

[Book a conversation](#)

