



OPERATIONAL HEALTH CHECK

Assessment Report

A structured read of process clarity, data quality, and decision quality, translated into findings, priorities, and a sequenced next move.

PRIMARY FINDING

Information Consistency

PREPARED	4 August 2026
ASSESSMENT	12-question diagnostic across three areas
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OVERALL MATURITY

● **Developing**

3

CAPABILITY
AREAS ASSESSED

12

DIAGNOSTIC
QUESTIONS

5

PRIORITIES
IDENTIFIED

PRIMARY FINDING

Information Consistency

Operational information exists across the business, but the absence of authoritative sources limits confident decision-making downstream.

OVERALL MATURITY

LEVEL 2 / 5

Developing

Several foundational elements are shaky. Investment in process clarity and data definitions will pay back quickly.



5 CRITICAL · 4 PARTIAL · 3 WORKING

MOST SIGNIFICANT FINDING

No single source of truth

Multiple sources of record for the same metric.

PRIMARY OPPORTUNITY

One number the business can act on

Once each metric has one system of record, reporting stops being negotiable and decisions move on the first read.

IMMEDIATE PRIORITY

Establish authoritative sources

For each key metric, decide which system holds the version of record, before rebuilding any report.

Improvement compounds from what is already working. These capabilities are in place today, the rest of the report treats them as the base to build on.



Aligned performance measures

Key stakeholders use the same measures and definitions when talking about performance.



Decision-critical data available

Reports give decision-makers everything they need to make a well-informed call.



Clear stage ownership

Accountability is clear at every step, problems find their owner quickly.



Operational goals are understood

Performance expectations appear to be generally understood across the organisation, the assessment could not have been completed without shared reference points.

Where this can create even more value

Two extensions of the capabilities above, each with a short path to impact. Both appear again in the action plan.



A written definition of success

Putting the intended outcome on paper turns shared instinct into a reference every metric can be tested against.



Reports tied to named decisions

Naming the decision behind each report converts reporting effort into decision support.

WHY THIS MATTERS

The opportunities in the pages that follow extend these capabilities. None of them requires starting over.

03 Current Operating Model

HOW THE ORGANISATION RUNS TODAY

Four dimensions, read at a glance. Fuller bars mark practice that is already consistent; the note beside each names what that looks like day to day.

Foundation



Foundations exist but success and purpose are not fully aligned.

Information



Definitions and sources vary, the information layer needs alignment.

Measurement



Reports are useful, but some outcome measures are missing.

Decisions



Decisions happen, but their outcomes are not always tracked back.

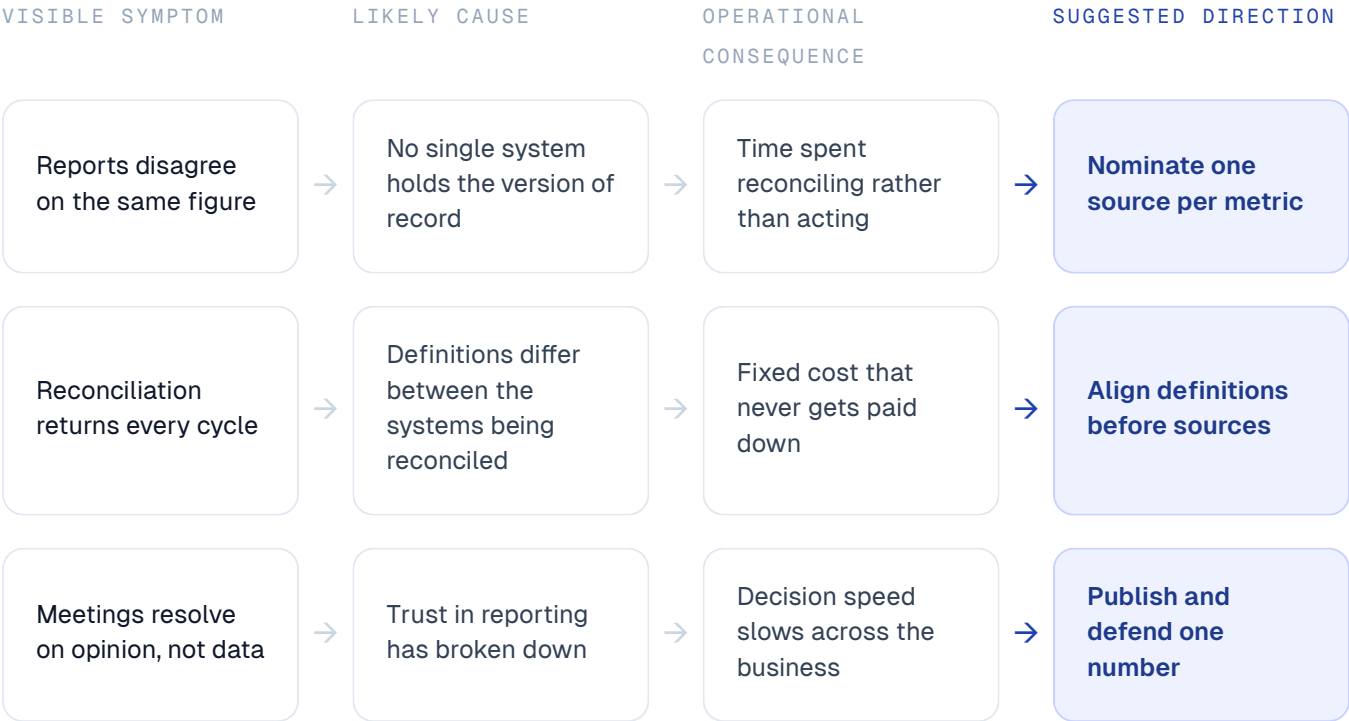
OVERALL PICTURE

The dimensions carry a real load, the leverage sits in the foundation and information dimensions.

What the assessment surfaced, the operational cost each one carries today, and the move that closes it. Ordered by leverage.

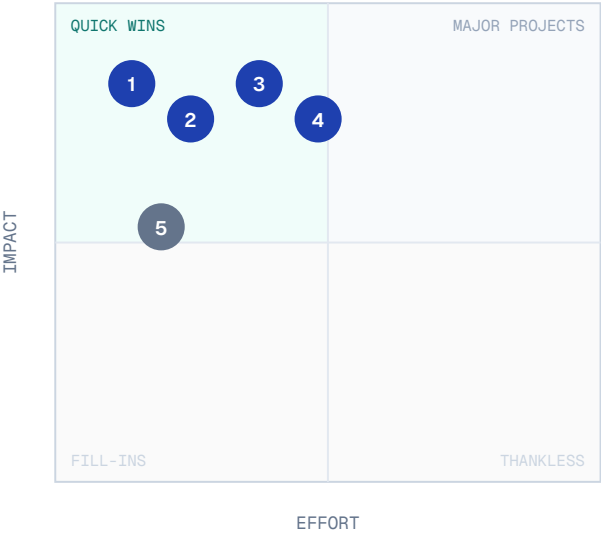
STATUS	FINDING	BUSINESS IMPACT	RECOMMENDATION
● Priority	Clear definition of success Process clarity	Time is spent debating what the outcome should be rather than pursuing it.	Write the definition of a good outcome down in plain language.
● Priority	Numbers that contradict each other Data quality	Conflicting numbers force every decision through a reconciliation step.	Nominate one system of record per key metric and document it.
● Priority	Data that does not match what you see Data quality	Reports keep costing time to produce while quietly losing influence.	Reconcile the least-trusted report against what the team observes.
● Priority	Numbers with no clear origin Data quality	Traceability of the numbers weakens, no metric has a durable owner.	Document ownership for every key metric in one shared place.
● Priority	Getting to the real cause Decision quality	Problem-solving becomes guesswork rather than a repeatable method.	Define the standard order in which numbers are checked.
● Opportunity	What the data is actually for Process clarity	Reports are produced without clarity on which decisions they feed.	Tie each recurring report to a named decision it feeds.
● Opportunity	Measuring activity instead of results Data quality	Attention is directed to activity rather than to results.	Test each metric: if it improves, does the business improve?
● Opportunity	Words that mean different things to different people Data quality	The same word means different things in different reports.	Agree one definition per shared term used across reports.
● Opportunity	Actions that actually move the needle Decision quality	Corrective actions frequently fail to move the numbers they targeted.	Record what was checked and concluded after each fix.

Each row traces one pattern from the symptom that shows up in the business to the point where acting actually changes it.



The visible symptoms sit downstream of a governance choice that has not yet been made. Rebuilding any report before that choice is settled reproduces the same disagreement in a new format.

Sequenced by leverage, impact weighed against the effort to get there. The quadrant shows the same trade-off the ranking already assumes.



#	INITIATIVE	IMPACT	EFFORT
1	Definitions of success	HIGH	LOW
2	Shared definitions	HIGH	LOW
3	Authoritative sources	HIGH	MEDIUM
4	Metric review	HIGH	MEDIUM
5	Investigation method	MEDIUM	LOW

Reading the quadrant: high impact / low effort belongs at the top of the plan; high impact / high effort is worth doing but not first.

Each step earns the next. The outcome line states what changes in the business once the step is done, not what gets produced.

DEFINE

Definitions of success

ACTION	Write down what each key process is meant to produce.
WHY	Metrics chosen before this step are chosen by default rather than by intent.
OUTCOME	Faster leadership decisions and downstream reporting that starts earning its keep.

ALIGN

Shared definitions

ACTION	Agree one definition per shared term used in reporting.
WHY	Conflicting numbers usually originate here rather than in the systems themselves.
OUTCOME	Monthly reporting effort drops as the same figure reads the same across teams.

GOVERN

Authoritative sources

ACTION	Nominate one system of record per key metric.
WHY	Until one source is authoritative, reconciliation returns every cycle.
OUTCOME	Reconciliation hours redirect to action; forecasts and automation inherit trusted numbers.

MEASURE

Metric review

ACTION	Test each metric against: if this improves, does the business improve?
WHY	Reliable data about the wrong things produces confident decisions in the wrong direction.
OUTCOME	Decisions and investment start tracking what actually moves margin and growth.

STANDARDISE

Investigation method

ACTION	Define the order in which numbers are checked when metrics move.
WHY	Without a fixed sequence, the most visible explanation wins by default.
OUTCOME	Recurring incidents fall, each fix compounds into durable improvement.

SEQUENCING NOTE

Automation, dashboards, and AI tools belong after this sequence, not within it. Applied to unresolved definitions or conflicting sources, they scale the existing problem rather than solve it.

Questions where capable people inside the same organisation often answer differently. Divergence is the signal worth following.

01 Are we agreed on what good looks like?

For each key process, what output, at what standard, by when, would we all write down the same answer?

FOLLOW-UP

For each recurring report: what decision does it inform, and who is that decision-maker?

02 Are we measuring the same thing?

If we each defined our three most-used metrics right now, how closely would the definitions match?

FOLLOW-UP

When two systems disagree on the same figure, who decides which is right, and is that decision recorded?

03 Are we measuring what actually matters?

Which of our current metrics would we genuinely miss if it stopped being produced next month?

FOLLOW-UP

When was the last time a report told us something we knew to be untrue, and what did we do about it?

STANDING QUESTION WORTH REVISITING

Which of our reports would we genuinely miss if it stopped being produced next month?

This diagnostic works backwards from a single question: what is each process meant to produce, and what does it produce today? The gap between those two answers is where it looks. It is a short assessment, not a substitute for a full review.

- Based on questionnaire responses from a single respondent
- Does not prescribe specific technology
- Identifies likely improvement opportunities, not confirmed root causes
- Not a substitute for a detailed assessment involving the wider team

What happens next?

01 Explore independently

Use the roadmap as a starting point for a small team. The priorities and questions are enough to run with.

02 Discuss the findings

A 30-minute session to identify which issue is causing the others, and where the leverage sits in your specific setup.

03 Go deeper with a structured assessment

RECOMMENDED

A structured review with the relevant stakeholders, observation and interviews. Result: a validated diagnosis and a plan the wider team has already agreed to.

IN ONE SENTENCE

Your organisation already produces the operational information it needs, the next step is defining who owns each number, so the same figure reads the same across every report.