SOUTH ZONE REVIEW

Alberta Health Services

Final report

August 2018

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Executive summary

Executive summary

Alberta Health Services (AHS) engaged Capelle Associates to complete an organization review of the South Zone's Operations (South Zone). The objectives were to develop an accurate picture of how work is done within current authorities, processes and structure, determine opportunities for improvement, make recommendations for optimal alignment of positions, accountabilities and authorities, people, deliverables and tasks, provide a framework for implementation of recommendations, and support executive decision making and next steps.

The review focused on South Zone leadership, but will indirectly impact the work of 5,413 positions. Interviews were completed with 120 individuals who were either South Zone managers (defined as being accountable for the work of others regardless of level or title); physician leaders; corporate/provincial or clinical support program managers; or members of the Executive Leadership Team. The review also included a document and literature review, and analysis of employee information with comparisons to our benchmarking database.

It should be first noted that the South Zone is a lean operation from a management perspective. This observation is based on the fact that the South Zone has both a very low percentage of managers (2% of all employees within the South Zone) and high number of direct reports per manager (on average ~49 direct reports per manager). Both these numbers differed greatly from our benchmarking database. Our benchmarking database, comprised of 85 organizations across multiple industry sectors, shows that organizations (on average) were comprised of 12% managers, and had around 8 direct reports per manager. Recognizing that healthcare organizations often have fewer managers and more direct reports per manager, we worked with AHS to benchmark these numbers against peer healthcare organizations in Canada. The Conference Board of Canada report (*Talent Management Benchmarking: Human Resources Trends and Metrics, Fourth Edition,* Conference Board of Canada, 2017) showed that, on average, health care peer organizations had approximately 29 direct reports per manager. This was also lower than the number in the South Zone, further emphasizing our view that the South Zone is a lean operation.

Through conducting the review, we came away extremely impressed by the ability of leaders to effectively manage within the lean operation. Due to the fact that the South Zone was quite lean, we did not identify significant opportunities for cost savings. However, we did identify a number of ways to further strengthen the organization design of South Zone to enable its continued evolution.

Improve alignment of positions. The South Zone is currently functionally aligned in a hybrid model. This means that one Senior Operating Officer is accountable for a zone-wide portfolio of programs (Community Programs, including Mental Health & Addictions) and two Senior Operating Officers are accountable for a specific geography (Medicine Hat Regional Hospital and surrounding community sites and Chinook Regional Hospital and surrounding community sites). This hybrid model results in some duplication of work across the zone and creates some challenges for provincial groups to work with the South Zone on zone-wide initiatives. We suggested that the South Zone move to a programmatic model. This means that each Senior Operating Officer would be accountable for a zone-wide portfolio. This would enable better program planning across the zone, better alignment between the South Zone and AHS provincial groups and would help ensure a more equitable focus on acute-based care and community-based care. It would also help reduce duplication of work. In order to make this effective, the South Zone would need to take steps

necessary in ensuring a continued focus on strong site-based accountability. The new programmatic design would not result in a change in the number of managers or layers in the South Zone.

We also suggested maintaining the Dyad leadership model (a physician sharing decision making with an operational leader) in the new design. However, there may be a need for some changes to physician leadership positions to appropriately pair them with operational leaders. Where possible, the position alignment of physician leaders should align with the position alignment of operational leaders. Therefore, if the South Zone moves to a programmatic model with operational leaders having zone-wide accountability for programs, we would expect the dyad physician leaders to have similar zone-wide accountability for programs. This helps facilitate shared decision making as both an operational leader and physician leader would be accountable for the same program, or portfolio of programs.

Improve alignment of accountabilities and authorities. If the South Zone were to move to a programmatic design, it would be critical to align accountabilities and authorities in the new design. Our review identified areas where accountabilities and authorities should be improved. There were instances where managers indicated they were accountable for certain work yet did not feel they had the necessary authority to get that work done. By aligning both accountabilities and authorities in the new design, the South Zone will be able to strengthen local decision making. It would also be important to improve the organizational working relationships between the South Zone and corporate/provincial groups. This involves clarifying what the South Zone is accountable for and what corporate/provincial groups are accountable for. If both groups (the South Zone and corporate/provincial groups) have a strong understanding of what they can expect from the other, it will result in a more effective organization.

Improve alignment of people. We also recommended a revised process for matching people to positions. Our process uses multiple research-based criteria that help ensure people are appropriately matched to positions based on their capabilities and the requirements of the position. It can also provide the foundation for employee development and succession planning. This process considers and accounts for AHS' desire to have their leaders and staff "Live the AHS Values."

Improve alignment of deliverables and tasks. Finally, through interviews with South Zone managers, we discovered that managers spend a large amount of their time on deliverables and tasks that could be done by a lower level resource (e.g. they were doing a considerable amount of administrative work to fill a vacant position). This is both costly for the organization and the individual. It is costly for the organization since AHS is paying a manager to do work that could be done by a more appropriate and less costly resource, and it is costly to the individual since they are spending a large proportion of their time on work that they may consider disengaging. The South Zone should look for ways to elevate the work of managers and ensure they are performing work that is appropriate for their levels and capabilities. This would involve process realignment and task redistribution.

In order to make the new design successful, the organization design changes that were agreed to should be implemented. We recommended the implementation be led by South Zone leadership, with the support of an internal AHS team and external consultants. We believe AHS can do the majority of the work, while we (the external consultants) bring in experience, skills, processes and tools that can expedite the process, develop capability, and enhance the likelihood of success.

Section 1:

Project and report overview

1. Project and report overview

1.1 Background

Alberta Health Services (AHS) is the first and largest province wide, fully integrated health system, and is responsible for delivering health services to over four million people. With over 100,000 employees, it is one of the most complex organizations in Canada. This complexity is further enhanced by the unique relationship between physicians and the organization. Physicians are not part of the traditional "employment hierarchy". Many physician leaders are structured in dyad relationships with administrative leaders, in which there is shared and complementary decision-making. AHS is a traditional management hierarchy with loosely defined cross functional accountabilities and authorities. AHS is organized on both a functional and geographic basis. There are provincial programs (e.g. Mental Health & Addictions), strategic clinical networks (SCNs), corporate support services (e.g. Human Resources), clinical support services (e.g. Pharmacy) and five geographic zones within two sectors. The geographic zones contain the majority of the operations resources across the province. The South Zone is one of three geographic zones within the Central and Southern Alberta sector. The South Zone consists of the Alberta region south of Calgary, including both Lethbridge and Medicine Hat. The South Zone has approximately 5,400 employees, of whom 110 are considered to be people managers.

1.2 Objectives

AHS is looking to improve its organization design in order to improve employee engagement, patient and families' experience, health outcomes, and financial stewardship. It was decided that AHS would initially conduct a smaller scale pilot project that could provide information related to a potential broader approach. The South Zone was chosen for this pilot project. South Zone has historically operated with separate geographic structures (e.g. Acute Care West and Acute Care East) which may be creating unnecessary complexity and increased administrative costs. The assessment would provide recommendations related to improving the alignment of positions and the clarity of accountabilities and authorities. Additionally, the assessment would consider factors such as more consistent care across the zone, better alignment with physician leaders, increased clarity of leadership roles, improved coordination of functions, and a decrease of unnecessarily ambiguity. The second (potential) phase of the project would be to undertake an implementation of the changes that are decided following the assessment.

1.3 Benefits

Capelle Associates has spent over 25 years perfecting our Optimizing Organization Design® approach. This approach was developed to improve organization performance and is based on over 100 large scale projects and 24 research studies that we have completed to date. Our approach provides executives with significant opportunities for improved organization performance, including the following:

Better patient focus

- By providing better alignment and clarity of positions, your employees are better able to focus on what matters – your patients.

Better employee satisfaction

- Our approach leads to recommendations for multiple design improvements, including the manager – direct report alignment. This leads to better relationships with managers and better employee engagement.

Better strategy implementation

- Organization design provides the foundation for strategy implementation. A sub optimal organization design can result in a weaker strategy implementation. Conversely, optimizing organization design provides the foundation for stronger strategy implementation.

Better human resource management

- Our approach provides the foundation for human resources management. This includes all aspects of human resources management including talent acquisition, management and retention.

Better financial performance

- On average, we identify potential annual cost savings of about $2,500 per organizational position. However, the real prize is developing a more effective and efficient organization that produces better financial performance on an ongoing basis.

Significant return on investment

- Based on our current fee structure, and previous engagements, our research shows our reviews lead to an average potential annual return on investment (ROI) of 589%.

Sustainable competitive advantage

- Better financial performance, patient / customer satisfaction and employee satisfaction all help drive your competitive advantage. Since optimizing organization design requires skill and commitment, it can provide a more sustainable competitive advantage that cannot easily be copied.

1.4 Methodology

The following methods were used in this review.

Document review and literature search

Over 50 relevant organization documents were reviewed and a literature search was conducted.

Interviews

Interviews were conducted with 120 individuals within Alberta Health Services, the majority of which were managers within the South Zone (defined as being accountable for the work of others regardless of level or title). Interviews were also conducted with some physician leaders, members of the Executive Leadership Team, and some managers from corporate and clinical support programs.

Interviews were scheduled for up to one hour. The interviews focused on a description and assessment of the nature of work; perceived time span of one's own position; time span analysis for each direct report; managerial work; functional alignment; clarity of managerial and cross functional accountabilities and authorities; strengths; and opportunities for improvements.

Provision of employee information

Employee information was provided to us for 5,413 positions within the South Zone in order to complete organization charts and a vertical alignment analysis for the organization. Information provided includes the position title, name of incumbent, job grade, and immediate manager name, position title and whether the position was currently filled or vacant.

Organization design benchmarking database

Comparative information is provided from our organization design benchmarking database. It includes 70,746 manager-direct report relationships from 85 different organizations. Comparisons to the organization design benchmarking database are used where possible and appropriate throughout the report. This information was supplemented by healthcare specific information gained through the Conference Board of Canada and healthcare benchmark information provided by AHS.

It is important to note that the organization design benchmarking information is compiled from many organizations ranging in size (number of employees), sector (public, private and non-profit) and organization level (number of management layers).

1.5 Project support

We appreciate the exceptional support provided for this project. In particular, the Executive Director, HR Business Partnerships (Central & Southern Alberta) and the Director, HR Analytics & Planning played key roles. As well, we appreciate the contribution of those setting up the interviews, as well as those who were interviewed and the cooperation that they extended to us.

1.6 Consultants

The project was staffed by Ron Capelle, Graeme Capelle, Bob Lavery and Ivanka Dimitrova.

Ronald G. Capelle, President and CEO, has over 35 years of organization experience. He and his colleagues have developed the Optimizing Organization Design® approach. This approach is based on over 100 large scale projects and 24 research studies that they have conducted over the past 25 years. The research and client experience show that this approach leads to better employee satisfaction, better customer satisfaction and better financial performance.

Ron has written *Optimizing Organization Design: A Proven Approach to Enhance Financial Performance, Customer Satisfaction and Employee Engagement* (San Francisco, Jossey-Bass, 2014). This book includes a description of the approach; insightful comments from over 30 executives on their success in using this approach; 23 previously unpublished research studies; and four case studies.

Ron has successfully completed many very complex projects, including improving the operations of an organization in over 60 countries. He has consulted with virtually all types of organizations in the private sector, nonprofit sector and the government sector. He has supported global clients with operations in North America, South America, Europe, Asia, and Africa.

As well as consulting, Ron has completed extensive research into organization design and uses the data to offer clients a customized, proven approach to strategic organization design. This includes benchmarking databases with over 68,300 manager – direct report relationships and over 13,000 employee satisfaction / organization design questionnaire responses.

With a Ph.D. from York University, Ron is also a Certified Management Consultant (CMC); a Certified Organization Development Consultant; a Registered Psychologist (CPsych); a Certified Human Resources Leader (CHRL); and has completed the academic requirements for the Directors Education Program (University of Toronto Rotman School of Management and ICD Corporate Governance College).

Graeme Capelle, Manager, Consulting Services has worked with organizations in both the public and private sectors. This work has included organization design, capital planning, and leading the redevelopment of a comprehensive performance management system.

Immediately prior to joining Capelle Associates, Graeme worked as a Senior Consultant with EY's (formerly Ernst and Young) Health Care Advisory Practice, providing cost improvement, performance management, and organization design advisory services.

Graeme provides consulting services in organization design assessment, implementation and task alignment across a wide range of industry sectors.

Graeme has a B.Sc. from the University of Western Ontario and an MBA from the DeGroote School of Business at McMaster University.

Bob Lavery, Director, Research and Analysis, has worked in the public and private sectors in a variety of positions, including operating his own research, statistics and data management company. He manages our organization design data, statistical analysis and research functions.

Bob has a B.Sc. from the University of Toronto and a M.Sc. from the University of Western Ontario. He has a Ph.D. from Queen's University in Kingston, and was a NSERC post-doctoral fellow at the University of California, Berkeley. He has published research papers in professional journals and magazines.

Ivanka Dimitrova, Manager, Client Services is accountable for providing client services, supporting marketing initiatives, and managing the office at Capelle Associates.

She has over 20 years of experience in administration, office management, and development. Her varied background in different organizations has prepared her to deliver appropriate solutions to complex issues.

With a bachelor degree in Literature, and an educational background in economics and web design, Ivanka continues to expand her academic career and is currently pursuing her CGA designation.

Section 2:

Organization design principles

2. Organization design principles

We believe there are some principles foundational to optimizing organization design. Since organizations go through ongoing change, working within these principles provides the flexibility of being able to change the design of an organization on an as-required basis, while at the same time also maintaining a strong and consistent framework. Application of these principles will vary depending on the situation. In some instances, AHS may determine that a principle is not appropriate for a specific situation and choose not to apply it. These variances should be tracked and monitored as part of an internal process. It is important to note that these principles are not a replacement for management judgment. We would suggest adopting the following principles.

Aligning positions

- AHS, and the South Zone in particular, should have the optimal number of strata.
- Every position should be in the right stratum.
- Position titles should be used in a consistent and stratum appropriate manner.
- Each stratum can be divided into sub strata. The strata should become a foundation for human resources management systems such as position evaluation, succession planning, career planning and compensation.
- Every employee (with the exception of direct output support roles (e.g. Executive Assistants)) should have a manager exactly one stratum above, both in terms of complexity of work done and capability to work at that level.
- Spans of control (number of direct reports) should be optimal for the required work.
- Functional alignment should be set up on a primary and secondary basis. Types of organizing could include geographic and programmatic.

Aligning accountabilities and authorities

- Accountabilities and authorities should be clear and appropriate for each type of position (e.g. manager, physician leader, employee, etc.).
- Managers should be accountable for their direct reports, and all employees should be accountable for using their best efforts (doing their best).
- Cross functional accountabilities and authorities should be clear and appropriate, specifically related to provincial groups and zones.
- Every employee should have only one manager, but may have multiple cross functional relationships.
- Cross over point managers should manage the “white space” between direct reports, provide appropriate context and prescribed limits, and provide context clarification and issue resolution mechanisms.
- The appropriate managerial and cross functional accountabilities and authorities should be established for all processes.
- The organization design framework, particularly related to accountabilities and authorities, should be used for all projects.

Aligning people, deliverables and tasks

- Employees should be matched to positions in terms of information processing capability, skilled knowledge and application. These criteria consider and account for AHS' desire to have their leaders and staff "Live the AHS Values".
- Employees should be working at the appropriate level of complexity for the stratum of their positions.
- Employees should be completing tasks that are appropriate for their level of work.

Suggested action:

1. The organization design principles presented should be adopted and adhered to.

Section 3:

Towards optimal organization design

3. Towards optimal organization design

In this chapter, we will provide our analysis and recommendations on moving toward optimal organization design within the South Zone. There are several points that should be noted in reading this chapter.

The first point is that the suggestions in this chapter (and the report in general) are intended to be input to managerial judgment and decision making rather than a "carved in stone" set of recommendations. Because we specialize in organization design, and can provide different perspectives on analysis and understanding, our view is that we can help managers make better decisions. However, at the end of the day, this is about management judgment.

The second point is that we have organized the sections of this chapter around our five organization design criteria (aligning positions, accountabilities and authorities, people, deliverables and tasks). We have also provided suggested actions throughout the chapter. Most of the suggested actions are around higher-level decisions (e.g. higher-level position alignment). Much of the other analysis is not intended for initial executive decision making but rather for a more detailed implementation process.

The third point is that we do provide some organization charts with suggested position alignment in the functional position alignment sub-section. These are more high-level charts that are useful in initial decision making related to the functional alignment of the South Zone. Further work will be required to determine exact position alignment as part of a comprehensive implementation.

The fourth point is that in this review we did not assess any individuals. This review is about understanding the work, and making decisions on optimal ways of doing it. Any assessment of individuals would come in a Talent Pool process that would ideally be a part of implementation.

The final point is that this chapter in particular, and this report in general, are not intended to be just a stand-alone document. They are intended to provide the basis for discussion and decision making. Out of this will come the best decisions.

3.1 Aligning positions

This section will introduce our recommendations on position alignment within the South Zone. We will provide a brief primer on vertical alignment methodology, provide our vertical alignment analysis, and provide by an overview of what we believe the vertical alignment should be, including a description of what we believe the core work of the zone is. We will then provide some options for a functional alignment of positions, including our suggested option.

Vertical alignment primer

We define an organization as a stratified human system. It is stratified because there is a hierarchy in terms both of position titles (e.g., manager, director, and vice president) and of compensation (job evaluation systems determine different levels of compensation for different positions). It is also stratified because there is a hierarchy of reporting relationships (one position "reports to" another).

Hierarchy is a fact: It is universal and incontestable. Our approach does not create hierarchy - we find it in every organization we go into. We find different levels of position titles, compensation, and reporting relationships. Some may prefer to not have a hierarchy - some even pretend that it does not exist. We do not consider this to be helpful. However, it is important to remember that this is a hierarchy of work, not of human worth. All human beings should be valued and treated with respect. Further, all levels of work in an organization are critical to its success. To think that people who occupy lower positions in the work hierarchy have less value as human beings is misguided and harmful. The question is not how you can get rid of a hierarchy. Rather, it is how to set it up in the most effective, efficient, and fair way.

Jaques (1996) and his colleagues discovered a method to measure a position's complexity. The method is ''time span,'' which is the deliverable with the longest target completion time in a position. They determined that there is a universal system of organization strata. Each stratum is different in terms of the nature of the work, its complexity, and the information processing capability that an individual requires to function in that stratum.

One of the important implications of appropriate stratification is that every employee should have a manager exactly one stratum above, in terms of both the complexity of work and information processing capability. This is called requisite manager–direct report alignment (Jaques, 1996). There are two suboptimal alignments.

The first is when a manager and direct report are in the same stratum. This is called compression. This situation is not reflected in an organization chart, which is just boxes drawn on a piece of paper. It is only when you understand the complexity of the work that you can identify the problem. Some symptoms of compression are lack of clarity, redundancy, confusion, and conflict. The manager is being paid extra money to be a manager but is not providing the necessary level of work and the organization is not getting full value for its money. The direct report will often be micromanaged and consequently not use all of their capability. This is a good example of how poor organization design results in both employee dissatisfaction and reduced financial performance.

The second suboptimal alignment is when a manager and direct report are more than one stratum apart. This is called a gap. The manager is at too high a level relative to the direct report: there is a missing position between the two. Symptoms of a gap may include a manager complaining that the direct report has no

initiative and/or the manager being "pulled down into the weeds." Another symptom of a gap can be a direct report complaining that the manager gives no direction. These complaints generally are treated as a performance issue when there is actually a structural defect caused by a missing position.

Vertical alignment analysis

In this section of the report we will analyze the vertical alignment of the South Zone. This section deals with a snapshot of the South Zone at a point in time, and as such is a useful tool for understanding the current accountability hierarchy and where improvements can be made. This section of the report does not take into account any subsequent changes to the organization design that may be required as a result of decisions on recommendations made later in this report.

The information shown within this chapter is based on the employee data provided to us by AHS, as well as the information collected in the interviews. It should be noted that some changes were taking place as this review was being conducted. Not all of these changes are reflected in this analysis.

In this chapter we will compare the South Zone information to our organization design benchmarking database, which includes 70,746 manager-direct report relationships from 85 different organizations. Comparisons to the organization design benchmarking database are used where possible and appropriate throughout this chapter.

It is important to note that the organization design benchmarking information is compiled from many organizations ranging in size (number of employees), sector (public, private and non-profit) and organization level (number of management levels). It is also important to note that this database is from organizations before they have completed organization design improvement. Therefore, the benchmarking information is not aspirational, but rather the baseline from which organizations can make improvements. Supplemental information was collected to provide context for the healthcare industry

Overview

A complete accountability hierarchy for all 5,413 South Zone positions was prepared. For each position in the accountability hierarchy the following information is provided:

- The unit in which the position resides
- the title of the position
- the name of the incumbent in the position
- the stratum of the position, as measured by time span (TS), is provided by the manager and is found immediately below the name of the incumbent
- the stratum of the position, as perceived by the incumbent, is found immediately below the time span. This is referred to as self span (SS) and is used as a check on clarity of delegation
- the location of the position
- the head count total (total number of employees)

For each comparison in this chapter, the scores for the South Zone are shown, followed by the comparative benchmarks from our database.

We also divided the South Zone into 3 groups based on the Senior Operating Officers (SOO) to provide additional insight into the organization (*Table 3.1-1*).

Number of employees by Senior Operating Officer

Table 3.1-1

		Frequency	Percent
Group	SOO - Acute East	1160	21.4
	SOO - Acute West	1516	28.0
	SOO - Community	2701	49.9
	Other	36	.7
	Total	5413	100.0

The 3 groups are Acute East, Acute West, and Community (charts #30 to #91). 36 positions, most from quality improvement, are not included in the group analysis.

Percentage of managers and span of control

The distribution of AHS manager positions, that is, employees with direct reports (2.0%, n = 110 / 5,413) is significantly lower than our benchmark database (11.9%, n = 10,218 / 85,985, X^2 = 493.1, P < 0.001, *Table 3.1-2*).

Percentage of managers

Table 3.1-2

		Comparison	
		AHS	Benchmark
Manager	Yes	2.0%	11.9%
	No	98.0%	88.1%
Total		100.0%	100.0%

The percentage of managers for the South Zone does not vary significantly among the 3 SOO groups (X2 = 2.95, P < 0.229, *Table 3.1-3*). All three groups have very low percentage of managers.

Percentage of managers by Senior Operating Officer

Table 3.1-3

		Manager		Total
		Yes	No	
Senior Operating Officer	SOO - Acute East	1.6%	98.4%	100.0%
	SOO - Acute West	1.6%	98.4%	100.0%
	SOO - Community	2.3%	97.7%	100.0%
Total		2.0%	98.0%	100.0%

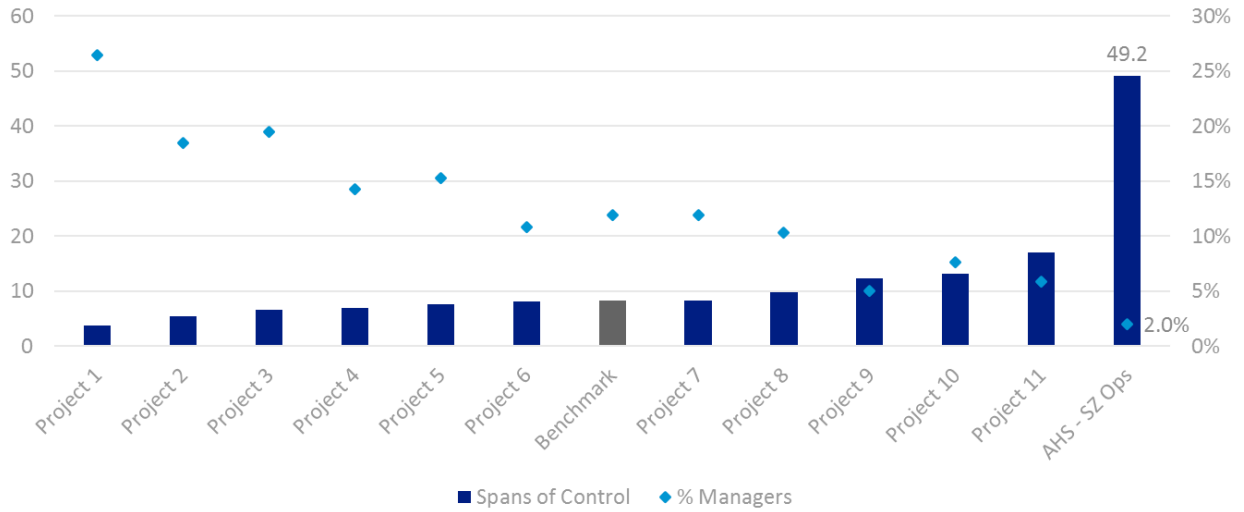
The average span of control of the South Zone (i.e. number of direct reports, 49.20) is notably higher than our benchmarking database (mean = 8.30, t-test, t = 6.94, P < 0.001, *Table 3.1-4*).

Average span of control

Table 3.1-4

		N	Mean	Std. Deviation
Average Span of Control	AHS - South Zone	110	49.20	34.228
	Benchmark	10058	8.30	14.761

A comparison of our 12 most recent projects reviewing organizations with >100 managers shows that the South Zone represents a significant outlier in both percentage of managers and span of control (*Figure 3.1-1*).



Comparison of span of control and %managers by project

Figure 3.1-1

With respect to the Senior Operating Officer groupings, Community had the lowest span of control (43.55) while Acute East and Acute West both had spans of control over 60 (*Table 3.1-5*).

Average span of control by Senior Operating Officer

Table 3.1-5

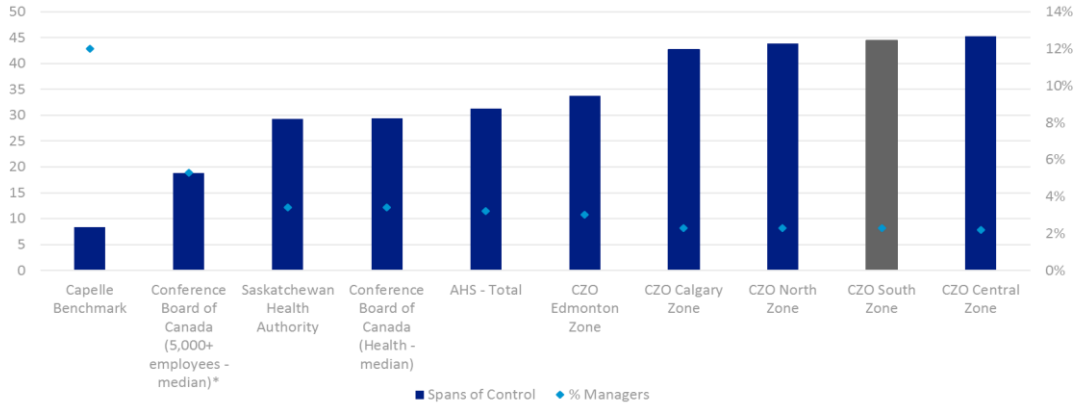
		Mean	N	Std. Deviation
Senior Operating Office	SOO - Acute East	61.00	19	43.487
	SOO - Acute West	60.60	25	34.504
	SOO - Community	43.55	62	28.845
	Total	50.70	106	33.947

The difference was significant among the groupings of Senior Operating Officers (ANOVA, F = 3.47, P = 0.035). A multiple comparison test (Fisher's LSD method) revealed that Community had a lower span of

control than the other 2 groups. The same test showed that the span of controls of Acute East and Acute West did not differ significantly.

These span of control numbers are directly related to the percentage of manager numbers that we have just reviewed; the higher the percentage of managers, the lower the span of control. Two additional points should be made.

First, AHS has conducted a previous study related to spans of control related to healthcare comparators. This information from peer healthcare organizations in western Canada and a Conference Board of Canada report (*Talent Management Benchmarking: Human Resources Trends and Metrics, Fourth Edition,* Conference Board of Canada, 2017) shows that the South Zone has one of the lowest percentages of managers and highest spans of control within AHS and is higher than the Canadian healthcare median. These span of control calculations differ slightly from our methodology. We include vacant positions as part of our calculations, and these other calculations do not. That is why the South Zone calculation of span of control provided by AHS (44:1) is slightly different than our result (49:1).



Comparison of Healthcare span of control and %managers (excluding vacancies)

Figure 3.1-2

The second point is we realize health care organizations do tend to have lower percentages of managers and higher spans of control than other types of organizations. Our benchmark consists of a broad range of organizations, and we will certainly not be recommending our benchmark is something that AHS should aspire to. However, taking into account both points, we believe there are more modest improvements that could be made, and we will be discussing them in this chapter.

Layering analysis

An overview of the vertical alignment, based upon time span analysis, is shown in *Table 3.1-6* to *Table 3.1-9*. These tables provide a comparison between AHS and our organization design benchmarking database. The layering results are summarized below.

Currently, the South Zone has up to 6 layers. This is measured by counting the number of layers between a front-line worker and the Chief Zone Officer and including both of these top and bottom layers in the count.

Looking more closely at the SOO groups within AHS, we find that Community has 5 layers each while Acute East and Acute West has 4 layers (*Table 3.1-6*)

Number of layers by Senior Operating Officer

Table 3.1-6

		Number of Layers	Head count
Senior Operating Officer	SOO - Acute East	4	1160
	SOO - Acute West	4	1516
	SOO - Community	5	2701

Table 3.1-7 shows the percentages of manager-direct report relationships in this sample that are requisite (manager time span is one stratum above direct report time span), compressed (manager and direct report have same time span), or have gaps (manager time span is more than one stratum above direct report time span). We compare this with our organization design benchmarking database. Again, it should be noted our benchmark consists of organizations that have been reviewed before improving their organization designs. Therefore, these numbers are not aspirational.

Layering analysis

Table 3.1-7

		Comparison	
		AHS - South Zone	Benchmark
Layering	Requisite	80.3%	54.0%
	Compression	12.6%	36.7%
	Gap	7.1%	9.2%
Total		100.0%	100.0%

Administrative positions are not included in this analysis. This exception recognizes that, in this type of direct output support position to a manager, it can be appropriate to have the two positions more than one stratum apart.

We found that there is a higher percentage of requisite manager-direct report relationships in the South Zone (manager exactly one stratum above direct report) relative to the benchmarking database (80.3% vs. 54.0%, *Table 3.1-7*).

There is less compression (manager and direct report in same stratum) than the benchmark (12.6% vs. 36.7%). The proportion of gaps (manager more than one stratum above direct report) is slightly lower than the benchmarking database (7.1% vs. 9.2%). The distribution of these AHS numbers is significantly different than our benchmark database ($X2 = 1201.0$, $P < 0.001$).

There was a notable difference among the 3 groups with respect to the distribution of layering situations ($X2 = 563.7$, $P < 0.001$, *Table 3.1-8*).

Layering analysis by Senior Operating Officer

Table 3.1-8

		Layering			Total
		Gap	Requisite	Compression	
Senior Operating Officer	SOO - Acute East	6.2%	93.3%	.6%	100.0%
	SOO - Acute West	.8%	92.8%	6.3%	100.0%
	SOO - Community	11.8%	65.5%	22.7%	100.0%
Total		7.1%	80.6%	12.3%	100.0%

Acute East and Acute West have the highest percentage of requisite situations (93.3% and 92.8% respectively) while Community has the lowest percentage of requisite situations (65.5%). The highest compression is in Community at 22.7%. The high compression in Community is likely related to home care RNs and Managers having Stratum 2 time spans due to their annual accountabilities.

It should be noted that our research shows that the manager – direct report alignment is the single most important sub factor of organization design. It is, by itself, directly related to employee satisfaction, customer satisfaction and financial performance.

An important point to be made is that this information shows a significant number of requisite situations (80.6%) within the South Zone. This metric, by itself, would be a positive outcome for the organization as it shows that the majority of employees are working in an optimal situation. However, we believe that this number is misleading. The reason behind such a positive number is that the majority of non-managerial employees were given Stratum 1 Time Spans. Managers would then be (predominantly) given more annual budgetary accountabilities resulting in a Stratum 2 Time Span. Therefore, the majority of manager-direct report alignments show as requisite. However, we would expect the South Zone Managers to actually operate at the Stratum 3 level, and a large portion of the South Zone employees to ideally operate at the Stratum 2 professional level. Therefore, the seemingly positive requisite alignment number appears to be an artifact of a negative factor. Positions appear to be in a requisite Stratum 2 – Stratum 1 alignment. However, many positions are operating at too low a level (e.g. manager positions and professional level positions). There should actually be a Stratum 3 – Stratum 2 – Stratum 1 alignment.

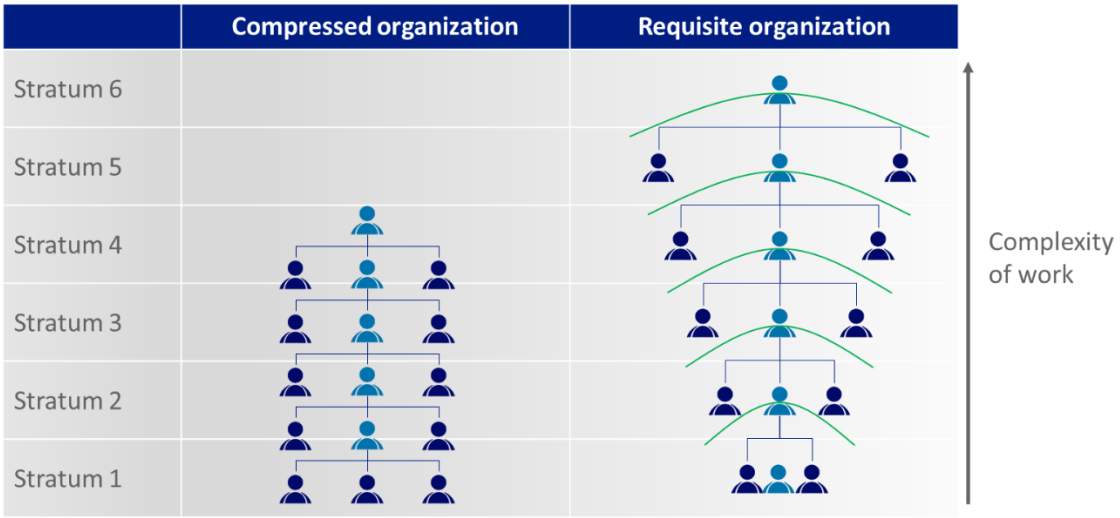
We conducted further analysis to better understand this situation. We tagged each manager with a Time Span that we would expect based on what we assume to be their optimal Strata. We then compared this information with their actual Time Spans. This is shown in *Table 3.1-9*.

Manager Time span (actual and optimal) cross tabulation

Table 3.1-9

			Optimal Time Span					Total
			1	2	3	4	5	
Actual Time Span	1	Count	0	3	1	0	0	4
		% within Time Span	0.0%	50.0%	1.4%	0.0%	0.0%	
	2	Count	0	3	64	4	0	71
		% within Time Span	0.0%	50.0%	87.7%	36.4%	0.0%	
	3	Count	0	0	8	2	0	10
		% within Time Span	0.0%	0.0%	11.0%	18.2%	0.0%	
	4	Count	0	0	0	5	4	9
		% within Time Span	0.0%	0.0%	0.0%	45.5%	100.0%	
	5	Count	0	0	0	0	0	0
		% within Time Span	0.0%	0.0%	0.0%	0.0%	0.0%	
Total		Count	0	6	73	11	4	94
		Count within Optimal Time Span	N/A	3	8	5	0	16
		% within Optimal Time Span	N/A	50.0%	11.0%	45.5%	0.0%	17.0%

What we found was that only 17% of managers had a time span that we would consider optimal. This issue was particularly prevalent at the Stratum 3 Manager level (11.0%) and the Stratum 5 SOO level (0.0%). This leads us to believe that the South Zone is a fundamentally a compressed organization as illustrated in *Figure 3.1-3*. It's important to note that even if managers would choose to, and be capable of, working on longer time horizons, the organization may not create an environment that is conducive to this (e.g. annual planning cycle).



Compressed and requisite organizations

Figure 3.1-3

Suggested action:

2. There are issues with percentage of managers, spans of control and manager-direct report alignment. These should be resolved as part of an integrated initiative to optimize organization design.

Vertical alignment of positions

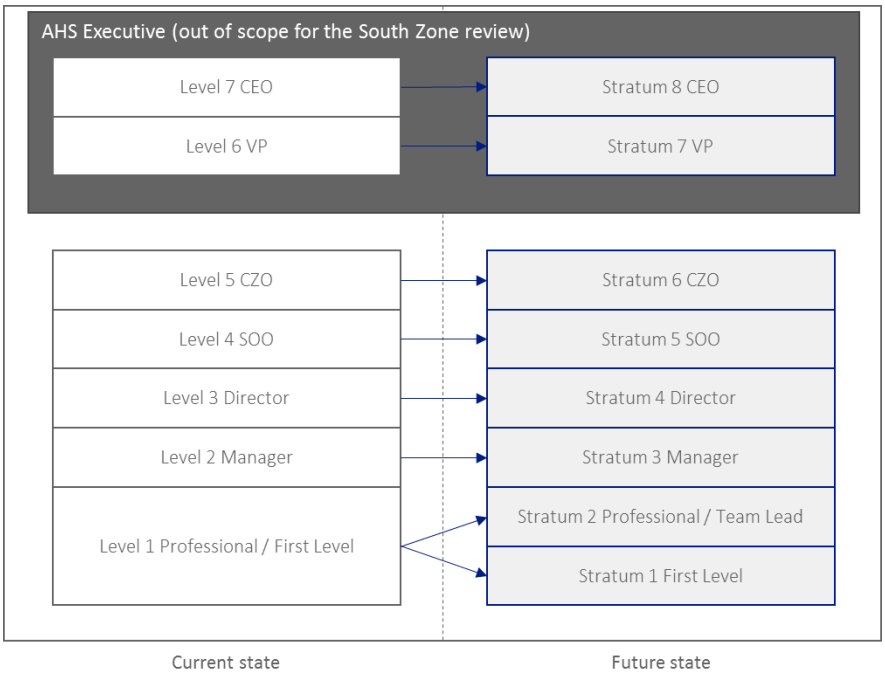
Based on our analysis, we will introduce what we believe the core work of the organization is, and how Stratum 3 service delivery units can become the building blocks for the South Zone's organization design. We will then outline what the stratum of the South Zone should be and discuss how we believe this fits into the broader AHS organization as a whole.

An organization should be properly stratified. Stratification is based on the complexity of work which is influenced by the size of the organization. As previously discussed, there is considerable research showing that each stratum of work is fundamentally different. Each stratum has a different nature of work, a different complexity of work, and a different information processing requirement for individuals in that stratum. What one often finds in an organization (as is the case for AHS), is that there are layers of positions but not strata. The layers are not research based or operationally defined, and therefore lead to various issues.

The most fundamental issue is that the current first level in the South Zone (and in AHS) actually has two different levels of work that should be in different strata. In Stratum 1, we would expect to find first level positions in which the work can be largely proceduralized. This is important work and still requires judgment, but procedures can be used to get most of the work done. More complex issues can be raised to a higher-level position. The first level would include positions such as Health Care Aides. It should be noted that each stratum can be divided into sub strata. So, different positions might both be at a Stratum 1 level, but might be in different levels of sub strata.

In Stratum 2, the work requires dealing with more complex situations in which procedures can't be used to get most of the work done. There is a greater requirement to "get beneath the surface" to figure things out. This requires a cumulative or diagnostic capability. This is the stratum in which we would typically find most professional positions (Registered Nurses, Physiotherapists, etc.) and often the first level of management positions. We believe that this Stratum 2 professional work is the core level of work of AHS.

So, when we understand the complexity of work, and properly stratify it, we have six strata instead of the current five levels. This is shown in *Figure 3.1-4*.



Current and future state organization
Figure 3.1-4

It is important to note that properly stratifying the work does not mean adding more layers of management. In fact, we would suggest that the South Zone has, for the most part, the right number of managerial layers. Stratifying the South Zone remedies several issues. First, it provides an opportunity to correctly recognize the complexity of work, resolve the current issue of two different levels of positions being incorrectly seen as being at the same level, and develop proper stratification. Second, the manager positions are not operating the right level of complexity and can be pulled up to the appropriate Stratum 3 level. We will have more to say about this shortly since we believe that the Stratum 3 managers should be "running the operations". If they are operating at too low a level, as we believe is currently the case, they pull down the whole organization. Third, our research and client experience shows that every employee should have a manager exactly one stratum above (both in terms of the complexity of work done and the capability to work at that level). This stratification supports that happening.

Once the South Zone appropriately stratifies the Stratum 1 first level employees, Stratum 2 professionals and Stratum 3 managers, they can build effective Stratum 3 service delivery units.

Suggested action:

3. Stratum 1 first level positions, Stratum 2 professional positions and Stratum 3 manager positions should be properly stratified within the South Zone.

Stratum 3 service delivery units

In the South Zone, service delivery units – led by either managers (e.g. Manager of Home Care) or unit managers (e.g. Manager, Inpatient Psychiatry) – often contain a mix of both professional and first level

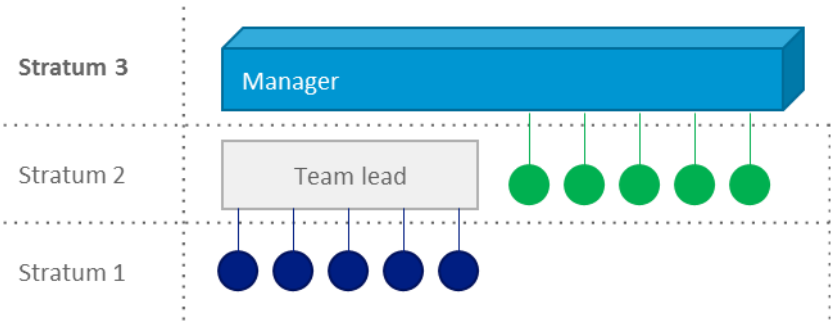
employees. We believe that these units should be the accountability of a Stratum 3 manager. The Stratum 3 managers should be accountable for an optimal number of direct reports that enable them to perform the required managerial work. Currently, as structured, we do not believe this is possible due to the extremely high spans of control. Throughout the report we provide suggestions on how to decrease the current spans of control and improve the work of the zone. One suggestion is through the introduction of Stratum 2 team lead positions, which is discussed in the following paragraphs.

In addition to improving the spans of control, these service delivery units could be more optimally designed to elevate the work of the Stratum 3 manager and ensure that they have the capacity to do true managerial work.

The starting point in redesigning the units is understanding the work within them. It is our belief based on interviews and our document review, that RNs and Allied Health professionals should generally be Stratum 2 professional positions. However, we have some reservation in that we are unsure how consistently they perform Stratum 2 work, compared to how often they perform Stratum 1 work. This is an important point that we will discuss later in the report. Nonetheless, the Stratum 3 manager position should be the manager for all Stratum 2 professional positions. This would be in keeping with the recommended manager-direct report alignment.

We also believe that there are Stratum 1 positions. These would appear to include Health Care Aides and Unit Clerks. We are not entirely clear about the LPN role. Further task analysis could add clarity to this situation.

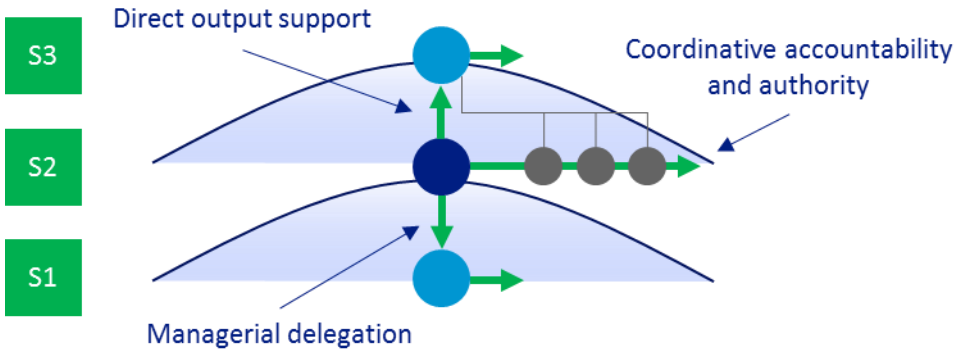
If the manager should be at a Stratum 3 level, and if the direct report professional positions should be at a Stratum 2 level, and first level positions should be at a Stratum 1 level – we have a problem. There is a gap between the Stratum 3 manager and the Stratum 1 positions. Our research shows that this results in a disconnect that negatively impacts both performance and satisfaction. The recommended solution is to create Stratum 2 team lead positions to be accountable for Stratum 1 positions. This is shown in *Figure 3.1-5*.



Stratum 3 service delivery unit
Figure 3.1-5

This Stratum 2 team lead could have managerial accountability and authority for the Stratum 1 positions. The Stratum 2 team lead could also have coordinative accountability and authority for Stratum 2 professional positions. This could include accountability for shift staffing, scheduling, assigning work, etc. Lastly, the Stratum 2 team lead could provide direct output support to the Stratum 3 manager. This could

include providing support for various improvement initiatives. A visualization of the work of the Stratum 2 team leads is provided in *Figure 3.1-6*. AHS would need to take a measured approach in the design and implementation of this position to ensure there is alignment with the team-based care model.



Work of the Stratum 2 team lead
Figure 3.1-6

There is probably some similarity between this suggested team lead position and existing clinical leader positions seen on some inpatient units. However, we believe there could be significant value in bringing these accountabilities into an out-of-scope Stratum 2 team lead position that has managerial accountabilities for Stratum 1 positions. Benefits could include improving the span of control of the Stratum 3 managers, reducing some of the 'day to day' managerial burden of the Stratum 3 manager, and improving the work performance and employee satisfaction of Stratum 1 employees by ensuring they report to a position exactly one stratum above.

Suggested action:

4. In some cases, Stratum 3 service delivery units should be strengthened by the introduction of a Stratum 2 team lead position.

Stratum 6 Organization

Based on our analysis, we believe that a Stratum 6 configuration is appropriate for a Zone. The only qualification that we would have is that South Zone is the smallest of the zones. However, there is too much complexity to try to shrink it down to a Stratum 5 level. *Table 3.1-10* shows the types of positions within the South Zone we would expect to see at each stratum, as well as their expected time spans and information processing requirements. Further description of the time spans and information processing requirements can be found in the organization design primer.

South Zone strata and positions

Table 3.1-10

Level or Stratum	AHS Position	Time Span	Information Processing
6	CZO	10 – 20 years	Abstract cumulative
5	SOO	5 – 10 years	Abstract declarative
4	Director	2 - 5 years	Parallel (if and only if)
3	Manager	1 – 2 years	Serial (if then… then)
2	Team Lead or Professional	3 – 12 months	Cumulative (and-and)
1	First Level Position	0 – 3 months	Declarative (or-or)

What are the implications for the vertical alignment of AHS? Above the CZO we have a Vice President position, and above the Vice President position we have a President & CEO position. This would make AHS a Stratum 8 organization. While we have not analyzed these two upper levels, this would appear to be a possible outcome. When AHS was set up, there was a relatively arbitrary decision that it should have 7 layers of management (there was no analysis of complexity of work). AHS is an extremely large and complex organization. Healthcare is complex and the core level of work is Stratum 2 professional work (this is an extremely important point in understanding complexity and strata). Further, it has about 100,000 employees. That would make it one of the largest organizations in Canada. In terms of comparators, at a Stratum 7 level, we would expect to find smaller Canadian banks, Canadian national railways, major Canadian retailers and federal government departments. Given the differences in complexity and size relative to AHS, given our analysis, and given some comparators, we would be comfortable with this likely Stratum 8 outcome, notwithstanding that additional analysis would create a more complete picture.

Suggested action:

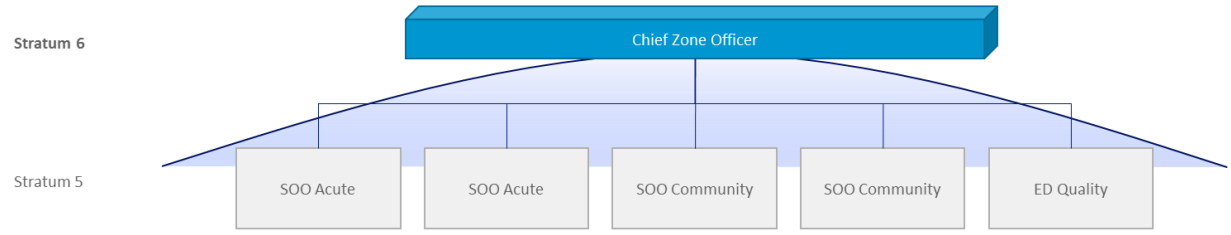
5. The South Zone should be a Stratum 6 (6 level) configuration.

Functional alignment of positions

Now that we have identified what the Stratum of the organization should be and what the core work is, we can begin to design the functional alignment. If we view organization design as both a science and an art, the science would be the vertical position alignment and the art would be the functional position alignment. We believe that this functional alignment should be driven by the organization's strategy, which is why we presented three options for functional alignment during an options analysis workshop. Participants at this workshop included members of the Executive Leadership Team, the South Zone Leadership Team and Human Resources. The following section of the report will discuss each option, including their strengths and risks to mitigate. We will also provide our suggested option moving forward. In reading this section it's important to remember that there are usually several options that are available to an organization as long as managerial and cross functional accountabilities and authorities are appropriately set up.

Option 1: Hybrid design

The first option is to maintain a very similar design with the introduction of one addition Community Senior Operating Officer. This is shown in *Figure 3.1-7*.



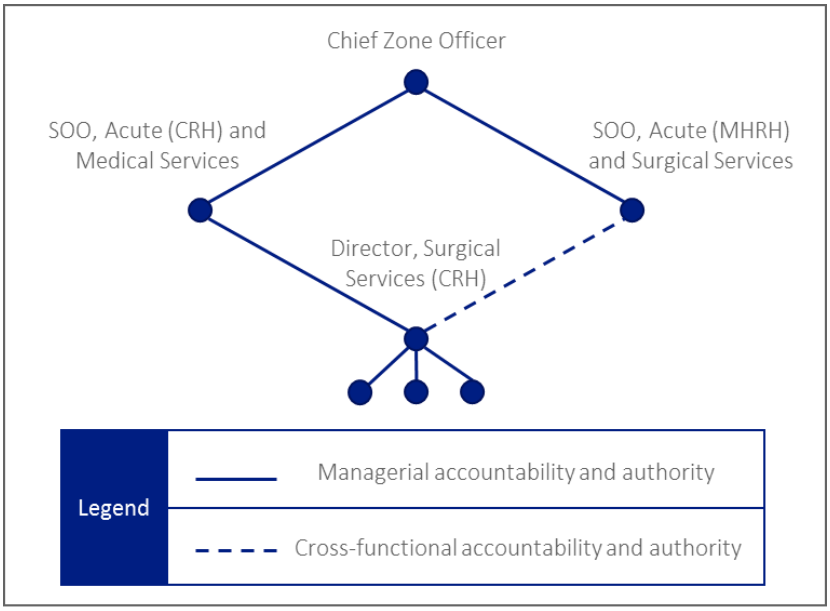
South Zone hybrid design
Figure 3.1-7

Strengths

- **Least disruption to the Zone.** Organization design can be a resource drain on the organization and there should be a strong strategic reason to dramatically shift the functional alignment of the organization.
- **Strong site-based presence.** Each Acute SOO would be managerially accountable for one of the regional hospitals so services could be more easily planned around each hospital's unique requirements.
- **Equitable SOO workloads.** The current Community SOO has a head count of ~2,700 people in their organization and a span of control of 9. Both these number are significantly higher than the Acute East and Acute West SOOs. This design would alleviate some of the perceived work imbalance.
- **Stronger emphasis on community-based programming.** Having two SOOs accountable for acute care and one SOO accountable for community-based care creates a perception that there is a greater focus on acute care which runs counter to AHS' strategic direction of "bringing appropriate care to the community." Adding an additional Community SOO would rebalance this focus.

Risks to mitigate

- **Program planning.** Maintaining two Acute SOOs that are managerially accountable for a regional hospital can result in challenges to program plan across the Zone.
- **Single point of program accountability.** If a SOO has managerial accountability for a regional hospital there would, by definition, be two points of accountability for multiple programs (e.g. Surgical Services east & west). One way to get around that situation is to add a cross functional programmatic accountability for each SOO. An example of this would be the SOO, Acute is managerially accountable for the Medicine Hat Regional Hospital (MHRH) and has a cross-functional, coordinative accountability for Surgical Services. Conversely, the SOO Acute that is managerially accountable for the Chinook Regional Hospital (CRH) could have cross functional accountability for Medical Services. This is shown in the figure below.



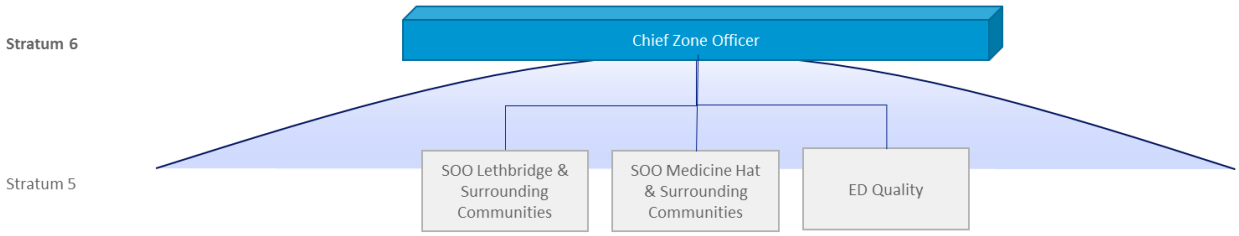
This solution would still require unique directors at each site (e.g. Director, Surgical Services MHRH and Director, Surgical Services Chinook). It could also limit the Directors' ability to specialize since there are duplicative Directors across each site.

- **East / west silos.** It was identified multiple times during discussions that there are silos between the eastern and western parts of the zone. We would have some concern that maintaining a SOO as managerially accountable for each site (Medicine Hat and Chinook) could discourage breaking down these silos and could be less conducive of working across the zone. There would also continue to be duplication of work across the zone.
- **Community programs with elements of acute care.** The community programs would still have managerial accountability for some acute units (e.g. Acute Inpatient Psychiatry) that could add further complexity to the design.

There are some substantive benefits to this design. However, our concern is the added complexity that comes with some SOOs having managerial accountability for a site (e.g. Medicine Hat Regional Hospital) and some SOOs having managerial accountability for a program (e.g. Mental Health). Our preference is to functionally design on an 'either-or' basis as much as possible (e.g. program or geography) to limit the complexity. Additionally, one of the major drivers of the review was to identify a design that encouraged more consistency across the zone, which this would not necessarily accomplish. However, we can certainly see benefits to this approach and feel it can be made effective assuming cross functional accountabilities and authorities for acute programs are made clear.

Option 2: Geographic design

The second option is to develop a geographic design with SOOs being accountable for a specific site and their surrounding communities. This is shown in *Figure 3.1-8*.



South Zone geographic design
Figure 3.1-8

Strengths

- **Geographic divides are real.** Zones seem to be created around both electoral divisions and referral patterns. These seem less tangible than the true community divides that exist between Lethbridge, Medicine Hat and the surrounding communities. An argument could be made that the organization should be designed directly around the communities that are served. This is not an uncommon approach in general, or health care in particular.
- **Stronger community-based planning.** Designing around communities can help enable stronger, and longer-term, community-based planning.

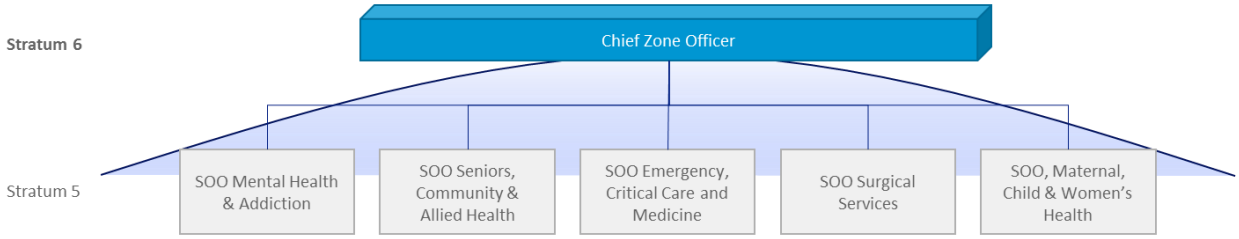
Risks to mitigate

- **Program planning.** The issue of program planning becomes amplified with two SOOs that are managerially accountable for a specific geography.
- **Single point of program accountability.** Similarly, to option #1, there would be two points of managerial accountability for all programs. The solution of creating cross functional accountabilities and authorities for programs for each SOO may be less feasible since the positions would have extremely large roles already.
- **East / west silos.** This would exacerbate the current silos that exist between the east and the west. It would represent a movement to a design that more closely aligns to the former health regions, which is something AHS is looking to move away from. There would also continue to be duplication of work across the zone.

We recognize that this option may not be feasible and runs somewhat counter to many of the reasons AHS chose to conduct the review. However, we wanted to present this option since we have some questions regarding the size of the South Zone. The South Zone currently has ~5,000 employees in an organization of ~100,000. We believe it could be designed around two fairly clear Stratum 5 geographical units which leads us to question whether it is the optimal size for a Stratum 6 organization. This is something that can't be answered as part of this review, but if further organization design work takes place, we would suggest this be a question AHS considers.

Option 3: Programmatic design

The third option is to develop a programmatic design with SOOs being accountable for specific programs. This is shown in *Figure 3.1-9*. Note: *Figure 3.1-9* shows a potential option for the division of programs based on our discussions throughout the process. However, this specific programmatic division should be further reviewed to ensure it best meets the needs of the patient population.



South Zone programmatic design

Figure 3.1-9

Strengths

- **Program planning.** AHS seems to be organized in such a way that places emphasis on longer-term program planning (e.g. developing mental health & addictions services to be best meet the needs of a changing patient population). Creating SOO positions that are accountable for unique programs would encourage this focus within the South Zone. In addition, increasing the number of Stratum 5 SOOs could provide the "bandwidth" to focus on more longer-term accountabilities and authorities at a program level. This could also be cascaded down the organization, where Directors are accountable for a single program or sub-program (e.g. obstetrics) instead of the current alignment where Directors are accountable for multiple programs.
- **Alignment between the South Zone and AHS provincial groups.** As currently structured, provincial programs and SCNs have to work with multiple stakeholders from the east and west to implement zone-wide programming. This can create added complexity and duplication of work. Creating single points of program accountability below the Chief Zone Officer can help reduce this issue.
- **Acute and community-based focus.** As currently structured, the Chief Zone Officer is the cross-over point manager between community-based programs and acute hospitals (three SOO positions). This makes it more difficult to shift resources between acute care and community-based care as required. As AHS looks to continue shifting care into the community, creating single points of program accountability could enable this since leaders are accountable for the budget in both acute and community-based settings.

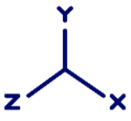
Risks to mitigate

- **Site-based accountability.** The major concern regarding this design is you are removing a site-based managerial accountability at the SOO level. Therefore, the Chief Zone Officer would ultimately be the single point of managerial accountability for both the Medicine Hat Regional Hospital and Chinook Regional Hospital. It's important to remember that while the managerial accountability and authority would be removed from the SOOs, the South Zone could build in a number of supports that would allow the appropriate site-based accountability and authority to remain:

  - Stratum 3 managers should be localized as much as possible when resource numbers justify it. If resource numbers don't justify a local Stratum 3 manager, consideration could be made to ensure there is a local Stratum 2 team lead presence.

  - The South Zone could maintain Stratum 4 program directors in each regional hospital to assist with a smooth transition. This would mean the Stratum 4 program directors may not be as specialized (e.g. Director, Maternal, Child & Women's Health vs. Director, Obstetrics). However, keeping a site-based position would mean the Stratum 3 managers have more direct leadership support. This may be necessary until AHS is able to elevate the work of Stratum 3 managers.

  - Stratum 5 program SOOs that are localized to the regional hospitals could be delegated strong cross functional accountabilities and authorities relative to the directors and managers on-site for emergency / urgent issues. This could include cross functional accountabilities and authorities like coordinating, stopping and prescribing. So, while the managerial relationship is to the programs, SOOs that have cross functional accountabilities and authorities for the sites could deal with issues that require immediate action.



  - Stratum 3 site managers should be maintained and cross functional accountabilities and authorities should be aligned for site coordination and patient flow. These Stratum 3 site managers could report directly to the Stratum 5 program SOOs that have site-based cross functional accountabilities and authorities. While this would create a gap situation, we feel that it would be acceptable under the circumstances.

- **Travel time and virtual work.** This design would create additional reporting relationships that are "virtual" where either a SOO/director or director/manager are at different locations. This would create additional cost to the organization, both in terms of travel expenses and "windshield" time. AHS has strengthened their capabilities to enable effective virtual working, but it would be necessary to align additional resources (e.g. workstations, videoconferencing) if required.

- **Rural facilities.** The rural facilities would still require a Stratum 3 site manager that would not be aligned to a specific program. We would suggest all Stratum 3 rural sites report up through directors that report to a single SOO with rural site accountability for the South Zone. This would encourage similar management and processes for rural sites. We would also suggest adding cross functional abilities and authorities to program directors relative to the rural sites (e.g. Emergency Program Director and a rural ED).

This design has a number of substantial benefits. It would allow for more longer-term program planning across the zone, better align with provincial programs and SCNs, reduce the duplication of work between the east and the west, and help breakdown the silos that have existed since the two regions were separate health authorities. However, it is important to note that there is no functional alignment that will, on its own, solve all of the problems. In order to make an organization design effective there has to be concurrent alignment of accountabilities (both managerial and cross functional), deliverables, people and tasks. In this particular case, it will be critical to ensure site-based supports are in place and optimized to limit and discourage the creation of new, program-based, silos.

Suggested action:

6. Contingent on the appropriate site-based supports being put into place, the South Zone should be functionally aligned on a programmatic basis.

3.2 Aligning accountabilities and authorities

Once positions are aligned vertically and functionally, the next step in optimizing the South Zone's organization design is aligning accountabilities and authorities both managerially and cross functionally. This section will introduce a delegation analysis, and outline what we would expect the accountabilities and authorities to be for team leads, managers, directors, EDs/SOOs, the CZO and physician leaders. We will also introduce the need to clarify cross functional accountabilities and authorities between provincial groups and the zones.

Delegation analysis

A delegation analysis provides perspective on the clarity of delegation with an organization, and can be indicative of issues related to accountabilities and authorities. The clarity of delegation of work is determined by the concurrence between a manager's time span rating, and the perception by the direct report of her/his time span (self span). In other words, for a Clear Context, both the time span as determined by the manager and the self span as provided by the direct report would be in the same stratum. It should be noted that this analysis is limited to individuals who were interviewed. Therefore, this is a more limited analysis than the layering analysis.

Delegation analysis

Table 3.2-1

		Comparison	
		AHS - South Zone	Benchmark
Delegation	Clear Context (TS = SS)	65.5%	62.9%
	Broad Context (TS > SS)	13.1%	18.2%
	Narrow Context (TS < SS)	21.4%	18.8%
Total		100.0%	100.0%

TS = Time span, SS = Self span

The delegation analysis shows slightly more accountability relationships with clear context relative to the benchmarking database (65.5% vs. 62.9%, Table 4.5). The South Zone has a lower percentage of managers with broad context (13.1%, time span higher than self span) than our benchmarking database (18.2%). There are slightly more accountability relationships with narrow context (time span lower than self span) than we normally find (21.4% vs. 18.8%). The distribution of the South Zone's numbers is not significantly different from our benchmarking database (X2 = 1.59, P = 0.452).

The distribution of delegation situations does not differ significantly among the 3 groups of Senior Operating Officers (X2 = 3.75, P = 0.441, Table 4.5b).

Delegation analysis by Senior Operating Officer

Table 3.2-2

		Delegation			Total
		Broad Context	Clear Context	Narrow Context	
Senior Operating Officer	SOO - Acute East	23.5%	58.8%	17.6%	100.0%
	SOO - Acute West	5.3%	63.2%	31.6%	100.0%
	SOO - Community	13.3%	68.9%	17.8%	100.0%
Total		13.6%	65.4%	21.0%	100.0%

Community has the highest percentage of clear delegation (68.9%) followed by Acute West (63.2%) and Acute East (58.8%). Acute West had the highest percentage of narrow context; 31.6% of their managers are in a situation where the self spans are greater than their time spans.

The delegation analysis provides another opportunity for improvement.

Our view is that accountabilities tend not to be as clear as they should be. This would be reflected in these delegation results.

Expectations of AHS managers:

During the South Zone interviews, signs of micromanagement became apparent in a number of areas. Since we do not evaluate people as part of this process, we cannot be sure whether this was individually driven or a system issue. However, since signs of micromanagement were fairly consistent and were generally not specific to individual managers, we believe there are some broader systems issues that can be improved upon.

In many instances, managers indicated that they were not clear on what's expected of them as a manager. There should be clarity on what it means to be a manager, including specific expectations as they relate to accountabilities and authorities. We believe that one of the fundamental expectation of managers should be to provide appropriate context and prescribed limits to direct report positions. This is outlined in the organization design primer. Context includes factors such as the organizational framework and the managers' specific (and preferably stratified) deliverables. The limits can include both organization limits (e.g. related to resource limits on units, skill mix on units, etc.) or personal limits (e.g. "give me important bad news early"). Providing context and prescribed limits to direct reports can help better allow them to exercise their judgment in achieving specific outcomes.

Clarity of accountabilities and authorities:

Another issue was the lack of clearly defined accountabilities and authorities. Generic accountabilities and authorities should be developed for employees, managers at all levels, and physician leaders. These should then coincide with the position specific accountabilities and authorities. Lastly, they should be clearly documented in position descriptions. In the following pages we will provide further detail on accountabilities and authorities related to specific position types, and further information on our model of accountabilities and authorities can be found in the "Introduction to organization design" chapter.

Suggested action:

7. Generic accountabilities and authorities should be developed for types of positions as appropriate (e.g. managers). These should be clearly documented in position descriptions.

Stratum 3 manager positions

The Stratum 3 manager position should be accountable for improving the work of their units and their teams. This accountability should have a time span going out as far as 12 to 24 months. Currently, the manager positions tend to operate more at the Stratum 2 / Stratum 1 level and seem to be more of a day to day management role. In order to enable managers to do the Stratum 3 improvement work that we would expect, the organization should free up capacity. We provide suggestions on how the organization can free up this capacity in the Aligning Tasks section.

Like any position, Stratum 3 managers should have the commensurate authority necessary to achieve their accountabilities. This did not seem to be the case in the South Zone. Managers identified issues related to the approval process for basic managerial tasks (e.g. filling vacancies, ensuring the necessary equipment is on the unit). These controls seem to be historical in nature and may have been implemented for justifiable reasons at the time (e.g. fiscal responsibility). However, these controls should be reviewed to ensure that they appropriately align with the accountability for managing a budget. We typically recommend a manager be accountable for the selection and induction of direct reports (subject to organization policy and appropriate leadership approval) and that manager's leader be accountable for deciding on net new positions for the manager's portfolio (subject to organization policy).

Stratum 2 team lead positions

Further discussion on this position can be found in the vertical alignment analysis section. To summarize, we would expect this position to have managerial accountability and authority in relation to stratum 1 direct report positions, and coordinative accountability and authority relative to stratum 2 professional positions. The position would also provide direct output support to the Stratum 3 manager positions. These positions would only be implemented where appropriate.

Stratum 3 site manager positions

We would expect the Stratum 3 site manager position to have similar generic accountabilities and authorities as all Stratum 3 managers, but also some unique cross functional accountabilities and authorities which we will discuss.

The position has accountability for some site coordination in addition to accountability for the patient flow team. We would suggest that site manager position has a coordinative cross functional accountability with some of the corporate and clinical support programs (e.g. Capital Management). The site manager should have the authority to be informed about tasks that are on-going, to bring people together, to make suggestions on how the work should be done, and to resolve bottlenecks or problems. The position would also require the accountability and authority to escalate certain issues if they cannot be resolved.

The South Zone may also consider aligning clear advisory and service provision cross functional accountabilities and authorities for the patient flow component of the role. The advisory interaction would be related to moving patients as effectively as possible within the site, and the service provision component could be related to things like discharge planning or linking the patients with community supports.

Naturally, this role will need further study and clarification of what the cross functional accountabilities and authorities should be, and it will be a critical element should the South Zone move towards a programmatic functional alignment.

Stratum 4 director and Stratum 5 SOO positions

As positions move into the Stratum 4 and Stratum 5 levels they become more strategic in nature. These positions should be accountable for deliverables stretching out between 2-5 years and 5-10 years respectively. We recognize that these are long time horizons, so AHS may choose to shorten these to align with the environment they operate within. These positions become critical in planning and implementing system wide changes within the South Zone. For example, we might expect a Stratum 4 Surgical Director to be accountable for a redevelopment project of their surgical suites, or might expect a Stratum 5 Senior Operating Officer to implement a zone-wide mental health operational plan. Naturally, implementing on long term plans is only one component, as they still have the basic managerial accountabilities outlined in the earlier section.

These positions would also be a primary cross functional connect point between the provincial programs and SCNs, where they would have overall accountability for operationalizing some of the new practices and procedures that the provincial programs or SCNs develop.

Stratum 6 Chief Zone Officer Position

The work of the Stratum 6 Chief Zone Officer marks the transition from what we would call business unit work (e.g. Mental Health & Addictions Program or Medicine Hat Regional Hospital) to corporate work. The position becomes accountable for a group of entities (Programs or Sites) and is accountable for their creation, development, modification, amalgamation, and divestment. As the needs of the patient population are changing, we would expect this position to generally be accountable for changing the system within the South Zone to best meet the future needs of that patient population (e.g. moving towards more preventative and community-based care). Work at this level would typically have a time span of up to 10 to 20 years, but would similarly have to align with the environment the South Zone operates within.

Summary managerial accountabilities and authorities

Based on the previous discussion, the following table outlines the overall position profiles for each stratum within the South Zone.

Delegation analysis by Senior Operating Officer

Table 3.2-3

Stratum of Position and *sample position*	Category of Information Processing required	Type of work	Sample work duties
Stratum 6 *CZO*	Multiple Whole Systems	*Work at this level involves the creation, development, modification, amalgamation and elimination of whole systems*	• Shifting the focus of care from an Acute based model to a Community based model
Stratum 5 *SOO*	Unified Whole System	*Work at this level involves creating unified, whole systems*	• Implementing a 5-year, zone-wide mental health operational plan
Stratum 4 *Director*	Parallel Paths	*Work at this level involves parallel processing to improve unit performance*	• Developing and introducing new community-based programs • Managing the redevelopment of a new surgical suite
Stratum 3 *Manager*	Serial Paths	*Work at this level requires long term planning and short term implementation of a serial pathway*	• Implementing and sustaining new care pathways • Cultural improvement on a unit
Stratum 2 *Team Lead / Professional*	Diagnostic Patterns	*Work at this level cannot be proceduralized, or even fully described and requires a diagnostic capability*	• Developing and managing long term care plans for patients • Undertaking complex patient assessments
Stratum 1 *First level*	Procedural	*Work at this level can generally be proceduralized*	• Activities of daily living (ADL) tasks • Instructing a patient on a rehabilitation routine

Suggested action:

8. The South Zone should develop position specific accountabilities and authorities for each position based on stratum and functional requirements.

Physician leadership positions

We want to be clear that our expertise is in organization design and we do not consider ourselves to be experts in healthcare and physician leadership. However, based on prior experience, and what we learned through our discussions and document / literature review, paired with our framework for organization design, we are able to provide suggestions that we believe could strengthen the accountabilities and authorities of physician leaders.

Alberta Health Services currently operates a dyad model in the upper levels of physician leadership (AZMD and above). Since this model is based on dual accountability between dyad partners, it runs counter to our belief that it is preferable to have a single point of accountability. We find having a single point of accountability allows for greater clarity in decision making among other things. However, we recognize and appreciate the need for strong physician leadership within AHS, and understand some of the drivers behind moving to a shared accountability model between dyad partners. Therefore, we would not propose to change this alignment, but will provide suggestions on ways to further strengthen it.

First, we believe that accountabilities and authorities should be aligned based on the FTE of the physician leader. There should be clearly defined accountabilities and authorities for physician leaders that are in Dyads (currently defined by AHS as being >0.4 FTE), Partnerships (between 0.1 and 0.4 FTE) and Advisory (<0.1 FTE) positions (source: AHS Dyad Leadership Model: A Primer, revised 2012). For each of these positions, there should be position descriptions that provide position summaries, position specific accountabilities, position specific authorities, cross functional accountabilities and authorities, position specific requirements and generic accountabilities and authorities. The dyad primer states "(while) the dyad model does not have "single point" of accountability, accountability is nonetheless assured by clear role descriptions, well-defined shared and distinction of responsibilities, joint and team accountability agreements and strong partnership/teamwork." Interestingly, we did not find clear role descriptions or well-defined shared and distinction of responsibilities (this seemed mostly dependent on the people in the role); and the joint and team accountability agreements seemed relatively incomprehensive and not consistently applied to all dyads. Clarifying accountabilities and authorities and documenting expectations in a position description can strengthen the structure behind the role, support effective performance management, and limit the dyad being so "person dependent" as it was often described to us.

Second, appropriately determining where dyad joint leadership should exist. If the goal is truly dual accountability and shared decision making as described in the dyad primer, then we would have questions as to whether a 0.5 FTE physician leader operating in dyad partnership two and a half days per week can ever truly have the same accountability and authority as an operational director that is operating in the same dyad partnership for five days per week. Consideration could be given to create dyad partnerships that consist of physician leaders that are >0.8 FTE. There may be an opportunity to consolidate some of the smaller FTE (>0.2 FTE) positions into more fulsome physician leader positions.

Third, integrate physician leaders more fully into the organization. This could include the basics that employees would typically expect such as recruitment and onboarding, position descriptions, training and development opportunities and performance management. This is currently done to some degree, but we would see there being important opportunities for improvement. Bringing the physician leaders more into the fold of AHS could help strengthen the connection physician leaders have with AHS. During a number of discussions, it was noted that in some cases physician leaders with smaller FTEs seemed less like extensions

of AHS and more like union representatives of the physician population. That would not seem to be the intention of the physician leadership model.

Last, we would suggest reviewing the managerial and cross functional relationships to the Sector VPs and the CMO office. We often find that dual reporting relationships can create dysfunction within an organization, and consideration should be given to clarifying the managerial and cross functional accountabilities and authorities. Perhaps the managerial accountabilities and authorities roll up through the dyads and the Sector VPs, and strong cross functional accountabilities and authorities exist within the office of the CMO.

Suggested action:

9. The physician leadership model should be strengthened through appropriately matching accountabilities and authorities with the physician leader's FTE; appropriately determining where dyad joint leadership should exist; and, providing support and development for physician leaders.
10. The managerial and cross functional relationships between physician leaders, Sector VPs and the CMO office should be reviewed.

Accountabilities and authorities between South Zone and provincial groups

Provincial groups (provincial programs, SCNs, corporate support programs and clinical support programs) were outside the scope of the review. Therefore, we did not provide specific recommendations related to position alignment within these areas. However, due to the fact there is such interdependence between the groups and the South Zone, we felt it was important to comment on ways to strengthen the relationships. It is important to note that since we interviewed a very limited number of managers from provincial groups, and we do not have a fulsome set of information, we were unable to test the validity of some of the information we received from interviews with South Zone managers.

A key element for any high functioning organization is the clarification and alignment of cross functional accountabilities and authorities. Unfortunately, there does not seem to be a strong framework for this work. Provincial groups work closely with the South Zone, and do not report managerially to the South Zone. It is therefore important that the cross functional accountabilities and authorities between the groups be clarified and aligned.

A starting point to this work is defining what the accountabilities and authorities of provincial groups should be. During interviews we received multiple answers on what these groups are accountable for, suggesting that this clarity does not currently exist. Should certain provincial groups act in more of an advisory capacity? Or should they act as more of a service provider (recognizing that there will be a mix of multiple cross functional accountabilities and authorities)? Using our cross functional framework outlined in the dyad primer could provide substantial benefit in clarifying the relationship between the groups. From there, related resourcing could be considered. If the roles of certain provincial groups are more advisory in nature their resourcing should reflect that. If they have additional service provision cross functional accountabilities and authorities, then they would have greater need for additional resources.

One thing that we found interesting to note was the major challenges of the South Zone seemed to be with the SCNs, provincial programs and corporate support programs. In each of these cases, their role seemed less clear, and there seemed to be less clarity in what the South Zone could expect to receive from these groups. Conversely, not once was a clinical support program (Diagnostic Imaging, Labs, Pharmacy) brought

up. Our hypothesis is that this could be due to the fact that clinical support programs have a clearly defined service provision cross functional accountability and authority, whereas the cross functional accountabilities and authorities of the other groups are less clearly defined.

Suggested action:

11. The cross functional relationship between provincial groups (provincial programs, SCNs, corporate support and clinical support) and South Zone should be reviewed.

3.3 Aligning people

It is important that there be a clear way of matching people to positions (both managerial and physician leadership positions). We will introduce how we suggest matching people with positions based on the three criteria we use, originally detailed in the organization design primer. We utilize a methodology for matching people to positions that is based on three criteria: Information processing capability, skilled knowledge and application. These criteria consider and account for AHS' desire to have their leaders and staff "Live the AHS Values".

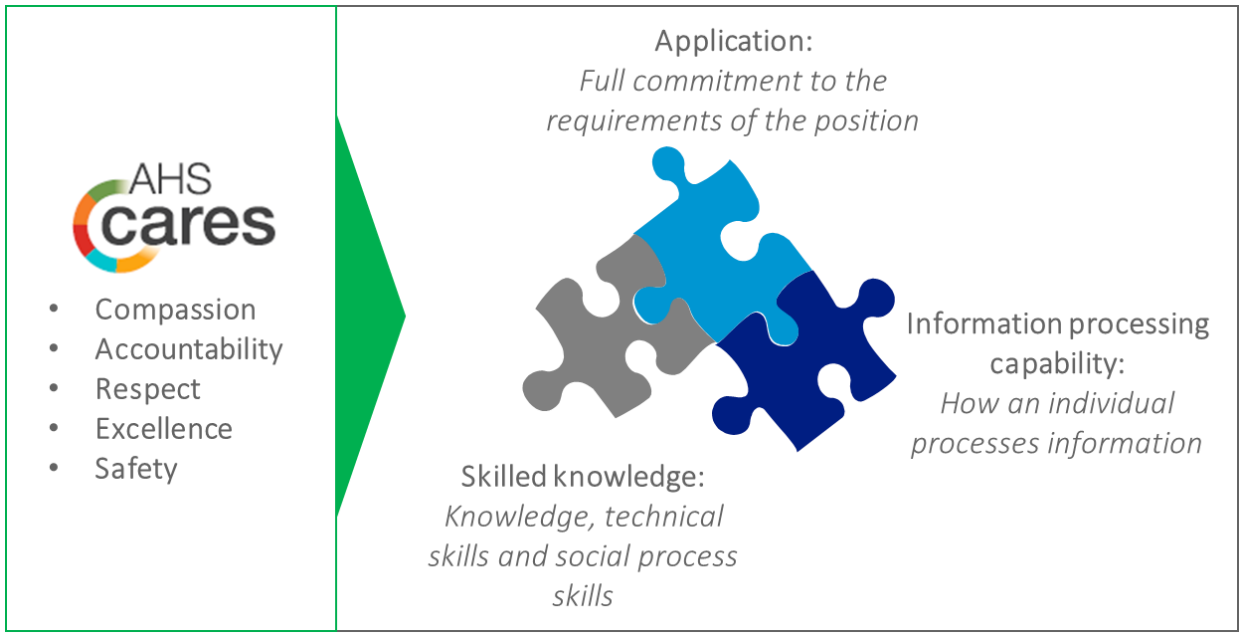
When matching an individual to a Stratum 2 position or higher, it is critical that they are matched only if it is determined that they have the required information processing capability for the position. What we've often found is that organizations will often select individuals based on their performance in their previous role, as opposed to what they are believed to be their potential is for a new, higher-level role. This is described as the Peter Principle, which was originally published by Laurence Peter, which states that "managers rise to the level of their incompetence." Information processing capability is often the critical factor determining success or failure.

In addition to information processing capability, another critical factor is application. Will individuals fully apply themselves to all of the requirements of a position? Sometimes people move into management positions without really wanting to be managers. We've found this particularly prevalent in organizations that have a strong professional worker presence, similar to AHS with RNs. Managers are often selected based on their performance as professionals as opposed to their required capabilities as managers. In some cases, an organization can lose their highest performing professionals and get their lowest performing managers.

The last criteria to match people to positions is skilled knowledge. This is critical when clinically trained professionals are promoted into management positions (often immediately accountable for a large workforce and budget). The people matched to many of these positions may not have the necessary skilled knowledge at the time they are matched since they haven't had prior management or financial training. There should be a focus on enhancing the skilled knowledge of new managers as soon as they are matched. A number of managers questioned the effectiveness of the training they received when they initially moved into management.

Building on these previous points, these three factors can be used to match physicians to physician leader positions. It is important to match physicians with positions that they have the requisite information processing capability (e.g. a Stratum 4 physician leader with a Stratum 4 information processing capability). In addition to this, and an issue that may be more unique to physician leaders, is ensuring that they have the right levels of application for the position. In order to operate successfully in a position, the individual must fully apply oneself to all the requirements of the position. This can be an issue if a physician is reluctantly "taking their turn" in a leadership role, compared to a physician that wants and is willing to fully apply themselves to the role. It will be important to build a pipeline of physician leader talent, identify high potential candidates early, and provide the supports necessary to help develop their managerial capabilities. It will be important that the people matched to positions 'Live the AHS Values'. These values, *AHS cares*, are *compassion*, *accountability*, *respect*, *excellence* and *safety*. We would see these values aligning strongly to our model of matching people to positions, which includes information processing

capability, skilled knowledge and application. The shared values can be used to further develop the sub-criteria within skilled knowledge (which includes knowledge, technical skills and social process skills). For example, within social process skills, AHS employees would need to demonstrate certain behaviors aligned to *respect* and *compassion*. Within knowledge and technical skills, AHS employees would need to demonstrate the knowledge and technical skills that are required for *excellence*, *accountability* and *safety*. Further, demonstrating the shared values could be a requirement of the position, and all employees would be required to show 'full commitment to the requirements of the position' – which is the definition of application (our third criteria).



Matching people to positions criteria

Figure 3.3-1

Suggested action:

12. People should be matched to positions based on the three criteria of information processing capability, skilled knowledge and application. These criteria consider and account for AHS' desire to have their leaders and staff "Live the AHS Values".[1]

Managers and 'felt fair pay'

We touched on the importance of application in the previous section, so it's important to identify a concern we have with the current compensation within AHS that can lead to decreased application at the manager level.

[1] Capelle Assoicates understands AHS has made the commitment that no employee will be out of work as a result of the South Zone Review. While some leaders may end up in new or changed roles, no employee will have to apply for his or her own job. Where jobs are effectively unchanged, it would be expected that the incumbent would continue in that role.

Capelle Associates, and other researchers before us, have researched the link between Time Span and compensation. Our research studies, and references to other research studies, can be found in our book *Optimizing Organization Design*. What's been shown is that time span, and the companion measure of information processing requirement, is closely related to 'felt fair pay', which is an employee judgment about the financial value of their work. We have also found that, unsurprisingly, employees that are paid within the appropriate range based on time span and information processing requirement have a higher job satisfaction. Our conclusions based on our research and others is that appropriate compensation matters and it is often not optimal (only 63% of the time based on our research).

Why this becomes significant within AHS is what's happened as a result of the public-sector wage freezes across Alberta for the non-unionized employees. These freezes over the years have created a system where managers are sometimes paid less than the employees that they manage. This is, not surprisingly, an issue. Within the South Zone, of the 92 employees listed as Managers or Unit Managers, 14 of them (15%) had employees with higher annualized salaries. Further to this, we believe this number to be artificially low as the annualized salaries do not take into account the overtime compensation unionized positions often receive. We believe that if it was possible to resolve, or at least improve upon this issue, there would be organization improvement.

3.4 Aligning deliverables

It became evident early in the interviews that there are opportunities to improve the current organizational planning and review process. This was reinforced by our analysis of expected time spans vs. actual time spans; and the higher-level work that one would expect but is missing. We will outline how an organizational planning and review process could be implemented.

Organizational planning and review system

The current Alberta Health Services Health Plan and Business Plan (2017 – 2020) is broken into four overarching organization goals. These goals are both externally focused (e.g. improve patient & families' experiences) and internally focused (e.g. improve the experience and safety of our people). These goals provide the structure for the South Zone's Operational Plan (2017 – 2020). Within the South Zone's Operational Plan specific 2017/18 actions are assigned to South Zone leaders (primarily the SOOs, in addition to some EDs and provincial directors (e.g. HR). The majority of these actions seem shorter term (e.g. annual), although some do seem to stretch out over multiple years. The broader planning process of AHS, and the more specific planning process within the South Zone, seemed somewhat disjointed.

We would suggest a cascaded organizational planning and review process similar to the one illustrated in the organization design primer. We would expect the South Zone to have a long-range plan that is the ultimate accountability of the Chief Zone Officer and Zone Medical Director dyad partnership. From there, independent deliverables are cascaded down the organization to each SOO, director and manager. This allows for local decision making with a provincial framework. These deliverables could form part of a comprehensive performance management system. In addition to the deliverables, we would expect each manager within the organization to have their own resource plan. The organization's mission, vision and shared values would be incorporated into each manager's deliverables. One of the issues that came up during interviews was that the planning process was not cascaded down the lower levels of management within the zone, therefore it was not clear how their deliverables fit into a broader picture. This would help drive decision making to the right levels in the organization move away from what is often perceived as a "top down" culture.

The organization should also look to ensure that planning and review is a unified, singular process that still encourages localized variation. What we mean by this, is zones shouldn't be accountable for running independent planning processes, rather should be a part of a planning process that is consistent and standardized across AHS. However, while the process does not change, the unique needs of the communities the zones serve would still be met by allowing localized variation of the specific deliverables.

Suggested action:

13. A comprehensive organizational planning and review system should be further enhanced and aligned.

3.5 Aligning tasks

This section will focus on opportunities to better align tasks that came up through our discussions. We believe that one of the most critical aspects of elevating the work in the organization will be freeing capacity for Stratum 3 managers so that they can operate at their full capability. Through discussions with these managers it became apparent that they spend a large portion of their time undertaking Stratum 1 tasks. One manager remarked that "South Zone managers have become experts in two things: Time keeping and recruiting." We do not believe that the work of managers can be elevated unless there is some action aimed at freeing up additional managerial capacity. Managers expressed frustration with working long hours (often 12+ hours per day) and the term 'burnout' was used frequently. A number of opportunities to free up this capacity were discussed during interviews.

Aligning clinical leader positions

We have already outlined the benefit we believe could be achieved by introducing a Stratum 2 team lead position with managerial accountability and authority for Stratum 1 positions. Should a decision be made to move in this direction, consideration could be made to introduce more clinical leader positions while further clarifying their accountabilities and authorities. We had the sense that this position's accountabilities and authorities were less clear and some managers expressed frustration about not receiving the support they would expect to receive from a position like this.

Aligning educator positions

A number of managers brought up the importance of adding more educator positions. Currently, these seemed scattered throughout the organization on a seeming piecemeal basis. Interestingly, educators also report directly to individual unit managers in the Lethbridge site yet report to a centralized site manager in the Medicine Hat site. By introducing more educators, the Stratum 3 manager can decrease the amount of clinical education work they're required to provide. Additionally, the educators would be able to provide direct output support to the Stratum 3 managers when a new project (e.g. care pathway, collaborative care) is being implemented on a unit.

Reducing the administrative burden of HR processes

As AHS came into being, the HR function was organized on a provincial basis. South Zone managers had the perception that this shift resulted in an administrative burden being placed on them for processes like recruitment and selection, attendance management, and onboarding. Large portions of these processes are Stratum 1 work the organization is currently paying Stratum 3 managers to do. By building in more administrative HR support, either in a centralized model or (preferably) localized on site, AHS can shift some of this work to a more appropriate, less costly, resource. While the concept of self-service is good, and AHS can realize significant benefits of scale, it's important to remember that AHS managers have significantly different requirements than many managers in the private sector. Managers in the private sector may have up to 10 direct reports (*Figure 3.1-1*), while AHS managers can have up to 100 direct reports. This creates a situation where managers are constantly filling vacancies or dealing with attendance issues. We understand that HR is already undertaking some of this improvement work which is a positive step in the right direction.

Reducing the administrative burden of Finance processes

In addition to HR processes, managers expressed frustration with some of the financial processes. The two financial processes most commonly brought up was the approvals process for filling vacancies and approvals process for purchasing. Managers indicated that they are required to get four approvals to fill a vacant position. Additionally, a number of managers indicated how difficult and time consuming the process can be for replacing basic and necessary equipment such as chairs on their unit. We would recommend reviewing both processes to see if there are ways to streamline and remove unnecessary and time-consuming roadblocks. In both cases the controls seem significantly stronger than we would expect, and AHS does not seem to be providing managers with the appropriate authority.

General administrative support

If steps are taken to reduce the administrative burden from HR and Finance processes, consideration should be given to adding additional administrative support for South Zone managerial positions. There was a perception that a large portion of manager's time was spent on Stratum 1 administrative tasks, so moving this to a Stratum 1 administrative resource would ensure that these tasks (if they must exist) are being completed by the most cost-effective resource.

Reviewing the FT / PT split

We were surprised to discover the reliance the South Zone currently has on part time and casual employees. For example, in an analysis of all Manager positions that report up through the two Acute SOOs (n=33), we found that on average 30% of their direct report nurses (RNs and LPNs) are full time employees, while 70% of their direct report nurses (RNs and LPNs) are part time (casual nurses – of which there are many – are excluded from this calculation). Multiple Manager positions even had a FT:PT ratio of less than 15:85. When looking at the workload demands that coincide with span of control, it's important to remember that full time and part time employees can require a very similar managerial workload (e.g. they call require training and development, performance management, attendance management, etc.). Therefore, AHS could consider moving to a model that includes more full-time nurses and fewer part time, which would decrease the managerial demands that directly correlate with spans of control. Interestingly, in Ontario, the Registered Nurses Association of Ontario has been pushing to ensure at least 70% of their nurses working in acute and long-term care facilities are full time (Source: RNAO's 70 per cent Full-Time Employment for Nurses Survey, 2014).

Suggested action:

14. Changes should be implemented to free up additional capacity for the Stratum 3 managers to perform stratum appropriate work.

Section 4:

Towards implementation

4. Towards implementation

In this section, we discuss implementation. In other words, how does one implement the desired improvements?

There is a rich history of thought on this topic, beginning with a body of work called organization development. It largely focused on the process of change, often working with smaller units (e.g., groups within organizations). One of the significant sets of writings was the Addison-Wesley Series in Organization Development, composed of 18 books published between 1969 and 1981, and edited by Schein, Bennis, and Beckhard. These books also included a number of related topics. There are other important books from this era, including The Planning of Change (Bennis, Benne & Chin, 1969; Bennis et al., 1976). Additional books that we found to be of value include Conner (1993) and LaMarsh (1995). The term that is currently most commonly used for this area is change management. While we don't do generic change management, we have developed an approach to change management in the service of optimizing organization design. The foundation for us is understanding organizations as systems in environments.

It should be understood at the outset, in line with this organization development theory, that employee engagement is an important factor facilitating design implementation. There are several aspects to this. First, implementation is often easier in organizations that have higher levels of engagement and trust. Second, during an assessment phase, it is important to engage employees (e.g., we generally interview all managers and have a questionnaire that can be completed by all employees) and have strong communication with them. This communication could include objectives (e.g., in this approach, the objectives could include employee satisfaction, customer satisfaction, and financial performance, which can lead to a win-win-win situation). Communication could also include the approach to be used and the feedback process that will be utilized after the review. Finally, in the implementation, employees are involved in the design of their own areas. It is very much a hands-on implementation, involving learning, doing, and feedback.

The starting point is the organization systems change model. The basic objective of this Optimizing Organization Design® approach is to improve performance. This requires an understanding of the current state of the organization, and the direction to move it to a future desired state. Our Optimizing Organization Design® approach requires a strong implementation approach in order to reach the desired future state. This chapter outlines the approach that we use.

4.1 Objectives of an organization design implementation

While the specifics of each organization design implementation will vary, the general objectives tend to be consistent. The overarching objective is to improve organization performance. Our research and executive experience shows that this approach, as we describe it, leads to improved organization performance. Implementation should focus on both what should be changed and how it should be changed.

Our previous discussion of how organizations function shows us what should be changed. The implementation process generally focuses on some combination of the following factors:

- Improve vertical alignment of positions (e.g., increase requisite alignment and decrease gaps and compression).

- Improve functional alignment of positions (e.g., have ‘‘like’’ functions better clustered together).
- Align and further clarify accountabilities and authorities of positions.
- Improve clarity of cross functional accountabilities and authorities (e.g., include in position descriptions and provision of education and training).
- Align people with positions.
- Improve matching of employees to positions (e.g., develop and implement talent pool process) to improve current fit and future requirements.
- Align deliverables with positions.
- Develop and implement an organization planning and review system.
- Ensure that positions in each stratum are working at the right level of complexity and are in concert to move the organization in the desired direction.
- Align tasks with positions.
- Identify any areas in the organization where there is lack of differentiation between Stratum 1 and Stratum 2 positions.
- Analyze and optimize task configuration.

In parallel, a robust organization design implementation process should also do the following:

- Improve the level of organization design capability (e.g., transfer materials, methods, and skills to the internal team and the organization).
- Improve the functioning of critical related systems (e.g., human resources and organization planning and review systems).
- Implement organization design effectively and efficiently (utilizing appropriate project management and people change management best practices) resulting in a transformational change of the organization that can be sustained.

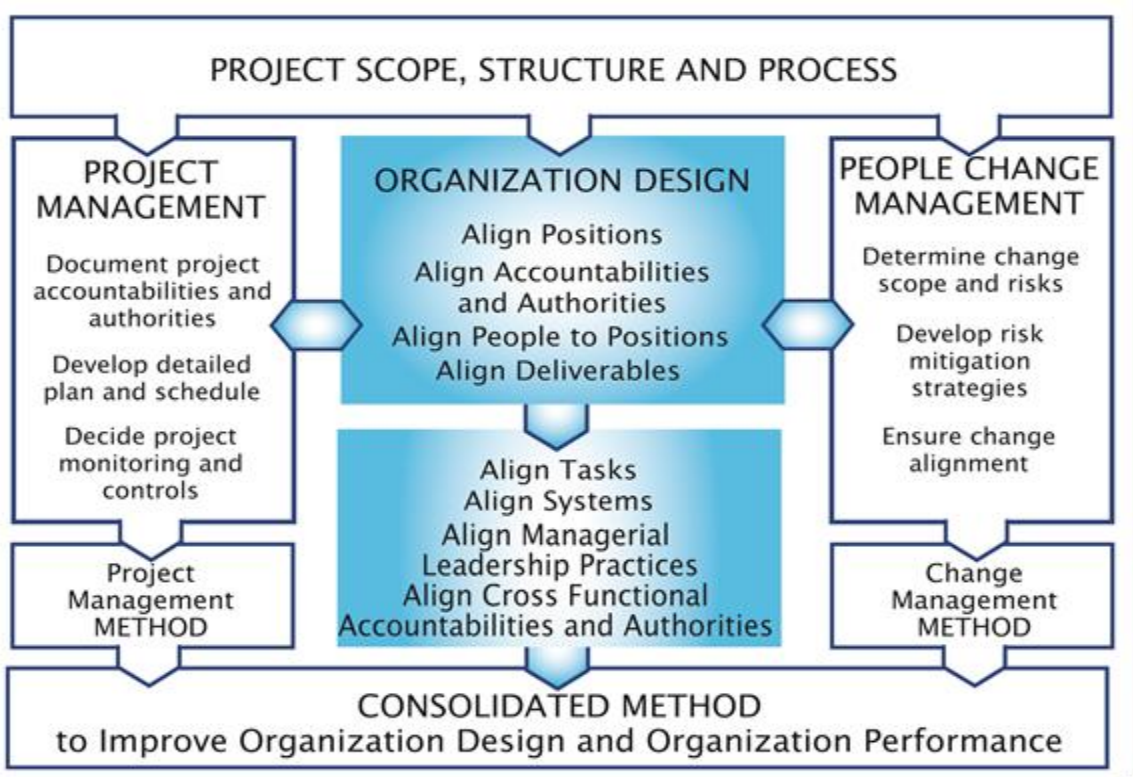
Successful implementation requires that a plan be developed to serve as the roadmap for the implementation process. In the development of this plan, the points in the next sections should be considered.

4.2 Organization design implementation components

We have developed a model of organization design implementation that includes components for both the what and the how of implementation. The model (*Figure 4.2-1*) includes the following four components:

- project scope, structure, and process
- organization design (the content of change)
- project management
- people change management

The effective combination of these four components can result in a consolidated method to improve both organization design and organization performance.



Organization Design Implementation Model

Figure 4.2-1

Project scope, structure and process

Fundamental to the success of any implementation process is having an appropriate project structure that is staffed by individuals who have the required information processing capability, skilled knowledge, and application. Positions should be established and filled. The head of the organization would be the accountable executive for the implementation. This individual would likely appoint a direct report as the internal project team executive to be accountable for the implementation project. This individual may directly lead the project team, or, in very large organizations, may appoint an internal project team director. Project positions would be established and staffed. There is a requirement for clearly stated accountabilities and authorities for each position. Clear accountability for the overall change process, including the necessary management commitment, support, and visibility of that commitment and support, is vital.

The accountable executive must make it clear that all managers (defined generically as being accountable for the work of direct reports) become accountable for their parts of the change process. Within this context, managers (in both line and support functions) must then make the necessary macro decisions, provide the framework and issue resolution and context clarification process mechanisms necessary to move towards them, and demonstrate visible support for the change process.

The project executive would be accountable for monitoring and supporting each major change initiative. In larger organizations, the project executive would appoint a project director, and ensure the acquisition of the project team members, together with appropriate administrative support. Through cross functional

support, the internal project team would support the managers accountable for various elements of the change process by providing the following support:

- developing the project plan and implementation processes
- developing the new or improved processes that arise from approved recommendations
- developing the support materials that are required for the natural work team implementation meetings
- facilitating education and training sessions
- providing advice to implementing managers
- coordinating the implementation work
- monitoring the implementation, resolving issues as they arise, and escalating those issues that cannot be resolved

It would also be necessary to ensure that sufficient capacity exists on the team to ensure the necessary activities in people change management and project management can be carried out.

The internal project team must be resourced appropriately. External expertise can provide specifics in terms of organization design and change management but adapting these principles to the organizational context requires expertise within the organization, i.e., balancing the business with the change principles. Some of the important related points are outlined below:

- Because managers accountable for implementation in their organizations or functions are still accountable for maintaining their business operations, anything the project team can do in a cross functional way to support them will minimize disruption in the workplace during the change process.

- The best value-add for any organization is to obtain external expertise for the more highly specialized skills that typically do not exist within the organization and, while using the support of those with this expertise, do most of the work in house.

- In an implementation project of this sort, a great deal of external expertise, in the form of materials, methods, and skills, is naturally transferred to an internal project team and lessons learned from this transfer can then be used in the future to support managers and help maintain the integrity of the new organization design.

Organization design

By carefully orchestrating the sequencing of several streams of work, the new organization design can be introduced in such a way that it does not overload managers in terms of the amount and sequencing of their work. These streams generally include aligning positions, accountabilities and authorities, people (to positions), and deliverables. Depending on the circumstances, other streams can include aligning tasks, systems, managerial leadership practices, and cross functional accountabilities and authorities.

It should be noted that this grouping is slightly different than the alignment factors discussed earlier, when we discussed alignment of positions, accountabilities and authorities, people, deliverables and tasks. In the organization design implementation model, we retain those five factors, although ‘‘align tasks’’ is dropped to a lower section because it tends to follow in a limited number of cases, and is not part of the

comprehensive implementation. As well, we add three new factors: align systems, managerial leadership practices, and cross functional accountabilities and authorities. The three factors are described as follows:

- Align systems: In order for the change to be transformational and sustainable, it is important to optimize related systems. This would generally include organization planning and review, human resources (including compensation), project management, and process management. While much of this work is done in the initial cascades (e.g., positions, accountabilities and authorities, people and deliverables), there are often additional opportunities for further enhancement that require a different focus.

- Align managerial leadership practices: This is leadership related to the accountabilities and authorities of a manager. Again, the focus is on the initial cascades, particularly with aligning accountabilities and authorities (and especially manager accountabilities and authorities). However, since this area requires significant skill building, additional focus is often desirable. As well, because most organizations do management training of some kind, this process can become the foundation for management training that would cover selection, setting context and prescribed limits, providing resources, delegating, development, managing performance, team building, and removal from position. An important part of this process, aligning teams, creates an opportunity for the manager to set context for direct reports, and for them to develop expectations for their work together in the new organization design. By working together in this way, manager and direct reports establish a strong foundation for the team working relationship, an important part of building teams in a new organization design.

- Align cross functional accountabilities and authorities: This is an extension of ‘‘align accountabilities and authorities’’ but best left as a separate cascade at the end of the series. There are two reasons for this. First, we find that it is the most difficult cascade, and needs the other alignments in place to operate most effectively. Second, we generally work with natural work teams through the other cascades but, in order to do the cross functional work, we often need different configurations of people (e.g., those involved across the organization in major initiatives such as information technology or product development).

These streams of work are explored in more detail below:

- Aligning positions includes implementing the optimal alignment of positions from both vertical and functional perspectives; dealing with discrepancies of time span and compensation, including compression and gaps; and adding, removing, and modifying positions as required. Ideally, a master organization chart will be maintained on which all changes are recorded.

- Aligning accountabilities and authorities includes clarifying employee and managerial accountabilities and authorities (including generic ones) and initial work on cross functional accountabilities and authorities. These are documented in position descriptions.

- Aligning people to positions entails developing a talent pool process in which management is accountable for evaluating and improving fit to position. Managers assess employees according to several criteria, including information processing capability, skilled knowledge, and application. The talent pool process is used for staffing both new and significantly changed positions. This further requires managers to determine current and future requirements and capabilities.

- Aligning deliverables entails developing and implementing a framework to ensure that positions in each stratum are working at the right level of complexity and in concert to move the organization in the desired direction. This usually involves enhancing organization planning and review.
- Aligning tasks can take place at a later point in parts of the organization where there is lack of clarity between Stratum 1 and Stratum 2 positions. To achieve this, managers are required to determine the tasks that are performed and look for opportunities for improvement.
- Aligning systems generally includes both organization planning and review and human resources. The systems are reviewed and adapted and strengthened to appropriately support the organization design implementation and to help ensure its sustainability.
- Aligning managerial leadership practices is often skill building in a real situation. One of the most important areas is building the new teams.
- Aligning cross functional accountabilities and authorities will help to break down silos by clarifying how work gets done across the organization and establishing a common understanding of integrating work across functions. This work begins at an earlier stage but generally benefits from more comprehensive work at a later stage.
- The organization design implementation model provides the planning, design, and development of the implementation of the organization design changes throughout the organization in an effective, efficient, and sustainable way.

Project management

Project management is concerned with ensuring that the expected results are obtained on time and within budget and to a specified level of quality. In an organization design implementation, ensuring that the implementation is carried out in an appropriate and effective way can be a complex business. Following are several activities that should be attended to in this stream of work:

- Describe in writing the key accountabilities of the accountable executive, and the key deliverables expected of that position.
- Describe in writing the key accountabilities of the line and functional managers that are accountable for the change, the key deliverables that are expected for each position, and the authority (mostly managerial) that is delegated to them by the accountable executive to implement this change.
- Describe in writing the key accountabilities of the internal project team executive and the internal project team director who are accountable for provision of the support for the change, the key deliverables that are expected of these positions, and the authority (mostly cross functional) that is delegated by the accountable executive to implement this change.
- Determine the number of and type of positions that will be required on the project implementation team.

- Describe in writing the key accountabilities of each project team position, the key deliverables that are expected of the position, and the authority (mostly cross functional) that is delegated to that position by the project team director to support the change.
- Recruit or assign individuals to each of the project team positions. Team members should be available for the duration of the project (on a full time or part time basis as required), and ideally migrate later to established positions within the organization in order to maintain the institutional learning.
- Design and put in place the main processes for the project team, e.g., meeting structure, reporting and monitoring requirements, etc.
- Determine the detailed project schedule for achieving the planning, design, and development deliverables.
- At the end of planning phase, develop the consolidated implementation plan.
- At the end of the project, conduct a review to determine lessons learned.

In totality, this approach as it is described becomes the project management method for the organization design implementation.

People change management

People change management refers to the application of a structured and disciplined change management methodology that can increase the possibility of success of this project, increase engagement in the process, reduce project time and cost, and at the same time mitigate the people risks associated with such a major change. These aspects of people change management are dealt with in implementation planning:

- education and training
- two-way communication

The basic purpose of education and training is to equip employees with the skilled knowledge they need to carry out their accountabilities in a way that is consistent with the new model of operating. It is important to provide education to managers in a macro way for implementation purposes. It is also important to provide training to employees (including managers) that will help them change their behaviour and way of doing things over time. We are using training in the usual literal sense, as the provision of behavioural/change training and skill based training.

In keeping with the principles of implementation, related meetings constitute an opportunity to do the real work required in the cascading implementation process, for example, working through and clarifying cross functional accountabilities and authorities of the natural work team.

The second aspect, communications, does not need to be especially resource intensive, but it is an important component of the change process. Negative employee reactions generally do not result from decisions that have been made and communicated effectively and in a timely manner. Rather, negative employee reactions are more likely to come from indecision or poor communications that allow rumours to proliferate. Rumours tend to accentuate the negative spin on impending decisions, and in the absence of solid communication, people may assume the worst.

In totality, this approach as it is described becomes the people change management method for the organization design implementation.

Consolidated method

The final box at the bottom of *Figure 4.2-1* represents the consolidated method to improve organization design and organization performance. Each of the four components contributes critical aspects to the success of a project.

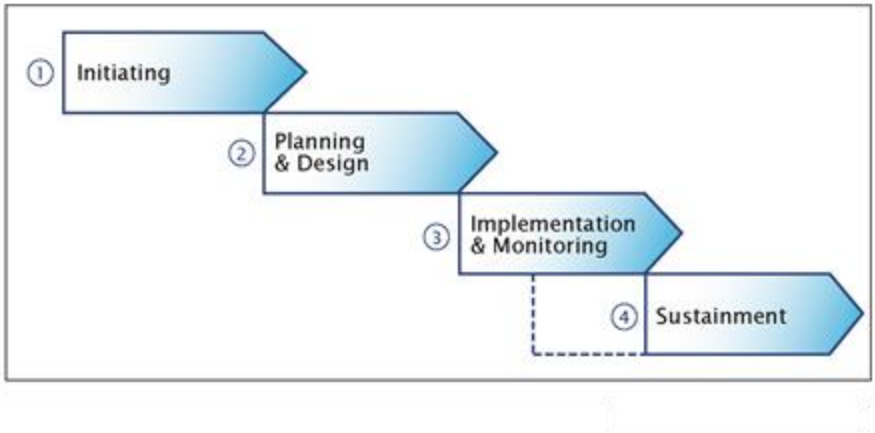
4.3 Organization design implementation process

We have discussed the components of the organization design implementation model. We now discuss the process. Implementation projects require the most significant investment of resources at the beginning. The time and energy spent in properly designing the project structure and processes will reap tangible benefits. The costs are generally much greater when an organization tries to implement change on the fly, because improvisation leads to rework and a confused (or at least less focused) work force.

The implementation process is largely concerned with pacing, which varies from project to project. We generally find that timelines range from 6 to 18 months, although full institutionalization may require longer. The underlying principles are usually the same:

- Implementation is always ‘‘front-end loaded’’: more of the work is done earlier than later.
- It is necessary to continue the timeline long enough to institutionalize the change. Resource requirements diminish significantly in the later stages of implementation. However, the objective is to “institutionalize” the change and avoid improvements that prove to be “a flash in the pan.”
- The single biggest factor in the pacing of the cascading implementation is the quality and quantity of internal resources. Having the right resources in place early and for the duration can significantly improve the quality and pace of the process.
- Research shows that the single most important success factor is the accountable manager staying the course to complete the implementation.
- The pacing of the implementation will be affected by the judgment of the accountable manager as they balance the desire for faster pacing with other organization requirements. However, regardless of the exact pacing, the model shows the general factors and sequencing that we would find in most implementation projects.

The process method (shown in *Figure 4.3-1*) comprises four sequential phases: initiation, planning and design, implementation and monitoring, and sustainment. A brief discussion of each phase follows.



Organization design process methodology
Figure 4.3-1

Initiation

Project parameters are defined during the initiation phase. The project manager is appointed. They may be given some other title, but basically this position is accountable for the project and project team. The resources required for this phase of the project are identified and acquired.

A project charter is established, and typically includes the following information: scope, structure, roles of internal team and consulting team, processes, macro timeline, macro plan and deliverables, estimated resource requirements, and macro people change management plan. The project charter is approved by the accountable executive on the recommendation of the project executive. The initial communication plan is developed, including feedback loops, and the first few communications issued.

Concurrent to the project initiation work, macro decisions are made with respect to the organization design, which provides the framework for the rest of the organization design implementation work.

Planning and design

During the planning phase, the desired future organization is further enhanced. The various project plans are crafted and integrated into the execution implementation plan.

The project structure and processes are finalized in this phase by the project manager. The project manager leads the process of designing the implementation of the new organization design. This includes: obtaining approval of the desired state organization design from the accountable manager, designing the materials necessary to support the cascading implementation, and ensuring the appropriate training of project team members that will facilitate the management meetings required for the implementation of the new organization design. The positions accountable for project management and people change management develop their respective plans in an iterative way. Issues are brought to the attention of the accountable manager, and decisions are made with respect to organization design, resourcing, and timing.

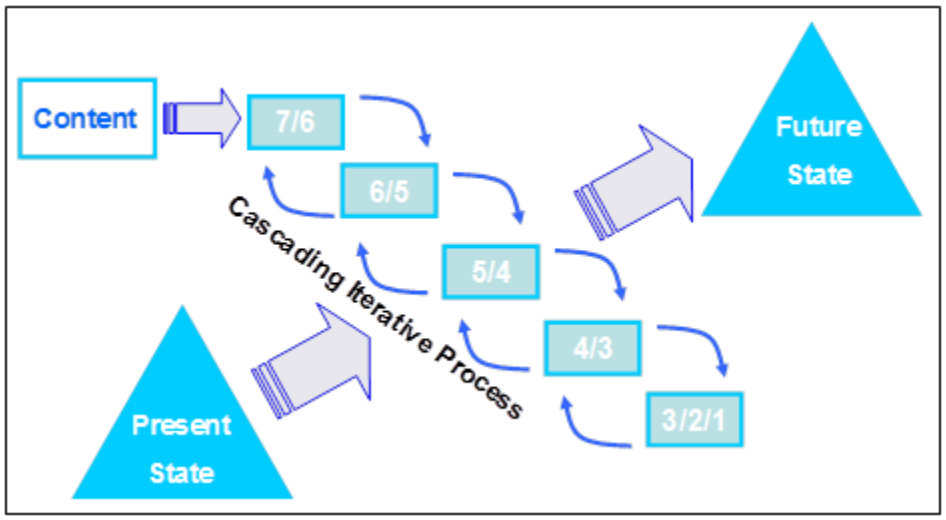
At the end of this phase, each of the three plans (organization design implementation, project management, and people change management) will have been approved and integrated into one project plan for the implementation. Ideally, all design and development work will be completed before the

cascading implementation rollout begins. However, some design work for meetings that takes place later in the implementation can be undertaken later. It is also necessary to have a feedback loop to improve materials during the process. There will also generally be a need for additional design and development on related systems in preparation for the second round of implementation.

Implementation and monitoring

The implementation is a series of cascading, iterative processes delivered within the context and prescribed limits set by the accountable manager. This would implement the new organization design, and at the same time deliver the education and training identified as core to the change during the planning phase. Line and support function managers would be accountable for implementation within their areas of accountability with support from the project team.

Figure 4.3-2 shows the model of a cascading, iterative implementation process with a Stratum 7 organization. The first event of implementation once the rollout begins is the senior management team meeting. This meeting brings together the accountable manager with immediate direct reports according to the new organization design. This meeting would be replicated at each stratum with stratum-appropriate materials.



Cascading, iterative implementation process
Figure 4.3-2

It is also important to review the various systems in the organization to ensure that they are properly aligned with the change process. To the extent that current systems (e.g., human resources, organization planning and review, etc.) do not support the changes (or in fact work counter to them), design work also has to be done to bring these systems in line with the changes. This work is not normally carried out by the project team directly, but the project manager would have an accountability to monitor the work and integrate it into the implementation.

Sustainment

The sustainment phase begins immediately after the first round of implementation meetings. This phase is concerned with integrating change support mechanisms into ongoing organization systems. For instance,

the project team may have some specific accountability with regard to staffing during the implementation, with support from Human Resources. After the implementation, the Human Resources function would need to be equipped to support the new organization as a part of their ongoing accountabilities. Sustainment is listed as a separate stream because of the importance of identifying the organization systems that may need upgrading (or creation), and developing a plan with key milestones that would be integrated into the implementation plan.

At the end of the implementation, a project implementation review is conducted to identify the lessons learned and improve future organizational changes and projects.

4.4 Organization design implementation principles

We have found that the following principles are useful for organization design implementation:

Cascading, iterative process

Any process that will be rolled out throughout the organization should start at the top. The senior level then replicates the process with their direct reports. This process is repeated at the next level, until everyone in the organization that should participate has done so. This is the cascading element, as each person in the organization participates in the process under the direction of their immediate manager.

Each manager participates in the process twice: once as a participant and once as a manager. This is the iterative process, as a manager can provide feedback to their manager or peer group management team on how to improve the process. Any unforeseen difficulties or consequences can be dealt with at each level of the process. Each manager has the accountability of setting the context of each session in terms appropriate for the strata with which they are working.

Education and training / Real work / Feedback

Each cascading process should include three elements. One element is educational. This is the information portion, explaining to employees what is required, i.e. a new process, an improvement in a procedure, and so on. The second element is implementation. Each session must have an element of doing actual work, so participants begin to internalize the new approach. For instance, for a new planning system, the first part of the session would describe how planning is done. The second part would engage participants in doing actual planning in direct interaction with their immediate manager.

The third part is a feedback loop. Participants should be given feedback for their learning, as well as given the opportunity to provide feedback on the process they are learning so that it can be continually improved.

In summary, this process involves both a knowledge and a skill-building component.

Natural work teams

Each cascading process should be rolled out through natural work teams (i.e., a manager and their direct reports) as much as possible. This is important, for real learning and sustainable change best takes place through “doing.” We find that individuals working with their managers in natural work teams have the benefit of doing real work as opposed to an artificial exercise. Making use of the natural work team also creates an environment where the manager can emphasize setting the context for the change that is being

implemented. In an artificial training environment, participants are less likely to make the connection to their "real" work.

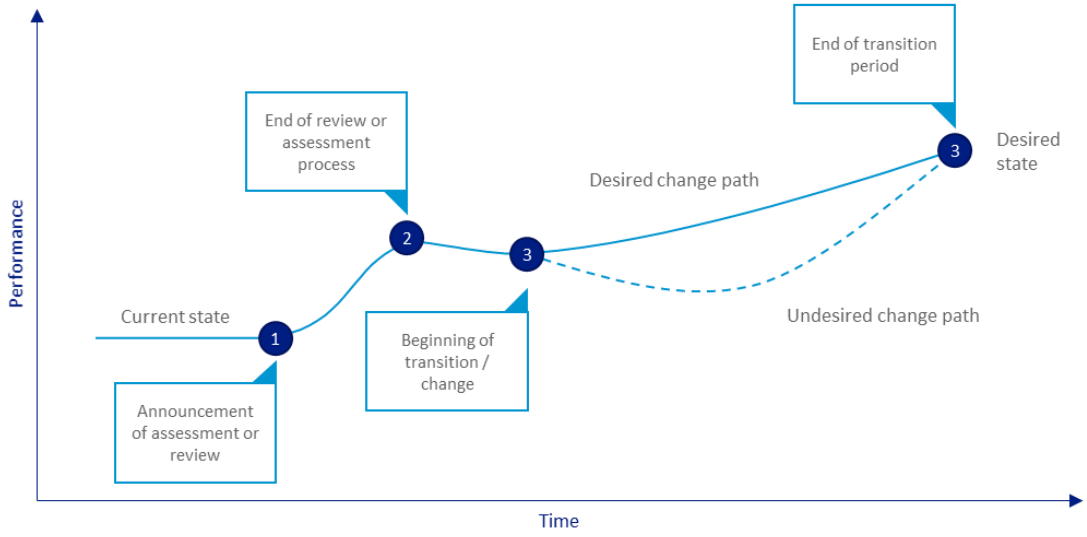
4.5 Strengthening the organization design implementation

We have discussed the implementation approach, and the importance not only of what we want to change, but also how we go about changing it. As part of this, we have discussed project management and people change management. There is another dimension: strengthening the change process. The purpose of a change process is to move from a current state to an improved future state within a target completion time. Once the decision to change has been made, a process is initiated, by gathering information or assessing the current state. *Figure 4.5-1* demonstrates desired and undesired change paths.

At Point 1, a review or assessment is announced. As there have been some issues or opportunities that led to the review, the announcement is often greeted by employees with optimism, along with some questions and concern. They may recognize the need for change, and most have ideas about what the changes should be. Particularly if the process is a participatory one, employee morale can actually improve during the review period.

This period of optimism has a tendency to peak at Point 2, when decisions are made as a result of the review. At that point, many employees realize that the changes they envisioned may not be implemented. There is also a general realization that the changes may have personal impact on them. When this idea takes hold, there may be a decline in morale. If care is not taken, this downturn can continue past the pre-change state, taking the organization along the undesired change path.

Management has its greatest opportunity to avoid the undesired change path at Point 2 by demonstrating effective and timely leadership. This means: making decisions early; announcing the decisions and providing compelling reasons for them that employees can relate to; supporting employees by listening to them; and by implementing feedback loops. The following points describe the key elements of *Figure 4.5-1*:



The change path
Figure 4.5-1

- Make decisions: At Point 2, the end of the review process, the faster that firm decisions are made, the better. Even an unpopular decision, that is firmly made, is better than a popular decision that is made after unseemly delays.

- Communicate: As soon as decisions are made, they should be communicated, together with the supporting rationale to obtain buy-in from employees. This includes communicating the process that will be followed to plan and execute the change.

- Celebrate early successes: Front-end load the change process so that early progress can be made in key areas. The moment some positive changes can be identified, communicate and celebrate them. The sooner the positive results from the changes can be seen and felt by the employees, the sooner they will support and promote the changes. Early wins and successes should come within three months. While the early successes may not be substantive in the long run, they are critical to build commitment and momentum.

- Build momentum: A change process needs to be maintained throughout at least one business cycle (often one year), and often more depending upon the scope of the change. The objective is to ensure that changes are institutionalized into the organization and its working systems and processes. The earlier in the process changes can be implemented and successes celebrated, the easier it will be to maintain the change process over time.

- Support employees: Management had an opportunity to review and discuss the recommendations of the organization design assessment and move personally, over a given period of time, through their personal change cycle. They need to support their employees going through the same process by explaining the need for the changes and by listening effectively to the feedback received from them to continually improve planned actions.

- Point 3 marks the formal beginning of the change process. As noted above, the quality and timeliness of decisions made in Point 2 and the demonstration of visible managerial leadership will be helpful to build positive momentum early on in the change process.

With the objective of moving effectively and with the committed support of employees through the transition period (illustrated by the path from Point 3 to Point 4), the implementation project needs to be carefully planned. Project objectives and deliverables are to be determined and a realistic project plan should be formulated to achieve them. People factors are to be assessed and analyzed to create an appropriate people change management plan and ensure employee readiness. The payoff for planning and executing the change successfully will be substantial. In addition to getting the benefits from the organization design improvements, the process of changing will be more effective, efficient, take less time and be supported by employees. A well-executed change project also builds employee confidence and sets the tone for future organizational change projects.

4.6 Internal – external team approach

Our experience shows that the best implementation comes from an internal - external team. External consultants can add value by providing:

- organization design knowledge and experience;

- knowledge about the organization gained from the assessment;
- implementation experience, including project and people change management.

The work should be done to provide the organization with the best results at the most reasonable cost. We have found that the internal team can generally do 70 - 90 percent of the work. The external team can provide the expertise that will support doing better work, doing it faster, and sustaining it better. The internal team doesn't have to "reinvent the wheel." The external team can bring in and adapt relevant methods and systems, work directly with the senior management team, train and qualify internal resources, and provide consultation as required (to both the internal consultants and senior managers).

The external consultant could provide direct higher-level support to the accountable manager and project manager, and attend senior management meetings in which the accountable manager is personally involved. The external consultant could also deal with the more complex organization design issues, and could be accountable for:

- helping to ensure "organization design integrity" of the implementation structures, processes, methods, and techniques from an organization design perspective;
- provision and transfer of organization design expertise, including optimal deployment of external consultants and their work.

The external consultant could also provide people change management and project management support. They would be the direct link to the project manager, and between the two of them they would oversee the implementation and would have coordinative and monitoring accountabilities.

The best value may be realized by combining the quality assurance from the external consultants, but having 70 to 90 percent of the work done inside the organization. This provides significant benefits at reduced costs.

Organization design managerial leadership keys to success

The literature on organization change has consistently shown that a significant key to success is the leader (or, in our terminology, the manager or executive accountable for the organization in scope). Our experience has been consistent with that. We have generally found our client executives to have been highly capable and committed to improving performance.

These executives seek the input of others, but are prepared to make and back up important decisions. We once worked with a newly appointed executive who understood the value of better design. His team of direct reports had a full range of responses to a proposed organization design initiative. The most common appeared to be, "Keep your head down; this too shall pass." However, the executive stayed the course. His team started to get onboard when they read the assessment and recommendations, and were even more fully engaged when they became directly involved in the implementation and could experience it firsthand. One of the main critics at an early stage became one of the strongest supporters as matters evolved.

The head of the organization needs to "stay the course.'" The objective is to transform the organization in a sustainable manner. While much of the work is front-end loaded, staying the course (ideally through at least two business cycles) with continuous improvement adds considerably to the benefits.

While all leadership is critical in organization design, the other particularly important individual is usually the head of Human Resources. A significant aspect of organization design relates to people and human resources systems and practices. While the head of the organization in scope should lead the organization design initiative, the head of Human Resources is often accountable for the internal project team.

Suggested action:

15. The organization design changes that are agreed to should be implemented. The implementation should be based upon the organization design, project management and people change management principles and practices outlined in this review.

Section 5:

Summary of suggested actions

5. Summary of suggested actions

Suggested action	Page #
1. The organization design principles presented should be adopted and adhered to.	15
2. There are issues with percentage of managers, spans of control and manager-direct report alignment. These should be resolved as part of an integrated initiative to optimize organization design.	25
3. Stratum 1 first level positions, Stratum 2 professional positions and Stratum 3 manager positions should be properly stratified within the South Zone.	27
4. In some cases, Stratum 3 service delivery units should be strengthened by the introduction of a Stratum 2 team lead position.	29
5. The South Zone should be a Stratum 6 (6 level) configuration.	30
6. Contingent on the appropriate site-based supports being put into place, the South Zone should be functionally aligned on a programmatic basis.	36
7. Generic accountabilities and authorities should be developed for types of positions as appropriate (e.g. managers). These should be clearly documented in position descriptions.	39
8. The South Zone should develop position specific accountabilities and authorities for each position based on stratum and functional requirements.	41
9. The physician leadership model should be strengthened through appropriately matching accountabilities and authorities with the physician leader's FTE; appropriately determining where dyad joint leadership should exist; and, providing support and development for physician leaders.	43
10. The managerial and cross functional relationships between physician leaders, Sector VPs and the CMO office should be reviewed.	43
11. The cross functional relationship between provincial groups (provincial programs, SCNs, corporate support and clinical support) and South Zone should be reviewed.	44
12. People should be matched to positions based on the three criteria of information processing capability, skilled knowledge and application. These criteria consider and account for AHS' desire to have their leaders and staff "Live the AHS Values".	46
13. A comprehensive organizational planning and review system should be further enhanced and aligned.	48

Suggested action	Page #
14. Changes should be implemented to free up additional capacity for the Stratum 3 managers to perform stratum appropriate work.	50
15. The organization design changes that are agreed to should be implemented. The implementation should be based upon the organization design, project management and people change management principles and practices outlined in this review.	66