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ANALYSIS OF MANAGEMENT PRACTICE

THE FOUR FRAMES FOR CHANGE MANAGEMENT IN HEALTH SERVICES

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ABSTRACT

The delivery of health services is complex, and this complexity is exacerbated by embedded wicked problems requiring solving through change management initiatives. To create sustainable solutions and improvement healthcare leaders and managers are required to have a well-developed understanding of their complex organisation from several perspectives. The Bolman and Deal framework postulates that organisations can be viewed through four frames: structural, human resource, political and symbolic.

This paper presents a collection of four real life published case studies to show the four frames from the perspective of assessment and intervention, demonstrating ways in which the Frames can be applied to healthcare organisations. A retrospective analysis of the case studies demonstrates that the application of the Frames can lead to identifying areas for improvement and innovation and that they can play a role in creating strategies for evaluating health service improvement initiatives. The full potential of the Frames is only realised when a comprehensive approach is taken by utilising all four frames. Only then a better understanding of complex organisations takes place, helping healthcare organisations to improve and innovate.

KEYWORDS

Four Frame Model, Case Studies, Innovation, Leadership, Change management

INTRODUCTION

A positive organisational culture is a key ingredient of well-performing organisations. Many organisational development specialists and senior leaders use frameworks to create strategies to enhance organisational culture. Good theories and frameworks are at the core of effective organisational development and change [1]. One of these frameworks is the Four Frames of organisations: *structure, human resources, politics* and *symbolism*. The Bolman and Deal [2] Four Frame Model was developed to assist in the comprehension and approach issues about organisational diagnosis, development, and change. The Model assists leaders to gain greater insights into organisational behaviour, via a reflective approach in which participants consider the predominant frames that they are strongest in and strengthen those where weaknesses are identified. From this approach an individual can develop improved capability to lead or manage in a complex environment by reframing or learning to view the organisation from multiple perspectives.

The model aims to develop outward awareness, that is, the strengths and weaknesses of colleagues in the context of each Frame. Previous studies have utilised this model to undertake change in higher education [3], data governance [4] and pharmacy leadership [5] creating sustainable organisational improvements. Each frame is a cognitive concept and is envisioned in this model as a set of ideas and assumptions that assist in organising complex situations within an organisation. This creates the possibility for identifying and interpreting how organisations and their employees' function, by gaining a better understanding of human interactions and processes, and therefore how to change them. A frame can therefore work in varying ways, as a guide, device, lens, filter, prism, or simply a perspective [2]. A key limitation of the four frames relates to it being a framework, and not a full theory. Therefore, while the four frames draw attention to important phenomena, they do not make causal predictions on the interrelations between them, and this could be seen as a limitation of this framework.

For people working within and across health organisations, concerns and challenges are often present around issues such as complexity, ambiguity, disbelief and even deception. The Four Frames Model can be utilised as a tool to gain a more comprehensive understanding of health services, looking inward and from an external perspective. The Frames can contribute to the identification of areas for improvement and innovation. Healthcare professionals are at the fore front of innovation, as many of them are passionate about improving care outcomes, through evidence-based practice [6] and therefore the Frames align well with many health professions. Furthermore, the Frames can also play a role in the development of strategies for evaluating health service improvement initiatives. In this way leaders and managers can better understand healthcare organisations and services [2].

THE FOUR FRAMES

The *structural frame* is about the structure of an organisation and governance, including accountability, work allocation, rules, guidelines, systems, and chain of command. Inclusive in this frame are goals, infrastructure, the characters (employees) and relationships they have with each other, and the way in which they are coordinated. Essentially it encompasses all that contributes to the organisational functioning as an integrated approach. Within this frame, leaders, and managers design, maintain, and align their structure with what is currently needed and what might be needed in the future, the conditions, jobs, know-how, as well as the situation of the organisation, and its objectives. When the structure does not fit with the need, then challenges are likely to occur. Re-organisation or redesign may bring the structure back into alignment.

The *human resource frame* is about understanding people and the way they relate to each other. The needs of individuals are varied and can include fulfilment, anxieties, prejudices, skills to offer, and developmental needs. This frame enables the focus to be upon the fit between the individual and the organisation, allowing a better understanding of the match or mismatch. By caring for its people through the application of this frame, the organisation can understand better how to meet individuals' needs as well as being able to train and educate the individual to meet the needs of the organisation.

The *political frame* places emphasis upon power, rivalry, and competing for limited resources. People in an organisation are the context of this frame, with a range of values and beliefs, differing behaviours and skills all competing for power and resources. It is also the people in the organisation who set the agenda, initiate bargaining, and negotiations, and in their relationship with others, build alliances, compromise, and coerce, as well as manage conflict. Common themes in this frame include competing interests and the struggle for power thus creating either a toxic or creative and innovative environment. From a healthcare perspective the Pathway to Excellence Program, a recognition program for healthcare organisations accredited by the American Nurses Credentialing Centre is a prime example whereby leaders use the political frame to create an innovative environment of evidence-based improvements [6]. The Program entails 12 practice standards enabling organisations to provide a positive work environment [7].

The *symbolism frame* is about the meaning attached to the activity, and the faith people have in that activity. This context focuses on the cognitive as well as the emotional reaction of members of the organisation to an activity, by focusing on the meaning of that they ascribe to the activity, whether as ritual or ceremony. Within the symbolism frame, it is the meaning of an action that matters more than the results; shared confidence and meaning within a group will instill energy, innovation, and depth into a project or activity. By contrast, procedures (formal and informal), guidelines, and managerialism matter less in this frame. Rather, team spirit, values, and the meaning that the group attaches to the project or activity, are the route to organisational effectiveness. The nature of this frame is to challenge leaders to create an environment in which faith, integrity, and meaning of a project or activity allows the support of its members. This notion becomes visible when patients and health professionals collaborate to improve an organisation's effectiveness and efficiency through a meaningful way to improve the delivery of healthcare, a core component of safe and high-quality healthcare [8].

For managers and health leaders, whether dealing with challenges of four-hour waiting times in emergency departments, community care needs, failures of safety processes, or underperformance of elective surgery, the Four Frame Model is a different way to try to understand and interpret health services, which are complicated and complex [9], and offer new ways to reframe health services. The frames are therefore a potentially powerful way to gain clearer understanding and perspective, leading to innovation to improve health services. The Four Frame Model can provide a new approach to effective change management. However, some limitations of the model need to be taken into consideration. The Four Frame Model allows leaders to be versatile and use appropriate frames of reference, adjusting their behavior to each challenge. However, this can introduce room for error, and if the wrong frame is chosen, it could damage or even destroy an initiative that once had potential. Similarly, the model provides almost no guidance in environments that have the kind of leadership that is more distributed. In that case, there are many agents simultaneously causing change, to the strategy becomes less clear because there is a variety of avenues to consider. The model simplifies the different management styles into a single approach when the truth is that sometimes several approaches are required to cause change. However, the four frames do have merit, and this demonstrated through four case studies proving the ways in which the Four Frame Model can be applied in management practice to successfully achieve change in a variety of health services.

METHODOLOGY

The four published case studies chosen share a commonality in that they all entail an improvement initiative. The case studies are underpinned by The Juran Trilogy [10] involving managerial processes including quality planning, quality control and quality improvement as a foundation for organisational quality management. These three interrelated processes are based upon Juran's seminal work that quality does not happen by accident, it must be planned, and that managers and leaders need to provide stability to prevent adverse change and performance variations, develop quality plans to meet new goals, and continually improve organisational processes and systems to create high quality services [11]. The focus of this paper is on how the four frames relate to the case studies and the outcomes of the case studies play a lesser role. The authors of this paper played a lead role in the case studies below, by implementing a planned organizational change.

CASE STUDIES

Case Study 1: "Patient Journey": Patient and family co-led redesign

The challenge with change in health services is being able to achieve evidence-based, meaningful solutions in a timely manner to effect sustainable improvement of patient outcomes, improved patient and staff experience and improved organisational impact. Campbell et al. [12] carried out 18 clinical health service redesign projects in the United Kingdom (UK) over a period of five years from 2003 and a further project in Tasmania in 2018 [12]. These projects were well sponsored by organisational leads and involved patients and families as partners (codesign) as a key part of the process for change. Project outcomes included broad health service improvements based on the needs and expectations of the stakeholders involved in these services [12, 13] and the development of a matrix sampling approach for health services, co-design research.

These redesign projects most obviously highlight how *Political and Symbolic Frames* can influence outcomes in health service improvement. Where Chief Executives make clear statements about the symbolic importance of projects by not sponsoring any other projects, the political implications are considerable amounts of power to deliver on one project, by one group of people. However, in the case of these projects, this standalone sponsorship also affected normal structural approaches (line management) through the undermining of local managers' power and influence. This created the potential for individual and collective resentment of those who were sponsored and protected to achieve their goals.

The *Human Resource Frame* becomes evident throughout these projects in the co-design components, that is working with consumers of the clinical services to better understand how to improve them. This also includes the utilisation of appropriate stakeholder engagement strategies and identifying the right people to fulfil the needs of consumers and the organisation. Healthcare staff are an important group of stakeholders in these projects as they can influence, and are influenced by, any systems and process change. This engagement also shows alignment with the *Structural Frame,* whereby ensuring all levels of staff in healthcare have a voice in redesign is part of the hierarchical nature of health service delivery. The development of various project parties, such as steering committees, working groups and sponsors play a major structural role in the success of redesign of health services.

Case Study 2: Integrating a reablement model in Community Care

In 2018, the University of Tasmania and local community care organisation, Family Based care (FBC), collaborated to develop, and implement a strategy for ensuring a reablement-based model of care was integrated into the service delivery model and that reablement was recognised as a stand-alone organisational value [14]. The project team consisted of FBC staff and University Nursing, Health Science and Medicine academics who worked together to develop training materials centred around how reablement could be utilised specifically as a tool within this organisation. These tools were utilised on an organisation wide level to provide a deeper understanding of the concept of reablement and how it applies to community care through the experiences of direct care workers and care coordinators.

There is clear alignment between the four frames and the way in which the reablement project was undertaken but also some inconsistencies that may have influenced the outcomes of this work. The project team started by utilising staff experiences and building upon existing behaviours to develop a needs-based training program in conjunction with staff, thus empowering them to grow professionally and personally. The *Human Resources* component of the project was strong and well supported by the organisation through shared vision and a focus on staff and client wellbeing. Opportunities were provided for staff to tell their stories in relation to reablement from the beginning of the project, in the education development phase, right through to the final stages of evaluation. Similarly, the *Structure* of the project focussed on how change could be made successfully and sustainably while meeting the needs of the staff in the organisation, their clients and more broadly the families of clients. Emphasis was placed on defining the goals, understanding what reablement was and how best to integrate this into a systems-based process. The care coordination staff worked closely with the project team to clarify the tasks involved in a reablement framework, to develop roles and responsibilities within the organisation and a sustainability model for ongoing success. *Symbolically*, this provided a sense of purpose and meaning for all staff working with clients, particularly when they were able to physically see the change in client wellbeing or when positive feedback was shared. The organisation also recognised the work of staff through rewards based on sharing their own examples of how they incorporate reablement into their daily support activities with clients and some of the benefits that their clients are experiencing.

The Chief Executive Officer (CEO) of FBC was one of the main drivers for this project, a clear *Symbolic* statement about the value of this work and potentially inspiring and motivating staff to get on board. *Politically*, this statement highlights the organisation's vision and how this vision affects the distribution of power. In our project, staff were equal, they were each provided opportunities to be involved in the development of solutions and processes and identifying what was and wasn't working. However, from an organisational perspective, staff were told that they must participate in the training component of the reablement project as part of their role, suggesting that a power hierarchy was still in play. Other political factors to be considered in this project include the organisational funding scheme – clients are funded federally as individual care packages and therefore the organisation wants to provide the best care that they can for the money

they receive. Ensuring that reablement is a part of their care model potentially reduces the pressure on residential aged care facilities and hospitals, thereby reducing health costs more broadly. As a motivating factor, the economic outcomes for this project support the initiatives of the organisation and more specifically the CEO and management team.

Some limitations were evident through the Four Frame model for this project. An inclusive model was utilized where all staff participated in training and evaluation, however this did not always align with addressing staff sense of purpose or inspiring staff on a care level. Feedback from some staff was received indicating that they already understood and implemented reablement daily and that their time was essentially wasted being told to attend training. Similarly, some staff felt reablement was not something that was appropriate for their clients, or themselves, and they found it difficult to understand why a new direction was necessary. *Politically* this conflict had implications for relationships within the organisation from a hierarchical, power perspective and implications for clients and families who may have benefitted from a reablement type care plan. Overall, the organisation has adopted a reablement model as a core value and staff adhere to this model as demonstrated a qualitative evaluation.

Case Study 3: Establishment of a professional doctorate as a joint university and health service initiative

The importance of research conducted by nurse clinicians has been well recognised through the improvements seen in organisational efficiency, improved patient satisfaction and decreased mortality rates [15]. In the Tasmanian Health Service (THS) a major issue had come to the fore in that a limited amount of research was initiated by nurse clinicians. Partly, this issue was caused by nurse clinicians being ill prepared to undertake a research project. The THS and the University of Tasmania (UTAS) have a strong partnership arrangement in place and through this partnership the opportunity was presented to develop a professional doctorate to enhance current limited research capacity of the workforce with and to establish an academic health precinct for nursing and midwifery. Part of this initiative was to build a cohort of doctorally prepared clinical leaders in nursing and midwifery with research projects focused on improving clinical outcomes for patients. At the time of the creation of the professional doctorate, a debate took place for doctoral studies to become more industry focussed and to develop and to maintain closer collaboration between universities and industry [16]. This debate informed the way the professional doctorate was created.

Examining the initiative from the *structural frame*, it is evident that THS leaders and managers saw the need for a professional doctorate to increase organisational and patient outcomes. Central to this insight was the necessity to ensure managerial support for research initiatives undertaken by employees within their workplace. This support did not exist in some parts of the organisation, contributing to employees struggling with completing their studies. As leaders there is a central role in developing the social architecture and balancing this with the task at hand, such as overarching support for research. Similarly, the *Human Resource* frame enhances the initiative by working towards student empowerment and supportive relationships. Undertaking a doctorate is a long process and strong relationships are necessary to sustain the employees and to keep the links between the organisations strong. In this way the basic leadership challenge of balancing organisational and human needs could be worked through.

From a political frame perspective, the THS and UTAS operate in different political environments, created by both organisations having different operational priorities. The THS from an operational point of view needs to ensure that patients receive treatment and are cared for. The health service regards this as the main role of the clinician, while the University regards research and the provision of education as their main tasks. Therefore, these different political environments and priorities can lead competition for limited resources. This became obvious when at times employees were denied research time when clinical priorities escalated. Managing the politics of both organisations is necessary to ensure that research is moving forward, and employees are not caught in a power struggle. In the partnership there must be advocacy for each other's positions, to find a middle way between research and clinical demands.

Lastly, the *Symbolic* frame assists us to see that our shared basic leadership challenge is to develop faith in the initiative and its aims. Opportunities for ritual, meaning and storytelling are important. Such as making opportunities for students and senior staff from both organisations to get together to tell their stories. Students enrolled in the program have been

willing to come to tell of their journeys and symbolically say to their peers "you can do this too and you can make a difference". Opportunities for celebration are important.

Case Study 4: An organisational research capacity building intervention

Limited research capacity in Allied Health professions was identified as an issue existing within the Tasmanian Health Service (THS). In response, in 2018 a group of University of Tasmania (UTAS) academics and THS Allied Health Professionals established the Tasmanian Allied Health Research Group Intervention Trial (TARGIT). This program was designed to have an outcome focussed approach including improved health research capacity and culture, centred on the design, data collection, analysis, implementation, and dissemination of practice-based research.

From a *structural* perspective as part of the task orientated frame the efforts of the combined UTAS and THS leadership teams stressed the creation of an achievable strategy with measurable goals and clear responsibility lines. The major goal concentrated on building research partnerships, developing research experience, and raising THS managers' awareness and appreciation of the importance and value of research in practice. A workshop was conducted that focused on researcher awareness and expectations, developing research questions, building rapport and academic collaboration.

As the *human resource* frame places more emphasis on employees' needs by giving employees the opportunity to perform their jobs well by focusing on personal growth, and job satisfaction. THS managers were involved in participants' progress through encouragement and a report became a mechanism for progress updates and promoted a sense of accountability amongst participants. Mentor meetings between academics and participants were held and the frequency of these meetings were decided by the participants. This unstructured approach was designed to ensure collaboration was natural and real, reflecting attributes of good research collaboration relationships. Meetings of the TARGIT cohort were conducted at 6 months and 18 months into the delivery of the program to regroup, energise, monitor progress, and support the TARGIT cohort. Throughout the delivery of the Program participants expressed that manager support was critical to their success. Participants had varied experiences with the support they obtained from their manager. Some described it as an enabler, others described it as a barrier to finding the time to carry out research in their practice.

In terms of the *political* frame, the relatively resource poor environment for research for Allied Health Professionals in the Southern Region of the THS was the start point. Limited collaboration opportunities with academics and relatively low visibility and prioritisation of research amongst health service management. As part of the *political frame* coalition-building was central to building support for TARGIT. Strategies used to build research capacity within available resources included the utilisation of opinion leaders and these leaders advocated and negotiated between different interest groups for use of limited resources. It became clear that managerial support, opinion leaders and a shared commitment to develop research capacity in a resource poor context is of vital importance. In addition, group work, training, mentoring, supervision, partnership development and protected time helped in creating strong partnerships between the University of Tasmania and the Tasmanian Health Service.

The *symbolic Frame* addresses people's needs for a sense of purpose and meaning in their work. Outstanding performance through celebrations was a key approach and these celebrations were part of a conference organised for participants to present their research. The sense of purpose and meaning increased and this led to organisational support for research and awareness of managers' roles as research enablers. The outcomes of participants' projects clearly demonstrated the benefits of practice-based research embedded as core health business. Many reported outcomes included increased organisational efficiency, staff satisfaction, reduced staff turnover, improved patient satisfaction and decreased patient mortality rate [16]. The program seems to have advanced the development of research culture amongst participants, managers and the academics involved in the process. This is reflected in enhanced awareness, sustained interest, and ongoing collaboration between UTAS academics and health professionals in the THS. Using all frames has shown to significantly contribute to an enhanced research culture in the local Tasmanian health workforce.

DISCUSSION

Four case studies have been presented highlighting the ways in which the Four Frames can be applied in various health service and academic settings to achieve meaningful and sustainable change. Utilising elements of each frame at points during change creates a robust method for meeting the needs of people and organisations in the healthcare context. Consistent with previous studies [17], it was found that the structural frame is best utilised to focus on the rational aspects of engagement and leadership, such as setting policies and goals evident particularly in the Family Based Care model for implementing reablement into existing organisational values. Having the opportunity to be involved in change, regardless of hierarchy is a motivating factor for participation and having an equal voice. The human resources frame focuses on the interpersonal connections among all workers and managers, something clearly demonstrated in capacity building through managerial support evidenced in the TARGIT case. The *political frame* focuses on the conflict that arises from inevitable competition among different organisational groups, such as various departments which is clearly demonstrated within the establishment of a professional doctorate engaging two politically distinct organisations. Consistent with previous research [18] change in higher education should be based on scale and sustain with a focus on culture, which connects the four frames as interrelated components. Power can be the key to successful change, and appropriate power holders can influence motivation through signs of progress [18]. The symbolic frame focuses on social realities, such as the need for inspiration and passion, which can be developed through defining and maintaining value systems that foster an effective corporate culture, evident in patient-centered healthcare models.

Adopting a multi-frame, evidence-based leadership approach to change within a team environment is key to a positive, meaningful outcomes. A clear understanding of the context and each situation should guide the weighting of each frame to be considered at a particular point in time. Scouller [19] suggests that where a leader ascertains that the principal issue within a team is lack of motivation and commitment, the leader may adopt a *symbolic* and/or *human resource* (Frame) approach. If there is confusion around priorities and responsibilities, more success may come from adopting *structural* and *political Frames*. If a group is experiencing uncertainty and anxiety about direction and progression, then *symbolic* and *political Frames* leadership behaviours are more likely to produce effective results. Organisations typically lean toward a *structural Frame* through a hierarchy system which has a specific chain of command, policies, and processes, set roles and technological structure for change [20]. Less attention is then given to the three remaining Frames which may result in unsuccessful change projects due to an imbalance in organisational thought. The reablement case study demonstrated a shift in balance across the four frames at different time points consistent with a previous pharmacy reform study [21].

An authentic leader will learn to recognise workforce needs, adopting the frame that best meets those needs, thus inspiring relevant and necessary change. The Professional Doctorate case study suggests that highly rated staff in the health service might not be supported to undertake doctoral studies. Which could be *symbolic*. However, this could also be of great political significance, impacting the relationship between the two organisations. Bolman and Deal propose [2] that leaders should see the challenges of their organisation through these four frame lenses, so they have a complete picture. This method then allows leaders to decide which frames are most appropriate for meeting goals, aligning with values and visions of an organisation. This is a huge benefit for leaders because it provides an evidence-based, direct model of problem-solving and change within an organisation. The Frames are meant to be used as needed, which means leaders are supposed to use one frame for a while and then change to another. And so, for redesign work in the health service, for example, translational research of all kinds, as well as practice development, four frames is an interesting set of lenses through which to envision the challenges of change.

The fundamental focus of each frame is an important part of the functioning of the organisation. The organisation's whole functions are essentially based on the four frames. To understand the whole organisation, each of the four frames needs to be utilised. And as such the four frames are indicative of areas for focus, consideration, and adaptation. The design of the Four Frames Model requires multi-frame thinking and its application in the same manner. Limiting the thinking and application to fewer than the four Frames is a constrained approach. When a comprehensive approach is adopted from

all four frames, better understanding of complex organisations occurs, and the specific focus of the organisation can develop, improve, and expand.

LIMITATIONS OF THE STUDY

The limitations of this paper include the relatively small number, and broad overview, of health services case studies chosen to represent the advantages and disadvantages of the Four Frame Model. A further in-depth exploration of larger case studies where local and organisational change are being undertaken would provide a more robust analysis and allow for greater generalisability. However, this paper has demonstrated the value of using the Four Frame Model in a small number of case studies.

CONCLUSION

This paper has examined several ways in which the Four Frame Model can be applied to complex healthcare contexts through four case studies. The structural frame clearly identified that people from all levels of an organization need to be involved in change, as it stimulates participation. The human resources frame can be used to enhance the interpersonal connections among all workers and managers through mentorship and a shared vision. The political frame can be used to handle conflict that arises from competition among different organisational groups and finally the symbolic framework can be employed to create sense of purpose and meaning through storytelling. Proposed change should focus on sustainability and culture connecting the Frames as interrelated components. From a practical point of view, the Frames would be useful for healthcare leaders, as a vehicle to initiate, implement and evaluate innovative practices. Furthermore, healthcare organisations who are planning to embark on large changes or are examining ways to enhance their organisational culture might find the Four Frame Model a useful framework for implementing improvement initiatives, to apply multi frame thinking.

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CONFLICTS OF INTEREST:

The authors declare no conflict of interest.

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