SPECIAL FEATURE

The Brilliance Project: trying to understand great performance in the health service

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Abstract

The motivation behind having brilliance as a focus for a project in healthcare is about trying to understand it, and from that, trying to find ways of spreading such understanding widely so that brilliance is more pervasive in health services. One member of the team commented that they had been referred to as running a brilliant team, and responded 'that if that was the case, how bad must the rest have been?' Sometimes it is not easy to see brilliance in what we do, let alone measure it, but on reflection we can remember times when the teamwork was just right, although we did not know it at the time, but now see it as having been a special time. Hugh B MacLeod of the Canadian Patient Safety Institute (CPSI) has been pivotal in inspiring this work, and some of his input is outlined. This paper describes more of the background and motivation behind the project as well as some of the potential ways in which the Health Management Research Alliance (HMRA) is investigating and going about this project.

Abbreviations: **AI – Appreciative Inquiry; B – Based; CPSI – Canadian Patient Safety Institute; E-BM – Evidence-based Medicine; GBS – Griffith Business School; HMRA – Health Management Research Alliance; HRT – Health Results Team; JHHS – Johns Hopkins Health System; NHS– National Health Service; PGPI – Press Ganey Priority Index; QI – Quality Improvement; SHAPE – Society for Health Administration Programs in Education; UNE – University of New England; UTS – University of Technology Sydney.**

Key Words: **brilliance; brilliant performance; quality improvement; patient safety.**

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Introduction

The Health Management Research Alliance (HMRA) was created in 2008 at Griffith University and in 2009 morphed into an entity sponsored by the Society for Health Administration Programs in Education (SHAPE). It is now co-hosted by Griffith University and the University of New England (UNE). [1] The initiative for the Alliance came from the Griffith Business School (GBS) and then developed into a partnership with health facilities at Griffith and then other universities. It was no mean feat to get this Alliance established and the challenge was to find a project that would kick-start the research program. It was through a lengthy consultation process that the Brilliance Project emerged. Yet its genesis was not really planned or anticipated. It came out of 'left field', because we resisted the temptation to decide too early on what might engage us as researchers in a new partnership arrangement that was cross-institutional and hard to nurture because of the professional silos and ranking pressures that drive research in Australia and New Zealand.

One of the very early initiatives taken by the GBS to support the HMRA was to appoint Hugh B MacLeod as a Visiting Professor towards the end of 2009. As stated above, he is currently the CEO of the Canadian Patient Safety Institute (CPSI). Prior to joining CPSI in February 2010, he held senior positions with the Government of Ontario as Associate Deputy Minister Climate Change Secretariat and Assistant Deputy Minister System Accountability and Performance for the Ontario Ministry of Health and Long Term Care. During his four years with the Ministry he also was the

Executive Lead of the Premier's Health Results Team (HRT) responsible for a provincial surgical wait time strategy, a provincial primary care strategy, and the creation of Local Health Integration Networks. He has many stories about the change reforms he was involved in but one in particular captured our imaginations.

He described how he entered the Health Ministry post-SARS with a reformist government and many challenges, one of which was to redress wait times in public hospitals in Ontario. The issue had risen to high priority in 2004 and a Wait Time Strategy was launched in that year through the leadership of the HRT. By 2006 Ontario had moved from being a laggard to a leader with respect to wait times. [2-3] What really struck us as being brilliant was Hugh's description of how they developed expert panels to address issues such as wait times, but then provided chairs of the panels with only a problem statement instead of the usual terms of reference. They also had other parameters but this one stands out as integral to tapping what he terms System Brilliance. [4] While SARS provided the 'burning platform' for reform, what Hugh and the HRT did was so left field to what most of us know about reform strategies. He always speaks about getting people to ask the right questions and makes constant reference to having to start new conversations in healthcare.

Hugh was subsequently able to visit Australia in April, 2010 and attend a workshop on April 27, at the University of Technology, Sydney, (UTS). It had been organised to review the research we had been doing on change and reform. [5] The idea for the Brilliance Project arose from this workshop at which by default, Hugh ended up the key facilitator and gave us inspiration to pursue this topic.

Brilliance emerges

Principally, Hugh spoke about the need to find 'pockets of excellence' or 'brilliance in the system' as exemplars for others and as levers for change. He described possible contenders as 'courageous units, innovative teams, groups offering creative solutions to intractable problems' and so on. He talked about how we can draw on such examples as part of creating a 'ripple effect' in healthcare and to start to focus on the positives and good stories as opposed to the endless negativities that pervade healthcare change and reform. He once again gave examples of his own experiences with the reforms in Ontario around waiting lists and other interventions. He talked about how they used Appreciative Inquiry (AI) [6] (see later for a brief discussion) in their approach to reform in Canada and some of the core values that drove the change initiatives. He kept coming back to starting a conversation about healthcare in which we talk about brilliance and excellence and bring these to the forefront. He also said we should look across many areas, not just the hospital setting, to find our examples. Hugh also pointed out that almost everything that has to do with change and reform has to start with a focus on the relationships (the soft side) that have to be built and managed to achieve ongoing change or resilience. He went back to examples such as his expert panels and what they were able to achieve that others had failed at in the past. He also gave examples of experiments in primary care that forged new relationships and networks. [2-3] Hugh was inspirational, passionate and principled and he was worth listening to because he has had success as a reformer. He did not want to advocate a recipe book for others to follow but rather said that the reforms he helped to create were part of a transformational journey from which he has distilled lessons others can look at and learn from and then adapt to their own circumstances. At the finish of Hugh's presentation the group went into a discussion about a 'common project' around the idea of excellence and brilliance. It was evident very early on that everyone present had a different notion of what this might be and the issues it raised. The following attempts to summarise some of the key points:

- What stories would indicate that something is brilliant and/or excellent?
- How would we find them? How would we select them?
- Is it a project we could do on our own? Is it national and in what way?
- What grants would be needed to do this sort of research?
- How do we get a clear direction for what to do?
- How do we know when something has contributed 'brilliance' to the system?
- What do we mean by the 'soft side' – is it communication, culture, politics or leadership?
- What do we mean by relationships and relational?
- Should we start somewhere and see what happens?
- Do we need to understand what the difference is between change and transformation?
- Should we look at how we can explore new ideas, such as patient stories, combined with systematic/analytic discussions in order to identify good experiences?
- How are areas of excellence promoted in the system?
- Are there examples of good governance for the changes that are coming with the (then) Rudd reforms that might qualify?

- Is it to find a link between presenteeism, quality and safety and who is doing it well?
- Is it about resilience?
- Do we need a skills and toolbox approach?
- Is it about courage, discipline, leadership and the ability to deal with paradox as something that can't be resolved?
- Who are creating different conversations in healthcare?
- Is the adoption of AI a useful approach in the context of identification of brilliance or excellence?

The key questions that seemed to be raised in the 'wash-up' were: how do we define excellence and brilliance and how do we describe it? It was regretful that not everyone who is in the project had the opportunity to listen to Hugh because those of us who were present underwent a transformation of sorts and our journey started so differently to the rest of the group. It is still not a given that we will all arrive at the end with a common understanding of what brilliance means in healthcare and maybe that is as it should be. But at least some of us thought that it was worth thinking about what AI might mean for the project.

Appreciative inquiry

Hugh, in his presentations, praised the impact of AI as a new method of data collection and analysis. AI is 'an organisational development process or philosophy that engages individuals within an organisational system in its renewal, change and focused performance'. [6] AI is founded on a number of assumptions including that the way organisations change is about the way they inquire. AI's philosophy also asserts that if an organisation continues to inquire into problems or challenges, then it will keep finding them. However, an organisation that attempts to identify what is best about itself will uncover more that is good.

The basis of AI builds on the work of earlier action research theorists and practitioners but was embraced and established by Cooperrider of Case Western Reserve University and Suresh Srivastva in the 1980s. [6] While difficult for some cultures to take on board, the appreciative approach takes its inspiration from 'the current state of "what is" and seeks a comprehensive understanding of the factors and forces of organising (ideological, techno-structural, cultural) that serve to heighten the total potential of an organisation in ideal-type human and social terms'. [7] AI should have the following characteristics: appreciative, applicable, provocative and collaborative.

Grounding the brilliance discussion

As part of the UTS discussion, Paul Bate et al's book, *Organising for Quality*, [8] was also mentioned as it contains seven in-depth case studies from leading hospitals in the United States and Europe that have done exceptionally well (drawing on an evidence-based criteria such as peer assessment, quality awards and prizes) in their improvement journeys. Associate Professor Ros Sorensen from UTS had championed this book as a possible template for a project and it is worth outlining what it has to offer because it does show how to tap brilliance. The book focuses on cultural and organisational processes of Quality Improvement (QI) and produces a checklist of the most probable challenges that would be useful for practitioners to know about before embarking on a similar journey. The study used a team-based research approach that deliberately set out to cherry-pick organisations that were known to be successful and early adopters of QI. They did not capture all aspects of these organisations; only studying parts of them, namely the strategic (macro) and departmental or unit level (micro). The study adopted a qualitative, ethnographic case study approach (especially using narratives) to capture the complexity of the QI journey, utilising the journey metaphor as a powerful way to frame the presentation of their findings in much the same way that Hugh does. They did not set out to develop a model, given the unknown nature of what they were exploring and the complexity involved and therefore, never found a one best way to improve service quality but rather, to show that each organisation had its own template for change, again as Hugh advocates. What these entities all possessed were people in them who had the ability to identify the challenges they faced and then do something about them. Bate et al concluded that an enabling structure and culture were two of the most important things to sustain change associated with high performance, and this resonates with what Hugh had said of his experiences. [8] The mindset that sustained these successful journeys is one that is flexible and opportunistic because change, as they found, was dynamic (often unpredictable with lots of unplanned turns and roundabouts), processual and emergent. The case studies each brought a different perspective to the understanding of the QI journey in terms of their meta-narratives or key themes.

However, they argue that one of the biggest and most significant difference between their research and others on quality in healthcare, is that they have moved 'the spotlight away from the science of QI (the systematic, left brain aspects) to the social science of improvements (the messy,

right brain, human or people aspects). We see quality as not just method, technique, discipline or skill, but as a human and organisational accomplishment as a social process'. [8] They go on to describe how hard, left brain technical and operating systems factors (score-cards, metrics, measurement systems and technology, clinical pathways and evidence-based medicine (E-BM)) have dominated quality research while their research reveals how important it is to look at the right brain and the sociology, aesthetics and the organisation of improvement (organisation, culture, language and cognition, politics, value systems, identity, leadership, structure, strategy, citizenship etc). [8]

Bate et al's example of the San Diego Children's Hospital's complete revamp of components of its quality agenda shows how it moved away from the American Institute of Medicine's criteria, which focused almost entirely on left brain thinking, to developing their own that included such things as light, colour, texture, aroma and so on to frame their approach and really, to start a new conversation. The turning point in this case (ie, key decision point or defining moment) was when architects asked the hospital's Executive: 'What do you want this new facility to feel like?', effectively forcing a right brain focus that was nowhere on their quality radar. This case study is an example of what would qualify as brilliance because the hospital found that by changing their focus to the patient experience, as distinct from the journey, and using the lens of feelings, effectively gave them a significant competitive edge. [8] They would not have had the profound change in values and culture if they had stayed focused on a left brain quality mindset.

As a further way to move the project forward, both authors were invited to give a version of how they might approach brilliance in their own research. The point of doing this exercise was to show that by looking at the issue of brilliance or excellence, we do not have to be bound by any particular paradigm or approach (left brain only for example), and that we can select from any area of healthcare in which we have an interest and think we have seen brilliance. The real strength of the project could be the fact that we draw on a multidisciplinary approach and askew any tendency to silo our research. We could feasibly produce a book such as Bate et al's, but with a much greater richness in method and areas covered (eg, the inclusion of primary care or community-based healthcare initiatives and even Area Health Service governance). We could make sure that we pay particular attention to the relationship issue as Hugh had suggested. We could also look at how Bate et al framed their study and perhaps use their approach, if we want to start afresh. The fact is, we were engaged in a new conversation in which we had to keep our options open. We also told colleagues of how we had had dinner at UNE when Hugh was visiting and that we had two people from the Hunter–New England Area Health Service present on whom we tested our assumption that people in health know when they see brilliance. We asked them if they could identify a pocket of brilliance or excellence and they did and got very animated about the example they gave us which, without prompting, did not involve a hospital. Anyway on to our examples.

Liz outlined how she had been looking at exemplary leadership since 2004 and in particular, how she had chosen her case studies. She argued that most studies of leadership point to the particularly intractable problem of engaging doctors as clinician managers or when engaged, their inability to provide the leadership needed to enact reform and change. However, she argued that failed, faulty or flawed engagement, especially on the part of doctors, dominates the discourse of leadership in healthcare and this means that we lose sight of the fact that 'successful', 'good' or 'exemplary' leadership does occur at the level of clinical units, which is where she focused her study. Her research seeks to make a contribution to the study of leadership in healthcare, and in the realm of the clinician manager as doctor by addressing the issue of exemplary leadership, a topic that is now mentioned in the recent United Kingdom National Health Service (NHS) review of leadership. [9] Her research involves discovering how clinician managers, namely doctors who were identified by their peers to be exemplary leaders, interpret and frame their leadership experiences and to what extent their co-workers produce confirming or disconfirming accounts so that different approaches can be developed for leadership programs. She is interested in those clinician managers who are at the level of a head of department or equivalent and who, as Bolden, Petrov and Gosling [10] would argue, are situated at the interface of the discipline, the profession, the institution and the academic realm and hence, are in the thick of leadership contradictions, paradoxes and conflicts. Her work has given her examples of what she says are 'WOW' moments when what clinicians are doing have left her feeling that this is brilliant. An example that she recounts is of a Head of Unit who, along with his team, have created a new governance structure in which, though he is the official head of the unit, he has a committee with a Chair to whom he reports and is held accountable for a range of matters. In short, this is a distributed model of leadership that would merit being used in many contexts not just health and is at the core of good governance, teamwork and ensuring professionals engagement. This was not the only example she gave.

Johns Hopkins Health System

Contrasting Bate et al's [8] approach, Steve was keen to make the point that some organisations are known to be brilliant, and have remained so. They have organisational development approaches that are useful, but these alone do not create brilliant performance. An example of such a health organisations is Johns Hopkins Health System (JHHS). [11]

JHHS has identified Service Excellence as a leading organisation-wide priority. 'Our objective is to achieve excellence in customer service equal to our excellence in education, research, and clinical care'. The surprise here is a separation of customer service from education, research and clinical care, where the customer/patient focus certainly remains central in education and clinical care, with the customer being clearly identifiable. Part of the justification is that health services in the United States are driven by the realisation that the way to keep their customer base remains excellence in clinical care, but also in the service mentality and presence of their staff.

Press Ganey Priority Index

A key part of the development work in excellence/brilliance is the use of the Press Ganey Priority Index (PGPI). [12] Press Ganey is a company that has been providing consultancy into a large range of health services in North America. One of the services they provide is PGPI. The method is commercially protected, but essentially it is a means by which priorities can be set for managerial intervention, when trying to achieve excellence in a service. Such a priority might be the identification of a key focus such as 'keeping people informed'. In this instance the notion of 'People' needs to be defined; such as patients, their relatives, employees, other service areas, visitors and doctors – the reality being all of the stakeholders that the departmental team communicates with. The next stage in the process is the identification of the nexuses of communications where improvements could be made. Similarly, the PGPI might identify 'involvement in decision-making', which could be argued to be a subset or a close relation to 'keeping people informed'. Developing systems that avoid the frustration felt by patients, employees, doctors and nurses, when these individuals have useful input to offer, but decisions are made without them. Even if the correct decision is made, teamwork and trust is affected by failing to involve key personnel in the decision-making process.

Johns Hopkins Health System – service excellence

One of the key themes of this paper is the ongoing question about how excellence/brilliance is judged. JHHS use a range of metrics based on different satisfaction results including patient satisfaction, referring doctor satisfaction, payer satisfaction (with an emphasis on the private health insurer's views on the service), and finally, employee satisfaction. [13] The latter is a move from the usual employee satisfaction about their own employment conditions, to their judgement about their satisfaction with the overall care package or service that they were part of and provided to the patient.

JHHS have other processes that are similarly engineered to ensure a systematically high standard. But JHHS was known to be a centre of excellence long before these systems were put in place. There must have been excellence and brilliance there already. The systems undoubtedly contribute to the quality of the service, but their existence does not create excellence or brilliance. They are merely systems for continuous quality improvement. However, some of the concepts and issues that they focus upon assist in creating an environment that can lead to excellence and brilliance. But that requires exploring the right brain issues involved because most of the above tells us about the left brain approach, whereas we need both to give us deep insight into brilliance at JHHS. Command and control seem to abound in JHHS, but this is not all the story, as recent developments include an excellence centre that focuses more on the soft side and a blog that is similarly designed. [11,14] Bate et al [8] show precisely this in their case of the San Diego Children's Hospital where clinical pathways are used in a mindful way and not as a mindless cook book approach. This is because there are certain things going on in the hospital and at the departmental level that are not only about measuring E-BM, and the like but also have to be described and captured in narratives and stories that make for great reading about the soft under belly of the quality journey and that is what brilliance should also be about.

The current situation with the Brilliance Project

Members of the HMRA were invited to a meeting in Sydney where it was agreed that everyone would have an opportunity to discuss what they thought might be a project that captures brilliance in healthcare. Members presented a variety of methods by which brilliance in healthcare might be uncovered or explained. All of the methods again had validity to colleagues present and it remains the challenge to find a method or methods to reach into the soft and undescribed aspects of brilliant performance in health

services. However, even with the different perspectives and methods you could still tag them around the left and right brain approach mentioned by Bate et al. [8] It is interesting that neither Bate et al nor MacLeod have focused on one domain alone and that is the challenge for us. We did come up with some things to ponder for the next meeting where we will have to decide upon some projects.

Conclusion

Hugh [15] recently wrote a paper that clearly identifies the need to balance the right and left brain approaches but even that requires a new conversation in various areas of healthcare that many might not see as necessary. Our own experiences with the Brilliance Project show that it is all too easy to slip back into the same old worn questions and answers about finding proof of brilliance in conventional ways and having to measure it and prove it quantitatively only so that slowly we end up back where we started. Each of us will have to think very hard about how our expertise, which in health is dominated by left brain thinking and methods, pushes us to see the world in a particular way, hence having a preferred take on brilliance that we might find hard to shake. If it was so easy for our colleagues at the dinner at UNE to tell us an anecdote about what they saw as an example of brilliance, why is it so hard for us to accept this as a starting point and go look at what they meant? Or for that matter, ask you our readers – what is your take on brilliance?

Competing Interests

The authors declare that they have no competing interests.

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