Collection of writings in memory of Professor Aidan Halligan, MA, MD, FRCOG, FFPHM, MRCPI, FRCC
Collection of writings in memory of Professor Aidan Halligan, MA, MD, FRCOG, FFPHM, MRCPI, FRCC

Friday 24th July 2015
Collection of writings in memory of Professor Aidan Halligan

Contents

1. Obituary 6

Papers by Aidan

2. The Francis report; what you permit, you promote 14
3. Lessons in leadership 16
4. The need for an NHS Staff College 18
5. Homelessness is a healthcare issue 23
7. Implementing clinical governance: turning vision into reality 26
8. Twenty-four-hour ambulatory blood pressure measurement in a primigravid population 31

Selected tributes to Aidan

9. Aidan Halligan - Goodbye to a good and wise man
   Roger Kline 37
10. Dr Michael Dixon tribute to Aidan
    Neil Durham 41
11. A tribute to Aidan Halligan
    Ann Pettit 43
12. Remembering Aidan
    Alex Bax 45
13. Hundreds pay tribute to health professional,
    Leicester Mercury
    Samantha Fisher 49
14. Three Lessons From a Good Man
    John Walsh 52
15. Euston Square Station – 1st May 2015
    Humaira Fiaz and Mayarun Nessa 56
16. A Tribute to Aidan Halligan
    – Reflections on what he taught me
    Siobhan Sheridan 57
17. Letter to the family and friends of Aidan
    Camila Batmanghelidjh 61
OBITUARY

Professor Aidan W.F Halligan
MA, MD, FRCOG, FFPHM, MRCPI, FRCC

Aidan Halligan died suddenly at home aged 57. He was a compassionate doctor and an outstanding leader who was proud of his Irish heritage. He courageously challenged the status quo in healthcare. He confronted bullying and harassment and championed a culture of high quality care delivered by well-led teams.

‘Doing the right thing on a difficult day’ was his mantra and he delivered on this every day. His email address made his priority abundantly clear even before the message was read... aidan@patientsmatter.org.

Aidan could never pass by someone in need, whether a colleague or someone quite unknown to him and living rough on the street. He always had a word of comfort or cheer for them. He was oft to say “…people will forget what you have said, people will forget what you did, but people will never forget how you made them feel”.

He was invited to speak at many events at home and across the globe; the content was as inspirational as it was challenging. He spoke without notes, from the heart, with wonderful humour, peppered with stories and never failing to make a lasting impression on his audience; the whole delivered with a beguiling self-deprecation. ‘I failed my finals’ he would say “can you believe that!’ Failure for him was never the end as
long as the lessons were honestly learned and responsibility for the mistake fully taken on board.

He and his wife Carol qualified together from Trinity College, Dublin in 1984. Aidan went on to be the youngest professor in his specialty of gynaecology and obstetrics, a Fellow of his College and the youngest doctor to be appointed Deputy Chief Medical Officer for England.

Between 1999 and 2006 Aidan held a number of very high profile appointments; notably as Head of the NHS Clinical Governance Support Team, then Deputy Chief Medical Officer and finally Director of Clinical Governance for the NHS. Much to Aidan’s credit the National Audit Office (NAO) Progress Report of 2003 made it clear that clinical quality issues were becoming more mainstream, clinical governance was imbedded in the corporate systems of most trusts and that there was evidence of growing staff acceptance of the purpose and nature of clinical governance components and their place in healthcare organisations.

Late in 2006 he turned his back on high office for the freedom to try out new ideas. For two years he ran Elision Health Ltd, an innovative training establishment in Leicestershire where surgical and multi-disciplinary teams could develop their skills. This approach was far ahead of its time.

In 2007 Aidan was appointed Director of Education at University College London Hospitals (UCLH) responsible for curricular and non-curricular education across all staff. His major achievement was the commissioning of a state of the art simulation “Learning Hospital” Education Centre – the first of its kind: designed around human factors education, with
sixteen CCTV cameras, simulation theatre and viewing room, simulated ward and a minimally invasive/robotics centre. This has been a resounding success, improving both quality of care and team leadership.

From 2008 to 2013 Aidan was Chief of Safety for Brighton and Sussex University Hospitals (BSUH), the first position of its kind in the NHS where he encouraged staff to speak up for those in their care, and for each other, and to focus on great bedside care. He constantly innovated and appointed the first independent Patient Safety Ombudsman with a whistle blowing remit across the hospital.

During this time he was asked to visit the field hospital at Camp Bastion in Afghanistan and the busiest and clinically the most challenged A&E in the world. A multinational hospital that was led by British regular and NHS reservist doctors and nurses whose personnel formed the largest contingent. He came back determined to replicate the leadership and cultural experience he had witnessed and to help colleagues at home fulfill their potential as leaders, so as to improve the care of those in their charge. He observed that if well-led teams, with a holistic focus on the patient can function in such an environment then why not back at home in one of the most developed Health Systems in the World.

Aidan’s response was Staff College, which he launched in 2010 hosted by the UCLH Education Centre and benefitting from the Learning Hospital facilities. The leadership experience espoused is based on the military’s selection and assessment techniques and delivered by a faculty of handpicked military, NHS and civilian leaders. Aidan has created a unique offer
where participants are able to see themselves as others see them and where their leadership skills can be developed in a safe, challenging yet supportive environment. Feed back is universally positive and stands testimony to Aidan’s vision and courage in setting it up with no commission, no regular income, just a determination that this was the right thing to do. The first devolved Staff College campus is now running successfully at Aintree University Foundation Trust in Merseyside. Staff College holds an annual leadership lecture for the Faculty and Alumni. Sir Robert Francis QC and Duncan Selbie, CEO of Public Health England have spoken and are the College’s first two Honorary Fellows. There is a proposal to name this event ‘The Aidan Halligan Memorial Lecture’ in Aidan’s memory.

The death of a homeless man outside UCLH resulted in Aidan engaging with Dr Nigel Hewitt in 2008 to set up a specialist homeless team. Aidan saw there was both system failure and profound injustice in the way homeless people were treated by the NHS, and by society in general. Building on the success of the first team Aidan decided the best way to make progress was to form an independent charity. ‘London Pathway’ came into existence in 2009. As the work spread in 2010 it became simply ‘Pathway’, with Aidan as its Chairman from the start. Pathway hospital teams are rooted in Aidan’s simple philosophy of combining personalised care and respect for the individual within a coordinated and holistic service delivered by the professional.

There are now ten Pathway teams in ten hospitals around the country and Pathway is a national charity focused on improving the health of the most excluded. Many thousands
of homeless people have received better care as a result of Aidan’s vision.

Latterly he went on to devise Well North, a strategic collaboration between Public Health England (PHE) where he was Leadership Advisor, the University of Manchester and a range of partners in 9 local areas across the North of England. The Programme seeks to reduce health inequalities and worklessness, a cause of ill health, and importantly improve individual, family and community resilience. The Programme brings both hope and opportunity to underserved people and communities; seeking out local leaders and supporting them, with partners in Staff College, to take on the challenges faced by circumstances that may have challenged their estate or street for generations. Aidan’s vision for Well North is to counter the philosophy that public services can be driven by a combination of (economies of) scale and standardisation. It aims to provide insight and evidence of what works, and together with those charged with delivering their local services, aims to help people voice what matters to them, and with the support of their community, take action to address those concerns.

Most recently Aidan was appointed Honorary Colonel of 256 Field Hospital. He delighted in this appointment, entering into every aspect of training and social life with his customary vigor; including tackling the high-level confidence course when this was sprung upon him.

Much too early and in his prime Aidan leaves his wife Carol and daughters Molly, Becky and Daisy, a large close family and a whole army of colleagues and friends, who together with
people who had just met him once, will never forget him. It was not what he said or even what he did. The true essence and enduring spirit of Professor Aidan Halligan was how he made you feel.

Present Appointments:

- Director, Well North (1.1.14 to date)
- Principal, NHS Staff College
- Director of Integrated Clinical Care, Central Manchester University Hospitals NHS Foundation Trust (1.1.14 to date)
- Deputy Medical Director, Aintree University Hospitals NHS Foundation Trust (1.1.14 to date)
- Leadership Advisor, Public Health England (1.1.14 to date)
- Chairman of Pathway – The Homeless Health Charity, UCLH (2009 to date)
- Chairman, Faculty for Homeless and Inclusion Health, College of Medicine (2010 to date)
- Member of the Health and Social Services Ministerial Advisory Panel for the Jersey Health Service (2009 to date)
- Vice President of the College Council, College of Medicine, Information, Communication and Research steering group (Sept 2011 to date; Member from 2010)
- Defence Academy of the United Kingdom: Member of the Joint Services Command and Staff College Advisory Panel (March 2103 to date)
- Chairman of the Assurance and Accountability Working Group for Inclusion Health, Department of Health
• **Non Executive Director**, Safetynet Board, Ireland (July 2014 to date)

**Honorary Appointments (1.5.03 to date)**

• **Honorary Colonel** 256 Field Hospital (17.3.13 to date)
• **Visiting Professor in the Department of Surgical Oncology and Technology of the Division of Surgery, Anaesthetics and Intensive Care** Imperial College London (1.2.05 to date)
• **Honorary Chair**, University of Manchester (from 1.1.14)
• **Honorary Visiting Professor**, Faculty of Health and Life Sciences, University of Liverpool (from 10.3.14)
The Francis report: what you permit, you promote

Aidan Halligan

Director of Education, University College London Hospitals NHS Foundation Trust, 250 Euston Road, London NW1 2PG, UK
Correspondence to: Aidan Halligan. Email: aidan@patientsmatter.org

What makes our National Health Service special is a very simple principle of British life: that the moment you’re injured or fall ill...the moment something happens to someone you love...you know that whoever you are, wherever you’re from, whatever’s wrong, however much you’ve got in the bank...there’s a place you can go where people will look after you and do their best to make things right again. The shocking truth is that this precious principle of British life was broken.

Prime Minister Statement in response to the public inquiry into the Mid Staffordshire Francis Report, 6th February 2013.

Our lives begin to end the day we become silent about things that matter.

In the end, we will remember not the words of our enemies but the silence of our friends.

Martin Luther King Junior

SILENCE FROM THE MEDICAL PROFESSION HAS BEEN DEAFENING SINCE THE RELEASE OF THE FRANCIS REPORT

Speech from the medical profession has been deafening since the release of the Francis report, and the patient stories emerging from Mid Staffordshire. What happened in this hospital should be a hammer blow to the conscience of our profession. What is most stirring about Mid Staffordshire is the destruction of our faith in values long held to be fundamental to our trusted National Health Service (NHS). Just as the printing press shattered the monopoly of the priests, the information in this report about appalling professional behaviours is altering the relationship between patient and doctor.

The medical profession’s technical and scientific brilliance has not been matched by its leadership or compassion – and yet, ironically, the profession’s authority arises from how much it cares. Sir Henry Tate commissioned Sir Luke Fildes to capture the character and bearing of the physician in 1891 in his now famous ‘The Doctor’, of which one million engravings were sold. It resonated with the public’s impression of a doctor. How many would sell today? Where have our voices been on behalf of patients since the report was published? As other hospitals are named, the number of avoidable deaths rises steadily. Why has it taken the release of the Francis report for other information to surface?

Journalistic punditry abounds and everyone has a theory, but there is a sense of suspended disbelief. Do we accept what Francis has concluded? Were these deaths and so many others avoidable? Have any lessons been learnt and how do we demonstrate what has been learned? We know, in graphic detail, beyond any attempt at denial, what happened. We know what should have happened. Why was there such a difference? The Francis report explains that it was a failure of the organization’s ability to deliver quality and safety. In the same year, an Institute of Health Improvement report said that the NHS had developed a widespread culture more of fear and of compliance than of learning and innovation.

The culture described by Francis at Mid Staffordshire was characterized by disempowerment, poor communication, isolated professionals, and processes. Staff averted their gaze. There was a disconnect between staff and the Board; a culture of fear and poor human resource practices. The consequences were a subtle withdrawal...
of enthusiasm and the avoidable deaths of 1200 patients.

We are, in the end, all responsible for our actions, conduct and work. The privilege of professions in this country is their right to self-regulate, and wedded to that right is a responsibility to self-police. That duty of self-policing is better characterized as peer leadership, which is built on moral courage and integrity.

We are occasionally led into disbelieving the evidence of our own eyes. There is nothing as deceptive as an obvious fact. Everyone knows, nobody says. The phenomena are well described: normalization of deviance and wilful blindness. These life-threatening phenomena can only be addressed through leadership. Can leadership, then, be taught? The problem is that what is offered reflects what is expected – little of what is taught on traditional leadership programmes prepares would-be leaders for the reality of leading.

There is no doubt, no matter what the rhetoric, that the current drive to cut costs in the context of increasing demand, will inevitably impact, and at scale, on our duty of care to patients. The horrors at Mid Staffordshire Hospital were failures of clinical care but, to quote Heather Wood, author of the Healthcare Commission Report into Mid Staffordshire, ‘these were the symptoms of a serious underlying illness’. Too many people in leadership, from whom we ought to expect more, have been willing to bend the truth and re-write facts for their own convenience. The roots of this affair go much deeper than those who caused immediate harm to patients. The cultures of target setting and corner cutting that caused such anguish to patients and their families, and which have been replicated elsewhere, were set far higher up in the health service. But who was to blame? Apparently, no one and everyone.

Francis and others are, of course, correct: accountability is not about punishing people. True leadership is having the conviction to be accountable. As Leo Amery said to Chamberlin in 1940:

You have sat too long here for any good you have been doing. Depart, I say, and let us have done with you. In the name of God, go.7

What you permit, you promote.

References
5 Wood H. Mid Staffs shows what’s wrong with NHS management. BMJ 2013;346–774
Lessons in leadership

Aidan Halligan1,2

1Director of Education, University College London Hospitals NHS Foundation Trust, London NW1 2PG
2Chief of Safety, Brighton and Sussex University Hospitals NHS Trust, UK

Correspondence to: Aidan Halligan. Email: aidan@patientsmatter.org

“...there is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For, the reformers have enemies in all those who benefit by the old order and only lukewarm support from those who profit by the new order, because of the incredulity of mankind, who do not truly believe in anything new, until they have the actual experience of it.”

Niccolò Machiavelli (1469–1527)

General practice led commissioning is central to the NHS reform programme with a clear mandate to deliver service change and improved efficiency.1,2 Leadership decisions and the development of good leadership are important in any age, and perhaps, just now, more important than they have ever been before. The presumption of confidence in the NHS is the greatest asset it owns. Mismanagement of initiating this new order of things could seriously undermine that public trust.

Those who cannot remember the past are condemned to repeat it – at the heart of every major NHS inquiry over sixty years, there have been two critical issues: the first is people and relationships, which for those looking in from the outside, appears to be a nebulous, somewhat hard to understand issue, when the presumption is that all healthcare professionals work together to act in the patient’s best interests. The second issue is the brutal lack of kindness – something us professionals struggle to come to terms with, but the issue that most angers the general public and leads to demands for public inquiries. Anyone who has been seriously ill knows that it is the individual acts of kindness on the part of nurses, doctors, receptionists and portering staff that make it possible to cope.”

History suggests that we don’t learn the lessons – in fact, experience reflects that we make the same mistakes with increasing confidence. It is almost as if we invest vast amounts in public inquiries but never seem to pause long enough to understand, learn from and respond to the lessons emerging. How many more public inquiries do we need to fully grasp the cost of poor, indifferent or absent leadership among our professionals? How much more regulation is possible? Once you lose trust in a person, a political party, the brakes in your car, the safety of an airline or the competence of your hospital or GP, then everything about your fallen object of trust is seen with new eyes. Consider the growing elderly population for instance. There is a real, evidence-based (regulatory body report after regulatory body report) concern on their and their relatives’ part that an NHS elderly medicine ward is a place of no return.4 In the drip, drip of insights seeping daily from the Francis Mid Staffordshire Foundation Trust Inquiry, the steady erosion of trust in the NHS continues. The emergent consensus is that there was a lack of clinical engagement – that the doctors and nurses didn’t seem to care enough. The culture described wasn’t confined to just one hospital but is known to exist in part and in whole throughout the NHS. That culture has at its heart poor leadership – individuals in responsible positions who failed to take responsibility, who permitted poor behaviour, who themselves displayed unacceptable behaviour – through their attitude, emails, conversations, clinical care and relationships with their colleagues – good individuals who did not do the right thing, particularly on a difficult day and were not accountable. Individuals who had completed many leadership development
programmes. Individuals who did not act, less because of a lack of regulatory guidance and more because of a deeply felt reluctance to go against ‘how things are done around here’. How many local GPs knew what was happening in Mid Staffordshire and couldn’t find their voices to protest? Similarly, how will clinical commissioning groups challenge secondary care consultant led services that are deemed not to be of an acceptable standard? Don’t we spend a fortune on leadership development and if so, what is it we teach? How do you influence a poorly behaving colleague in an organization with weak governance and workforce practices? All of this has been known for many years and certainly before the Mid Staffordshire inquiry began.3–7

Without fit for purpose leaders and proper leadership development of the over 250 clinical commissioning groups who will assume £60 bn of funding from 2013, there is real potential for the undermining of public trust in the NHS and for clinical catastrophe at scale.

Governance and regulation from outside are important but they are less important and can do less for patients than professionals at the bedside and in the surgery. Self-regulation needs revisiting: doctors influence doctors and nurses influence nurses. Leadership and vision are everything in this context.

This piece is an introduction to lessons in leadership which will offer real life learnt lessons on how to influence capable professionals to do the right thing on a difficult day. There will be no mind numbing case studies about ‘enablement’ ‘empowerment’ or ‘process re-design’. There will be stories on the understanding that narrative is data and that there is no such thing as an isolated incident.

References
1 Department of health. Equity and Excellence: liberating the NHS. DH, 2010
The need for an NHS Staff College

Aidan Halligan
University College London Hospitals – Corporate Trust HQ, 250 Euston Road, London NW1 2PG, UK
E-mail: aidan@patientsmatter.org

What is the nature of the issue?

‘Our lives begin to end the day we become silent about things that matter.’ – Martin Luther King

As we head into the most severe financial cuts yet experienced by the NHS, there can be no doubt, no matter what the rhetoric, that a drive to cut costs will inevitably impact on the duty of care to patients. Rather than a disaster for patient care, the timely emergence of a new cadre of clinical leaders could allow this challenge to become the NHS’ finest hour.

‘A recognized but extremely rare complication results in an avoidable patient fatality. A structured debrief surfaces inadequate team safety training. Of the seven consultants in the specialty, five recognize the need for standardizing technique and implementing team training. Two of the consultants do not, and claim that the complication is just one of those things.’ (Author’s experiences of anonymized NHS situations)

It is extraordinarily difficult to measure the results of leadership and yet the results of leadership seem extraordinarily important. Healthcare is dominated by the extreme, the unknown and the very improbable, conditions that demand leadership, and, yet, we spend our time focusing on what we know and what we can control. Doctors and nurses are not managed into patient care, they are led. Behaviours and values are the lynchpin of sustainable performance. People measure their behaviours and beliefs by those around them. You get the behaviours you train for. You get the behaviours you reward. Behaviours need example. Teams need leaders. Every doctor and nurse in the NHS is part of a team. The importance of effective leadership is widely recognized and yet, to date, despite numerous attempts to address concerns about leadership development, there has been limited visible evidence of success. Undeniable characteristics of a well-led, open culture are easy to recognize but deceptively difficult to implement. Chief among those characteristics are staff speaking well of each other and an understanding and acceptance of the need to tell the truth to power. These hard to measure characteristics cannot be taught or imposed, they are the consequence of enabling trust, encouraging challenge and creating commitment. They are the consequence of leadership. Organizational reputation is about promises kept by doctors and nurses in the moment of patient care versus bold and principled mission statements.

In 2001, West found strong associations between the number of staff trained to work in teams and lower patient mortality rates. In a study of 61 hospitals in England, strong associations with lower mortality were found between the quality of a team safety training, encouraging challenge and creating commitment. They are the consequence of leadership. Organizational reputation is about promises kept by doctors and nurses in the moment of patient care versus bold and principled mission statements.

We propose to establish an NHS Staff College where selected leaders will be taught to express themselves, to challenge assumptions, to be innovative, to take risks, to try out new ways of doing things, to confront vested interests, to win over sceptics, to disagree openly and honestly, to manage their careers, to circumnavigate NHS politics, to do what is right, to lead. These leaders will be taught to communicate effectively and deliver organizational values, and beyond that, to performance manage expectations with a clear focus on what is right for each and every patient. In addition, these leaders will be taught to review organizational performance and capabilities, and to translate performance review findings into priorities for improvement.
There are widely held, substantive concerns about a colleague’s clinical performance and safety. He is nearing retirement and has a big private practice. He is generally recognized as a bully. Management seem content to do nothing and HR is ineffective.’ (Author’s experiences of anonymized NHS situations)

Since the inception of the NHS, more than 30 public inquiries have been conducted to address catastrophic failures in patient care. The same common themes emerge from each inquiry: professional isolation, disempowerment of staff, poor communication, ineffective systems and processes and inadequate leadership – the most recent example being Mid Staffordshire Foundation Trust. These recurrent lessons centre on people and relationships, poor collaboration, poor team working and a poor sense of patient-centredness. It is almost as if a clinical conspiracy of silence prevailed at the heart of such failing organizations. It seems as if progress is elusive because culture in healthcare has not changed.

In a role defined by the unintended consequence, medical leadership rails at the limitations of straight line thinking. Reality emphasizes the folly of valuing scientific knowledge or management diktats above all else, when hard evidence so often turns to thin ice on the wards or in theatre. The seductive simplicity of a P value or a management target provides no answer to what patients actually present with – their complicated lives, their experience of suffering and their personal styles.

‘A highly performing, technically excellent, long established surgeon is systematically disrespectful, aggressively condescending and routinely abrasive and intimidating to colleagues. His behaviour undermines morale and saps enthusiasm. Medical line management and HR feel they can do nothing.’ (Author’s experiences of anonymized NHS situations)

The focus must be on how doctors, nurses and other frontline staff can work together in well-led teams, rather than organizational restructuring. The recent National Audit Office Stroke Report emphasized the criticality of effective joint team working both within the specialist stroke unit and with social care to support discharge and then ongoing rehabilitation. One of the features identified as having led to a relatively successful implementation of the National Stroke Strategy was national and local leadership. Similarly, in another recent report by the National Audit Office on dementia, a similar conclusion was reached. Leadership, team working, good communication and collaboration are words that slip so easily onto the page. They are so effortlessly written and so comfortably accepted. And yet, the gap between the rhetoric of well-led teams versus the reality of the dominance of custom, practice and tradition is a consequence of confusing ease of understanding with ease of implementation. This gap reflects a values deficit where values are the moral underlying principles, the intangible character and spirit that should guide and develop the health service. Bridging that gap can only be built on leadership. The image of the medical profession continues in large part to be an idealization that reflects our medical student aspirations rather than our actual experiences. We appear to have slept-walked into a situation where salaried GPs feel less stressed than GP partners and where consultants, rather than trainees, are delivering direct patient care. This manages the known in the short term, while self-reliance and duty have been replaced by regulation and bureaucracy. And, we, as a profession, in the large scheme of things, have stood by almost, arguably, paralysed and watched this happen.

‘Patient falls, despite numerous management interventions, continue to rise.’ (Author’s experiences of anonymized NHS situations)

The real obstacles to quality and safety improvement in the health service are often found in unmeasurable patient care moments and include complacency, a lack of urgency, denial, averting the gaze, arrogance, institutional blindness and an acceptance of passive learning from mistakes made. Leadership for quality and safety improvement can influence each of these obstacles by reaching into the far recesses of individual discretionary energy. There is a clear resonance with the current quality, innovation, productivity and prevention programme (QIPP), which would support the concept that effective leadership provides safer services that reduces activity and makes for better and more cost-effective care.

Faced with an unyielding bureaucracy and inevitable budget constraints, organizations will
tend to do what they have always done, but faster. To achieve effective integrated care, culture management is as results-critical as performance management. The realities of patient experience and patient safety are less about bold and principled words than about the prevailing culture and promises kept by staff.

‘Medical record documentation is appalling and a common theme in severe untoward incidents.’ (Author’s experiences of anonymized NHS situations)

Since 2000, when To Err is Human® stimulated action to eliminate errors and mitigate the resultant harm in the United States and An Organisation with a Memory® initiated similar efforts in the United Kingdom, healthcare systems worldwide have devoted considerable attention to the safety of patients. Yet, despite attempts to reduce adverse events through multilevel interventions, there has been little substantial change in the critical area of healthcare culture – an area that has the greatest potential to produce sustainable improvements in patient experience and safety.11

‘Twenty two percent of ward medications do not reach patients.’ (Author’s experiences of anonymized NHS situations)

Frontline staff represent what is best about our NHS. Day in and day out, on weekends, bank holidays, 24/7, 365, they do whatever needs to be done, whenever and wherever patient need arises. They deserve the very best leadership – leaders of compassion who are clearly vocationally motivated and who are transparently accountable. Leaders of character and competence who act to achieve excellence. Character is the product of our best and worst experiences. It is who we are. It is our compass and the model for our values. Real leaders know themselves and the more we know ourselves, the better we will lead. Typically, however, the job description specification to run a leadership course in the NHS doesn’t include any management or leadership experience. Imagine being taught to fly by someone whose credibility was based wholly on study and analysis of flying, together with experience of education models, but had never actually flown? It is for this very reason that MBA schools are often so weak on leadership development. If ever there was a need to systematically develop NHS leadership, now is the time.

NHS organizations have countless stories about real doctors and nurses who faced excruciatingly tough decisions, where the conditions were not supportive and action needed to be taken, and often was, but more often was not.

What could we do even better?

There is an abundance of high-flown rhetoric, jargon and management-speak written around leadership. There is simply no easy way to develop those critical leadership skills. No matter how able you are, it is a set of skills that you can only acquire by doing. Leaders liberate others to be honest with themselves so that they can find the inner strength to do what they would rather not do. Medical leadership is no different. All too often the development programmes that exist do not achieve these desired results.

How, as a doctor or nurse, do you make your caring relevant? Good care, badly delivered, is always diminished. What is the point in keeping your head low, because you feel you can’t influence, when at some point in the future, that ‘averting of your gaze’ will come back to haunt you?

Leadership lifts people above their ordinary, personal wants and self-interest. It moves them beyond the material considerations of reward and coercion. It is leadership which motivates others to do more than they originally intended and often even more than they thought possible. Leadership comes to the fore in times of turbulence and change when people need to be shown a new way ahead even if their instinct is to stick with the familiarity of the old, whatever its cost.

In every organization there are hidden barriers to individuals doing their best. People are not contributing fully because they are unconsciously or consciously sidelined by others. These barriers are derived from the organization’s culture, the team dynamics and personal and interpersonal experiences. An effective leader would clearly understand the culture that they are operating in and be able to navigate and influence it through behaviour. It has often been said that culture eats strategy for breakfast – it doesn’t matter what wonderful and seemingly inspirational documents are produced to inspire and motivate frontline staff, if ‘the
way things are done around here’ isn’t aligned to the objectives of those documents, then whatever improvement programmes are planned, they are designed to fail. If patient safety and quality are not seen as an excellence to be achieved, then they will be seen as a standard to be complied with. Aptitude for leadership is not synonymous with the ability to lead – there are many individuals who have, on paper, everything that a leader should have to be successful. What they often don’t have is that inner strength from which they derive the courage and the will to act as they would wish to, particularly in adverse circumstances. Leadership programmes, more than anything else, should identify truths that help us cope with life as a leader. Many so-called leadership programmes are, in fact, management programmes, which can be defined as courses that provide the tools required to manage money, resources and people. Such courses are essential, but of limited value if not coordinated and directed by a leader.

Leadership is energizing people through motivation and inspiration – not by pushing them but by pulling them through satisfying basic human needs for achievement, a sense of belonging, recognition, self-esteem, a feeling of control over one’s life and the ability to live up to one’s ideals. Such feelings touch us deeply and elicit a powerful response. They are not the product of an MBA. They are not the product of a clever 10-modules syllabus. They are the product of leadership training and, crucially, experience that is delivered by leaders for leaders. The NHS Staff College can respond to this significant unmet need.

The NHS has had a massive increase in funding over the last decade but has failed to deliver better services proportionate to that investment. The question arises as to whether this is because the investment has primarily gone into the physical component of health delivery. It is accepted in the military that the best tanks in the world are useless if the soldiers manning them have no will to fight and are poorly led. An NHS Staff College, properly developing leadership and ethos and directly addressing the conceptual and morale components of health delivery, would accrue returns for the NHS out of all proportion to the investment required to run it. If the individuals, who by nature of our organizations are our greatest resource, are neglected, the cost incurred will be a lost battle or a Mid Staffordshire debacle. If we develop our staff, they will regularly exceed all expectations.

**Practicalities of the Staff College solution**

The NHS Staff College will aspire to encourage and equip the present and future leadership of the NHS to continually put the best possible care for the patients, staff and the public we serve at the very centre of their personal and corporate endeavour. They will be leaders who care passionately about the development of their own leadership skills and of those with whom they work and have responsibility for.

What will differentiate the Staff College leadership development from other leadership initiatives will be taking people out of their comfort zone and then building them back up with the fundamental blocks in place. This leadership development programme will also be different in that it will deploy the well-tried technique of teaching the fundamentals of leadership by those they will be leading. This programme will recognize that making tough decisions is often a lonely place and will seek to improve the sense of isolation that some people find themselves in when making those difficult decisions.

This will be an elite course, drawing students, directing staff, visiting contributors and key-note speakers from among the very best. There will be a strong commitment to learning from the experience of those who have excelled in the past; while developing skills that will be fit for purpose in the future.

The critical objectives of the NHS Staff College will be to equip individuals, within an NHS leadership framework, with both personal and institutional leadership skills. At the heart of the taught modules and curriculum will be four fundamental strands of leadership development:

1. **Self-awareness:** A series of exercises, immersive simulations and observations, which will allow delegates to get to know themselves through personal insights and relate these insights to how others see them. They will learn to recognize their recklessness, timidity, ego, emotions and their need for popularity.

2. **Self-management:** Among the most challenging hurdles for leaders to overcome is their ability to manage their own egos. These challenges...
come upon us in the most unlikely moments. This module will build on their self-awareness and employ that understanding to manage stressful and often uncertain moments, with targeted acquisition of skills to overcome the usual blocks of status quo inertia, limited resource, demotivated staff and opposition from powerful vested interests. The foundation methodology underpinning the self-management module is immersive simulation with structured feedback through expert facilitators, filmed scenarios and peer review.

(3) Leading the team: To achieve effective integration, the philosophy within teams must be team-centred, not self-centred. The culture has to move towards task conflict good, personal conflict bad. Once the beliefs and energies of a critical mass of people are engaged, conversion to a new idea will spread like wildfire. This module will combine self-awareness and the ability to manage moments of personal challenge to deliver team-leading capability.

(4) Big leadership: This final module will combine the self-awareness, self-management and the delegate’s ability to lead a team across a wider scope. This will allow them to explore how a combination of all they have experienced can support their ability to work outside of their normal environment, to influence policy, to see opportunity and to manage upwards.

Delivery of these objectives will be through a combination of personal development as leaders and development of the skill-set required to deliver consistent, sustainable performance. Personal development will be reinforced by mental attributes including the will to persevere, self-discipline, initiative, sound judgement and self-confidence. Core leadership values and ethics will be a consistent theme throughout.

The initial phase of the Staff College programme will comprise an off-site introductory briefing with, subsequently, a modular programme with an experiential theme underpinning throughout, with performance, simulations and role play exercises assessed not just against results, but against leadership performance (the ‘how’ will be measured as well as the ‘what’). There is an opportunity in this NHS Staff College initiative to set a new global standard in the development of healthcare leaders.

Recently, the Institute for Health Improvement, the American Joint Commission and the Rand Corporation concluded from three separate surveys across the NHS that there was a damaging rift between doctors and managers, i.e. that general practitioners and consultant contracts had de-professionalized and have had the peculiar effect of simultaneously demoralizing and enriching doctors. It was suggested that vocation is being managed out of healthcare professionals and that there is a tendency towards working to rule. These reports concluded that there was a culture of fear and slavish compliance. Inadequate leadership is a relentlessly recurring theme. If we always do what we always did, we will always get what we always got. The time is ripe to introduce an NHS Staff College.

References
1 West M. A matter of life and death. People Management 2002 February 21
4 Care Quality Commission. Review of the Involvement and Action Taken by Health Bodies in Relation to the Case of Baby P. London: CQC; 2009
6 Ham C. Another five year plan for the NHS. BMJ 2010;340:5-6
12 NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges. Medical Leadership Competency Framework. Coventry: NHS Institution for Innovation and Improvement; 2009

EDITORIAL

Homelessness is a healthcare issue

Nigel Hewett  •  Aidan Halligan
UCH Homeless Team, University College Hospital, 235 Euston Road, London NW1 2BU, UK
Correspondence to: Nigel Hewett. E-mail: nigelhewett@nhs.net

DECLARATIONS

Competing interests
None declared

Funding
None

Ethical approval
Not applicable

Guarantor
NH

Contributorship
Both authors contributed equally

Acknowledgements
None

Chronic homelessness is a red flag symptom, marking a significantly increased risk of ill-health and premature death. For too long the NHS has dismissed homelessness as simply an issue of housing and social care, but there is a growing body of evidence that long-term homelessness is fundamentally an issue of health.

A recent study of homeless patients (including hostel-dwellers) admitted to hospital in Glasgow with drug-related problems found that they are seven times more likely to die over the next five years than housed patients with the same drug-related reason for admission.1 Research from Canada shows that a 25-year-old man living in a shelter or rooming house has only a 1 in 3 chance of surviving to 75 years, compared to 2 in 3 for all 25-year-old Canadian men.2 The average age of death for homeless patients in the UK is between 40 and 44 years old.3

One consequence of the failure to treat and prevent the health outcomes of homelessness is increasing expenditure in secondary care. For example, comparison of practice-based commissioning data from a GP practice for homeless patients in Leicester with the activity of neighbouring inner-city practices shows that homeless patients attend A&E six times as often as the housed population, are admitted four times as often, and stay twice as long. The result is unscheduled secondary care costs that are eight times those of housed patients.4 There are estimated to be 40,500 homeless people in England (defined as rough sleepers plus those in hostel accommodation) generating secondary care costs of £85 million annually.5 Investigations by the Office of the Chief Analyst have shown that high secondary care costs associated with prolonged stays are not, as might be supposed, the result of bed-blocking. Comparison of duration of stay with Hospital Episode Statistics data shows that the lengths of admissions are generally appropriate for the admitting condition. In other words, homeless patients stay twice as long in hospital because they are twice as sick.

Chronic homelessness is characterized by trimerbidity; physical ill-health with mental ill-health and substance misuse. Primary care is the only specialty with the training and skills to address all of these issues in one consultation and most of the innovation around healthcare for homeless people has arisen in primary care.

There are a number of high quality homeless health services around the country that have developed innovative and collaborative methods of working with homeless people. But rarely has a Joint Strategic Needs Assessment identified an excluded group and commissioned a new service to meet their needs. Usually these services have been chiselled out by local champions, against active and passive resistance from commissioning bodies, but perhaps this is going to change.

A recent Cabinet Office project on 'Inclusion Health' draws attention to the particular needs of excluded groups such as homeless people, sex workers, gypsies and travellers, prisoners and those with learning difficulties.6 The combination of complex needs with chaotic lifestyles results in low expectations of healthcare, which are frequently realized. Both patients and those who specialize in addressing their needs often feel isolated and discriminated against by a system that seems to blame the individual who does not fit narrowly-defined criteria for access to services.

The Marmot review6 highlights the fundamental unfairness and injustice inherent in the increasing inequalities of our society, and the economic and social consequences that impact on the rich as well as the poor. He proposes a system of
Homelessness is a healthcare issue

‘proportionate universalism’ – helping all sections of society ‘but with a scale and intensity that is proportionate to the level of disadvantage’. For the homeless population this raises the possibility of improving outcomes by targeted investment, with the very real prospect of reducing unscheduled expenditure in secondary care.

Homeless patients and those who work with them are accustomed to the creativity and ingenuity that arises on the edge of chaos. One radical approach is to encourage multi-agency community teams onto hospital wards. At UCH, people with an experience of homelessness join a GP and nurse team on regular ward rounds to visit homeless patients throughout the hospital, advocate for their treatment in hospital, plan for their discharge and support them in the community. Early indications are that this approach improves care and discharge planning, while offering overall savings by reducing the small numbers of patients with very prolonged durations of stay.

Marmot encourages us in the words of Pablo Neruda to ‘rise up with me against the organisation of misery’. Working with homeless people to improve the health of their peers gives health professionals the opportunity to re-kindle the passion and vocation that took them into the caring professions, and offers the prospect of improving healthcare systems for the benefit of us all.

References
5 Inclusion Health. Improving the way we meet the primary care needs of the socially excluded. See http://www.cabinetoffice.gov.uk/social_exclusion_task_force/short_studies/health-care.aspx
The NHS is failing homeless people, says Professor Aidan Halligan. So why does this vulnerable group feel excluded from something they so badly need?
Education and debate

Implementing clinical governance: turning vision into reality

Aidan Halligan, Liam Donaldson

Clinical governance was the centrepiece of an NHS white paper introduced soon after the Labour government came into office in the late 1990s. The white paper provides the framework to support local NHS organisations as they implement the statutory duty of quality, which was placed on them through the 1990 NHS act. Clinical governance provides the opportunity to understand and learn to develop the fundamental components required to facilitate the delivery of quality care—a no blame, questioning, learning culture, excellent leadership, and an ethos where staff are valued and supported as they form partnerships with patients. These elements have perhaps previously been regarded as too intangible to take seriously or attempt to improve. Clinical governance demands the re-examination of traditional roles and boundaries—between health professions, between doctor and patient, and between managers and clinicians—and provides the means to show the public that the NHS will not tolerate less than best practice.

In 1998 Scally and Donaldson set out the vision of clinical governance: “A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” In this paper we take the story forward. Two years on, how is clinical governance faring in the NHS, and, with the advent of the national plan for the NHS, how is it being developed in practical terms?

Why clinical governance?

For most of its first 40 years the NHS worked with an implicit notion of quality, building on the philosophy that the provision of well trained staff, good facilities, and equipment was synonymous with high standards. The quality initiatives that followed, such as medical and clinical audit, took a more systematic approach. However, they were often criticised as professionally dominated and somewhat insular activities whose benefits were not readily apparent to the health service or to patients.

During the 1980s, managers and policymakers in many parts of the public sector, including health care, tried to apply the approaches of total quality management and continuous quality improvement. These approaches, which were developed in Japanese industry, were not widely accepted, perhaps because they were viewed as too management driven with no clearly identified role for clinical staff.

An internal market was introduced into the NHS in the early 1990s, but there was little evidence that opportunities were taken to embed quality improvements into the health service at a structural level. However, around the same time the NHS was given a national research and development function, and this forced it to re-examine the role of clinical decision making in improving quality. Adoption of the philosophy of evidence based medicine has resulted in more effective and consistent transfer of the lessons of research into routine practice. This has been carried forward as a core component of clinical governance.

Clinical governance was introduced at the end of a decade in which quality had been more explicitly addressed than ever before. It offers a means to integrate previously rather disparate and fragmented approaches to quality improvement—but there was another driver for change. The series of high profile failures in standards of NHS care in Britain over the past five years caused deep public and professional concern and threatened to undermine confidence in the NHS. Unwittingly, these events seem to have fulfilled a key criterion for achieving successful change in organisations—the need to establish a sense of urgency.

Summary points

Clinical governance represents the systematic joining up of initiatives to improve quality

Since the introduction of governance in the NHS, structures have been put in place to set standards and ensure that they are met

New approaches are needed to leadership, strategic planning, patient involvement, and management of staff and processes

The NHS Clinical Governance Support Team is providing task based training for health professionals, who learn as they do

Further details of the clinical governance development programme are available on the BMJ’s website
Key elements of the NHS quality strategy

Standards:
- National Institute for Clinical Excellence
- National service frameworks

Local duty of quality:
- Clinical governance
- Controls assurance
- Assuring quality of individual practice:
  - NHS performance procedures
  - Annual appraisal
  - Revalidation

Scrutiny:
- Commission for Health Improvement
- Educational inspection visits
- Learning mechanisms
- Adverse incident reporting
- Learning networks
- Continuing professional development
- Patient empowerment:
  - Better information
  - New patient advocacy service
  - Rights of redress
  - Patients’ views sought
  - Patients involved throughout the NHS
- Underpinning strategies:
  - Information and information technology
  - Research and development
  - Education and training

Framework to support quality improvement

Clinical governance is the central element of a framework that supports the delivery of quality. The box lists the national structures and mechanisms that help to develop and reinforce local clinical governance. The National Institute for Clinical Excellence and national service frameworks are important in setting quality standards. The National Institute for Clinical Excellence has a key role in appraising new technology (such as drugs and medical devices), providing guidance on the appropriate use of treatment interventions and procedures, and developing clinical guidelines for the management of specific diseases. The institute also produces clinical audit tools to support clinicians in local clinical governance activities. National service frameworks define evidence-based best practice for specific chronic diseases or patient groups. The standard setting mechanisms of these bodies are reinforced by the Commission for Health Improvement, which inspects clinical governance arrangements and provides feedback to local NHS organisations to inform development.

Policies to deal with poor practitioner performance and to learn effectively from adverse events and errors have been added to clinical governance structures to improve the safety of the clinical environment.

The national system of rapid assessment to examine concerns about a doctor’s practice will enable poor performance to be recognised earlier and tackled through a range of flexible interventions. It will also be more effectively linked to a reformed system of professional regulation.

The NHS plan has strengthened ways in which patient and citizen participation can influence the quality of health services. A patient advocacy and liaison service will be established, and patient advocate teams (with access to chief executives and with their own executive powers) will be available for patients and their families. The plan commits the NHS to improving patient information, consent, and participation. There will be patients’ forums and more lay contribution through trust boards to the work of the National Institute of Clinical Excellence, Commission for Health Improvement, and professional regulatory bodies, as well as to the work of the new NHS Modernisation Board. A new NHS charter will formalise these commitments.

What might clinical governance look like on the ground?

From listening to NHS audiences across England over the past two years, we sense that healthcare professionals feel clinical governance is the right idea. Most want to work in an organisation with a strong positive culture of teamwork, and all want to find better ways to deliver quality care.

Delivery of clinical governance will include new approaches to leadership, strategic planning for quality, patient involvement, information and analysis, the management of staff, and process management. There is no one way to develop each of these areas, but certain underpinning organisational attributes are essential to successful implementation. Whatever their style, organisations need a clear understanding of what might be expected under each criterion.

Effective leadership
An organisation benefits from being clear about (and being able to describe) how it is led and how this leadership is followed through at every level in the organisation. A well-led organisation will know how the vision, values, and methods of clinical governance are being communicated effectively to all staff. Such communication gives staff a common and consistent purpose and clear expectations. Good leadership empowers teamwork, creates an open and questioning culture, and ensures that both the ethos and the day to day delivery of clinical governance remain an integral part of every clinical service.

Planning for quality
Clinical governance cannot be developed by doing what “seems right.” Health organisations need a plan to develop the quality of their clinical services. The plan should be based on an objective assessment of the needs and views of patients, assessed exposure to clinical risk, regulatory requirements, staff capabilities, unmet training needs, and a realistic appreciation of how present performance compares with that of similar services and best practice standards. It is also important to ensure that key underpinning strategies (such as information technology, education and training, and research and development) are serving the purposes of quality assurance and quality improvement. Ownership of the plans needs to be generated not just at board level but right down the organisation in individual teams.

Being truly patient centred
Health organisations must be clear how information and feedback from former and current patients is used to assess and improve the quality of services.
Empowering patients with information, and increasing their contribution to planning services, can greatly influence the development of clinical governance. Contributions from patients will affect not just the responsiveness and performance of services but the process through which quality improvement initiatives are identified and prioritised (box).

All staff need to be patient centred in their work—from the doctor discussing treatment options with a patient in the consulting room, to the primary care nurse ensuring that the elderly diabetic woman can get in contact for advice if she has worries, to the hospital manager spending time in wards and clinics to see the care patients receive and listen to their comments.

Information, analysis, insight
A health organisation establishing a culture of clinical governance must develop excellence in the selection, management, and effective use of information and data to support policy decisions and processes. For information and data to be useful they must be valid, up to date, and presented in a way that provides insight. Good data and information used to highlight, for example, differences in outcome, shortfalls in standards, comparisons with other services, and time trends, are essential. This information is vital to tell staff how they are doing and show where there is room to do even better (box).

Ordinary people doing extraordinary things
People who work in the NHS must be able to make the best possible contribution, individually and collectively, to improving health care. The ideal of a service that enables all staff to develop and use their full potential, which is aligned with the organisation’s objectives, is rarely met.

One step towards this goal is for education and training to support the organisation’s implementation of clinical governance so that knowledge and skills are reinforced in the workforce. However, developing a workforce that is fit for purpose goes much wider than this. At the most basic level it means ensuring that staff feel valued, that they share in the policy discussions about developing clinical governance, and that management is seen to be trying to tackle their problems and concerns as well as seeking their ideas for improvement and innovation.

An effective workforce also needs appropriate technical support—for example, access to valid best evidence to support clinical decisions. Finally, the creation of a culture that is free of blame and encourages an open examination of error and failure is a key feature of services dedicated to quality improvement and learning.

Good service design
It is important to step back and examine how processes in the delivery of health care can be better designed. An organisation working towards implementing clinical governance could begin to describe how new, modified, and patient specific services are designed and implemented. It could include how changing patient requirements and changing technology are incorporated into healthcare service designs; how processes for delivering healthcare services are designed to meet patient, quality, and operational requirements (including best practice requirements); and how design and delivery processes are coordinated and tested to ensure trouble free and timely introduction and delivery of services. An integral part of process management includes examining how processes to design healthcare services are evaluated and improved to achieve better performance.

Demonstrating success
The ability to measure the quality of services is essential for successful implementation of a culture that supports clinical governance. Measures of effectiveness might include waiting times and turn

Case study: sharing information to improve quality in trauma and orthopaedics

Traditional system (as described by professionals from the trust)
- No system for benchmarking performance against national outcomes
- Clinical data were not shared
- No forum for discussion of clinical incidents or complaints
- No system to agree and implement new policy, guidelines, or protocols

After multidisciplinary review and agreement of shared objectives
- Weekly team meeting of all 7 surgeons, nurses, physiotherapists, managers, and junior doctors
- Care pathways and protocols have been agreed and are shared
- Agreed mechanism exists for implementing national recommendations and guidelines
- Mechanisms have been developed to review and deal with clinical incidents and complaints
- Clinical outcome data are shared and reviewed to allow modification of practice across the service
- Clinical outcome data are collected for benchmarking purposes

Case study: family centred care for children with complex needs

Traditional management (as described by professionals from the NHS Trust)
- Children were referred to each therapist individually
- After referral the child and family attended clinics in various places at various times
- Reports were returned, at various intervals, to the referring doctor
- Reports were reviewed in isolation—without the benefit of collaboration between professionals
- The child and family attended several clinics and often became confused about objectives, possibilities, work required, etc
- It could take 2 years for a child to reach the end of the evaluation process, during which time need had often changed

Response
Multiprofessional collaboration has facilitated the design of a family focused, effective, speedy package of care that is planned and delivered to suit the convenience and needs of the child and his or her family. A new service is currently being piloted.

Solution
- On first referral a child is visited at home by a member of the locality based team and the family’s health visitor
- Areas of need are identified and appropriate professionals arrange to assess the child and family at a time and place that suits the child and family
- All assessments are completed within 6 weeks and a single needs assessment report is produced in conjunction with the child and family
- Together, the child, family, and healthcare professionals agree the goals of healthcare intervention and formulate an action plan
- Progress is reviewed regularly
Examples of improvement initiatives undertaken by delegate teams

Primary care group where care of women with postnatal depression was found to be “hit and miss”—Early warning signs were often missed. Women with postnatal depression, and staff supporting them, felt that there was inadequate support. All professionals have agreed to implement the Edinburgh postnatal depression scale, training has been agreed and implemented, and interprofessional, evidence based assessment and management protocols have been developed.

Urology: discharge summaries found to be of variable quality and value—Eight surgeons and primary care professionals have collaborated. Discharge information is now produced by computer. It is legible, accurate, and timely, with full details of investigations planned, results to date, follow up plans, etc. Because data are now shared by all surgeons, the information provides a database for audit and measuring performance.

Long delays for initial referral and poor patient focus in adolescent mental health service—Multidisciplinary teams are working with healthcare professionals in primary care to produce shared referral, assessment, and management guidelines. A triage system has been developed to reduce waiting times; evening clinics have been set up so that clients no longer need to take time out of education; guidelines and standards are being reviewed and agreed across professions and organisational boundaries.

Ambulance service where blame culture meant critical incidents went unreported—In the past, a paramedic who made a drug error would have been instantly demoted to technician; there would have been an investigation, a disciplinary hearing, and a warning letter placed in the personal file. “Re-offence” within 12 months would result in dismissal. Now, with development of a “no blame” culture, system flaws are identified: drug storage has been amended so that systems became supportive of staff and protective of patients.

Further examples of improvements made as a result of the clinical governance development programme are available at www.cgsupport.org

Clinical governance development programme

The NHS Clinical Governance Support Team was established in 1999 to support the development and implementation of clinical governance.1 The team is now a part of the Modernisation Agency. Its aims are to promote the goals of clinical governance throughout the health service; to act as a focus of expertise, advice, and information; and to offer a training and development programme for clinical teams and NHS organisations.

The team runs a clinical governance development programme for multidisciplinary delegate teams drawn from organisations across the NHS. Delegate teams attend a series of five, task oriented workshops (learning days) punctuated by eight week action intervals spread over nine months. During this time delegates lead project teams in their organisations as they review, design, and deliver quality improvement initiatives. To date, 250 organisations have committed multidisciplinary teams to the five day programme.

The support team reinforces top down support for delegates by visiting health organisations and meeting their boards. The team helps boards to understand what staff have already achieved and plan support structures and dissemination strategies to spread clinical governance initiatives throughout the organisation.

The visits help the board to develop an organisational culture that supports whole system, multilevel improvement initiatives and healthcare professionals who “learn as they do.”

The programme follows the RAID (review, agree, implement, demonstrate) model (figure) to initiate a project culture within their organisation. The first stage is a large scale review of current service. Delegates gather staff and patient views, come to understand and define the baseline existing service, and collect evidence about current best practice. The process encourages the examination of traditionally accepted unwritten rules and beliefs.

The agreement phase involves flagging up the route to initiate improvement. It ensures that all healthcare alliances and partners have been involved and are contributing to defining a vision for the service. This phase is about winning “hearts and minds.”

The implementation phase capitalises on the enthusiasm previously generated. Healthcare professionals are keen to measure, to know, and to prove that they are making an important difference for patients. They move naturally into the demonstration phase, where improvement activities are reflected in hard data that is then used to inform future development.

Each team of delegates works with a support team programme manager, who makes regular site visits. Delegates are helped to identify existing resources within their organisation and to secure more if necessary. Training, research, and educational materials are made available, and delegates have telephone and electronic access to the team and programme managers for advice and support. The box gives some examples of improvement initiatives that have been introduced by delegates. Further details of the programme are available on the BMJ’s website.

Conclusions

The first investigations into failing services carried out by the Commission for Health Improvement showed organisations that were poorly led.2,3 There were cliques and factions among groups of staff, management was ineffective, staff with concerns about standards of care were marginalised or worse, adequate systems were not in place, and the service was not seen through the patients’ eyes. The fact that these dysfunctional organisations were associated with such poor quality care will not surprise anyone who has read the succession of inquiry reports into NHS failings over the past 10 years.

The NHS has been late in realising that healthy organisations matter to patients. The challenge of
Measuring quality of life

Who should measure quality of life?

Julia Addington-Hall, Lalit Kalra

One of the reasons behind the rapid development of quality of life measures in health care has been the growing recognition of the importance of understanding the impact of healthcare interventions on patients’ lives rather than just on their bodies. This is particularly important for patients with chronic, disabling, or life threatening diseases who live without the expectation of cure and have conditions that are likely to have an impact on their physical, psychological, and social wellbeing.

Health professionals frequently make quality of life judgments when making decisions about the care of disabled patients, and the professional’s view on expected quality of life is often the key factor in determining whether effective treatment for a life threatening condition will be given or withdrawn. Professional’s perceptions may, however, be at odds with those held by their patients. It is therefore important to ask patients to assess their own quality of life using one of a growing number of reliable and valid measures.

Choosing an appropriate measure and using it in clinical practice can be problematic. Deciding to use a measure, however, presupposes that patients are able to assess their own quality of life and complete a quality of life measure. Some patients—and in some conditions many patients—are unable to do this because of cognitive impairments, communication deficits, severe distress caused by their symptoms, or because the quality of life measure is too burdensome physically or emotionally.

These may be precisely the patients for whom information on quality of life is most needed to inform decision making.

Proxies—both healthcare professionals and lay caregivers—can provide useful information particularly on the more concrete, observable aspects of quality of life.

Scores from proxies may be influenced by their own feelings about and experiences of caring for the patient.

When a clinician’s assessment of quality of life is at odds with that of the patient, the patient should have the final word.

advantages of using proxies to rate quality of life, debate the reasons why a proxy’s view and a patient’s view may differ, and suggest directions for future research.

Can proxies provide useful information on quality of life?

Quality of life tools measure subjective experience. Completing a quality of life measure on behalf of someone else requires proxies to put themselves in another person’s shoes, to imagine what it feels like to...
Twenty-four-hour ambulatory blood pressure measurement in a primigravid population


Objective: To establish the profiles of 24-h non-invasive ambulatory blood pressure measurement (ABPM) during the trimesters of pregnancy and the puerperium in normotensive healthy primigravidae.

Design: A prospective study in which 24-h ABPM was performed on six occasions in each subject: in the first trimester between 9 and 16 weeks' gestation; in the second trimester between 18 and 24 weeks; in the third trimester between 26 and 32 weeks and between 33 and 40 weeks; and finally at 6 weeks post partum.

Method: One hundred and six Caucasian primigravid women who were normotensive at their first booking visit were recruited consecutively from the antenatal clinic and had 24-h ABPM performed with the Spacelabs 90207 ambulatory system.

Results: Of the 106 women recruited, 98 completed 24-h ABPM on four of the five measurement occasions. Four women delivered prematurely before 33 weeks' gestation, thereby missing one ABPM measurement. Changes during pregnancy and the puerperium were assessed against the ABPM performed in the first trimester. There was no difference for daytime or nighttime systolic blood pressure between 9 and 33 weeks, but it rose significantly from 33 to 40 weeks. At 6 weeks post partum, systolic blood pressure was not significantly different from the daytime pressure in the first-trimester ABPM but was raised significantly at night. Diastolic blood pressure decreased significantly between 18 and 24 weeks for both daytime and nighttime. From 33 to 40 weeks it increased in parallel with systolic blood pressure, and at 6 weeks post partum it was raised significantly compared with first-trimester values for daytime and nighttime. The nocturnal fall in blood pressure was preserved throughout pregnancy with a significant difference between daytime and nighttime measurements present on all measurement occasions for systolic, diastolic and mean blood pressures and heart rate. There were significant differences between daytime ABPM and clinic blood pressure for both systolic and diastolic blood pressure up to 33 weeks. From 33 weeks until 6 weeks post partum there was no significant difference between daytime ambulatory and clinic blood pressures.

Conclusion: This study provides reference values for ABPM in healthy primigravidae with generally uncomplicated pregnancies.

Journal of Hypertension 1993, 11:869–873

Keywords: 24-Hour ambulatory blood pressure, pregnancy, primigravidae.

Introduction

In developed countries more mothers die in the perinatal period from pregnancy-induced hypertension than other causes, and the incidence of toxemia is greatest among primigravidae [1]. Consequently, blood pressure measurement is one of the most frequently used screening tests in pregnancy [2]. Conventional blood pressure measurement has several shortcomings in pregnancy: it provides a measurement that represents only a fraction of the 24-h blood pressure profile, usually under circumstances that may have a

From the Rotunda Hospital and the "Blood Pressure Unit, Beaumont Hospital, Dublin, Ireland.

Sponsorship: This study was supported by the Friends of the Rotunda, The Charitable Infirmary Charitable Trust and The Health Research Board.

Requests for reprints to: Professor E. O’Brien, The Blood Pressure Unit, Beaumont Hospital, Dublin 9, Ireland.

Date of receipt: 12 November 1992; revised: 8 May 1993; accepted: 21 May 1993.

© Current Science Ltd ISSN 0263-6352
pressor effect, and the technique is fraught with potential errors [3,4]. The development of devices capable of accurately measuring 24-h blood pressure non-invasively is proving valuable in predicting the cardiovascular complications of hypertension in the non-pregnant population, and it is likely that the technique will also prove useful in pregnancy [5,6]. Although reference values are now available for 24-h ambulatory blood pressure measurement (ABPM) in non-pregnant subjects [7-9], the use of the technique in pregnancy [10] has grown in the absence of such reference values. The present study was therefore undertaken to determine the profiles of ABPM in the trimesters of pregnancy and the puerperium in healthy primigravid women who were normotensive at the onset of pregnancy.

Subjects and methods

Subjects
One hundred and six primigravid women attending for their booking visit to the Rotunda antenatal clinic, who did not have a history of hypertension, renal or cardiovascular disease, or diabetes mellitus, were asked consecutively to enter the study. An explanation of the potential values of ABPM ensured that none of the women approached refused to participate. The study was approved by the hospital ethics committee.

Twenty-four-hour ambulatory measurement
ABPM was performed with the Spacelabs 90207 (Spacelabs Inc, Redmond, Washington, USA) [11] on five occasions in each subject: first trimester, at the booking visit between 9 and 16 weeks’ gestation; second trimester, between 18 and 24 weeks; third trimester, between 25 and 32 weeks and between 33 and 40 weeks; and in the puerperium at 6 weeks post partum. The Spacelabs 90207, which was programmed to deflate in 8-min intervals every 30 min throughout the 24-h period, was fitted between 0900 and 1000 h. Subjects were instructed to keep their arm still during recording. A cuff containing a bladder appropriate for the arm circumference was selected according to criteria of the British Hypertension Society (BHS) [12]. The 24-h period was divided into daytime (1000–2259 h) and nighttime (0100–0659 h) periods. A 24-h record was acceptable only if there were more than 15 daytime and nine nighttime readings.

Clinic blood pressure
One clinic blood pressure was measured carefully at each attendance for ABPM, using a standard mercury column sphygmomanometer according to the BHS recommendations [12], with particular care being taken to ensure that a cuff containing a bladder with dimensions appropriate for the arm circumference was chosen, and that subjects were seated and relaxed with the arm supported at heart level. In keeping with the BHS recommendations [12], diastolic blood pressure was taken as Korotkoff phase IV.

Statistical analysis
The 24-h ABPM data were analysed with the SAS Software Package (SAS Institute Inc., Cary, North Carolina, USA). Quantiles were calculated using the weighted average method in SAS PROC UNIVARIATE [13]. The first ABPM was compared with those in the second and third trimesters using one-way analysis of variance for repeated measurements in SAS PROC GLM [14]. $P < 0.05$ was considered statistically significant.

Pregnancy outcome
The internationally agreed definitions of gestational hypertension and pre-eclampsia were used to determine the outcome of pregnancy [15].

Results

Subjects
A total of 106 primigravid Caucasian women considered from a socioeconomic viewpoint to be representative of an urban Irish population, who were normotensive upon recruitment (blood pressure $<150/90$ mmHg at the first visit), not taking any medication other than iron and folic acid supplements, gave written informed consent. Six women dropped out during the study (four moved out of the Dublin area, two could not attend for ABPM because of domestic difficulties and the records of two patients were excluded from analysis because they lacked the requisite number of measurements), leaving 98 mothers who completed the study. Of these, four delivered prematurely after 33 weeks’ gestation, thus missing the fourth measurement between 33 and 40 weeks. No patient defaulted from the study because the procedure was found to be unacceptable.

Subject characteristics were: mean age 24.5 years (range 18–32), mean height 160 cm (range 150–170) and mean weight gain during pregnancy 9.9 kg (range 2.8–16). Of the mothers 48% were unmarried, the instrumental delivery rate was 30% and 12% were delivered by Caesarian section.

Twenty-four-hour ambulatory measurement
Four hundred and ninety-six 24-h ABPM were performed, yielding 11,572 daytime and 5,413 nighttime blood pressure measurements for analysis. An average of 23 daytime recordings and 11 nighttime recordings were obtained. Table 1 shows the means, medians, SD and 95th centiles for daytime and nighttime systolic and diastolic blood pressures for the five periods of measurement.
Changes during pregnancy and the puerperium were assessed against the first ABPM performed in the first trimester. There was no difference for daytime or nighttime systolic blood pressure between 9 and 33 weeks, but it rose significantly from 33 to 40 weeks ($P < 0.001$). At 6 weeks post partum systolic blood pressure was not significantly different from the daytime pressure in the first trimester ABPM ($P = 0.30$) but was raised at night ($+4$ mmHg, $P = 0.005$).

Diastolic blood pressure decreased between 18 and 24 weeks for both daytime ($P < 0.001$) and nighttime ($P = 0.04$). From 33 to 40 weeks it increased in parallel with systolic blood pressure, and at 6 weeks post partum it was raised compared with first-trimester values for daytime ($+5$ mmHg, $P < 0.001$) and nighttime ($+4$ mmHg, $P < 0.001$).

Mean daytime blood pressure decreased between 18 and 24 weeks ($P = 0.005$), but remained constant during the night until 33 weeks. From 33 to 40 weeks it increased for both daytime and nighttime ($P < 0.001$). At 6 weeks post partum both daytime ($+5$ mmHg, $P < 0.001$) and nighttime ($+5$ mmHg, $P < 0.001$) mean arterial pressure remained elevated.

Heart rate increased steadily from early pregnancy until 33 weeks. At 6 weeks post partum it had fallen below the first-trimester level for both daytime ($-5$ beats/min, $P = 0.001$) and nighttime ($-7$ beats/min, $P < 0.001$).

The nocturnal fall in blood pressure was preserved throughout pregnancy, with a significant difference ($P < 0.001$) between daytime and nighttime measurements present on all measurement occasions for systolic, diastolic and mean blood pressures and heart rate.

Table 2 gives confidence intervals for the mean differences between ABPM1 (9–16 weeks) to ABPM4 (33–40 weeks) and ABPM5 (6 weeks post partum), demonstrating a drop in blood pressure over the first three ABPM with a return to normal levels by ABPM4.

### Office blood pressure

Table 1 shows the means, medians, SD and 95th centiles for clinic systolic and diastolic blood pressures for the five gestational periods. There were significant differences between daytime ABPM and clinic blood pressure for both systolic ($-8$ mmHg, $P < 0.001$) and diastolic ($-9$ mmHg, $P < 0.001$) blood pressure up to 33 weeks. From 33 weeks until 6 weeks post partum there was no significant difference between daytime ambulatory and clinic blood pressures.

### Outcome

Seven of the 100 mothers developed pregnancy-induced hypertension. Four of these were classified as...
gestational proteinuric hypertension (i.e. pre-eclampsia) and three had gestational hypertension (diastolic blood pressure ≥ 90 mmHg on two or more consecutive occasions more than 4 h apart [15]). Two of the mothers with pre-eclampsia were delivered by Caesarian section; the remaining two and the three with gestational hypertension were induced and delivered vaginally. Three of the four women who subsequently developed pre-eclampsia had elevated nocturnal systolic blood pressure between 18 and 24 weeks. This finding was observed 13–21 weeks before its clinical detection.

Discussion

Hypertensive disease of pregnancy remains a major cause of morbidity and maternal death [16,17] and it contributes significantly to perinatal morbidity and mortality [18,19]. Any technique that can potentially give insight into hypertensive disease of pregnancy is therefore to be welcomed. The recent development of accurate devices for measuring 24-h ABPM is one such technique [11]. There are no published data yet on the accuracy of the SpaceLabs 90207 in pregnancy, but we have recently validated it according to the BHS protocol [11] in pregnant normotensive women and shown it to achieve an A grading for systolic blood pressure and a C grading for diastolic blood pressure (O’Brien E, unpublished data, 1993). The grading achieved for systolic blood pressure is one grade higher than in non-pregnant subjects, and the grading achieved for diastolic blood pressure is one grade lower. The better performance for systolic blood pressure can be explained by the fact that the SpaceLabs 90207 is more accurate in lower than in higher pressure ranges [21]. One of the interesting features to emerge from the validation study in 85 subjects was the ability of diastolic blood pressure measured by auscultation in pregnant women, which suggests that the apparent diastolic inaccuracy of the device in pregnancy may be due to this phenomenon rather than to the inherent inaccuracy of an automated device.

There have been relatively few studies of blood pressure change in normal pregnancy, and some of these studies have been biased by preconceived opinions concerning the definition of normal blood pressure and the blood pressure criteria for pre-eclampsia [22]. Nevertheless, the general consensus from the literature is that both systolic and diastolic blood pressures tend to fall in pregnancy, reaching a nadir in the middle of the second trimester and returning to prepregnancy levels at term [23–25]. In our primiparous women, there was a statistically significant rise in both systolic and diastolic blood pressure from 33 weeks’ gestation. There was no fall in systolic blood pressure between the first and second trimesters and, although diastolic blood pressure did decrease in the second trimester during the daytime and night-time, the decrease, although statistically significant, was not of the magnitude previously reported [22]. The observed decrease in daytime mean arterial blood pressure in the early part of the second trimester with a rise towards term is in accord with an earlier study [27], whereas nocturnal mean arterial pressures remained constant until 35 weeks. Nocturnal systolic and diastolic blood pressures and daytime diastolic and mean arterial blood pressures were all significantly higher at 6 weeks post partum. Although the time at which blood pressure returns to normal after pregnancy is debatable, if, as suggested by MacGillivray et al. [28], it can be assumed that the blood pressures observed at 6 weeks post partum are equivalent to prepregnancy blood pressure, it would appear from the present study that any fall in blood pressure in pregnancy must occur very early, rather than (as has been suggested) in the middle trimester [27]. The occurrence of higher clinical systolic and diastolic blood pressures than daytime ABPM up to 33 weeks, but not thereafter, is of interest.

The diurnal pattern of blood pressure during pregnancy has been investigated in a non-ambulatory setting using direct [3] and indirect [5] measurement techniques. Such studies have shown a preservation of the normal circadian rhythm in pregnancy and its reversal in established pre-eclampsia. Four of the present primigravid women developed pre-eclampsia in late pregnancy. Interestingly, three of these women had lost their nocturnal dip in blood pressure between 18 and 24 weeks’ gestation. This finding was confined to this group and occurred 13–21 weeks before the women were diagnosed as toxaeic. This observation, together with the recognized unreliability of clinical
blood pressure [28], suggests that ABPM may have an early predictive value in toxemia and merits further study.

Acknowledgement

The assistance of A.M. Burke was acknowledged with gratitude.

References


Selected tributes to Aidan

Aidan receiving the Doolin medal in 2014
Goodbye to a good and wise man

A good man died yesterday. Aidan Halligan was a man whose footsteps we should all try to follow, in our own different ways. He did the right thing wherever he could and sometimes when it was very difficult to.

Professor Aidan Halligan was Director of Well North, a Public Health England initiative to improve the health of the underprivileged across the North of England. He was Principal of the NHS Staff College for leadership development and was Chair of Pathway, a charity developing NHS services for the homeless. He had been Deputy Chief Medical Office for England,

But, above all, Aidan Halligan was a wonderful human being. I first heard Aidan speak at a conference organised by Action against Medical Accidents (AvMA) the UK charity for patient safety. In the middle of an eloquent speech about patient safety he was challenged from the floor by a patient who complained about poor care at his then hospital and suggested he was a hypocrite because the hospital ignored her complaint about poor care. Aidan responded by immediately apologising, leaving the lectern, passing his card to the patient and publicly saying he would be happy to visit her at home at a time of her choosing. He later told me he had met the lady in question, her complaint was justified and upheld, and steps had been taken to redress and learn from the situation.

I asked to meet him. At short notice he gave me two hours of his time, proudly showing me round the stunning patient...
safety facility he had helped create at UCLH and quizzing me relentlessly about my values and what motivated me.

I went off and read some of his articles. In Life in the slow lane: making hospitals safer, slowly but surely http://jrs.sagepub.com/content/105/7/283.short Aidan and colleagues set out evidence of a successful approach to learning from mistakes.

Such work complemented his exhilarating speeches on leadership. In one he reminded us that “We know when we see a leader. They inspire us and when we’re inspired we become determined. And when we are determined we go further. That’s what leadership is about... And it’s your example that counts, not your rank. And if you care about patients to the point of being selfless, people will always respect that.” http://www.recoverystories.info/learning-leadership-how-to-become-a-leader-in-the-nhs-by-professor-aidan-halligan/

Aidan introduced me to the first NHS Patient Safety Ombudswoman, Delilah Hesling, herself a former victimised Brighton whistle-blower to whom Aidan was an immense source of strength, even in adversity. Delilah told me “Aidan was the brain child behind my role when he was our Chief of Safety at Brighton and his vision was to see an Ombudsman/Guardian in every NHS Trust. He sent me to the Francis Inquiry seminars and told me to meet Julie Bailey and tell them about my role, which I did. Julie suggested Helene Donnelly who was a whistle-blower in Mid Staffs be invited to take up a similar role. Aidan created ripples of good practice where ever he went. He did much more than support me in this role. It was his vision, he designed and created it.”
He wrote widely on leadership. He wrote that “too many people in leadership, from whom we ought to expect more, have been willing to bend the truth and re-write facts for their own convenience.” He criticised the “cultures of target setting and corner cutting that he argued caused such anguish to patients and their families, and which have been replicated elsewhere, were set far higher up in the health service.” He asked “who was to blame? Apparently no one and everyone.”

He wrote in Health Service Journal that the Francis Report on Mid Staffordshire “provides the single greatest leadership challenge the NHS has ever faced. And if we always do what we’ve always done, we’ll always get what we’ve always got. We don’t need a randomised controlled trial to tell us what every healthcare worker knows - some wards, teams, departments, divisions and hospitals are better led than others and this perception goes well beyond able management or command. At its core, leadership is a purely moral and emotional activity. It is unconnected with seniority and only loosely related to intellect and it is about the ability to engage, motivate and inspire. It is defined by our values and implies having moral courage, integrity and the conviction to accept accountability.”

You can get a flavour of Aidan’s wisdom on leadership here

Aidan was a graduate of Trinity College Dublin and it may be that his experience as an Irishman, and his personal experience of bullying, led him to his sharp insights on race discrimination. He was certainly one NHS leader who understood the depth of racism in the NHS and the scale of
denial about it in some quarters. In his most recent years Aidan put his immense energy to work in a radical public health initiative as Director of Well North, a Public Health England initiative to improve the health of the underprivileged across the North of England.

I had occasion more than once to hesitatingly ask for advice on tricky issues and on every occasion his wisdom humbled me. A wise, gentle man, who cared desperately about those less fortunate than himself.

Goodbye Aidan. You will be missed by many. We need NHS leaders like you more than ever.

Roger Kline,
Director, NHS Workforce Race Equality Standard:
Engagement and Research at NHS
Apr 28, 2015
NHS Alliance chairman Dr Michael Dixon has paid tribute to a former deputy chief medical officer for England who has died aged 57.

Dr Dixon said: ‘The premature death of Professor Aidan Halligan at the age of 57 sees the loss of a giant in British medicine, who was a friend and frequent speaker at NHS Alliance conferences. A man of unequalled courage, integrity, colour and passion. A man who spoke truth to power and everyone else. He is, quite simply, irreplaceable.

‘Many will remember him as the national clinical leader for clinical governance, as part of health service reform at the turn of the century, and then as a charismatic deputy chief medical officer. He could have achieved high office in the NHS..."
or anywhere else, but he was an independent thinker who would not trade integrity for promotion.’

Dr Dixon added: ‘He then pursued his two lifelong ambitions to improve the quality of clinical leadership and lead improvement in care for those in most need, which led to groundbreaking work on behalf of the homeless. Latterly, he was leading the NHS Staff College from strength to strength and had started a ground breaking project, Well North, to improve the health and care of deprived communities in 10 cities of the north of England.

‘Aidan will be remembered by many generations as an outstanding orator. Without notes, he would bring an audience to tears or laughter; but always with a serious underlying message as to how we could all do better. He was an enemy of cant, vested interest and inflated egos. To everyone else he offered support, hope and wise counsel. Aidan was a deeply good man and will be irretrievably missed.’

By Neil Durham on the 30 April 2015
A Tribute to Aidan Halligan

It was with great sadness that I learnt of the sudden death of Professor Aidan Halligan at the age of 57 years. Professor Aidan Halligan was Director of Well North and Principal of the NHS Staff College for leadership development. He will be sorely missed and I offer my condolences to his family, friends and colleagues.

It is hard to accept the loss of such a caring, vibrant, courageous man who made such a positive difference to patient care. Aidan had the courage to speak out about challenging issues. He was passionate about addressing health inequalities and he transformed services for homeless people. The wellbeing of patients and staff was at the heart of his practice. The NHS has lost one of the most compassionate leaders I have ever met. Aidan was an open and approachable person and role modelled warm, engaging and inclusive practice. He was genuinely interested in how things were going for staff personally as well as professionally.

I was privileged to have known Aidan and to have shared several thought provoking conversations with him. He enjoyed a good debate and challenged me to reflect on my values and motivation. He changed my response to homeless people and inspired me with his compassionate leadership. Aidan wrote a lot about NHS leadership and Roger Kline describes this eloquently in his recent tribute (https://www.linkedin.com/pulse/aidan-halligan-goodbye-good-wise-man-roger-kline).

Our initial meeting was at a conference where he shared his own personal journey in meeting the needs of homeless
people and disadvantaged communities. I was inspired by his genuineness and courage. We spoke about the role of the health visitor in addressing health inequalities and building community capacity and we agreed to share our ideas further. At our next meeting at UCHL we had to find a free room because Aidan did not have an office. He believed offices can create boundaries between managers and staff. As we searched for a free room he smiled and greeted everyone personally and they reciprocated. It was clear that Aidan genuinely cared for people and that he was well liked and respected. We talked about learning from mistakes and the after action review approach he developed with colleagues. He was committed to creating a blame-free culture and facilitating long-term learning.

More recently Aidan was an expert advisor to the Institute of Health Visiting (iHV) project which developed a support framework to foster resilience in health visiting. He also wrote about creating a compassionate culture for the voices section of the iHV website. In the voices piece he said that “the greatest gift we can provide others who are suffering is not advice but encouragement”. I am very grateful for the support and encouragement he gave me. I will miss his Irish wit and the kindness and wisdom he shared.

Thank you Aidan. It was a serendipitous moment when we met and you will continue to inspire me to be an advocate for clients and to keep compassion at the heart of my practice.

“Go n-éirí an bóthar leat”

by Ann Pettit
Remembering Aidan

The trouble with trying to write something about Aidan is that his own words, aphorisms and turns of phrase keep coming to mind. He would be thinking about how his words might make others feel, what messages he was communicating, what the purpose was. What would Aidan have said? What would he have done when a close colleague and friend died suddenly and completely unexpectedly?

One of his stock phrases was how the best people “do the right thing on a difficult day.” Grief certainly makes for some difficult days.

I first met Aidan when he came to see me in City Hall in London. Boris Johnson had just been elected and I was thinking about my own future. A colleague had called to warn me that a man called Professor Halligan was coming to see me and that I should be prepared: he had decided to sort out homeless health for the NHS. “A force of nature” - a phrase Aidan used about others. As he started talking I was pulled in by his intensity, self-deprecating wit, and Irish warmth. At the end of this first meeting he said, “Alex, I can see you are going to leave City Hall, give me a call when you do.” Aidan always seemed to be watching people, trying to understand what motivated them and what they felt.

When I arrived at UCLH Aidan had already started a homeless team, created and led by Dr Nigel Hewett and Trudy Boyce. Aidan selected people very carefully and was incredibly loyal to people he believed in. “You get your authority by how
much you care”. This sums up Nigel and Trudy, they both have huge authority and I think Aidan loved them for it.

Aidan could be both irritating and frustrating. He would be late, take calls in the middle of conversations, fire off multiple ideas in multiple directions. He would not leave something alone once he decided there was a problem, and if he found one route blocked he would immediately start looking for another way. Sometime he would see problems where we couldn’t see them. Over the six years we worked with Aidan, Nigel and I realized that often Aidan’s thinking was three or four steps ahead of us. He had already moved on, was thinking fast, and trusted us to fill in the gaps. When I confessed to not knowing what you did after you had occupied the beach, Aidan delighted in telling me, “Get off the goddam beach.”

Aidan enjoyed playing the politics of the NHS. The spread and breadth of his connections was incredible. As we talked about trying to spread the Pathway approach to homeless healthcare, Aidan would talk about finding ‘the right angle of entry’. Aidan was hugely amused when a TB nursing colleague pointed out some of the other connotations of this phrase. I already miss the Monday morning volley of emails – people he had met, papers he had read, ideas or suggestions of further action – all sent well before others had even got out of bed.

As we established Pathway as a charity Aidan naturally became Chairman of the Board. He was an impossible person to brief for Board meetings. He trusted the team he had assembled and always wanted to push on to the next thing, to discuss the next problem. But his antennae for how people felt were always on. Aidan noticed Pathway’s finance director seemed
uncomfortable about a decision on pay rates taken in a hurry at the end of the meeting. He immediately asked about the consequences of the board’s decision for our lowest paid staff. Ignoring the agenda Aidan opened the next meeting announcing that we had made an error, and asked the board to reverse the decision.

Three years ago Aidan decided we should organize international conferences to put the Faculty for Homeless and Inclusion Health further on the map. He opened each event and gave a closing address. He was fond of quoting Martin Luther King – “our lives begin to end the day we become silent about things that matter”. Having committed us to the events he worried endlessly that they should set the right tone, and each year he seemed more and more drawn in by the evident passion and commitment of colleagues who work in homeless health. I think Aidan felt most at ease with a group of people whose motives he decided must be true. People don’t work in homeless health for the money or status. After this year’s conference a 30 year veteran specialist homelessness GP said the events now ‘felt like coming home.’ Aidan knew the value of home.

Aidan never seemed to have a script for his speeches. At the 2014 Faculty conference I was sitting next to him as the final plenary session drew to an end, reminding him of people he needed to thank, and things it would be good if he said. He asked if we should run another event – I whispered how expensive, complicated and time consuming organising conferences was, but how much strength people seemed to draw from coming together. He opened his closing address by
saying “I’ve just spoken to Alex and can confirm that we’ll be running another conference next year.”

During the last weeks we have received innumerable messages of condolence, support and appreciation. So many people want to say how much inspiration they took from him. At our first conference Aidan summarized what he had learned: that the best homeless health services ‘never give up on a patient.’ For Pathway it is clear that we must never give up on his vision of a society where there are no catastrophically sick, lonely, frightened, people living without hope.

A couple of years ago a line from William Blake suddenly became part of Aidan’s rolling repertoire: “He who would do good to another must do it in Minute Particulars: general Good is the plea of the scoundrel, hypocrite, and flatterer.” There are hundreds of possible epitaphs for Aidan and, we sang Jerusalem at Aidan’s funeral, so maybe Blake is a good place to stop.

by Alex Bax
Hundreds pay tribute to health professional who died suddenly, aged 57

Prof Aidan Halligan and his wife Carol Furlong

The wife of a health professional who died suddenly at the age of 57 has received more than 450 cards and 100 letters in tribute to him.

Professor Aidan Halligan, of Stanford on Soar, died due to heart problems.

Prof Halligan, who was born in Dublin, leaves behind his wife, Carol Furlong, and daughters Molly, 25, Rebecca, 22, and Daisy, 20.

Prof Halligan qualified in medicine at Trinity College, Dublin, in 1984, which is where he met Carol. They married in 1985.
Carol, 55, said: “There is a huge gap left where he used to be.

“We are devastated to lose him so suddenly. It has been very hard. I am very proud of what he achieved.

“He was charismatic and he never stopped. He was driven, dedicated and unconventional. He was a bit of a maverick. He enjoyed independence.

“We have three daughters. He was a fantastic dad and very dedicated.”

Carol said the family had been overwhelmed with the response from people after her husband’s death.

“It’s astonishing. It is a great comfort,” she said.

Prof Halligan’s work in Leicester started in 1993. He was senior lecturer and then professor of foetal maternal medicine and consultant obstetrician and gynaecologist at Leicester Royal Infirmary/University Hospitals of Leicester NHS Trust.

During his time at the infirmary, he helped Penny Hefferan, who lost two babies due to pre-eclampsia.

With the help and support of Prof Halligan, Penny and her husband Mike went on to have two healthy children, who are now teenagers – 17-year-old Millie and Keir, 15.

In tribute, Penny said: “He respected his patients. He was honest, open and truthful. He treated people knowing they were intelligent – he never fobbed you off.”

The couple met Prof Halligan after they had lost their first child, Emma-Jayne.
“The first time we met Aidan, he helped us through a tough time,” she said.

“He could not change what had happened, but he did everything he could and he supported us through that process.”

Penny said her second pregnancy was difficult. Her son, Christopher, was born prematurely at 28 weeks and only lived for six weeks, but Prof Halligan supported the couple “every second of the way”.

Penny later fell pregnant for the third time and it was a “miracle” when Millie was born healthy, with the support of Prof Halligan and midwife Trudy Boyce.

“We had lost two, the chances of having a third were not good,” said Penny, who went on to have another healthy baby.

A spokesman for University Hospitals of Leicester and the University of Leicester said: “Aidan was a remarkable man who was dedicated and committed.

“He will be greatly missed by his many friends, colleagues and the patients he cared for and our sympathy and thoughts are with his wife, Carol, and their three daughters at this sad time.”

by Samantha Fisher
Leicester Mercury | Posted: June 30, 2015
Three Lessons From a Good Man

‘I bring you with reverent hands the books of my numberless dreams’

W B Yeats

‘The future belongs to those who believe in the beauty of their dreams’

Eleanor Roosevelt

On Monday I was at an academic discourse at the University of Leeds. I checked my emails on my phone and read an email entitled ‘Professor Aidan Halligan’. The message broke the news that Aidan Halligan had died suddenly. I was hit by a deep sadness and sense of shock. It was as if a glass screen had descended around me. I could see mouths move and hear words but I couldn’t connect with what was going on around me. I felt a deep sense of loss and the world at that moment and evening seemed a poorer and darker place. Over the next days those two words ‘saddened’ and ‘shocked’ were used again and again by friends and colleagues to sum up how they were feeling.

Aidan Halligan held many posts. He was Deputy Chief Medical Officer of the NHS, university professor, director of Well North and the chair of Pathway. I met Aidan a few years ago at a meeting of Pathway in London. Pathway is the national network of homeless health services. I spoke on the model of care we use at York Street Health Practice in Leeds based on hope and being alongside others. After the talk Aidan came over to introduce himself and that’s how we met. Aidan taught or maybe re-taught me many things. In his honour I would like
to mention three of the lessons this good man shared with me. I hope – I really hope – I can still hear and practice them.

The first lesson was the commitment to people. Everything Aidan did was about making things better for others. The work to create caring hospital pathways for homeless people. The work in Well North to change poor health in the north of England for communities. His leadership work to support values and courage. All this was about putting people first. The day after I received the news of Aidan’s passing I got a call from a colleague who manages a third sector homeless service. He said he wanted to pass on his condolences to his NHS colleagues who were at that time in a sad place. I was so touched by this kindness. He went on to say he had only met Aidan once but the memory had stayed with him. It had inspired him. Another good Third Sector housing support colleague emailed with a similar kind message – the one meeting that made a deep lasting impression. Aidan connected with people. Aidan connected because Aidan cared. People felt that and remembered the experience. There was a Maya Angelou aspect to Aidan, ‘I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.’ Aidan called us to always put people at the centre of our work and plans. He wanted to create large scale change that could really benefit people.

The second lesson was about catching. When I spoke at that meeting in London I saw Aidan writing things down. In subsequent meetings a phrase or sentence would lead to Aidan taking a small notebook from his pocket and writing down the words. He seemed to be catching words, ideas and dreams.
Perhaps many of us do this in different ways. Aidan seemed to be systematic about it. Not allowing any good thought or quote to fall into the ether. Rather to collect and fuse them into plans, visions and actions. Behind this was a belief in the innate wisdom of people. Aidan was open to everyday wisdom and I am sure found it in a thousand unexpected places. He then reflected it back into meetings, teaching and writing. He teaches us how we should be open to others and their wisdom – often echoing from their experience and intuitive depths. I remember how in Manchester at a meeting he shared how a nurse in A and E had taught him so much about what compassion was as she cared for and valued the homeless people who attended the hospital she worked in. Aidan didn’t pretend to have all the answers. He did, I believe, see those answers as living in our co-work, collaboration and in listening to people.

The last lesson is that Aidan looked deep. He knew the value of systems, structures, data and academic rigour. He certainly knew how to build and shape organisations. He knew how to generate the discourse and actions that lead to real lasting change. Aidan also knew about what people needed. He had a deep gaze into the human person and journey. Last year we sat in a coffee shop in Leeds talking. Aidan’s words express his depth. He said that life is all about identity. Finding out who and what we are. Aidan said it was when we find ourselves that everything fits and starts to work. His words made sense of my own life and journey. It also actually fits all those psychological categories of ‘integration’, ‘individuation’ and ‘self actualisation’. Aidan saw how values, gifts and our deepest self are so key. He also knew that it is when we tap into these
living streams of energy and potency that we become fully alive and life somehow becomes new.

Someone once said that if we stand on the shoulders of giants we can see for miles. Aidan was a giant. He called us – beckoned us – to come and see what he saw. Many of us did. He showed us how cities and services working together can make a difference. How caring pathways can be built for the most vulnerable of our people. And perhaps most importantly that we can be the writers and makers of our dreams. Goodbye Aidan and thank you for everything. We will continue that fight for social justice, kind care and being who we are at our best. That is your legacy and message. We want it be ours too.

by John Walsh

(A special thank you to wonderful midwife Deirdre Munro @DeirdreMunro for sharing the Yeats quote)
Euston Square Station – 1st May 2015

Service information

Date: Friday 1st May 2015
Time: Quote of the Day

Leadership is doing the right thing on a difficult day.

In memoriam of Professor Aidan Halligan
UCH.
A Tribute to Aidan Halligan
– Reflections on what he taught me

Sadly, earlier this week, the world lost a man who was fundamentally focused on making it a better place...

Professor Aidan Halligan had done so much in his life it was hard to believe that he was only 57 years old. Most recently director of Well North, he had also been the first NHS director of Clinical Governance, was Deputy Chief Medical Officer for England. and the founding Chairman of Pathway healthcare for homeless people.

For me, as for many others, Aidan was a wise mentor. We met at an event that we had both been asked to speak at for HR professionals in the NHS. I was instantly struck by Aidan’s presence, wisdom and quiet determination and we chatted about shared Irish heritage and an interest in the challenges of leadership. Aidan was Director of Education at UCL and invited me to see the work being done there on Leadership. Over our meetings from that point I learned many things from him and have reflected on just a few of them below.

1. Connect with people, wholeheartedly.

My first visit with Aidan was at UCL’s leadership centre. We wandered the office with Aidan explaining the work being done there, what they were learning and introducing me to the team. In the midst of our wanderings an Irish gentleman stopped us ‘Professor Halligan?’ he said, slightly deferentially. Aidan stopped and focused on the man. ‘You treated my mother’ he said. Immediately Aidan recalled him, his mother
and spent a few moments in deeply attentive conversation with the man.

Time in conversation with Aidan was a precious experience. I never saw him check his phone, a blackberry, not even his watch, even though he must have been an insanely busy man. He always paid complete attention to whoever was speaking, stopping only occasionally to take out his notebook and make a note of something in the conversation that had struck him in some way.

Aidan had an ability to be wholeheartedly in the here and now with another person which gave him an ability to connect with other human beings in the most amazing and uncommon way.

‘It’s your example that counts, not your rank.’

Aidan Halligan

2. Compassion is Action

It always inspired me to listen to Aidan talk about his work. I recall a lunch meeting, shortly after I had attended a workshop on Compassion Based Mindfulness with the wonderful Chris Irons. Chris has talked about a definition of compassion that only made full sense to me when I next met with Aidan.

‘Compassion is noticing the suffering of another and being sufficiently moved by it to help them in some way,’

The last time I saw Aidan he was talking to me about Well North. It was in its early stages, but just as with our conversations about Pathways I was struck by Aidan’s quiet, understated, stubborn, determined, kick ass approach.
Aidan set his mind to doing something, it was absolutely unquestionable that something would be done.

Many of us are moved by what we see. Aidan did something about it. Compassion is action.

‘People respect courage and they respect compassion’
Aidan Halligan

3. Begin

After the conversation on compassion I continued to develop a growing interest in how well or otherwise human beings can be enabled to retain their compassion working in organisational environments. I thought it would be fun to bring together a group of people who might have a view or perspective on that to share and discuss. Somewhat naive of me perhaps as there are wonderful organisations and institutions researching it all over the world.

In spite of that, when I contacted Aidan to say that I would like to introduce him to Chris and some others who I thought would be interesting participants in such a debate he didn’t hesitate for a moment to say that he would be happy to join it. I was to let him know the date and he would be there.

I hesitated too long before starting. And now that conversation can’t ever happen in quite the same way...

Aidan didn’t wait, he didn’t procrastinate about whether he was the right person. He began. And took others with him along the way.
‘We know when we see a leader. They inspire us, and when we are inspired we become determined. And when we are determined we go further. That’s what leadership is about…’

Aidan Halligan

4. Ask the ‘Beautiful Disturbing Question’

Aidan always took time to understand what I was up to at work, at home, in my volunteering. He was always interested in my volunteering at Crisis, my trustee role, and my work initially in the Civil Service and more latterly in the NSPCC. He always demonstrated a keen interest in what I was learning, and shared what he was learning along the way.

He had a skill for asking what the poet David Whyte calls ‘the beautiful disturbing question’ and my thinking benefited on so many occasions from his occasionally perturbing ability to do that.

At a lull in our conversation as I described the fullness of life and work he would always catch me out with the same one. Leaning in and giving me his full attention he would say in his gentle Irish voice,

‘And tell me Siobhan, are you happy?’

I’m certainly happy that I knew this wonderful man. To have had the chance to learn from him. To have witnessed so many wonderful qualities at play in a single human being. Thank you Aidan.

by Siobhan Sheridan
May 3, 2015
Letter to the family and friends of Aidan

Dear family and friends of Aidan,

I am so sorry that I can’t be with you at the funeral. I came across this extraordinary man Aidan, who has touched all our hearts with his profound compassion, in my capacity as the founder of a charity called Kids Company.

Aidan was passionate, incisive, and extraordinarily kind. His energy was like a jet engine, but he had the flair and the delicacy of a ballet dancer. What I loved about him was his humility. You could clearly see his IQ rocketed through the roof, yet he was so in touch with the experiences of the homeless people he wanted to protect that I almost believed he had slept on the streets himself.

He loved his team, both at the hospital and at Pathway, the charity he helped initiate. I was there planning it in the early days with him and what came across was his genuine appreciation for everyone who contributed or opened a door. We would have naughty giggles about people who blocked more than they solved, but he was always, even in his irritation, good-natured.

Aidan was a visionary. I always marvelled at how he got things done in an expansive and systemically complex way – yet he was attentive to detail, available at the end of the phone, and so utterly humane. The heavens have gained a great man... but he’ll probably be organising God now!

I’ll really miss him, as I’m sure all of you will. But, people like Aidan never leave. Their magic dust is sprinkled everywhere.
– the light of it guides everyone who has come in touch with him towards better things. Aidan’s greatest talent was the recognition of gifts in others. Through his appreciation, so many grew to be stars. So, he will forever be catalytic – and generations will know that Aidan Halligan inspired them to great things.

You can’t bottle him – so let him be free amongst us, this great companion to kindness.

With love and best wishes,

Camila Batmanghelidjh
4th May 2015
Selected Tributes To Aidan

Aidan with Robert Francis QC and members of 256 Field Hospital at an NHS Staff College Alumni Event
Aidan’s family have kindly requested any donations in Aidan’s memory to be sent to Pathway at www.pathway.org.uk and click on ‘Support us.’ Thank you.