

*HOSPITAL/HEALTHCARE CHAPLAINCY
JOINT TRAINING OFFICE*

THE MIRFIELD REPORT

Report of the workshop on chaplaincy leadership held at
The Community of the Resurrection, Mirfield, West Yorkshire
on 16/ 17th January 2006

May 2006

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The Hospital/ Healthcare Chaplaincy Joint Training Office is sponsored by the Hospital Chaplaincies Council of the General Synod of the Church of England, the Health Care Chaplaincy Steering Committee, Free Church Group - Churches Together in England, the Catholic Bishops' Conference of England & Wales and South Yorkshire Strategic Health Authority

A – EXECUTIVE SUMMARY

- The discussions reported here took place at a workshop on chaplaincy leadership held at Mirfield in January 2006. A small group of chaplaincy leaders had been invited to discuss leadership skills as a pre-cursor to defining training and development requirements for leadership in healthcare chaplaincy.
- Personal experiences were used to develop an analysis of the leadership skills required in healthcare chaplaincy. Leadership was a requirement of all chaplains with a progressive growth in their expertise and skills. There appeared to be a gap in the training and development available for chaplains with a leadership role beyond their own organisation.
- The workshop identified a matrix of skills in healthcare chaplaincy derived from the NHS national leadership qualities. It was proposed that these be discussed widely and used as the basis to inform development of future chaplaincy leaders.
- Issues associated with the regulation of chaplains as healthcare professionals were also considered. The regulatory framework for chaplains is already complex and statutory regulation is not accessible. An alternative involving the NHS, the faith communities and the professional associations was considered.
- The results of these discussions are being circulated for comment with a view to reaching a broad consensus during 2006. It is the intention that these issues should be taken forward by NHS, faith communities and the professional associations thereafter.

B - INTRODUCTION AND BACKGROUND

1. These papers report the discussions at a workshop on chaplaincy leadership held at Mirfield in January 2006. The discussions covered the development of chaplaincy leadership skills and aspects of professional regulation. More detail about the arrangements for the workshop is included in Annex 1.
2. This report is aimed at healthcare chaplains and chaplaincy bodies. It will be used to clarify the requirements for leadership skills in healthcare chaplaincy and may also provide a basis for the leadership development workstream within the *Caring for the Spirit* NHS Project. The discussions about regulation are intended as a basis for the development of a regulatory framework which can unite the efforts of the chaplaincy bodies with the NHS to the benefit of users and carers.
3. Leadership skills have always been included amongst the cluster of skills required of managers and practitioners but have not been prominently or explicitly emphasised in chaplaincy. The occupational standards updated in 2002ⁱ make only a small reference to leadership (in the knowledge of leadership which underpins the standard for managing and developing a chaplaincy service) whilst the workforce strategy published in late 2003ⁱⁱ included a chapter on strengthening education and training with only a small section on leadership and management.

4. The Joint Training Office has been interested in the development of leadership since the revision of occupational standards which was co-ordinated by the Training and Development Officer. A short course in 2002 included a module on leadership which was provided by the NHS Leadership Centre and a further module on leadership was provided both to the strategic planning course in 2004 and to the leadership study day in 2005.
5. Running in parallel with these events was the input provided by senior chaplaincy figures to the preparation of the workforce strategy, and the emerging day to day changes in the NHS post 1997. The NHS Leadership Centre¹ was launched in April 2001 and the NHS Leadership Qualities Framework (LQF) was published in October 2002. The LQF is explained in more detail in Annex 2.
6. Sarah Mullally, the former Chief Nursing Officer, spoke of these changes at the College of Health Care Chaplains Annual Study Course in 2002. Her messageⁱⁱⁱ that "...we improve the experience of people through leadership based on service" was well received as was her encouragement of chaplains as being "absolutely central to achieving the challenge of improving care...". That she should also be responsible for leading chaplaincy services within the Department of Health made this input particularly relevant.
7. Healthcare chaplains are accountable to the local NHS or other healthcare provider for service delivery. They represent their faith community in offering religious care within a general framework of spiritual healthcare. They are therefore also accountable for those aspects of their work to the faith community.
8. The drive towards professionalisation of healthcare chaplains is being led by the College of Health Care Chaplains with the other professional associations. The regulatory framework for chaplains is complex and the wish to add statutory regulation makes this more so. The section included in these papers goes into some of these aspects in more detail.
9. At the conclusion of the workshop, we agreed that further discussion was necessary on leadership qualities and on an approach to regulation. These papers are therefore being circulated for wider discussion amongst chaplains and chaplaincy bodies with a view to agreeing a way forward which all can share in the Autumn 2006

¹ The NHS Leadership Centre was part of the Modernisation Agency established in April 2001 to support the NHS in England, and its partner organisations, in the task of modernising services and improving experiences and outcomes for patients. The Modernisation Agency was superseded in July 2005 by the NHS Institute for Innovation and Improvement.

C - LEADERSHIP

Impressions and experiences

10. We discussed our impressions and experiences of chaplaincy leadership touching on local and national issues, the interaction of the chaplaincy bodies and the difficulty of achieving a consensus on issues. We were all keen to see progress made on the current important issues affecting chaplaincy both nationally and locally. We would like to see all the chaplaincy bodies working in partnership to advance our cause.
11. There was a worry about the fragmentation of chaplaincy amongst a number of chaplaincy bodies and concern that we appeared disunited in our efforts to represent views adequately. We do not consider that one body could or should represent all our interests but we want a contribution from each body and an involvement of them all in the shared development agenda.
12. Some of us were very clear about what was important for chaplaincy locally. There were busy schedules of service delivery and an important range of challenges in the Agenda for Change profiling; the emphasis on knowledge and skills development; the need for research evidence to prove the value of healthcare chaplaincy to NHS employers and the importance of networking through chaplaincy collaboratives. Sustaining the effort within Trust chaplaincies needed leadership based on effectiveness and the practical aspects of chaplaincy.
13. We reflected on whether the way in which we undertook our work in our Trusts had given the impression that we were content with the progress of external issues and with the different representation of chaplaincy by different bodies. It was for consideration whether our ability to adapt to different circumstances internally also meant we avoided indicating our views externally. There might have been a period when the emphasis on internal clarification had been achieved at the expense of external confusion and a lack of clarity.
14. The emergence of a number of leaders at national level meant that greater emphasis was needed on co-ordination and partnership working between them and between the bodies they served. Some of these leaders were valued because of their faith background but it was not clear what was their responsibility to provide leadership to chaplains generally. Where there were large numbers of chaplains within the faith community or the membership body, the need for pastoral support was diffused because of the presence of other bodies which also claimed this role.
15. The challenge seemed to be how, from their position embedded in the NHS, could these national leaders make the leadership of their community significant for the healthcare community. There was no clear answer but one participant suggested that, on the evidence, there was a need for leadership of the leaders.
16. This was supported by the view that there was a multiplicity of national fora, making it difficult to determine the focus of leadership in healthcare chaplaincy. A more strategic and professional leadership at national level was favoured. "Connectedness" was necessary between local and national leadership and between the different elements of national leadership.

17. We noted that the leadership was vested both in officers and in (chaplains) bodies. We considered that these bodies did not exist well in today's society and that some simplification of the chaplaincy map might be useful in due course. At the same time, the authority of the faith bodies over the faith aspects of chaplaincy and the accountability of the chaplain to the NHS body was complex and difficult. It was as if there was a struggle for power and for identity between these bodies which was outside the concern of most chaplains but might be very important to all in the long run.
18. In taking stock of our discussion, we noted the important relationship between authority, accountability and responsibility as points in one triangle. We placed power as an issue in the middle of the triangle and acknowledged its important relationship to the perceived identity of the group.

Potential and existing chaplaincy leaders

19. Leadership skills were thought to be implicit in all aspects of chaplaincy work at local (Trust) level as the work of ministers of religion was itself a leadership role. We considered that all chaplains would therefore need to exhibit leadership skills in their work in addition to the chaplaincy occupational standards and to the chaplaincy profiles/ outlines within Agenda for Change. The leadership exhibited by an entry-level chaplain would be less developed than that of an experienced or specialist practitioner-level chaplain but the idea of this leadership being an essential part of all chaplaincy work was important.
20. Team Leaders in chaplaincy were responsible for managing resources including financial and workforce resources. They would also be expected to exhibit the leadership aspects of management in terms of agreeing and setting the direction and pace of change. There had not been an identification of the leadership skill set for those working beyond Trust boundaries or across Trusts.
21. Examples of those who were working at a higher level than solely within Trusts included those Team Leaders who were involved in mergers or who provided services from one Trust to another and the Lead Chaplains appointed by South Yorkshire SHA. These roles supplemented those which were in positions of authority at national level; who served on national level working groups; or who represented colleagues in some geographical position.
22. We were concerned about the different emphasis in the tasks between the various national leaders. The picture of these was at best piecemeal but we supported the need for a representative voice for chaplaincy at national level and for advocacy generally. Those who did this work needed to have good people skills in influencing, persuading and negotiating and sufficient preparation to enable the task to be carried without too great a challenge to usual levels of tenacity and self-belief.
23. National leadership would also require skills in communication with the media and other organisations as well as with colleagues and with their membership. Such training is often already offered to Trust senior managers and clinicians and chaplains should be able to access this locally. If they cannot then ways must be found for them to do so.

24. When leaders did emerge, it was hoped that they would be concerned with strategic issues as much as with the day-to-day and with managerial as well as theological issues. There was a need for chaplaincy leaders to strengthen the “connectedness” between chaplaincies and the work of chaplains; between the NHS and the faith communities and between the faith bodies and the professional associations.

Identifying and delivering development and support

25. Participants suggested that both professional and vocational aspects of the national leadership role needed to be developed. The emphasis given to continuing professional and vocational development would enable the NHS and faith communities to share an approach to chaplaincy. At the same time, the content of that learning and the levels of learning necessary to achieve satisfactory development for chaplains had not been formalised although both the Chaplaincy Academic and Accreditation Board (CAAB) and the Caring for the Spirit NHS Project^v had done work on these areas. It was hoped that these discussions could be concluded soon and the results shared.
26. The widespread use of appraisal systems was supported as the best way to identify development and learning needs. But there was some difficulty in fitting the system envisaged within the NHS^v with the vocational aspects of chaplaincy. At the same time, the faith communities have in place, or will develop, systems for their own continuing ministerial development which would not necessarily sit easily with the NHS process.
27. Sharing an approach to life-long learning between the NHS and faith communities was seen as difficult because of the effort which went into both aspects of the process. It was also the case that chaplains would be encouraged in this learning by an emphasis on both their chaplaincy skills and the development of themselves as ministers of religion. The final complexity was the separation of effort in education and development between the Multi-Faith Group’s Education Committee, the Chaplaincy Academic and Accreditation Board (CAAB)^{vi} and South Yorkshire SHA’s working group on continuing professional development.
28. Chaplains were all encouraged to have a spiritual director where appropriate for their faith development and to use a professional supervisor for the practitioner aspects of their work. Trusts did not challenge the need for spiritual direction but did occasionally balk at the need for professional supervision. Partly, this difficulty was because of the need to pay for a supervisor and Trusts were sometimes reluctant to do so.
29. Partly also, the need for supervision by members of a group which was not recognised by the NHS as a healthcare profession was cited. There was complete agreement that chaplains in their ministerial role were professionals – somehow, it was within the NHS that this was not formally recognised. We wondered whether the lack of confidence which made chaplains seek recognition as healthcare professionals was compounded by the lack of agreement about their work as expressed by chaplaincy leaders.

30. The variety of ways in which leadership could be demonstrated made identifying one or a narrow range of models difficult. In addition to the NHS KSF, we had the NHS Leadership Qualities Framework^{vii} available to us and we used this as the exemplar for our discussion. We understand that this might be reviewed and changed during 2006.
31. Ultimately, we considered that leaders need to be developed from those who show aptitude and who want to lead or who are in roles where a leadership contribution is a necessity. As part of the identification of leaders within the Trust, faith community and professional association processes, there was a need to ensure that national leadership was regarded as an option for personal development.
32. The emergence of chaplaincy collaboratives as the NHS' main pathway to develop standards and modernise chaplaincy would require chaplains to lead cross-Trust work more obviously. The identification of leadership roles within this and other local settings such as committee roles within the chaplaincy bodies might sustain this development well.

What do we need to get this work done

33. Action is necessary to achieve effective leadership at national level. This is likely to involve joint work by the NHS and faith communities to build on what is there already and to develop the connections which are lacking. We also think that the chaplaincy bodies will need to agree a joint approach to this work.
34. We might therefore best approach this work by identifying champions who would support the discussion about and the development of chaplaincy leadership. Obviously, we hope this might come from within chaplaincy but we also need support from Trust Boards and from the Department of Health in response to user needs for high quality chaplaincy.
35. A gap seems to have been identified in the training requirement for chaplains who need to contribute as leaders. Subject to the clarification of this requirement, we consider that additional funds may need to be identified within the NHS to support this development. Chaplaincy leadership is an essential part of work within the NHS and the NHS faith communities and membership bodies should champion it.
36. We wish to emphasise our view that chaplaincy is unique in three particular ways which support patient-centred working:
 - First, the coverage by chaplaincy of all patients and all staff is unique and uniquely difficult.
 - Second, the need to care for the leadership of the Trust with its complex external and political agenda is a challenge requiring the deployment of particular communication and pastoral skills.

- Finally, the task of “holding steady the organisation in all its constituent forms”² has tested the most experienced chaplain but is also valued by the most experienced managers who appreciate the knowledge and skill deployed.
37. The preparations for this workshop had included some discussion with the recently established Church Leadership Centre which had also asked to be kept in touch with our further deliberations.

Levels of chaplaincy leadership

38. We considered the levels of leadership required by the practitioner chaplain, the chaplaincy team leader with a Trust and the requirements of leadership at national level. This latter we exemplified as being either a person nominated to a national body requiring chaplaincy advice or as the chief officer for one of the bodies required to make public statement about chaplaincy policy issues.
39. We found the discussion about national level leadership difficult because of our relative inexperience. We were able to characterise what had been our experience in recent years which was that we had tended to concentrate on the services we offered within our Trusts.
40. Some of us had organised our own “national” work through running conferences or meetings and many of us had published our work as contributions to the research activity. We tended to work within individual Trusts with little cross contact except where there was a particular activity organised by a professional body. We had our existence mostly within the NHS with some external contact but little formalised in the way of links locally even within our Church organisations.
41. A few of us had represented our colleagues within a professional association or been involved in the work of national bodies. None of this work was exceptional, as it seemed to be focused on us either in a developed training role or as expert chaplains. The chaplaincy occupational standards encapsulated both these roles adequately.
42. A number of management models identify the need for managers to face both out of their organisation as well as into it. Such an approach fits well with the notion of chaplaincy which brings services into the organisation from various faith communities and needs to take back to those communities some understandings of the ministry undertaken. The broad scanning of the political horizon to identify issues of importance to chaplaincies is also necessary.

² Chaplaincy is thought by some to have a responsibility in holding/ containing the institution it serves for example by staff support, group facilitation, imaginative use of liturgy to express/ reflect the thoughts and feelings of whole wards and units or the whole organisation at times of disaster/ loss/ crisis.

43. Chaplaincy was perceived to sit in between the concrete practice of day-to-day ministry with patients, staff and visitors and the less certain world of executive management at the top of NHS organisations. This produces the classic “middle management sandwich” wherein the individual’s work and time is pressured by the competing demands of those below and those above them in organisational terms.
44. This seemed to match our own views well in that we are comfortable on our own ground. By contrast, the strategic role of leaders at national level meant that our daily work pressures appeared too little an issue for them and our wider concerns were diffuse because their locus was not clear to us.
45. We think that the leadership skills required by chaplains must be both of the managerial sort which represents their work nationally and also of the spiritual sort which draws its support from the faith communities. We broadly support the model set out in the *Caring for the Spirit* strategy which represents chaplains as experts. We consider that all chaplains should have an area of expertise or special interest where they can provide leadership.
46. Communications, people skills, tenacity, strength of character, intellectual flexibility, strategic influencing were all important requisites of the national leadership. Some elements of this profile were to be found in the KSF e.g. dimensions Core 4 Service Improvement, Core 5 Quality, G7 Capacity and Capability etc – all of which can face out of organisation as well as internally.
47. Even though the NHS LQF was applied most directly to NHS Directors, we considered it a useful guide for chaplaincy. We have therefore included in Annex 3 a matrix based on the current LQF which shows the levels of leadership we considered were needed for those who were leading chaplaincy.

D - REGULATION OF CHAPLAINS

Professional status

48. Chaplains have always been considered to be professionals in relation to their work as ministers of religion. Not surprisingly therefore, such recognition within the NHS was to be expected and its apparent lack, for example, by exclusion from the group of professionals accessing patient information without express consent caused some distress (and great practical and pastoral difficulty). For several years, chaplains have regarded the recognition of healthcare chaplaincy as one of the healthcare professions as important. Thus, recognition of chaplains as healthcare professionals is important both for the aspects of status but also for practical reasons.
49. Such recognition was thought most achievable by a route to professional status and statutory regulation with the Health Professions Council (HPC). The HPC regulates the allied health professionals whose work was thought to be most closely aligned with chaplaincy. By the end of 2000, the College of Health Care Chaplains which was leading on this work had received widespread support for its move towards identifying healthcare chaplains as professionals.
50. However in 2004, it became clear that the Department of Health was unlikely to support regulation of chaplaincy by statute as they considered that such regulation was not appropriate. This view publicised in the James report^{viii} indicated that the Department “did not support the College’s aspirations (to be registered under the Council of Healthcare Professions)”
51. Additionally, the Department of Health has also recently carried out a review of non-medical regulation which had considered whether other professions should be brought within a framework of statutory regulation. This review had looked at the proportionality of risks associated with the professions as the Department did not wish to burden them with unnecessary regulation. We were concerned with the apparent distinction of “essential” professions and would wish to consider this further.
52. We were informed that the Department considered that the dangers of chaplaincy practice were less severe than those arising from other behaviours such as fraud and health impairment. It was therefore suggested that these risks could best be managed within the general NHS codes of conduct such as that applying to managers^{ix}.
53. We were uncomfortable with these conclusions as we were broadly in agreement that the NHS could not regulate faith ministry aspects of chaplaincy but were also unsure whether the faith communities could be fully appreciative of the NHS aspects of care and management. We therefore accepted that statutory regulation was “both legally unacceptable and also contrary to Government regulation policy” but were anxious to identify a regulatory framework which met our concerns.

Professional regulation

54. In our discussions of an alternative approach, we were informed that professional regulation had four elements including standards of competence and conduct; standards of training; maintaining a register of those who have achieved the standard of competence; and maintaining a mechanism to oversee fitness to practise. The standards would be set by the profession regulator in the same way as applied in statutory regulation.
55. The standards of competence would set out the competences which define the work of healthcare chaplains. These would comprise areas of religious and faith-based ministry and areas of NHS professional practice. The inclusion of faith related content had been the determining factor in excluding chaplaincy from statutory regulation as this faith-related component could not be regulated by a secular statutory body.
56. We considered what regulators did and what alternatives might therefore present. Regulators set and maintain standards for competent and safe practice. They do this for the first occasion after qualification and seek to address all stakeholders needs. The driver for this work is protection of the public and the avoidance of a clash of interests.
57. We considered whether the professional bodies could serve as regulator for healthcare chaplaincy noting that the regulator was one body and there were several professional bodies currently. We appreciated that the professional body would have weakness in undertaking this role as its interest in advancing professional practice might clash with public protection. Considering these aspects at arms length might be preferable.
58. We considered whether a trade union could carry the regulatory function and were told that its emphasis on support for members and the development of their terms and conditions would be a significant clash of interest. It appeared unlikely that a trade union would be supported in carrying out a regulatory role in today's NHS even if a considerable degree of separation of functions could be achieved.
59. We considered whether a hybrid body could serve as regulator. This body needed to carry authority from the faith communities, the professional associations and the NHS so that the concerns of those about a single source of authority could be met. The combination of faith, profession and NHS emphasis could also be matched or supplemented by input from others who may be independent of these two aspects of care. These might include multi-faith participants and lay people, service users and employer representatives.
60. We had indicated that the links with sponsoring faith communities were sometimes distant and that this was a burden both for chaplains in seeking to represent their faith community but also to the faith community seeking to authorise them to do so. The link between chaplain and faith community was sometimes very extended and would benefit from a joint approach between faith community and the NHS organisation.

61. Emphasis was placed on the need for the NHS to have a larger say in how chaplaincy was developing. Chaplaincy development was often viewed as something in which the faith communities had the lead role but participants did not consider this was appropriate as so much of their work was not faith based. They suggested that more emphasis needed to be placed on work in spiritual and pastoral care rather than on religious care as the balance of work was this way^x. A better balance needed to be struck between the pastoral, spiritual, religious, managerial, leadership and educational roles of the chaplain.
62. We concluded that further discussion was necessary to clarify these ideas. At the same time, we considered that professional regulation³ offered hope to those who wished to work within the independent framework of professionalisation whilst also enabling an involvement by both NHS and faith community organisations.
63. Additionally, we considered that a form of over-arching authority would help the confused atmosphere in which chaplains currently worked. Although this was not a main reason for supporting this concept, it might very well enable unity of purpose during the search for a better solution.

³ For illustrative purposes, the regulatory body might comprise equal representation from NHS Authorities, faith-related bodies and chaplaincy membership bodies with representatives of users and carers, all chaired by an independent Chair appointed by the NHS Appointments Commission. The regulatory body would exercise the “usual” work of regulation as set out by the Council for Healthcare Regulatory Excellence including maintaining the register of those fit to practise as healthcare chaplains; setting the standards of behaviour and ethics for healthcare chaplains; setting the educational standards for healthcare chaplains and creating systems to maintain their skills; and dealing with concerns about healthcare chaplains who are unfit to practise because of poor health, misconduct or poor performance.

E - TAKING THE WORK FORWARD

64. We have spent time together considering what is the leadership requirement for healthcare chaplaincy. We offer our thoughts as a contribution to the discussion which we consider needs to take place both about leadership and regulation in chaplaincy.
65. We are mindful that recent years have been focused on a programme of change within the NHS and within chaplaincy which many have found painful. The focus on implementation of the new chaplaincy policy and of the workforce strategy from 2003 onwards is welcome but the apparent disunity amongst the leaders of the chaplaincy bodies has not met our expectations.
66. The opportunities to lead chaplaincy down a united pathway and to engender a sense of direction and pace in that journey is important to us and to those we serve. We are also mindful that the world faith chaplains whose work is endorsed so firmly in the policy guidance and the workforce strategy deserve a better example than we have all been able to provide.
67. We have concluded that our work as healthcare chaplains would be enhanced in three main ways:
 - first, we need the chaplaincy bodies to consider and agree the leadership competences which we endorse here and to apply these in their work. We suggest that South Yorkshire SHA might be asked to arbitrate if there is disagreement;
 - Second, we need the faith communities and the NHS to work more closely together in sustaining and valuing healthcare chaplaincy and its care of the healthcare family. We suggest that the Multi-Faith Group for Healthcare Chaplaincy be asked to host an event at which this could be discussed;
 - third, we submit that our own identity would be enhanced by acceptance of a framework of professional regulation agreed jointly between the NHS, the professional associations and the faith communities. We suggest that the Department of Health with South Yorkshire SHA might jointly lead this discussion.
68. We therefore propose the following two considerations for discussion by chaplains and chaplaincy bodies including those bodies which lead for the NHS:
 - To what extent are you able and willing to endorse the statement of leadership qualities included here in Annex 3 for practical application in the work of healthcare chaplains either as they stand or after review in relation to the NHS KSF ?
 - To what extent are you prepared to invest time in the approach to professional regulation suggested here which proposes bringing together the faith communities, the NHS and the professional associations as the professional regulator for healthcare chaplaincy ?

69. We are issuing this paper for discussion by chaplains and chaplaincy bodies at the beginning of May 2006 and requesting replies by the end of July . We will review the responses during the autumn period in order to propose joint action to harmonise this work for us all.
70. In addition to feedback for chaplains and the chaplaincy bodies, we will report our conclusions to the South Yorkshire SHA for further action in respect of the leadership matrix; to the Multi-Faith Group for further action in respect of an event which brings the family of chaplaincy bodies together; and to the Department of Health and South Yorkshire SHA in respect of the regulatory framework.

Arrangements for the workshop

- The workshop was convened by the Training and Development Officer (TDO) to focus on the identification, development and support required for current and future chaplaincy leaders. The TDO had been involved in these issues since 2001 and had devoted sessions to leadership within training courses and in one-day conferences. This was the first workshop on this topic.
- The workshop was held at the retreat house of the Community of the Resurrection in Mirfield, West Yorkshire. The intention was to undertake this work within a prayerful atmosphere .
- The workshop brought together a range of chaplaincy managers in acute and in mental health services. Participation was voluntary and by invitation of the TDO. For various reasons, and despite efforts to do so, It was not possible to achieve a balance of faiths, ages and gender. These participants were joined by one or two colleagues with expertise in leadership and education.
- The workshop was run with the input and involvement of those present and the programme was varied to suit them. The workshop used as its resource the personal experience of participants and had available but did not consider in depth the NHS Leadership Qualities Framework of which an extract is included here.
- At the end of the first day, a review of the issues raised led to the inclusion of two other issues with “leadership”. These were issues about statutory regulation and issues about the current configuration of chaplaincy services including their links with faith communities. It was only possible to consider the first of these in the time available.
- The workshop was facilitated by the Revd Tom Keighley, a consultant with an understanding of both the NHS and the faith communities. The format of the workshop was an exploration of personal experiences of leadership on the first day followed by consideration of emerging issues on the second. The results of the workshop were agreed by participants.
- Workshop participants agreed that what was shared amongst participants was not for individual external publication; that statements made should reflect personal experience and not be reports of others’ views; and that a single record of the event should be prepared by the TDO which should be anonymised.
- The workshop was attended by Revd Alan Brown ObCR (University of Leeds), Revd Peter Ellmore (Avon), Revd Nigel Goodfellow (Newcastle), Revd Steve Henderson (Swindon), Revd Susan Hollins (Beds and Herts), Revd Chris Johnson (Bradford), Revd Derek Johnston (Belfast), Revd Tom Keighley (Facilitator), Revd Jim Linthicum (Barnet), Revd Emma Louis (Sandwell, West Midlands), Revd Richard Lowndes (Southampton), Ms Ros Mead (Department of Health), Ms Paula Potter (Shropshire and Staffordshire SHA) Revd Mark Read (Gloucester), Revd Gareth Rowlands (Harlow), Revd Max Shepherd (Worcester), Revd Kevin Skippon (Derby) and Revd Susan Turner (Manchester).

The programme for the Workshop was as follows:

Workshop aims: To focus on the identification and support required for current and future chaplaincy leaders as part of the prospective work by the joint training office on leadership development.

Day 1

1200 Arrival

1300 Lunch

1400 Welcome and Introductions

1430 *Session 1 Personal experiences of good and bad leadership*

1600 *Tea*

1630 *Session 2 Work streams*
1 – How do we identify and engage with potential and existing chaplaincy leaders?
2 – How do we identify and deliver development and support?
3 – What do we need to get this work done?

1830 Evensong

1915 Dinner

2015 *Session 3 Feedback from work streams*

2115 *Compline*

Day 2

0715 Matins

0800 Breakfast

0900 *Session 4 Leadership issues – implications from yesterday's work*

1045 Coffee

1115 *Session 5 Action planning*

1300 Lunch

1400 Depart

The National Leadership Qualities Framework

There are fifteen qualities within *The Framework* covering a range of personal, cognitive, and social qualities. They are arranged in three clusters - **Personal Qualities**, **Setting Direction** and **Delivering the Service**.



The picture shows how the qualities are grouped and how the clusters work together. Each cluster of qualities is explained in more detail in the following pages.



Personal Qualities

The personal qualities and values are at the core of *The Framework*. The scale and complexity of the change agenda and the level of accountability means that NHS leaders need to draw deeply upon their personal qualities to see them through the demands of the job.

Self belief

Outstanding leaders maintain a positive 'can do' sense of confidence which enables them to be shapers rather than followers, even in the face of opposition. This prime personal quality is built upon success and learning in a broad range of varied situations over time.

Features of this quality include:

- Relishing a challenge
- Being prepared to stand up and be counted.
- Working beyond the call of duty, when this is required.
- Speaking up if this is needed. In doing so, their integrity and their motivation for service improvement will sustain them.

Self-awareness

Outstanding leaders have a high degree of self-awareness. They know their own strengths and limitations, and they use failure or misjudgment as an opportunity for learning.

Features of this quality include:

- Being aware of their own emotions.
- Being aware of their personal impact on others, particularly when they are under pressure as they have an understanding of the 'triggers' to which they are susceptible.

Self management

Outstanding leaders are able to pace themselves, staying for the long haul when necessary. Self-management, supported by emotional self-awareness, enables them to regulate their behaviour, even when provoked.

Features of this quality include:

- Being tenacious and resilient in the face of difficulty.
- Being able to cope with an increasingly complex environment - with the blurring of organizational boundaries and the requirement to work in partnership across the health and social care context.

Drive for improvement

Outstanding leaders are motivated by wanting to make a real difference to people's health by delivering a high quality service and by developing improvements to service.

Features of this quality include:

- A deep sense of vocation for public service driven by an identification with the needs of patients and service users.
- A primary focus on achievement of goals for the greater good of others, and not the leader's own reputation.
- Investing their energy in bringing about health improvements - even to the extent of wanting to leave a legacy which is about effective partnership, inter-agency working and community involvement.

Personal integrity

There is much at stake in leading health services. Outstanding leaders bring a sense of integrity to what they do that helps them to deliver to the best of their abilities.

Features of this quality include:

- Believing in a set of key values borne out of broad experience of, and commitment to, the service which stands them in good stead, especially when they are under pressure.

- Insistence on openness and communication, motivated by values about inclusiveness and getting on with the job.
- Acting as a role model for public involvement and the dialogue that all staff, including the front line, need to have with service users.
- Resilience that enables them to push harder, when necessary, in the interests of developing or improving the service.



Setting Direction

The outstanding leader sets a vision for the future, drawing on their political awareness of the health and social care context. This political astuteness and their vision for the future is underpinned by *Intellectual flexibility*. Coupled with *Drive for results*, this sense of *Seizing the future* is key in inspiring and motivating others to work with them.

Seizing the future

High performing leaders shape the future. They are motivated to take action to achieve a radically different future - one in which health services are truly integrated and focused on the needs of patients.

Features of this quality include:

- Making the most of current opportunities to bring about improvements that are of benefit to staff, carers or patients.
- Being able to interpret the likely direction of changes in the health service and beyond - using their political astuteness.
- Using their insights into the broad strategic direction of health and social care to help shape and implement the approaches and culture in their organisation, and to influence developments across the wider health and social care context.
- Underpinning their vision and action with a strong focus on local needs.
- Being prepared to undertake transformational, rather than just incremental, change where this will achieve service improvement.

Intellectual flexibility

High performing leaders are quickly able to assess a situation and to draw pragmatic conclusions. They are able to switch between the significant detail and the big picture to shape a vision - for their own service, organisation or across the wider health context.

Features of this quality include:

- Being receptive to fresh insights and perspectives from diverse sources, both internal and external to the organisation (driven by their values of inclusiveness and service improvement).

- Understanding that change may have to be radical to achieve health improvement.
- Being open to innovative thinking and encouraging creativity and experimentation in others too.

Broad scanning

High performing leaders in the health service demonstrate high levels of seeking and networking for information. By keeping abreast of developments, both locally and nationally, they are best positioned to shape the vision for a service or organisation as well as understand how to influence others.

Features of this quality include:

- Making it a priority to know about how services are being delivered and what the experience is of patients and users on the ground.
- Being persistent in getting the key facts of a situation.
- Having systematic ways of informing themselves about key developments.

Political astuteness

Outstanding leaders demonstrate a political astuteness about what can and cannot be done in how they set targets and identify service improvements.

Features of this quality include:

- Understanding the climate and culture in their own organisation and in the wider health and social care environment.
- Knowing who the key influencers are - both internally and externally to the organisation - and how to go about involving them, as required.
- Being attuned to health strategy and policy at a national and local level and being able to plan a way ahead that takes account of these strategies.
- Understanding that the role of leader in the health service is now broader than simply being responsible for one organisation and that no one organisation in the health service can be 'stand alone'.

Drive for results

High performing leaders are motivated to transform the services for patients and thereby to improve quality. The personal qualities at the core of the framework provide the energy and the sheer determination which fuel Drive for results.

Features of this quality include:

- Setting ambitious targets which may exceed the minimum standard required and taking calculated risks - all with the aim of delivering added value to the service.
- Focusing their own, and others', energy on what really makes a difference, rather than being constrained by methods which were used in the past.

- Actively seeking out opportunities to improve delivery of service through partnership and new ways of working.



Delivering the Service

High performing leaders provide leadership across the organisation as well as the wider health and social care context to make things happen - to deliver service results. They use a range of styles which challenge traditional organisational boundaries and ways of working and emphasise integration and partnership. The very best of these leaders at senior levels also help to shape national policy.

Leading change through people

Outstanding leaders are focused on articulating the vision with compelling clarity.

They keep up the focus

on change by reiterating the modernisation message and also through inspiring others to be positive in their support of service improvement.

Features of this quality include:

- Gaining the support of others by ensuring that they understand the reasons behind the change.
- Sharing leadership - with the team and others in the organisation and in partner organisations.
- Encouraging others, especially front line staff, to find new ways of delivering and developing services and to take the lead in implementation of change.
- Demonstrating a highly visible, authoritative and democratic leadership style which is underpinned by strongly held values around equality, diversity and openness.
- Taking a collaborative or facilitative approach in working in partnership with diverse groups.
- Enabling teams, within the organisation and across the health community, to work effectively together. Helping to unblock obstacles, identifying and securing resources, and taking care of teams and of the individuals within them.

Holding to account

Effective leaders have a strength of resolve that they can use in both holding others to account, as well as being held to account, for targets to which they have agreed.

Features of this quality include:

- Setting clear targets and standards for performance and behaviours, ensuring the processes are in place to support individuals in achieving these standards.
- Insisting upon improved performance if standards are slipping

- Creating a climate of support and accountability, rather than a climate of blame
- Holding people to account for what they have agreed to deliver.
- Being prepared to be held to account by others for what they have contracted you to do as the leader.

Empowering others

Outstanding leaders support the long-term capability of their own and other organisations that is essential for future development of services by empowering others.

Features of this quality include:

- Having the humility to work in the background, creating the space for others to take the lead on particular issues and to grow in confidence and capability.
- Being able to spot potential and support the development of people across the organisation.
- Taking personal responsibility for ensuring that diversity is respected and that there is genuine equality of opportunity.
- Fostering the development of others across the health community so that health improvement and service development agendas can be created and owned by the communities themselves.
- Engaging and involving users in service improvement.
- Developing relationships with service users which are equal, open and honest, and modeling the power-sharing which is required if solutions are truly to be at the discretion of the patient

Effective and strategic influencing

Leadership in the health service is characterised by an unusually high and complex level of influencing, which is seldom seen in leadership roles in other sectors. This particular quality runs through the whole framework; the most effective leaders make things happen by using particularly high levels of influencing.

Features of this quality include:

- Getting results by working in partnership, within their organisation and with a wide range of other agencies and individuals over whom they have no formal authority.
- Influencing relationships which are critical to achieving change in terms of service improvement.
- Being able to cope with ambiguity, as organisations continue to change role and shape, and the agenda for change in health gathers pace.
- Employing a range of influencing strategies - ones that will work for the long term and bring about change in modernising the health service.
- Combining *Effective and strategic influencing* effectively with *Empowering others*, to ensure that the health agenda is driven and owned by local people, by staff throughout the organisation, and by other agencies.

Collaborative working

Leaders in the health service work with a wide range of internal and external stakeholders. Effective leaders understand that truly collaborative working is therefore essential.

Features of this quality include:

- Ensuring that the strategy for health improvement, and the planning, development and provision of health services, are cohesive and 'joined up'
- Understanding and being sensitive to diverse viewpoints.
- Striving to create the conditions for successful partnership working.

Matrix of the suggested leadership qualities in healthcare chaplaincy

The descriptors used to describe the leadership qualities of chaplains are taken from the section of the LQF concerned with layout. This says that “each quality has between three and six levels, each of which has a ‘level descriptor’ giving examples of how behaviour at each level can be demonstrated. These levels are cumulative in terms of behaviours”.

Personal Qualities		Practitioner chaplain	Team Leader Chaplain	National Leader chaplain	Comment
	Self belief	Acts with confidence	Is confident in own ability	Takes on challenge	Progression levels 1 to 3
	Self awareness	Understands own emotions	Understands own emotions	Understands own emotions	All at level 2
	Self management	Demonstrates resilience	Demonstrates resilience	Demonstrates resilience	All at level 3
	Drive for improvement	Targets effort for service improvement	Targets effort for service improvement	Aims to make a difference with stakeholders	Level 1, 1, 2
	Personal integrity	Acts consistently	Chooses transparency	Shows personal courage	Progression levels 1 to 3
Setting direction					
	Seizing the future	Acts decisively	Thinks and acts up to 3 months ahead	Thinks and acts 4-12 months ahead	Progression levels 1 to 3
	Intellectual flexibility	Considers new information and perspectives	Integrates information	Clarifies complexity	Progression levels 1 to 3

Personal Qualities		Practitioner chaplain	Team Leader Chaplain	National Leader chaplain	Comment
	Broad Scanning	Personally investigates	Looks more widely for information	Seeks diverse viewpoints	Progression levels 1 to 3
	Political astuteness	Uses informal networks	Understands culture and climate	Understands the politics	Progression levels 1 to 3
	Drive for results	Strives to deliver local targets	Places a focus on improving performance	Places a focus on improving performance	Levels 1, 2, 2
Delivering the Service					
	Collaborative working	Appreciates others views	Works for shared understanding	Forges partnership for the long term	Progression levels 1 to 3
	Effective and strategic influencing	Uses direct logical persuasion	Uses direct logical persuasion	Calculates an impact	Levels 1, 1, 2
	Empowering others	Encourages and supports	Encourages and supports	Encourages and supports	All at level 1
	Holding to account	Assigns clear accountability	Assigns clear accountability	Assigns clear accountability	All at level 1
	Leading change through people	Manages the team	Manages the team	Manages the team	All at level 1

References

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