

**CARING FOR THE SPIRIT:
A strategy for the
chaplaincy and spiritual healthcare
workforce**

November 2003

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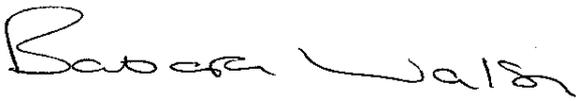
PREFACE

The preparation of this strategy for the chaplaincy and spiritual healthcare workforce is an example of the best collaborative practice within healthcare. A wide range of organisations and individuals has worked together in responding to our demands for evidence, comment, analysis, and help. This preface gives me the opportunity to thank them for their effort on behalf of all who work in healthcare.

Our own efforts in South Yorkshire were championed by a small group of senior faith and health leaders to whom I am grateful. Despite the busiest of lives, our champions have met regularly to discuss progress and to set the direction and pace for our work. We have sought to match the strategy to the vision they have painted and I look forward to further close working in the coming years.

Most of the day-to day work on strategy has been shouldered by members of the project team, many of whom are drawn from Trusts. They have read every draft and commented on every paper without complaint. The final version of the strategy has been greatly improved by their careful attention to detail and by their strong commitment to chaplaincy. The project team has also been supported by colleagues within other Workforce Development Confederations and within the Department of Health. Where focus was required, it has been applied with a thoughtful and helpful hand, which has benefited our work considerably.

Finally, I should also like to pay tribute to those who took part in the workshops, attended the consultation meetings or who just wrote in with their comments. This unsung band of contributors cannot be listed here but have shown by their enthusiasm and support that our efforts are worthwhile and appreciated. As our short video presentation says, chaplaincy is a hidden resource for the NHS. In seeking to make that resource more visible, I hope that what we have prepared here will serve chaplains and members of the spiritual healthcare workforce well in the coming years.



Barbara Walsh,
Chief Executive

November 2003

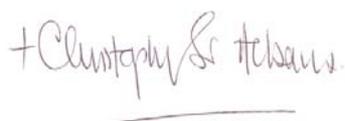
FOREWORD

We welcome this opportunity to affirm the work of healthcare chaplains and their co-workers who care for all those who use and work in the NHS.

A tradition of caring for the sick and supporting those who care for them is common to all faiths. It is often at the time of sickness, or in watching a loved one experience illness that some of the deepest spiritual questions are asked and the greatest challenges to the spirit arise. In their unique role, chaplains work with all healthcare professions and across the whole organisation to provide the spiritual elements of the holistic care offered by the NHS.

In all aspects of their work, be it acknowledging the spiritual dimension in one person or providing for a specific religious need in another, or dealing with the multiplicity of pastoral and advisory responsibilities for others, chaplains need support and development as individual members of staff. This strategy, the fruit of collaboration between those concerned with chaplaincy and spiritual healthcare, sets out a way to achieve that support.

As the modernisation of chaplaincy's professional work proceeds and as the multi-faith agenda unfolds, we commend chaplaincy's work of caring for the spirit and this strategy which supports them.



Rt. Revd Christopher Herbert
Hospital Chaplaincies Council



The Hon Barney Leith
Multi-Faith Group for
Healthcare Chaplaincy



Sarah Mullally
Chief Nursing Officer
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October 2003

EXECUTIVE SUMMARY

- This strategy is concerned with the chaplaincy and spiritual healthcare workforce. This workforce of about 3,500 paid members and up to 10,500 volunteers provides services for patients, staff and health organisations with a key aim of enabling individuals and groups in a healthcare setting to respond to spiritual and emotional need and to the experiences of life and death, illness and injury, in the context of a faith or belief system.
- The chaplaincy and spiritual healthcare workforce needs support in modernising to match the changes in healthcare and in spirituality within the UK. Our foundation exercise of user views demonstrated that the service is valued but, in some cases, difficult to access. We propose a vision for modern spiritual healthcare by the year 2010 and the strategy sets out the steps towards achieving this.
- The role of the chaplain¹ is a unique role and it is also very new to those faith groups without this approach in their traditions. The role has become narrowed and outdated in some places where no regular testing of models of work, research and audit findings sustain evolutionary change. We encourage an approach to practice which uses models for evaluation and which adopts research awareness as a core activity for all chaplains. A small literature study to assess the state of the evidence base is proposed prior to the formulation of a strategy for chaplaincy research.
- A narrowness of role development is also reflected in a narrow and short career pathway. This is unsuited to the needs of all faiths and fails to support those whose expertise is developing into specialist or advanced roles. We propose a wider and potentially longer career map with more opportunity for specialisation to reflect user and service requirements.
- We suggest a need to review the diversity of the workforce and to keep a focus on aspects of working lives where chaplains have lagged behind other members of the NHS workforce. We also point to a need for greater emphasis on continuing professional development.
- In support of the changes to careers and roles, we have reviewed the current training arrangements for chaplains. We propose that all chaplains in healthcare should be trained for this special and unique role. In particular, we consider that part-time staff and those providing chaplaincy in the world faith groups would benefit from a greater range of training programmes.
- To help with these developments, we propose that chaplaincies should work together in collaboratives which bring together the health, faith and educational bodies in partnership to support this new approach. We also suggest a modest investment in spiritual healthcare development units to facilitate changes in the first years of the strategy. We have set out arrangements for accounting for progress in our final chapter.

¹ The title “chaplain” is used to mean those authorised persons from the major world faiths who provide spiritual care in healthcare settings. In some settings, other designations may be found such as spiritual care giver according to local preference.

MODERNISING SPIRITUAL HEALTHCARE

- Background
- The changing context of care
- Constraints and limitations
- What do users think?
- Setting an agenda for action

Background

1. The origins of this review date back to the late 1990s when both the chaplaincy bodies and the NHS were preparing for change in line with changes in society. In 1997, the chaplaincy bodies established a working party to consider the impact and requirements of multi-faith² chaplaincy. This initiative had the support of the then Secretary of State for Health who was leading the drive to modernise the NHS.
2. These two strands of development came together with the formation of the Multi-Faith Group for Healthcare Chaplaincy (2002) and the publication of draft guidance on meeting the religious and spiritual needs of patients and staff (2003) which they had helped to prepare. At this same time, South Yorkshire Workforce Development Confederation, which had the lead on chaplaincy workforce issues, commenced the preparation of this workforce strategy.
3. Within the last five years therefore, changes have been instigated which have revised the policy and the structures concerned with chaplaincy and spiritual healthcare. This workforce strategy is designed to ensure that workforce issues are resolved and change facilitated in order to make the service provided by chaplains and their co-workers effective and efficient.

The changing context of care

4. The context of healthcare is changing. A strategy for the chaplaincy and spiritual healthcare workforce is needed to help chaplains and their co-workers respond to changes in society and in patterns of disease, to increasing public expectations and to a challenging new policy agenda for the NHS.
5. People are living **longer, healthier lives**. The number of elderly people in the population is rising and the settings for care are changing with new treatments and policies. Advising and supporting families and carers has been a growing part of the chaplaincy role and is more difficult when other family support mechanisms are less available. Increasing reliance is placed on inter-professional collaboration.

² In the context of this strategy, multi-faith working includes the nine major world faiths: Bahá'í, Buddhist, Christian, Hindu, Jain, Jewish, Muslim, Sikh, and Zoroastrian.

6. Trends in disease patterns point to a rise in chronic diseases, in mental illness and to some new infectious diseases. High technology healthcare will continue to be delivered within institutional settings but the length of stay for these events has shortened considerably. Increasingly, emphasis is placed on work across institutional boundaries and with local communities. At the time of need, patients are expecting/ expected to be involved in major choices relating to care but with less time and less support to consider these choices.
7. The NHS itself is also changing very rapidly through **the Government's programme of modernisation**. Trusts are now clearer about their priorities and staff are delivering better services and moving to new and modern roles. Funding for new equipment and buildings is making a difference on the ground. In these circumstances, chaplaincy and spiritual healthcare must respond with its own change programme.
8. In response to these changes, chaplains and their co-workers also now work in different settings and in different parts of the patient journey. Acute hospitals now have specialised chaplaincies working with children and with women as well as in specialist services such as palliative care. Mental healthcare has moved services into community-based settings where chaplains now provide services in smaller and more domestic healthcare environments. Most recently, chaplains have started working in primary care settings providing services in GP clinics and community premises.
9. There have been changes in the way people talk about their own religion/ spirituality. The most recent census included a question about **religious affiliation** to which 76% of people in the UK responded positively³. There is also growing research evidence that a large proportion of the UK population within health care has a strong spiritual belief even in the absence of a specific religious affiliation⁴.
10. Parliamentary consideration is being given to regulations which will effectively protect employees from discrimination/ harassment on grounds of religion or belief on a par with other discrimination legislation. At present, these regulations take the form of the Employment Equality (Religion or Belief Regulations 2003 and are the UK's response to the Employment and Race Directives adopted under Article 13 of the European Union Treaty.

Constraints and limitations

11. The context of care is changing but chaplains and their co-workers are often constrained by structures and processes that limit development and innovation. There is less clarity about spiritual healthcare than about other healthcare services, partly because smaller numbers of healthcare professionals contribute directly to spiritual healthcare. Chaplains and their co-workers must now ensure that they provide that greater clarity about what they do in order to move forward with other services.

³ Further detail may be found at National Statistics online
<http://www.statistics.gov.uk/cci/nugget.asp?id=349>

⁴ King M, Speck P, Thomas A. The effect of spiritual beliefs on outcome from illness. *Social Science & Medicine*. 48. (1999) 1291-1299

12. Chaplaincy is also constrained by the lack of ***suitable and modern facilities*** in which to provide services – for example, through lack of prayer rooms that include ablution facilities. There is great difficulty in providing central spaces for spiritual healthcare when so many other immediate care services also demand such space. That said, there is also no reason why chaplaincy should not be as adequately accommodated as other important services.
13. There is some evidence that ***recruitment of chaplains*** is proving difficult. The Christian churches are short of priests and ministers. Vacancies within the NHS for chaplains are proving hard to fill especially at senior level. Other faiths are grappling with the need to train people for work with the NHS. There is a need to widen the entry to becoming a chaplain and also to ensure that those who wish to make careers in the NHS are helped fully to do so via proper career development.
14. In giving attention to issues of recruitment, a wide range of improvements will be supported. New opportunities and requirements for chaplains in world faiths must be matched by systems and processes which support their entry, training and development. These changes need also to apply to established chaplains in post, many of whom remain part-time or working alone. The selection and recruitment of members of chaplaincy teams must rest more obviously in the hands of healthcare employers and team leaders responsible for determining service aims.
15. In order to achieve these new levels of entry to chaplaincy, new paths for education and training need to be found. These cannot rely solely on traditional approaches and will need to take account of wider community-based schemes. Emphasis will also need to be given to career pathways and to issues of reward currently identified but unresolved. Chaplains and their co-workers will need to place a greater emphasis on working as healthcare professionals alongside others and establishing their professional identity.
16. Increasingly, people in all sectors of the community are ***combining careers with family*** commitments, and with continuing learning and development. This trend affects chaplaincy also. Difficulties remain to be overcome in small teams and where finance is cited as an obstacle. Even with the introduction of appraisal schemes, there is often insufficient support for the continuing learning that is a necessary feature of modern professional practice. There are too few opportunities for career breaks or for academic study at higher levels of education.
17. Many chaplains aspire to recognition as healthcare professionals. The College of Health Care Chaplains has established a voluntary register as a first step towards applying for chaplaincy to be registered by the Health Professions Council. Within the NHS, Trusts would be concerned if professionalisation also were to restrict flexibility of roles. Seeking their support and commitment now will require careful preparation. Changes in regulation will also need to involve the churches and faith groups.

18. Whatever may be the course which chaplains set for their profession, the development of all those who provide spiritual healthcare will need equal priority. Small groups of staff such as the spiritual healthcare workforce need to be sustained because of the importance of their role and the difference they make to patient and staff care and to the healthcare organisation as a whole. It is in that spirit, that this strategy sets out to support and sustain a viable community of spiritual carers and to ensure that they are led and managed appropriately.

What do users think?

19. As part of the strategy work, the project team has sought evidence from a wide range of interested bodies and has provided opportunities for discussion by individual healthcare staff. In order to capture the views of patients and members of the public, a **foundation exercise** has been undertaken to obtain a snapshot of their experiences, needs, and expectations of the chaplaincy services⁵.
20. The health communities covered by this exercise were Doncaster and South Humber, Nottingham, and Leicestershire. Some 121 survey forms were distributed to voluntary organisations and 20 to each of the Trusts involved, of which 72 were returned by the end of May. These forms have been analysed and the results tabulated. The final report of the exercise was approved by the project team at its meeting on 20th June 2003.
21. The **evidence from the exercise** showed that user expectations were that the hospital would supply chaplains and that they would be accessible in all NHS facilities. The skills expected in a chaplain were those which one might find in a priest/ minister working in a community setting. When considering patient needs, the majority of users identified themselves as having religious needs. Significant weight was given to emotional support; help to understand what was happening in one's life; and worries to be shared in confidence.
22. The section on the experience of patients showed that only about half the number of patients were asked about their religious/ spiritual needs and only 15% were informed about the chaplaincy service. Information about worship/ sacraments was available to about the same proportion. One third of users were visited by the chaplain when in hospital. Access to chaplains was not easy as information was patchy and even requests for visits were not always met. When the visit did take place, it was usually helpful although somewhat delayed either after requesting or in making a request.
23. We consider that further studies of users views will be needed. These will consider aspects of chaplaincy such as publicity and information about chaplaincy services including worship and other religious rituals; details of referral mechanisms for the chaplaincy service including self-referral; and the nature and purpose of chaplaincy visits including the balance to be struck between general ward rounds and referral systems.

5 A full report of this exercise is available on the website of the South Yorkshire Workforce Development Confederation.
http://www.sywdc.nhs.uk/sys_upl/templates/StdLeft/StdLeft_disp.asp?pgid=2275&tid=50

Setting an agenda for action

24. There are about 400 whole time chaplains and 3000 part time chaplains working in healthcare in England. Chaplaincies also benefit from the services of support staff and of volunteers dedicated to chaplaincy work. Volunteers⁶ provide a range of services, from support work (such as transporting patients to services) through to co-working in helping with spiritual responsibilities generally. These co-workers average about 35 for each of 300 or so chaplaincies giving a total of 10500 people, and **the total spiritual healthcare workforce** number as about 13500 - 14000 people.
25. This spiritual healthcare workforce cares for the spiritual care needs of all patients, staff and carers within the NHS. The complexity of that work is changing with the variations in the proportion of faith groups within the population highlighted by our survey of chaplaincies last year. This increasing diversity of users, the support needs of the emerging workforce which cares for them, and the importance which users attach to spirituality together require careful planning to ensure quality of service is maintained.
26. The challenges and opportunities of a changing world as well as the weaknesses in the current system highlight the need for **a new strategy for chaplains and the spiritual healthcare workforce**. If we are to realise the full potential that the spiritual healthcare workforce has to offer, change will be necessary in working practice and in programmes of learning and development. Attitudes and beliefs within and outside the professions should also change so that the contribution to spiritual healthcare made by all faiths can be recognised and valued.
27. Spiritual healthcare is an important aspect of healthcare and the work of chaplains has widespread support. Holistic care includes care for the physical, social, psychological and spiritual dimensions of the person. All four elements contribute to the health and well-being of those we serve. At the same time, providing spiritual healthcare is not just the preserve of chaplaincy because the spiritual dimension is often expressed through the humanity of care offered by many health professions.
28. One of the challenges faced by this strategy is to persuade health organisations and other partners to acknowledge explicitly, and show commitment to supporting the spiritual needs of patients as an integral dimension of healthcare. We consider that all staff entering the healthcare professions should be aware of the important attributes and potential benefit that can be offered by the chaplaincy and that the particular contribution made by chaplains and their co-workers should be recognised.

⁶ Unpublished data from the 2002 National Survey of Chaplaincy – Spiritual Healthcare Issues; South Yorkshire Workforce Development Confederation; February 2002

29. In order to do this, and to enable chaplains and their co-workers to respond to the way society and the NHS are changing, action needs to focus on:

- Modernising spiritual healthcare
- Enhancing and evidencing the quality of spiritual healthcare
- Widening career pathways
- Strengthening education and training

Our plans in respect of each of these actions are set out in the chapters that follow. This is a challenging set of proposals which requires a positive contribution from all those who work in the NHS and from their organisations.

30. We believe that, with support from policy makers, managers and lead clinicians, chaplains and other members of the spiritual healthcare workforce will be able to make **a greater contribution to healthcare** by providing patients, staff and organisations with modern spiritual healthcare. We envisage that, by 2010, chaplains and their co-workers should be:

- Delivering evidence-based spiritual healthcare for all users needing such care in a patient-centred fashion and to agreed standards within agreed resources;
- Working as members of the healthcare professional workforce in multi-disciplinary teams which reflect the specialty and expertise of the chaplain in a variety of care settings;
- Supporting multi-faith working which respects the validity of all faiths as a pre-requisite for effective chaplaincy and acknowledges that patients and staff can expect all reasonable efforts to be made for them to receive spiritual care appropriate to their beliefs.
- Demonstrating professional standing through education pathways and attainments common to all chaplains and authorised appropriately by faith group mechanisms acceptable to all;
- Contributing to the leadership of healthcare services by effective management of spiritual healthcare and positive support to organisational and corporate objectives whilst also being able to give voice to those whose views do not accord with those of the organisation;
- Building effective and useful links with community groups and with faith groups locally and nationally.

31. In order to sustain this level of development, we consider that there is a need for **additional support to chaplains and to chaplaincies** and to their co-workers. Within the body of this report, we suggest that chaplaincies should work together in chaplaincy collaboratives to enable a wider experience and critical mass to inform the way forward locally. We also propose (in chapter five) that Spiritual Healthcare Development Units be formed under the auspices of WDCs/ SHAs to support the change process more generally.

ENHANCING AND EVIDENCING THE QUALITY OF SPIRITUAL CARE

- The unique role of the healthcare chaplain
- Models of practice and service
- Performance management
- Developing research capacity

The unique role of the healthcare chaplain

32. Chaplains are unique among the health professionals in that their caring task is primarily focussed upon religion and spirituality. As people formed within a distinctive faith tradition and representative of a faith group, chaplains are experts in religious belief, knowledge and practice. This professional distinctiveness enables them to function effectively in the NHS and to make a specialist contribution to health care. It is out of the integrity of their personal spirituality that chaplains are sensitive to and supportive of the diverse spiritual and religious needs of patients, carers and staff.
33. Chaplains are representatives of their faith communities which require them to live out the commitment of those communities to the wider world, in this case in a healthcare context. They must therefore be learned in the ways of the faith group and knowledgeable about the basis for its decisions and guidance. In this role, chaplains are accountable to the faith group for embodying its ethos and teaching appropriately. A regular checking-back and refreshment of this representative role is necessary.
34. Chaplains have to deal with some of the most difficult human experiences that result from illness and injury. They are often uniquely placed to relate to people in these circumstances, to discern their needs, and to provide forms of pastoral care. Chaplains also nurture well-being, foster hope and support people through the transitions that accompany a period of ill health. Consequently within the health care team a chaplain can become a key professional for a patient and an important link with carers, other agencies and the wider community.
35. One important aspect of the chaplain's role is in the ability to represent both the spiritual and the religious embodiment of faith for other people. Such an embodiment leads the observer to project on to the chaplain their views and expectations. These may be simple or complex, confused or clear, placid or angry. Without compromising his/her integrity, the chaplain is expected to express the spiritual needs of the individual in a meaningful and relevant way.
36. In understanding the relationship of spirituality to health care, chaplains recognise that values, meanings and beliefs play an important role in the life and work of the health care organisation. This distinctive perspective enables chaplains to be a resource to the hospital/service as an institution and provide insights into a wide range of issues. Chaplains work throughout an organisation and move easily across professional boundaries. They are therefore in a position to be able to listen to the stresses and strains of the organisation, to be an affirming and supportive presence, and to be a powerful reminder of the vocational aspects of care.

37. The specialist education and training received by chaplains and their experience in working with people in challenging situations can be a distinctive educational resource to health care organisations. Chaplains can contribute to training and development across staff groups and in a number of important subjects including communication skills, religious and cultural diversity, and bereavement care. In addition chaplains offer placement opportunities to students, provide input into the academic work of a health care organisation and collaborate in research programmes.
38. Chaplains provide effective links between the health care organisation and the faith group communities that can benefit both. This supports the move to wider public involvement and representation in the NHS and enables the provision of services that are sensitive to the needs of particular communities. Chaplains can facilitate community-based pastoral care resources. Many chaplaincies use trained volunteers from local faith groups.

Models of practice and service

39. The way in which much of spiritual healthcare is delivered is based on the guidance and models of care which existed at the inception of the NHS. Broadly speaking, this is the parochial model based on individual priests/ministers (mostly Christian) dealing with a predominantly bed-based clientele. Although some changes in healthcare have been reflected in changes in chaplaincy, for example in mental health care, and especially in a community setting, bed visiting by clergy is the prevailing model.
40. In more recent years, others have examined chaplaincies to derive a wider range of models and a broader analysis of activity within individual institutions. In particular, Helen Orchard's recent study in London⁷ suggested modelling practice for 15 different polarised service parameters in sponsor-defined and in employer-defined areas. There are other models in place but no consistent approach or shared understanding.
41. For spiritual healthcare to be delivered in a consistent and systematic way, reliable service models are required that enable best practice and are consistent with wider organisational structures. The use of models in healthcare is widespread and chaplaincy should take advantage of the progress made by other healthcare professionals and establish their own service model based on their own practice model and derived from a theoretical model.
42. One ***theoretical model of spiritual care*** which may help to guide this process of development is that provided below. This⁸ is developed from work by David Lyall and suggests that spiritual care has the following characteristics:
 - Spiritual care is a response to the spiritual needs of a person understood through exploring life events, beliefs, values and meaning.
 - Spiritual care is a means of therapeutic support to enable a person challenged by illness, trauma, or bereavement to find meaning in their experiences of vulnerability loss or dislocation.

⁷ Orchard, Helen (2000), *Hospital Chaplaincy: Modern, Dependable?*, Sheffield Academic Press, ISBN 1 84127 215 9

⁸ Mark Cobb's paper "the use of models in spiritual care" used at the workshop on chaplaincy practice – April 2003

- Spiritual care addresses the dimensions of illness, disability, suffering and bereavement that go beyond the immediate and the physical.
 - Spiritual care contributes to healing and rehabilitation in respecting the integrity of the person and by attending to wholeness in the midst of brokenness.
 - Spiritual care may incorporate psychological, social and religious dimensions.
 - Spiritual care may incorporate liturgical actions which embody the beliefs of a particular tradition if the person finds this appropriate.
43. This theoretical model underpins and informs the models of practice that guide chaplains in the way they work. It also supports a consistent and systematic approach to practice which will enable further development. As a starting point, many healthcare professions have developed **practice models** based upon a simple four stage framework such as that involving assessment, care planning, care delivery, and review.
44. An example of how this may be applied is given below:

Stage	Practice element	Example
1	Assessment	<i>A chaplain attends a patient who has requested a visit. The patient is elderly and is struggling to accept that she will need to live in a nursing home. The chaplain identifies issues of loss and social dislocation as well as detachment from a previously supportive faith group community.</i>
2	Care planning	<i>The chaplain plans to see the patient on a regular basis; makes contact with the care team and facilitates the patient's faith practices.</i>
3	Care delivery	<i>The patient is seen by the chaplain on a regular basis to explore the issues identified and to foster her hope. The chaplain works with other members of the care team to enable the patient to practise her faith</i>
4	Review	<i>Before the patient transfers to the nursing home the chaplain reviews with the patient her current situation and needs, and with the patient's permission refers her to the local minister who visits the nursing home.</i>

45. A further example using a more overtly religious aspect of chaplaincy is also given:

Stage	Practice element	Example
1	Assessment	<i>On admission, the patient indicates that they are practising their religion. A referral is made to chaplaincy. The chaplain visits the patient and assesses their religious/spiritual care needs in the context of the patient's healthcare plan</i>
2	Care planning	<i>The chaplain arranges to administer the sacrament of the sick prior to the patient's surgery</i>
3	Care delivery	<i>The chaplain administers the sacrament of the sick</i>
4	Review	<i>Following the patient's surgery, the chaplain visits and reviews the assessment, identifies current and future needs.</i>

46. Although this is a simple model, it is capable for use as a complex tool to explore practice and the skills/knowledge and procedures used. Using the examples cited, we can highlight several issues from this simple framework:
- At what stage did the patient consent to receive spiritual care?
 - Should the assessment include some element of physical and mental well-being?
 - What is the relationship between the chaplain's care plan for the patient and those prepared by other healthcare professionals working with the same patient?
 - What is the patient's involvement in setting goals and outcomes for this element of their care?
 - How is the process to be documented? How is confidentiality protected?
 - What happens when the patient is transferred to another service or discharged from hospital?

Answers to these and other questions will enable the model of care to be improved through testing and enquiry – part of the ethos of all healthcare professionals.

47. There is a wide range of models that inform the practice of healthcare professionals and many are based on the biomedical model that focuses upon the pathology of the patient and its treatment. Increasingly, more **person-centred and holistic models** are being recognised as valuable and therapeutic. These understand disease as one aspect of an illness process and take account of wider factors and the context of the patient's life. Different care models also support the ethical position of the patient as a person who contributes to decision-making and the care process. Chaplaincy holds a high value of personhood and is attentive to the wider context of the person. The implicit model of chaplaincy is one that needs better articulation but which has much to contribute to current developments in the care of patients.

48. Many of the people that chaplains support and care for are struggling to make sense of their lives following the impact of illness and injury. The model developed by Gerkin⁹ recognises that an important part of that process takes place by way of a dialogue between the particular life story of the individual and stories of the faith group communities and their beliefs and values. The chaplain is located in the space between the individual and the faith group she or he represents.
49. In this model, the role of the chaplain is to give empathic attention to the story of the individual whilst being able to facilitate an open dialogue between this individual story and the story of the faith community. It may be that, on occasions, the chaplain is focussed more on helping the person to articulate their story; whilst at other times the chaplain may be speaking more from the side of a faith tradition in order to enrich and inform the dialogue. The model suggests that a chaplain may move between the stories of the individual and the faith community to facilitate effective and caring dialogue.
50. The following example clarifies this model further: *A chaplain came across a man sitting in the chapel who was obviously distressed. So the chaplain approached the man and asked him if he would like to talk about what was troubling him. The man responded that his mother was a patient in the hospital and she was dying. "I have never given any thought to the fact that one day she would die, she's my mum and she's always been there for me. I don't want her to leave me now but I don't want her to suffer either."*
51. *The chaplain helped the man to express why he was distressed and the conversation focused on the past and all that his mother had meant to him; the present in terms of the suffering of his mother; and the future in terms of what it will mean for him to live with the loss of his mother. This was a conversation implicitly about the meaning and ultimate purposes of life as well as the meaning of death. The man told the chaplain that his mother believed in God and life after death, but that he wasn't sure. The chaplain facilitated a supportive dialogue in which these issues could be safely explored that took seriously the particular story of this man but were also informed by the story of the chaplain's faith community.*
52. Chaplains will need to decide for themselves whether their care of patients fits best with the biomedical model or with the social model proposed above or with some other model of their own adoption. Whichever model of care for individual patients is adopted by individual chaplains, this needs also to be aggregated into a **model of the service** provided for all users. In this way, the functions, roles and interactions of groups or teams which are organised together on the basis of common criteria can be demonstrated. Thus, the key roles of chaplains in providing spiritual care; meeting religious needs; and contributing specialist knowledge and skills can be modelled together.
53. The availability of the model of service enables the chaplaincy also to review whether the service is meeting the needs of users. It provides a working demonstration of how the service works and can be used as a check to ensure that the patient is at the centre of the service and that other users are given appropriate priority. This use as an audit and teaching mechanism for dialogue with others will enable best practice to be replicated in chaplaincy service.

9 Gerkin CV (1997) An Introduction to Pastoral Care. Nashville: Abingdon

54. A model of service will also help to clarify the difference between providing service to patients direct and providing service to patients by supporting those who care for them. In all healthcare organisations, supporting the staff who care for the patients is as important as supporting the patients direct. Moreover, in some instances, chaplains may have little choice in how to care for patients; for example, where they offer support to very young children through their carer, or in intensive care where care may be offered through the named nurse. With a range of options for the focus of care, from supporting individuals to supporting the whole organisation, a system which helps chaplains delineate different modalities of care will ensure an effective prioritisation of time and resources.
55. In the Bolton Hospitals NHS Trust¹⁰ the model of service has been developed into a care pathway approach and, in its full form, includes a map of the care pathway, the explanation of service provision, measures of outcome and an explanation of levels of spiritual care. Similar work has been undertaken by the Association of Hospice and Palliative Care Chaplains which has developed standards and an audit tool for their work. Not all chaplaincies will need to start with this complexity but mapping the progress and considering values and standards for each “step on the way” are useful ways to begin forming clearer and better understood service models for spiritual healthcare.

Performance management

56. Delivering spiritual healthcare is a complex task involving a small group of practitioners supporting all patients, staff and visitors within the NHS across at least nine world faiths and with links into faith group communities with differing cultures and backgrounds. But there is little information about spiritual healthcare available either from the workforce perspective or from the aspects of outcome and process. The size of its activity and the resources required for satisfactory delivery are not clear-cut and cannot therefore be adjudged fairly¹¹.
57. Within the NHS culture of management excellence, performance management is given emphasis because delivering services with public funds requires accountability ultimately to Parliament. The performance management framework used in the NHS is designed to integrate the challenges of the NHS Plan more fully into the general management of the NHS. Through the framework, the Trust can assess whether it is achieving economy, efficiency and effectiveness in its use of resources.
58. Spiritual healthcare is not included within the current performance management framework and therefore does not contribute explicitly to the assessment of efficacy of care which Trusts must make regularly. At the same time, chaplains have not provided a consistent view as to whether they should fully accept management responsibilities and they have not developed measurement tools of their own to support this work. As a result, data availability, levels of budget-holding, and routes for accountability vary widely across chaplaincy services.
59. As a first step towards performance management responsibilities, chaplains and their co-workers should agree what activities need to be managed and which

10 Based on work by Revd Neil Gray, Co-ordinator of Spiritual and Cultural Care, Bolton Hospitals NHS Trust

11 Work on one aspect is currently being undertaken by a NICE working group on supportive care

data would represent these activities clearly. This will be a complex task including as it will elements of activity, human resources, finance and quality data. Such data will need to be collected consistently across all chaplaincies and monitored for variance in accordance with best practice.

60. Starting to collect data about performance, organising its presentation and assuring its quality will consume resources of time and effort. These resources are not wasted but will support a clearer view about the work being done and the priorities assigned to it. Colleagues in other allied professions will be able to assist with ways to make this development phase worthwhile and meaningful.
61. Other examples of this work already in implementation within NHS Trusts are a useful and suitable starting point. They may not always include the requirements of all faith groups and often also do not accommodate the differences in chaplaincy styles between physical and mental healthcare. Work is commencing on the preparation of a chaplaincy minimum data set by a network of chaplains interested in research. This work will be monitored and supported by SYWDC where possible.

Developing research capacity

62. Fostering a research-based culture within the health service is essential to support the promotion of **evidence-based practice**. Policies for implementing clinical governance and improving access to research findings will increase the incentive for chaplains to remain research aware, to appraise research findings critically and to facilitate their implementation and to become active research workers. Collaboration with other chaplaincy teams, with research establishments and with academic institutions will continue to be encouraged to facilitate the possibility of staff secondments to acquire research skills.
63. All chaplains should learn during their initial training to appreciate the importance of research methods and findings for their profession and for clinical governance. As our small foundation study of user views has shown, there are aspects of day-to-day chaplaincy services which need to be reviewed, updated and re-tested. Such a study would be ideal for implementation within a large chaplaincy team or within a chaplaincy collaborative i.e. a group of collaborating chaplaincies.
64. As their career progresses, chaplains should have access to further research training opportunities either through higher specialist training or through continuing professional development. This will help them refine the interpretative and appraisal skills necessary to fully understand research methodologies and to operationalise research findings.
65. To assist with the development of chaplaincy research, we consider that the existing chaplaincy occupational standards should be supplemented with one concerned with research. A draft of this **research competency** is due to be commended to the chaplaincy bodies for consideration. We consider that research skills can be acquired readily as research training and qualifications are easily accessed locally (within Trusts or University Departments).
66. Equipped with the necessary competence, chaplains could contribute to the research agenda in four ways:

- Maintaining active and critical awareness of research including monthly journal clubs and annual audit of practice;
 - Sharing good practice and collaborating in research with other chaplains or healthcare professionals leading to publication and dissemination of original research findings¹²;
 - Undertaking a lead research role in initiating, co-ordinating and publishing research activity singly or collaboratively in accordance with the NHS research and development programme; and for some,
 - Developing a significant national/ international role which contributes to the furtherance and reputation of chaplaincy. This could be through attending multi-professional conferences; publication in international peer reviewed journals; submission of abstracts to conferences (either as posters or for oral presentation when invited to do so).
67. We understand that, amongst professional healthcare staff, between 1-2% are research active with the remainder research aware. We consider that in line with this finding, all chaplains should be research aware (active at the first level). Further involvement will depend on local interest and the availability of resources and on the emergence of professional development models which value a research contribution.
68. Care must be taken to avoid confusing these levels of engagement with the dimensions for research and development and for service development contained within the NHS Knowledge and Skills Framework (NHS KSF)¹³. This latter guidance places the ongoing evaluation of services and processes (such as audits) and action research to improve practice within the service development dimension.
69. The availability of more research fostered in this way will also assist those journals currently publishing in this area to develop clearer arrangements for peer-review of research-based material.
70. Within the UK¹⁴, the majority of ***evidence in support of the efficacy of spiritual healthcare*** comes from evidence generated about palliative care, elderly care and mental healthcare. At the same time, GPs and others noted that the degree of satisfaction with services often reflected the patients' underlying beliefs. It is also notable that very little of the research in spirituality encompasses studies which are quantitative.

12 As instanced in respect of Revd Nigel Copsey's work by the East London and The City Mental Health NHS Trust

13 The Knowledge and Skills Framework (NHS KSF) and Development Review Guidance – Working Draft; NHS Pay-HRD Department of Health; March 2003

14 The research undertaken in the USA is publicised at www.healthcarechaplains.org. A statement about the role and importance of professional chaplaincy in North American healthcare is published at http://www.healthcarechaplains.org/publications/publications/white_paper_05.22.01/05.html

71. These elements of evidence are important but more needs to be done to develop a clear statement about the evidence which supports efficacy in spiritual healthcare. Even now, there seems to be confusion as to whether spiritual healthcare is some form of complementary medicine and chaplains must resolve the ambivalent attitudes expressed towards their service by demonstrating its contribution to health and well being.
72. There is thus a need for further research into the structure, role and efficacy of healthcare chaplaincy. At the same time, it is not clear “where we are now” and what strategy should be selected both for the identification of questions and also for their resolution. We have therefore concluded that the starting point in the development of a strategy for chaplaincy research is **a review of the research literature** to identify and grade the published evidence about structure, role and efficacy of healthcare chaplaincy.
73. This study would be an extension of the questions examined by Helen Orchard in her research in London¹⁵ as follows:
- Does chaplaincy have a recognised remit ?
 - How are chaplaincy services responding to the needs of patients from a variety of religious traditions ?
 - What implications does the developing nature of healthcare delivery have for chaplaincy ?
 - What implications does the changing nature of society have for chaplains ?
- The literature review itself may also suggest other questions for further research.
74. The literature review should be undertaken by a designated research study. The research post would be advertised and tendered in the usual way and the work undertaken within two years of commencement. At the end of this period, the **research programme to support chaplaincy** could be identified and further activity devolved to the centres taking forward development work and to researchers generally.
75. In the meantime, we see no reason why research activity in spiritual healthcare should cease where chaplains are engaged in active enquiry. A follow-up study to the foundation exercise undertaken for this strategy would also be welcomed.

15 Orchard, Helen (2000), Hospital Chaplaincy: Modern, Dependable?, Sheffield Academic Press, ISBN 1 84127 215 9

WIDENING THE CAREER PATHWAYS

- Career development
- Improving working lives
- Achieving diversity
- Continuing professional development

Career development

76. For many years, there has been only a simple structure to the careers of chaplains within the NHS. Traditionally, there has been a single practitioner grade of chaplain and a trainee grade of Assistant Chaplain. In recent years, there has been a growth of Senior Chaplain posts for those carrying a management responsibility (chaplaincy team leader). Thus, advancement has been towards the managerial aspects of the role albeit within larger teams of chaplains.
77. These arrangements have their origin in the pattern of ministry in Christian traditions e.g. curate and vicar and, for example, reflect a particular view about the need to “test the call” which is the basis of much Christian training for ministry. Such an origin obviously does not fit today’s multi-faith perspective where faith groups have no established tradition of chaplaincy or in some instances of priesthood. Thus, an arrangement based on only one of the nine world faiths will need to be reviewed for this strategy.
78. There is a clear view emerging that this **short and narrow career path** is failing to contain all those who are already following careers in the NHS. Experts are emerging in education, research and in chaplaincy practice who do not fit readily into the current grading structure of chaplain and chaplaincy team leader. Many of these chaplains wish to stay within their chosen calling and the inevitable drift towards the management role is often unwelcome. At the same time, the NHS needs to retain these experts with their focus on service quality and effectiveness.
79. Many chaplains, who are senior in terms of their length of service, have no senior grade offering some specialisation for their expertise. Some narrowing of role over time occurs in most healthcare professions as the practitioner identifies and becomes familiar with the knowledge and skills associated with a more specialised role. This group of chaplains is also being pushed inexorably towards the management role rather than any other advanced role within chaplaincy. With the wide range of possible choices for such advanced practitioners, the NHS needs to provide opportunities for acknowledging a more senior role which is not managerial.
80. The short and narrow career path is also perplexing to those who wish to undertake a chaplaincy role within the world faiths which do not have a tradition of chaplaincy. Many of these are either senior in their faith group community or have leadership roles which equate to priests and ministers of religion. Some are already “religious experts” because of their training whilst others wish to undertake a narrower role than envisaged for the practitioner level of chaplain. The growth in demand for chaplains of all world faiths means that choices in career pathways must be able to fit with the skills and knowledge brought from outside the NHS.

81. We also have been concerned at the lack of clear training arrangements for NHS chaplains. There is a body of knowledge which chaplains (may) acquire during their work but which is not taught or outlined on entry to this work nor is the gaining of this knowledge tested at any time except by those who wish to undertake further study. We consider that the present apprentice-like scheme of training should also include the need to gain grounding in the knowledge of the subject as evidenced by qualification.
82. In summary, we see the need for **five main chaplaincy roles**. In addition to the current role of practitioner chaplain, trainee chaplain and service manager, we see the need for an advanced practitioner and for a specialist practitioner. In the longer term, and with progress being made in other aspects of the chaplaincy role, there may also be a need for a most senior level of practitioner equating with the consultant level posts in the allied health professions and in health science.
83. There is also a need for a tailor-made role along the lines referred to in paragraph 80 which may combine elements of all these main roles. We have not taken this development further at present but will do so in discussion with chaplaincy bodies in due course.
84. Currently, we envisage that these five main practitioner roles would work as follows:
- The trainee chaplain would be one newly appointed to work in healthcare. This chaplain would be “authorised” by their faith group and prepared for their work in religious and theological aspects.
 - The practitioner chaplain will have an acceptable level of qualification, experience and training to practise autonomously. This chaplain will be working at the basic and entry-level of healthcare chaplaincy able to undertake the full range of practice included in the chaplaincy occupational standards.
 - The advanced practitioner chaplain will be a chaplain who has acquired the knowledge and skills to offer a broad range of services at a higher level. This chaplain will be able to extend the range of their involvement in patient care issues at a higher level of competency. They will be better at what they do and will have acquired greater expertise for example in ethical issues or in multi-faith working.
 - The service manager for chaplaincy will usually be a chaplain who has acquired sufficient management skills to become a service manager. This chaplain will usually have undertaken specific management training and may well be qualified and published in one of the management disciplines.
 - The specialist practitioner chaplain will be a chaplain who after higher specialist training operates within a speciality role and across a narrow range of functions. This chaplain will be able to work more readily in a multi-disciplinary role bringing specialist knowledge and further experience to the work which would not be available otherwise. They will also be able to contribute to policy development because of their expertise.

85. We can envisage the need for **a consultant-level chaplain** i.e. for an expert whose practice may encompass or be devoted entirely to expert practice; professional leadership and consultancy; education, training and development; and research. We are not making formal proposals for such a post to be included generally now even though there may be exceptional circumstances for some individuals. Instead, we consider that, should the development of specialised roles so merit, a consultant-level post would be appropriate particularly in relation to other healthcare professions.
86. This new career map¹⁶ recognises and resolves many of the concerns raised by groups and individuals submitting evidence for this strategy. The proposals have been tested within the limitations of the discussion and consultation meetings with chaplains and with employers through the consultation draft. They have been broadly endorsed as satisfactory and need now to progress to a more formal stage of development.
87. We recognise that many chaplaincy or spiritual care services are undertaken by chaplains working single-handed in collaboration with a small number of other Christian ministers in healthcare and community settings. These chaplains have acquired the knowledge and skills to be autonomous practitioners but the scope for further development in these circumstances may be limited by time and other resources.
88. We also wish to acknowledge that these proposals should apply equally to part-time chaplains as they will to whole-time chaplains. The majority of healthcare chaplains are part time and their needs have often been subordinated to those with a whole-time presence in healthcare. We hope that a balance of opportunity can be achieved through the implementation of these proposals.
89. The proposals will need to be endorsed by faith groups, chaplaincy bodies and NHS bodies as well as with the “usual negotiating machinery” associated with pay and reward within the NHS. Currently, the NHS is reforming its pay and grading systems through the implementation of proposals within **Agenda for Change**¹⁷. Guidance about how to judge excellence and expertise in a spiritual dimension will need to be fashioned jointly between the NHS and chaplaincy bodies.
90. These proposals arise just as early implementer Trusts are assimilating their chaplains to national pay spines within the grading definitions for chaplains and chaplaincy team leaders already agreed. This will be followed by the roll-out of the methodology to all Trusts in the next two years. It is to be expected that instances of these new roles will emerge during this process and thereafter. We will collate examples for wider promulgation in due course.
91. We are conscious that many individual chaplains will be uncertain where they fit on the proposed new career map. If our proposals are accurate, many will have changes to make to the standardised description of their role in order to acknowledge their expertise, knowledge and skills. We consider that disruption to individuals will be reduced by the relevance of our proposals to the **Agenda for Change** implementation and moderated by the acknowledgement of their role in these new descriptions.

¹⁶ The chaplaincy career map has been represented in diagrammatic form in Annex 1

¹⁷ Agenda for Change – Proposed agreement; NHS Pay, Department of Health; March 2003

Improving working lives

92. Providing good working conditions which are sensitive to the needs of individuals is crucial to recruiting and retaining staff. The *Improving Working Lives* standard commits NHS employers to recognising that modern health services require modern employment services; to accepting a joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services with the needs of staff; and to providing personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns.
93. Chaplains and their co-workers need to ensure that the best practice found in several Trusts to support improved working lives is applied appropriately to all areas. The current inconsistency of approach is being tackled within Trusts and senior managers are keen to ensure that problems are eased and staff supported. Those who have worked with employers to improve these aspects have also been able to provide better services as a result.

Achieving diversity

94. Recruitment and retention of a more diverse workforce is essential to building a quality workforce in the right numbers and with the right skills and diversity to deliver quality services to patients and staff. It is therefore essential to fulfilling the requirements of the NHS Plan. Having a diverse workforce at every level also makes a vital contribution to being able to provide an effective, accessible and culturally sensitive service to diverse communities. This is particularly the case with spiritual healthcare.
95. The lack of detailed workforce statistics make it difficult to assess the current composition of the chaplaincy workforce in terms of gender balance and numbers of black and minority ethnic or disabled staff. The survey undertaken by South Yorkshire WDC¹⁸ was not detailed enough to gain a clear view with any detail. But each chaplaincy team needs to reflect the diversity of the local community served so that it can provide appropriately for different cultures, customs and structures.
96. In 2000, the Minister of State announced a series of initiatives¹⁹ to increase recruitment and retention of black and minority ethnic staff, all of which are relevant to chaplains and the spiritual healthcare workforce. The recent survey needs to be repeated with emphasis on gaining a clearer view of ethnicity within the spiritual healthcare workforce, and in the light of expected new policy statements in support of multi-faith chaplaincy teams.

¹⁸ 2002 National Survey of Chaplaincy – Spiritual Healthcare Issues; South Yorkshire Workforce Development Confederation; February 2002

¹⁹ The Vital Connection: An Equalities Framework for the NHS issued under cover of HSC 2000/014

Continuing professional development

97. Continuing professional development (CPD) as part of a lifelong learning framework is central to improving the quality of service to patients and to developing a workforce with skills necessary to deliver the health care priorities of the NHS in the future. CPD plays a crucial role in the maintenance of competence by individual practitioners and is likely to be increasingly important in the future for the maintenance of standards of spiritual healthcare.
98. CPD for chaplains takes place through a range of formal and informal mechanisms. Some aspects are firmly located in academic environments, requiring students to travel to higher and further education institutes for formal education. Others are workplace-based and may involve either formal competence assessment or more informal initiatives driven by personal development planning priorities. New learning initiatives, including the exploitation of IT-based systems, need to be explored and better developed to support CPD initiatives.
99. The Department of Health's e-learning strategy will ensure that all NHS staff have 24-hour access to learning services and resources from multiple locations to suit their individual needs. It is expected that NHS employers will wish to involve chaplains fully in the development of locally managed systems of CPD in NHS Trusts so that chaplains are supported to fulfil the requirements of clinical governance.
100. Many aspects of the chaplain's work will be amenable to development with other professionals for example in those aspects relating to team working and relations with other professionals. At the same time, the development of the NHS Knowledge and Skills Framework will mean that the existing statement of chaplaincy occupational standards will need further review in order for it to become an agreed reference for level descriptors. Work is in progress with the emerging sector Skills Council to pursue this recognition.
101. Until these changes are progressed, we consider that chaplains should continue to pursue aspects of CPD using existing appraisal mechanisms. These are likely to be based on the existing statement of occupational standards and the need to support the progress of colleagues within a framework of education and competency development. Such a system has been in use at Nottingham City Hospital for some time and is published and accessible.²⁰

20 Martin Kerry in Orchard Helen (2001), *Spirituality in health care contexts*, Jessica Kingsley Publishers.

102. Using the widest definition of competencies to include knowledge, behaviours and skills, we consider that chaplains should develop their own view of the competencies necessary for their practice for endorsement within their Trust. The sort of framework we have in mind is set out below as an example drawing on this work and can be used for job profiles and descriptions, training and development assessment and a variety of other purposes:

Chaplaincy Role	Knowledge (e.g. Strategic planning, operational management, Religious care, Spiritual Care, etc.)	Behaviours (e.g. Reflective, Spiritual, Accepting, Creative, Self-aware, Available, etc.)	Skills (e.g. Pastoral, Worship, Theological, Training, Communication, etc.)
Trainee			
Practitioner			
Advanced			
Manager			
Specialist			

103. We intend to publish a clearer guidance note about how to integrate the use of this framework into all aspects of professional development in due course.

STRENGTHENING EDUCATION AND TRAINING

- Changing educational relevance
- A training programme for NHS chaplains
- A training programme for chaplaincy volunteers
- Occupational standards for healthcare chaplaincy
- Leadership and management
- Modernising regulation

Changing educational relevance

104. In chapter one, we proposed that all staff entering the healthcare professions should be aware of the important attributes and potential benefit that can be offered by the chaplaincy and that the particular contribution made by chaplains and their co-workers should be recognised. In these circumstances, we consider that there is a need for **a staff awareness programme** to help with this understanding and to raise awareness about spirituality generally. We consider that it will be necessary to involve senior managers and others in understanding spiritual healthcare. Such a programme would also be offered to churches and faith groups and would enable chaplaincy collaboratives to establish wide links early in their lifetime.
105. We also consider that information about the relevance and importance of spiritual healthcare should form a part of the education of all healthcare staff and especially that of healthcare professionals. We are conscious that the GMC's publication "Tomorrow's Doctors" includes the need for understanding about death and dying and that the Department of Health's Essence of Care guidance includes a focus on the individual's spiritual and religious needs. We consider that these approaches should be extended to other aspects of spiritual healthcare and that this learning should be part of the curriculum for all healthcare professionals.
106. Educating staff about spiritual healthcare will enable them to contribute of themselves as well as help to meet the spiritual needs of their patients. But this education is not just to legitimise their involvement and should include learning outcomes about the role, differentiation and inter-relatedness of spirituality and religion and an appreciation of these important aspects in many peoples' lives.
107. On a more general note, we consider that chaplains are likely to have an important part to play in **education about spiritual healthcare** and should be fully involved in these programmes. Chaplains from world faiths other than Christianity may have a better understanding of minority issues and other cultures and their practices. Their involvement in educating staff both as to aspects of spiritual healthcare and cultural diversity should be seen as additional to the work they do as chaplains with patients and will have funding implications.

108. The recruitment of priests and ministers into the NHS has tended to assume that the training given to Christian ministers for parish or community based work is sufficient preparation for healthcare chaplaincy. We consider that being well trained for local/church ministry/leadership does not necessarily mean well trained for chaplaincy although it does provide a grounding in general pastoral work and in theological training. Just as the models of practice and career progression must change to fit today's reality, so the model of chaplaincy education must change to ensure modern educational standards for the spiritual healthcare workforce.
109. All chaplains need to be trained for their work and to reach a level of competence that reflects the knowledge and skills expected by the NHS and the religious and spiritual competence expected by their faith group. To achieve an evenness in attainment, there should be a **specific chaplaincy training** programme for those entering NHS work. Such preparation will need to be suitable for chaplains of all world faiths and to be tailored to their individual needs. This training will draw from and contribute to the training offered by the faith group from which the chaplain comes.
110. Developing this chaplaincy training programme will require careful discussion between faith groups, and chaplaincy, education, and NHS bodies. As the majority of chaplains are part-time and as their educational attainments will vary widely, this training must not act as a disincentive to their NHS work but neither must they be prevented from obtaining an adequate preparation. It is also clear that the training needs of chaplains in one particular faith group will vary in comparison with those from another. The flexible approach to training must enable commonality to be visible as well as diversity to be valued. We welcome the commitment to the development review process set out in *Agenda for Change* which we consider will support much of the processes we have in mind for chaplains.
111. During their training, chaplains need to gain experience in a number of settings where the day to day challenges vary in relation to the circumstances of the individual patient. At the same time, there will be a need to establish training arrangements with Trusts which contain sufficient capacity to educate trainees whilst also sustaining service delivery. We envisage that Trusts might agree to work together (in chaplaincy collaboratives) to ensure that chaplaincy teams can sustain trainees with adequate support and development throughout their training and across all aspects of spiritual healthcare.
112. In discussion of our proposals in draft form, we have received comments about **entry levels** to NHS chaplaincy and to NHS training posts. Many of these comments expressed concern at the difficulty of establishing a fair and level gateway. After consideration, we propose that entry to NHS chaplaincy and to NHS training posts should be limited to those who have attained at least 'A' level standard or equivalent in their general education and a degree-level or equivalent attainment in theological/religious education. We would expect to review these levels with appropriate advice in the near future and will publish a more detailed statement in due course.

A training programme for NHS chaplains

113. Our proposals for NHS training have tended to focus primarily on ministers and priests and on those in world faiths who are recognised leaders within faith communities and therefore already trained as leaders, priests or ministers. We recognise that our proposals need also to support the training of those in world faiths where there is no tradition of leaders/priests/ministers and also of those NHS staff or others who wish to be healthcare chaplains.
114. We consider that the faith groups should undertake the **religious and spiritual preparation** of healthcare chaplains. Our need to formalise a training programme for healthcare chaplains will mean the need for an agreed understanding of what this teaching might cover and also the possibility of delivering this training collaboratively. At the same time, the remainder of the underpinning knowledge needed by healthcare chaplains for their work should also be shared so that education and training provision can be optimised.
115. Because of the dual accountability of the chaplain to their employer and to their faith group, those who are wishing to train as healthcare chaplains have tended to develop within the faith community before expressing interest in healthcare. Even where there is no tradition of developing leaders/priests/ministers, it would now be appropriate for all the world faiths providing spiritual healthcare to select, train and authorise their own “chaplains”.
116. In seeking to formalise the training of chaplains in this way, we acknowledge the complexity of working with nine faith groups across communities with an uneven distribution within the country. As a basis tenet, we consider that new entrants to healthcare chaplaincy should be placed in training posts until their knowledge and skills as healthcare chaplains are formally evidenced. (A selection event does not always undertake this full assessment and often is more concerned with potential and suitability). Once so evidenced, the trainee would move to a practitioner level post.
117. NHS trainee chaplains will need **an individual programme of development** to help them develop the skills and knowledge necessary of practitioner chaplains. There is scope for the NHS, chaplaincy and education bodies to work closely together in developing this flexible and mentored approach for chaplaincy trainees. We consider that much of this learning should be work-based and will seek to develop an educational framework with NHSU which reinforces this approach.
118. The length of training required for NHS trainee chaplains will vary according to their experiences and backgrounds. Some will need a programme leading to a degree-equivalent award whilst others will require less time and may need a different level of academic attainment. An assessment will also need to be made about the value placed on time within communities caring for those who are well. This aspect of preparation may need to be included within the training period also.

119. We consider that NHS trainee chaplains need preparation for work in all settings including primary and secondary care; physical and mental healthcare; children, adolescents, adults and older people. As a basic requirement, we consider that NHS trainee chaplains would need education in the topic areas of pastoral care and chaplaincy; spiritual care and chaplaincy; religious care and chaplaincy; research and audit methods; ethics; communication skills and awareness; reflective practice; and creativity. These topic areas need to be coupled with personal/spiritual development and direction.
120. Chaplains joining the NHS for the first time should continue to undertake the introductory course organised by the faith groups and accredited currently by the School of Healthcare Studies at the University of Leeds. Discussions are being held with NHSU about the extent to which its proposed induction course for new NHS staff can replace this course.
121. NHS trainee chaplains will need **support from their employers** (mentoring, supervision, competence assessment) and from their faith group (selection, affirmation, spiritual support). These arrangements themselves will need careful establishment to ensure that there is a consistent approach which both sustains best practice and also supports academic achievement. The Development Unit approach we propose to foster spiritual healthcare will also support the development of chaplaincy training.
122. Progress should be mentored within a chaplaincy collaborative approved for training. The agreed skills set drawn from the NHS KSF and the chaplaincy competencies framework needs to be taught “top-down”, whilst the development of personal capacity to work with patients and to cope with the nearness of others’ distress/crisis should be developed “bottom-up”. We consider that, to foster this approach, NHS chaplaincy trainees should be educated using a system of reflective practice such as clinical pastoral education (CPE) which is widely used in other countries. Training in CPE would be needed for those collaboratives supporting trainees and for others wishing to gain these skills.
123. We envisage that further guidance will be made available during the autumn 2003 about the proposals for chaplaincy training and the relationships with chaplaincy collaboratives, faith groups and educational institutions. The introduction of more formal training arrangements will need careful preparation with NHS employers, existing training colleges, universities and with the NHSU.

A training programme for chaplaincy volunteers

124. We are aware that many chaplaincies use volunteers to assist their work and that these helpers are of great benefit to the service and receive training usually internally within their Trust. The nature of tasks undertaken by volunteers was surveyed by South Yorkshire WDC in 2002. Tasks range from care of the chapel through music or flower arrangement to tasks closely aligned to the work of chaplaincy with patients, for example in wheeling patients to worship or visiting them in wards.

125. Given the size of the volunteer commitment in spiritual healthcare, we recognise that this represents a sizeable organisational and management task for some chaplains. We have been assured that the majority of chaplaincy volunteers receive formal training for their role and we are admiring of the work which has gone into this little known aspect of spiritual healthcare. We intend to undertake a wider programme of examination before reaching any conclusions about a more formal standard for training of chaplaincy volunteers.

Occupational standards for healthcare chaplaincy

126. The chaplaincy bodies produced a statement of occupational standards in the early 1990s. This set out the key aim of chaplaincy as being “to enable individuals and groups in a healthcare setting to respond to spiritual and emotional need and to the experiences of life and death, illness and injury, in the context of a faith or belief system”. In general terms, chaplaincy bodies have accepted this as the key statement which guides chaplains in their work. Reference has already been made to the need to ensure that these standards can be used as reference in the NHS KSF.

127. This aim was supported by five key roles which chaplains fulfill including identifying and assessing needs for chaplaincy provision; managing and developing a chaplaincy service; providing opportunity for worship and religious expression; providing pastoral care, counselling, and therapy; and providing an informed resource in ethical, theological and pastoral matters. The statement of occupational standards has been well used as the basis for academic courses; practice development reviews; the formulation of job descriptions and person specifications; and for curricula development for shorter training courses.

128. Despite these signs of good usage, the occupational standards have not captured the hearts and minds of chaplains and their employers. Following a recent review and update of these standards, the Department of Health has provided a grant to improve access to their elements in an easier fashion. At the same time, we noted that, since these statements were first published, the recent review has added **competencies in supervision** and in **reflective practice** and we ourselves are suggesting a new competency in **research appreciation**.

129. As well as adding competences, evidence to this review has challenged the continued inclusion of counselling and therapy as core competencies for chaplains and their co-workers. We consider that chaplains should not have to train as fully qualified counselors to discharge their role effectively but we agree that chaplaincy competences should include counselling skills at a specified level, set within the context of an inclusive personal and professional developmental approach.

130. Of particular importance in the work which chaplains do is the element which is concerned with work to provide and maintain liaison between the NHS and local faith groups. This is encapsulated in the competence concerned with “managing and developing a chaplaincy service” (B.1). We consider that the chaplain’s dual accountability to their employer and to their faith group remains a strength to all parties in achieving a fruitful and vibrant link between the two.

131. We have been asked whether a formal structure would be useful to ensure that this communication between faith and secular bodies locally develops

successfully and have concluded that our proposals in total will embrace such a need. The development of chaplaincy collaboratives in each health and social care area will enable closer working and improved communication such that no further structural action should be necessary.

Leadership and management

132. Opportunities for chaplains to demonstrate leadership skills and capabilities will increase as a result of role expansion and as they become further involved in the changes needed to modernise healthcare services. The NHS Plan announced the creation of the Leadership Centre for Health as part of the Modernisation Agency. The Centre promotes leadership development and provides tailored support for individuals with leadership potential at different stages in their careers.
133. As chaplains lead their services through the changes and developments described here, ***the importance of leadership skills*** for delivery of high quality patient care will become self-evident. Transforming services through empowering and working with others will be crucial to delivering effective and long-term changes in spiritual healthcare delivery. Chaplains and their teams should seek benefit from the programmes which enable:
- Opportunities to develop wider leadership skills as more complex roles are developed;
 - Increased involvement in clinical audit and in the leadership needed for clinical governance;
 - Opportunities to develop leadership skills alongside other health care professionals and service managers, breaking down professional barriers and building working relationships.
134. Such programmes for leadership development are now being fashioned as part of organisational development programmes generally and Trusts will want to ensure that chaplains are fully involved. There are a range of opportunities for such learning including development opportunities within local health economies via WDC programmes and opportunities provided within and by local Trusts. We expect chaplains increasingly to take advantage of these opportunities.
135. In some Trusts, chaplains play an active role in planning and delivering education and training programmes for all staff groups, elsewhere they provide essential health and safety and audit activities or contribute to clinical ethics activity. We need to build on this good practice and increase opportunities for chaplains to expand their roles. Some may also wish to enter general management careers. We expect NHS employers to recognise the potential of chaplains and to facilitate and support their development.

136. Given the expertise that chaplains and their co-workers bring to their roles in spiritual healthcare, it is surprising this expertise has not been more widely applied across the NHS for the benefit of patients and other users. In general terms, the fragmentation of expert management evidenced in the 2002 survey of chaplaincies is liable to prevent chaplains delivering best value alongside other healthcare professionals. That survey showed a wide range of managers overseeing chaplaincy services and differences in the levels of managers involved in the work. We believe that the managerial talents within the spiritual healthcare workforce are not fully recognised because they are so diversely lead within the Service.
137. One aspect of service which has made the delivery of spiritual healthcare more difficult in recent times has been ***the differentiation of chaplaincy work*** from that of other healthcare professionals in regard to confidentiality and data protection. The apparent distinction between the work of different groups of professional services has delayed access to spiritual healthcare and made delivery more haphazard. The structuring of chaplaincy away from other groups with similar characteristics in their work behaviours is also detrimental to the need to modernise the delivery of spiritual healthcare.
138. The issue of data protection and informed consent is being pursued within the Department of Health and we envisage that remedial action will be put in place soon. In the meantime, there is a strong argument that allying the work of chaplains with that of the allied health professions would seem to make sense. This would avoid the confusion of designating their work as non-clinical i.e. not focused on direct patient contact and would assist the development of an holistic approach more readily.
139. For all of these reasons, we anticipate that chaplains should be managed at a high level within the clinical directorates and in close association with the other allied healthcare professionals. Both groups of staff will benefit from this alliance and spiritual healthcare will be strengthened also. At the same time, the chaplains work with staff members and staff groups should be enabled to continue although the priority must be service for patients.
140. Several of those who commented about organisational linkages with chaplaincy commented on the ***freedom to perform a prophetic role*** within the organisation. We consider that chaplaincy needs to be managed but we recognise also that, in addition to providing a patient-focused service in spiritual care, chaplains support members of staff and also provide links outside the organisation into local communities and groups. The fact that chaplains are managed should not suppress their ability to represent others' views and to provide advice and counsel to the organisation itself.
141. We recognise that the location of chaplaincy within Trust structures is not as easy as for services where linkages are long standing or service characteristics are clearly similar. Chaplaincy is unique in its role and must merit more attention rather than less for that reason. It is not appropriate for the lowest common denominator to be applied nor for chaplaincy to be allocated to managers to achieve a general management mix or diversity. We hope that Trust Executives will review their approach to this issue as opportunity arises.

Modernising regulation

142. The Government has indicated its intention to modernise and develop professional regulation to provide proper protection for the public and patients. Chaplains are currently regulated by their employers and by faith groups which together have provided a simple and well-accepted mechanism to achieve safe practice.
143. The emergence of a chaplaincy role within all world faiths makes the development of robust and recognised systems for authorising all those who undertake spiritual healthcare a more urgent problem. The Multi-Faith Group for Healthcare Chaplaincy is undertaking this work currently and we look forward to receiving a report of progress. At the same time, the College of Health Care Chaplains is applying for membership of the Health Professions Council and this process will add strength to the regulation of the chaplaincy profession.
144. In the interim period, we recognise that NHS Trusts are heavily reliant on existing mechanisms to sustain them through a period of change. We understand that the churches and the Multi-Faith Group have agreed a programme of modernisation and that this will include review and updating of all the mechanisms for the selection and appointment of chaplains and their co-workers. We expect this programme of work to be completed as soon as possible and look forward to a report from the Hospital Chaplaincies Council which is leading on this work on behalf of the churches and faith groups.

MAKING IT HAPPEN

- Conclusions
- Roles of NHS and chaplaincy bodies
- Spiritual Healthcare Development Units
- Implementation issues
- Key milestones

Conclusions

145. This review has demonstrated that significant change is required to ensure that the delivery of spiritual healthcare can be assured into the new century. The basis and traditions of chaplaincy within the NHS provide a strong starting point for the development of a truly multi-faith and multi-cultural approach to spiritual healthcare which can be endorsed by all. The purpose of the strategy is to focus attention forward to the challenges and tasks ahead.
146. We have proposed a clearer *career map* for those who wish to be chaplains working in healthcare. The introduction of new grades into chaplaincy will help to provide better outcomes for patients by improving quality and services; to provide a new career opportunity which recognises the expert contribution of experienced members of the workforce; and to strengthen professional leadership.
147. The *framework of education* proposed here will enhance the consistency and quality of those applicants from within the Service and clarify the requirements for those wishing to join. With a very significant part-time workforce, greater attention is needed to their support, development and training. At the same time, the public has a right to expect an educated workforce and we have made proposals accordingly.
148. A new training scheme for NHS chaplains is proposed which would enable current staff members to re-train and new members to develop appropriate skills within the NHS. We suggest that training be provided in the form of clinical pastoral education, conscious that this itself is also a new approach. We consider that this small innovation will make a large difference to both the practice and also learning skills of healthcare chaplains.
149. Our effort to make these numerous proposals into a coherent whole is focused mainly on the use of a competency framework which ties together the levels of chaplaincy and the knowledge, behaviours and skills required for excellent evidence-based spiritual healthcare. The apparent complexity of this framework belies the simplicity of the processes necessary to gain benefit from its use in continuing professional development.
150. A number of other proposals are included throughout this strategy document. They range from the need to enhance research capacity and skills through to the need to review the working of long established mechanisms such as those used for the recruitment and selection of chaplains. The number of changes is not as important as their achievement and we have set out the responsibilities of the bodies concerned and the key milestones in later sections.

151. To support this process of change and to enable communications between the various bodies, South Yorkshire WDC and its successors will retain a small **project infrastructure** to ensure satisfactory progress towards key milestones. This team will also publish guidance about aspects of these proposals to help with learning and local progress and will oversee any action which is required at a national level.

Roles of NHS and chaplaincy bodies

152. The proposals in this strategy are directed at Workforce Development Confederations and their successors for whom health and social care workforce issues are a paramount concern. WDCs represent and respond to the views of employers in health and social care, working closely with Strategic Health Authorities to achieve implementation of solutions to workforce issues. How chaplains are educated and work, the way in which they contribute to healthcare, and their interactions inside and outside health organisations are all issues which require the attention of WDCs.
153. Whilst these issues are of concern to WDCs who have the responsibility to enable the supply of suitably skilled people to work in health and social care, the need to support NHS Trusts in managing and leading the development of spiritual healthcare is also of concern here. Throughout the Service, chaplains and their co-workers provide spiritual healthcare which is accessible by all patients and their carers and by all members of staff. This is a significant task for NHS Trusts and is undertaken by a small workforce reliant in many cases on voluntary help.
154. To support WDCs and Trusts during the period of change envisaged in this strategy, we are proposing Spiritual Healthcare Development Units in suitable places across the country. More detail of their modus operandi is included in the following section.
155. The chaplaincy bodies include those whose concern is mainly with faith and religious issues in healthcare chaplaincy and also those membership bodies concerned mainly with representing chaplains within health and social care. The former group includes the Hospital Chaplaincies Council of the Church of England and the Free Churches Steering Committee for Health Care Chaplaincy. The latter group includes the College of Health Care Chaplains which is part of Amicus-MSF and the Association of Hospice and Palliative Care Chaplains.
156. There is change taking place within these bodies. We welcome the emergence of the Multi-Faith Group for Healthcare Chaplaincy as the Body representing the collective views of the nine major world faiths and other groups working in support of healthcare chaplaincy. In addition, the College of Health Care Chaplains, which is the largest of the membership bodies for healthcare Chaplains, is proposing to apply for membership of the Health Professions Council in the near future.

157. In determining how to take the action in the strategy forward, South Yorkshire WDC will agree an even distribution of work between its own direct commissioning and that undertaken by colleagues in Spiritual Healthcare Development Units. Our proposals for action focus on only a limited number of bodies for ease of reference.

Spiritual Healthcare Development Units

158. We indicated in chapter one that we considered that there was a need for additional support to chaplains, to chaplaincies and to their co-workers during the implementation of this strategy. Our suggestion is that WDCs adopt the development unit model, which has worked well in other professional change programmes, and provide additional staff and training capacity in support of those whose services are developing. There is great challenge to individuals in working across established organisational boundaries and in taking on new tasks and new methods of working. Appropriate support from Development Units will help ease these challenges.
159. The developments envisaged in this strategy are significant because this is the first strategy for spiritual healthcare to be launched in this way. We do not envisage that chaplaincies can or should be developed by South Yorkshire WDC alone and consider that local services should determine the detail of their own development even if the direction and pace has been set out here. We assume that locally WDCs will wish to support this process and that, within particular geographical areas, there should be a lead WDC to host and support the Spiritual Healthcare Development Unit. Currently, we envisage that four such units might be required in England.
160. The main thrust of work by the Development Units will be in providing leadership to Trust chaplaincies and chaplaincy collaboratives in developing their services in line with the direction set out in this strategy. There will be a need to facilitate discussion and understanding of the ideas contained here and to communicate new ideas which emerge during implementation. Particular knowledge may be needed in relation to research and audit techniques, data analysis and communication. At the same time, knowledge of education and faith group structures will enable rapid progress with these issues. It is very much to be hoped that the generality of support to change management and facilitation activities will be provided where necessary by lead WDCs.
161. Although we wish priority to be given to this work, it must take its place alongside other Trust and WDC priorities. Thus, there will be a limit on staff numbers although we envisage that each Development Unit will be staffed by one or two people usually drawn from the spiritual healthcare workforce. It is hoped that candidates for these posts would be drawn from local Trusts and that a secondment mechanism would ensure continuity when the development work is completed. We anticipate that this should take about three years depending on local circumstances.
162. At the end of this period, there will need to be a review of the continuing level of support necessary for the spiritual healthcare workforce development programme. In addition to the need to ensure continuity, consideration will also need to be given as to whether further development should be on a multi-professional and inter-agency basis.

163. It is perhaps worth recording that this development capacity and capability is not intended as a proposal for a structural change in the way Trusts or chaplaincies work. We expect the introduction of development units to facilitate rapid progress over the next three to five years as the main modernising steps are initiated and implementation started. For now, during this change process and thereafter, service delivery and the structures which sustain it are the remit of NHS Trusts.

Implementation issues

164. The ideas brought together in this strategy indicate the direction and pace in which NHS Employers intend to develop the chaplaincy and spiritual healthcare workforce. The strategy represents **a base from which development should start** and an indication of how it should proceed. There is a need still to balance the catching up phase of modernisation with the need to choose the correct forward direction. What is modern today may look outdated tomorrow.

165. The changes we have proposed are complex and far-reaching. They impact on a small and dedicated workforce of chaplains reliant often on voluntary help for the delivery of their service. Each chaplaincy is different but each also links with a range of faith groups and communities with clear ideas about their own faith and the care they offer for individuals within their purview. Such personal considerations require sensitive handling if change is to be implemented in a person-centred fashion.

166. A set of **milestones for the strategy** is included in this chapter. These have been costed and tested with colleagues for accuracy and provide an acceptable level of risk assessment for implementation to be based on them. They will need further development as implementation proceeds with those WDCs which choose to lead on aspects of the spiritual healthcare agenda.

167. We consider that the Spiritual Healthcare Development Units should be the main instrument for achieving the changes and developments we envisage over the time of the strategy. South Yorkshire WDC will lead on those aspects of implementation where a national role is necessary. We will also provide some (light) project management support to the implementation pathway and will account publicly for progress in association with partners.

Key Milestones

2003-04

- A. Publish guidance about the establishment of Spiritual Healthcare Development Units for discussion with interested parties
- B. Publish further guidance on models of practice and service
- C. Publish guidance on the proposed minimum data set for spiritual healthcare and its relevance to IT strategy
- D. Finalise and publish the chaplaincy standard for research

- E. Publish proposals for the development of NHS training in spiritual healthcare for discussion with education, NHS and chaplaincy bodies.
- F. Establish an awareness programme about spiritual care and its use and relevance in healthcare.
- G. Publish guidance about the use and requirements of clinical pastoral education
- H. Initiate work to align the chaplaincy occupational standards with the NHS KSF.

2004-05

- I. Establish Spiritual Healthcare Development Units in coterminous geographical areas across the Country.
- J. Arrange training sessions for chaplains interested in developing models of practice and service.
- K. Instigate a literature study to identify the state of availability of evidence about the role, structure and efficacy of spiritual healthcare
- L. Publish guidance on the use of the chaplaincy knowledge, behaviours and skills framework in continuing professional development
- M. Maintain liaison with the Multi-Faith Group for Healthcare Chaplaincy during their review of authorisation systems
- N. Maintain liaison with the Hospital Chaplaincies Council during their review of mechanisms for selection and appointment of chaplains

2005-06

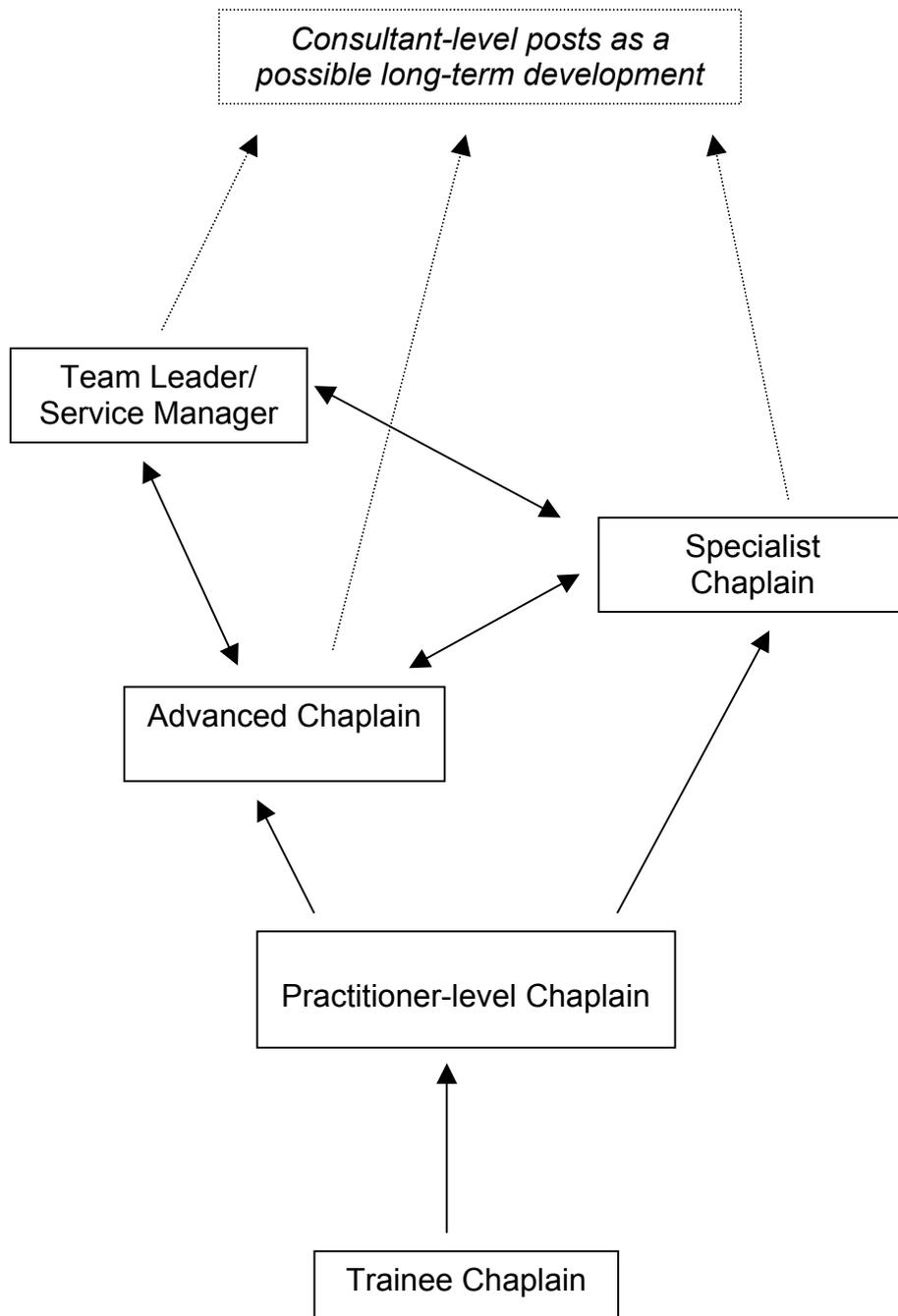
- O. Undertake and publish a survey of the diversity of the spiritual healthcare workforce to inform workforce planning and development
- P. Publish guidance about the training of chaplaincy volunteers

2006-07

- Q. Publish the literature study on the role, structure and efficacy of spiritual healthcare
- R. Publish proposals for a spiritual healthcare research programme based on the findings of the literature study
- S. Publish the statement of national chaplaincy occupational standards
- T. Survey the placement of chaplaincy in clinical directorates of NHS organisations

South Yorkshire WDC - November 2003

THE PROPOSED CHAPLAINCY CAREER MAP



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A large number of chaplains from Trusts across the Country contributed to the ideas, workshops and meetings associated with the formation of this strategy. Particular thanks are due to Revd Michael Forster who helped to edit the document as a whole.

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Cheshire and Merseyside Workforce Development Confederation
Churches Committee for Hospital Chaplaincy
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Newham Healthcare NHS Trust
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