CHCC COLLEGE OF HEALTH CARE CHAPLAINS

UNITE THE UNION in HEALTH

Towards Greater Diversity in the Healthcare Chaplaincy Workforce

***Draft* version for final consultation**

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Please respond before March 1st 2024

CHCC "Towards Greater Diversity" Consultation Document

Contents

Introduction

There is a clear need for greater diversity across the health and social care chaplaincy workforce. The CHCC strongly believe that increasing such diversity will enhance the profession and the service we deliver. We recognise that there has been little investment in chaplaincy workforce development across the UK to support such change. We have inconsistencies in education, training and recruitment alongside a proliferation of localised models, roles, and titles.

This said, recent years have witnessed several positive developments in healthcare chaplaincy, particularly with professionalization and registration. There has also been a gradual but notable diversification within the workforce, which is warmly welcomed. This said, a genuine, UK wide workforce transformation cannot occur in isolation but needs the collaborative effort of all stakeholders.

Historically, models of Christian ministry have shaped chaplaincy recruitment and provision. This created a bias against the perceived competency of other faith and belief communities in delivering chaplaincy. Much has changed in this regard, but progress has been sporadic and is not universal. Entry routes remain unclear, experience requirements are vague and our workforce diversity in terms of faith and belief remains inadequate.

We strongly believe that Healthcare Chaplaincy must be innovative, recognising the changing shape of healthcare and society at large with a workforce that can deliver for the future.

Amidst such innovation we need a positive mindset that **does not lose sight of the unique contribution that good Chaplaincy can make in healthcare**. If we are to avoid the very real risk of reducing our role to one which is narrow or even obsolete, we need to be able articulate our service in ways that our institutions can understand.

We believe that the obvious long- term solution is for healthcare chaplaincy to become a <u>fully regulated profession across the UK</u> with a shared understanding of what 'good looks like'. It is still too easy for teams and individuals to function as independent entities without reference to any common professional standards or oversight. This increases the risk of poor practice, allowing chaplaincy to be viewed as a 'lesser' profession within healthcare, and indeed risks the whole profession being side-lined within a fast-moving NHS.

Section One: What does good look like?

KEY POSITIONS

Please consider these in totality and do not take individual points in isolation.

1. **Workforce diversity brings a richness to the profession that benefits patients, service users, staff and the profession itself**. Commitment to diversity includes, but extends beyond, questions of faith/belief status to the *widest* understanding of inclusion. Team diversity has no direct correlation to the skills, abilities and professional competencies of any *individual* chaplain, but **greater diversity within the profession will have a profound impact on the nature of Chaplaincy regionally and nationally.** The wealth to be found within the deep-rooted, lived experiences of chaplains from diverse cultural, religious, and belief traditions should enhance all that we do, from direct care to the less obvious (such as research).

2. **Individual healthcare chaplains must hold a strong personal belief and value position, that is invested in *before* and *throughout* their working life**. All Chaplains need to be **deeply rooted and constantly nourished** to enable them to deliver the best quality care.[1] Chaplaincy is not a purely knowledge and skills-based profession, and it is right for evidence of such depth of belief and a commitment to ongoing nourishment to be an essential part of all recruitment across the UK.

[1] The fuller quote is subtler, from: **Wise and Professional, Faithful and Fair – A Double Manifesto for Healthcare Chaplaincy in the National Health Service** 'Essentials for wise chaplaincy, such as compassion, hope, and reverence for human dignity, need deep roots and constant nourishment' CHCC Conference, High Leigh, September 5-7 2016. Embracing this statement will have real implications for the shape of present and future workforce. It means that not everyone who wants to be a Chaplain is suitable to be so, or remains suitable, whatever qualifications or experience they may hold. It is a challenging premise to translate into best practice - but nevertheless we believe it is essential.

3. Healthcare Chaplains in all settings must be appropriately trained, competent and skilled professionals delivering excellent service**. Sometimes this requires a chaplain of a particular belief tradition but, in *most* situations, this service can be delivered without the need for the chaplain to be of the same religion or belief tradition as the patient, relative or member of staff** supported**.**[2] We therefore do not advocate any simple correlation of staffing to local demographics.

4. Notwithstanding the point above, we **still argue the need for rich diversity in larger teams, especially in terms of culture and belief.** Good chaplaincy understands the depth of spirituality *within* faith and belief communities and traditions and will not simply adopt a generic or reductionist understanding of spiritual care.[3] A team that does not embrace diversity is not well placed to understand or address the breadth of cultural, religious, pastoral and spiritual needs of a multi-cultural population.[4] It will not deliver the best of Health and Social Care Chaplaincy, neither outside of faith and belief practice nor within.

5. **There is no "one size fits all" shape for chaplaincy, despite our need for greater consistency.** The UK has different Governments, each helping to shape health and social care with varied cultural contexts. It is also clear that lone working is a radically different from working within a large team, as indeed is

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[2] This statement is an important one to make. It expressly challenges the suggestion that chaplaincy is best delivered by someone of the same faith, a 'co-religionist' or 'like-minded' professional (these are two phrases that have found occasional currency in chaplaincy discussions. We find neither clear or helpful). The rich diversity to be found *within* traditions and beliefs, and the uniqueness of individuals undermines any such presumption. Patients or staff members may prefer support from someone who shares their gender, or the same broad worldview, or the same sense of humour and so on - despite a radically different belief system. It is therefore overly simplistic to assume, for example, that a Hindu patient requires a Hindu chaplain or a non-religious patient exclusively requires a non-religious chaplain. The profession needs diversity, not so we can offer a "dating agency" model of care, but to ensure that individuals receive appropriate support whilst respecting their unique needs and preferences. In situations where, specialized care aligns with a patient's preferences, such as non-religious support or specific religious rituals, it of course remains important for chaplains to refer patients to colleagues who can provide the most suitable care.

[3] See UKBHC capabilities and competencies (https://www.ukbhc.org.uk/for-employers/standards-competencies/)

[4] This will notably differ depending on the size of the team and the local context - which is why a 'one size fits all' solution is not sensible across the UK.

working in a specialist setting. We need to be clear about models of working, but must allow for contextual variety.

6. **CHCC favours the adoption of a broadly 'inclusive' rather than a 'representative' model of service.** We recognise such a model has some key weaknesses (see below), both in the shape of care it offers and on our journey towards a diverse Chaplaincy workforce, but it can also deliver the best of care when adapted to meet local and service specific needs, and can deliver workforce diversity if the right attention is given.

7. **We remain committed to a UK-wide profession** and will work with all partners to improve it. This means, on occasion, that our understanding of the profession may be at odds with the current views expressed by the NHS in England, Wales, Scotland and Northern Ireland. Our views may equally be in tension with the ambitions for chaplaincy held by various faith and belief groups, or indeed by the UKBHC as the regulatory body. **This is to be expected rather than feared**. Our commitment is always to work in close collaboration with all in the best interest of the developing our profession.[5]

Our hope is also that these seven positional statements help focus our work and our collaboration with relevant stakeholders as we seek to diversify the workforce and improve Chaplaincy provision for patients and staff alike.

[5] The College works as closely as it can with other professional bodies and stakeholders. It has a place on the board of the regulatory body, the UK Board of Healthcare Chaplaincy - UKBHC. In England it supports and plays a role in the Healthcare Chaplaincy Forum, a vehicle for close collaboration with faith and belief groups (whose voice is mediated by the Network for Pastoral, Spiritual & Religious Care in Health), other professional bodies and NHS England. It also maintains close links with the Northern Ireland Healthcare Chaplains Association, and works closely with NHS Wales and NHS Scotland whenever it is able.

What will *good* chaplaincy look like?

Alongside these broad principles, we also have a clear vision of what good looks like- or what our profession *should* look like in 10 years' time if we can work together and get the support we need to make the change:

- A service that has evolved completely from our historical focus on supporting patients with 'faith' based needs to an inclusive profession delivering high quality care to those most in need, staff, patients, relatives and carers.

- A healthcare profession with a coherent model of working that is effectively understood by service users, colleagues and stakeholders alike.

- A service embedded within NHS commissioning and contracts of service, committed to the full breadth of chaplaincy services ensuring cultural, pastoral, spiritual, religious, and emotional needs of patients and staff are met safely across all health and social care settings.

- Adequate resources and funding for quality provision with the needs of our service users (Patients, staff, relatives, carers, visitors and institutions) at the heart of all we do, with a strong volunteer program to compliment delivery.

- A profession with accessible routes of entry for applicants from all faith and belief backgrounds, with equality of opportunity in employment, training and professional development. Clear opportunities for professional and leadership development and high-quality training across the UK

- A highly skilled, trained, safe and richly diverse workforce who are 'deeply rooted' and 'grounded within the security of their personal belief systems' and supported to do so.

Two: Reflections on models and paradigms

This chapter is intended to offer wider reflections which support the key statements above.

Evaluation of different models and paradigms related to workforce diversity.

There are, broadly speaking, two main paradigms of chaplaincy provision in the UK. These can be characterised, with some degree of over-simplification, into the *representative* or the *inclusive* approaches. In reality, most organisations across the UK offer some blend of the two. Both approaches have benefits and limitations when it comes to workforce diversity and inclusion (as well as for the experience of service users).

Representative models seek to include representation of diverse faith and belief groups within teams, often linked to local demographics. This has the potential benefit in some areas of rapidly increasing diversity in both recruitment and delivery, but also risks service delivery that is focussed on the needs of established faith and belief communities. In some areas it may also limit diversity and inadvertently restrict minority communities to insubstantial posts. This approach also struggles to deal with the significant proportion of service users who do not clearly associate with any single religion or belief position (or may be liminal, transitory and unclear in any such association). At worst, the approach risks limiting the breadth of our provision, with excessive attention paid to the religion/belief of the chaplains or those of shared faith among patients/staff.

Inclusive chaplaincy models seek to create a level playing field for all communities with regards both to recruitment and delivery. If the chaplaincy post does not have a designated faith tradition associated with it, it *should* mean that no single faith or belief community receives preferential treatment in recruitment or delivery. In practice, however, this model may still perpetuate established bias and may not ensure greater diversity among staff due to a number of other factors which affect recruitment and society[6]. It would take a scoping study across a geographical region

[6] Although it is dated, Savage's 2015 audit of visits showed a great lack of inclusivity of service users in a hospital where the inclusive model was used. This research hasn't been run again since, but without data to

where such practice is common (such perhaps as across Scotland) looking at the demographics of those in post to see if such inclusive practice has brought about greater diversity in ethnicity, gender, belief tradition etc. within the profession. In addition, in our positional statements above (section one) we noted how the most extreme adoption of such a model for chaplaincy would be ill-equipped to deliver safe and timely rites and rituals for patients as part of our core function.

Which model does the CHCC endorse?

The CHCC does not fully endorse either model, but favours the nuanced adoption of an *inclusive* approach, shaped by what works well on the ground in an effective Chaplaincy team, and adapted as required to meet local and service specific needs.

1. Inclusive models, implemented well, should reduce the chance of privileging one group over another in terms of employment or delivery if we monitor for hidden discrimination.

2. As we go forward, we need to be open to the insights which diversity may bring to our care and our paradigms.

3. In some settings (small teams, mental health, hospice etc.) a direct correlation between the 'religion' of the workforce and local demographics is clearly meaningless, and many have rightly left it behind.

4. Despite many teams in England moving towards an inclusive model, **we remain concerned that a significant number of advertisements for chaplaincy posts are not genuinely open to candidates of all faiths and beliefs**[7].

show how well services are accessed by different populations it's hard to assert that there is no preferential treatment. (Savage et al 'Social class in the 21st century', Pelican (2015)

[7] According to frequent surveys by the NPSRHCH

5. On a local, regional and national basis**, every effort must be made to diversify the workforce, ensure inclusive delivery paradigms and enable increased development of diverse talent.** Ironically, we note that sometimes this may demand a degree of *representational* thinking to achieve. For example, in a very multicultural community, a large team with every chaplain rooted in a Christian tradition with a local population that identified as 50% Muslim needs to address this urgently, no matter how inclusive the delivery model preferred by the local team or the NHS. We would expect the lead chaplain to take proactive steps to understand why the team has the demographic it has and seek support to lead change.

6. The College believes that it is necessary in the long term that all models are underpinned by appropriate research rather than any belief focussed or secularisation agenda.

7. **Idiosyncratic teams which evolve in their own way with little reference to the wider profession offer some value but also create a risk both for the profession and for patients.**

8. We are keen to encourage smaller teams to find peer support and share best practice from other teams: we believe this will lessen the tendency to become isolated from the profession as a whole. To this end, we would strongly encourage larger teams to offer that support to smaller teams.

9. The College is currently working on a position paper relating to 'on-call'. We acknowledge that historically, on-call services have tended to privilege Christian traditions over other faith and belief traditions in terms of service provision and recruitment. This needs to be addressed with some urgency in guidance.

Sector specific reflections

Mental Health Chaplaincy

Chaplaincy in Mental Health care settings has, for many years, worked to an *inclusive* chaplaincy model with limited or nominal representative patterns, except perhaps in the largest of teams. Chaplaincy staff typically focus on the broad spiritual/emotional/existential needs of their patients and have a mixed model for assessing religious needs, recognising that such needs sometimes **cannot simply be out-sourced to a faith or belief community**. This creates a tension in terms of quality of equitable safe provision for smaller providers, but is one that mental health chaplains are long used to. For many years it has been usual to have a single mental health chaplain from a particular faith or belief tradition, with no presumption that this had to represent the majority of the local demographic.

Hospice Chaplaincy

Hospice chaplaincy is not typically based upon a representative model but has very specific challenges around the expectation of the need for 'end of life rituals' that may strongly influence decisions on recruitment if there is an in-patient role. Hospices often look to encourage greater diversity and inclusion, with many posts advertised in ways focussed on 'spiritual care'. The real risk in such settings is an inadequately developed understanding of the professional Chaplaincy role, leading to experimental models that may struggle to deliver the full range of provision expected. We are aware of settings that have no professional chaplaincy in place, subsuming the 'spiritual care' role into nursing and asking faith groups to cover anything they cannot do. This is simply unacceptable. We recognise that the AHPCC works hard to ensure the highest quality of provision is maintained, but it is hard to restrain independent charitable bodies from seeking to re-invent the wheel, creating idiosyncratic role titles, depressing salaries or expecting the role of volunteers to stretch beyond that we would recognise as best practice in the profession.

Chaplaincy in GP surgeries/ Community chaplaincy

This is an emerging area of health and social care chaplaincy with evolving paradigms in play. Work can be focussed primarily on listening in 1-to-1 encounters that are 'booked' or pre-planned, or deeply embedded in responsive with multi-disciplinary team care plans. Chaplaincy recruitment and delivery is typically framed inclusively, although in some areas they may tie in closely with faith-based volunteer provision to provide additional support. There have been a number of experimental models in England, and in Scotland, there is a developed and well researched paradigm of Community Chaplaincy Listening (CCL). Sometimes this is delivered by paid chaplains, and sometimes by trained volunteers supervised by a paid Chaplain. The ACGP is also working hard to build the paradigm for Chaplaincy in a community/GP context. It may be that this area least requires a representative paradigm in place.

Different models across the UK

The 'English Model' (acute)

This is not really a model as such. To the extent that there a common pattern, Trusts still seem keen to retain features of a representative model. Monitoring by the NPSRCH suggests that an inclusive approach still only applies to a minority of posts.[8] Whilst the appointment of faith specific posts may be justified based upon the local demographics of the patient population or on call demands, it is clear that such recruitment is not always underpinned by a thorough Equality Impact Assessment. Staff demographics are also much less often considered. Despite this bias, in recent years there has been trend towards advertisements with open rather than faith-based posts. Whilst all chaplains may visit inclusively and support the spiritual needs of all patients, specific faith and belief posts often place a particular emphasis on visiting patients from their respective community. Some continue to do so exclusively, and

[8] Recent (Sept 2023) NPSRCH monitoring suggests that the average proportion of open posts over the last two years to be 35.2%, with the maximum in any quarter being 47.5%, and the minimum 19%. A full report is being prepared for publication.

faith and belief groups occasionally put pressure to ensure some posts remain this way[9]. In addition, local on-call requirements can compromise any desire to operate inclusively (see below).

This is quite a simplistic summary given the number of teams across England; some Trusts are developing or retaining models that swing considerably towards one paradigm over another. It is worth noting that a mixed model, with a bias towards *inclusivity* is broadly in harmony with the latest NHS England Guidelines.

The 'Scottish model'

Scottish Health Boards operate with a strongly inclusive chaplaincy model in that most chaplains are appointed to roles which are not determined by the demographics of the local population or to represent the tradition they may come from. This has been a consistent paradigm across Scotland for the last 20 years. Chaplains may come from a variety of faith or belief backgrounds[10]. Health and Social Care Chaplaincy is expected to deliver *spiritual care* to all, and to externally facilitate the religious care of those who require someone from a specific faith community or belief group. Chaplains are expected not to provide religious care (but anecdotally in practice often do so). Health Boards are expected to have Spiritual Care Committees: a forum for staff, chaplains and local faith and belief groups to share and discuss the development of the spiritual care service. Nationally, faith and belief groups do not have a formal voice in the development of Healthcare Chaplaincy.

The recent NHS Scotland framework has built on, but not changed this fundamental paradigm of working.

[9] Some English Trusts make faith specific chaplaincy roles a Band 5 role. It is the view of this paper that such practice clearly risks being discriminatory to non-Christian faith and belief groups in terms of expectation and career development opportunities and will rarely be appropriate.

[10] It seems, anecdotally, that the significant majority of paid hours seem to be undertaken by Chaplains associated with a few Christian traditions, but there is a reluctance among some teams to participate in demographic surveys to provide any clearer picture of workforce diversity.

The 'Welsh Model'

The Welsh model is broadly similar to the English, but the way in which it has developed within the culture and demographics of Wales mean that in many areas there can be a strong presumption that the Chaplain will be from a Christian background (especially in rural areas). More detailed analysis is required in this area, including how a need for Welsh-speaking delivery of spiritual care may affect models of working going forward. There are also specific demographic challenges that affect different boards which require individual solutions.

The 'Northern Irish model'

Chaplaincy in Northern Ireland is mostly *denominationally* based in terms of Chaplains and service delivery, with few from a non-Christian background. Most paid chaplains are part-time. Unlike most of the rest of the UK, chaplains may be funded by individual denominations as well as the NHS. A very few do work with a recognised inclusive role and management roles are integrated. The NHS resources CPE/PgCert training for paid chaplains.

Does CHCC consider any national model is better or worse?

In short, the answer is no. As stated above, we believe that a mixed model, with a strong emphasis on *inclusive* approaches, is probably best for acute in-patient settings. Inclusive models are also clearly appropriate in mental health, community and (mostly) in hospice settings.

A need for research. We believe **that greater research is needed on each of these 'models' as they impact on both patients and the chaplaincy workforce to review them in terms of diversity and inclusion.**

Do they actually foster a diverse workforce in real situations?

Are they are suited to deliver the full gamut of chaplaincy services across diverse communities or do they discriminate against the religious or the non-religious (or those many who are somewhere in between?).

Comprehensive data on the demographics of chaplains working in different settings or with different patterns of working would help to gauge the level of existing workforce diversity, to see whether there are clear trends and what steps are needed to improve diversity within chaplaincy volunteers, substantive chaplaincy posts and leadership posts. Similar, more subtle research is needed into service delivery.

We think any research carried out needs to consider:

- What are the strengths and weaknesses of these models in the light of 'what chaplaincy service is *for'*?
- Would a different model improve diversity and inclusion?
- Are there unintended consequences in changing the model?
- What about emerging community chaplaincy?
- What listening models are used?
- Do we let these models emerge and develop, or should we support a dominant model?
- Who should fund and resource research into chaplaincy models?

Three: Key areas for development

This section was perhaps the most difficult to draft. There are so many interconnected workforce issues that require development on a local, regional, and national level. To keep things as simple as we can, we've chosen to focus on a specific set of workforce "themes," following a consistent template for each. It's important to note that this approach does not imply any hierarchy of importance; rather, it is trying to find the clearest way to address these complex and overlapping issues.

1. Initial entry routes into the profession

Current position

There is no one clear entry route into paid chaplaincy. We suspect that, for the foreseeable future, a *diversity* of routes will remain; it is hard to envisage the profession as one entered through a single pathway following on from post-16 or post-18 education; not without stripping something vital and unique from the workforce.

Historically it was clear that entry into chaplaincy was especially favourable to Christian faith leaders (of several traditions), deemed automatically safe and competent to deliver chaplaincy and spiritual care simply due to prior formation and training in ministry. Such preferential treatment was reinforced by the three-fold division of funding across most of the UK (in the not-so-distant past) into Free Church / Anglican / Roman Catholic posts. It was *assumed* that such Christian ministers could meet the needs of the majority of patients (who would be Christian) and then *incidentally* could provide the broad pastoral and spiritual care for people of all other faith and beliefs. Although the situation has changed radically, this legacy still has an impact across all the UK. Advertisements still often seek 'ordination or equivalent', and a 'theology degree or equivalent', privileging this traditional pathway. The

presumptions and inequalities built into this model need challenging if we are to increase the pace of change in the workforce.
Such presumption may be built more explicitly into Northern Ireland chaplaincy, but it is hard to claim that it is not implicitly built into Scottish teams also without accurate workforce analysis.

Problems and challenges

Chaplains from non-Christian backgrounds (or traditions within Christianity such as Roman Catholic) are limited in many places to applying for roles providing specific religious care for members of their own community: a good percentage of these are unpaid. While there may be good reasons for this in some situations, it severely limits the development opportunities and, as outlined in our positional statements, is far from ideal.

Some faith and belief traditions have ways of working that do not translate simply across into chaplaincy paradigms of working. There is therefore a risk of simplistic presumption regarding equivalence across belief traditions, including non-religious beliefs. For example, the role of Imam is not co-terminus with that of a Christian minister, in training, pastoral experience or community expectation. The same applies to an experienced Buddhist practitioner. Without considerable work on education prior to appointment or promotion, and clear guidance during role creation and interview structures, there is a risk of an **uneven playing field in recruitment**, or, conversely, a risk of **unsuitable applicants and appointments** based on false presumption of skills and competencies.

All this points to a stronger role for registration and perhaps more significantly, robust, accredited education (such as PGCert and CPE) such as has been developed by several universities and accredited by the UKBHC. This said, if eligibility for posts is based *solely* on educational requirements to the exclusion of character and experience, then there is a risk that potential applicants with the right competencies and experience may not apply or move into the profession due to a perceived barrier. The balance of this is still to be explored.

What does 'good' look like?

- An approach that not only reflects the experiences of individuals, with parity across the experiences all different faith and belief communities but also considers the diverse training that individuals have received. To this end there must be a broad range of high-quality training that is accessible, and provides chaplains with the core skills, competencies and insights needed to work effectively across all faith and belief traditions.

- Training prior to role that is supplemented with training opportunities for continuous professional development within posts (see later). We strongly support the development of genuine Band 5 training posts (with the training funding inbuilt and automatic progression to Band 6 once achieved). Such posts should be 'degree level' but not 'degree specific'. We also strongly support the UKBHC in its expectation that PGCert, CPE and eventually an equivalent portfolio entry route is essential for Band 6 roles, with enough places to supply the number of chaplains in place so that such training becomes a clear expectation of all employers.

- We need Band 5 roles with funding elements to pay for such education which make Band 6 roles accessible beyond those with deep pockets or faith traditions that will subsidise them. This is NOT a justification of any permanent Band 5 roles: the **CHCC explicitly does not support the employment of 'assistant chaplains'** (*sic*) within the NHS at Band 5 or below - nor indeed within hospice or other sectors**.**

- **It is completely unacceptable for Hospices or private sector providers to be matching medical and nursing salary grades yet seek to avoid appropriate remuneration for spiritual care delivery.**

- We need clear and diverse routes that allow people to build up knowledge and experience relevant to Healthcare Chaplaincy that may lead them into Band 5 roles. We are not thinking of school leaver routes but significant local changes such as:
    - Work experience placements in every chaplaincy team for a range of people who may potentially consider entry into the profession, such as

professionals from other disciplines who may consider a change or those who have been volunteers for a while.
- Chaplaincy apprenticeships in larger teams.
- Diverse training opportunities with local faith and belief communities in every team.
- Honorary Chaplain roles that genuinely enable deeper experience to be acquired ready for a Band 5 training application or to support qualification requirements.

2. Volunteering and Workforce diversity

The use of volunteers in chaplaincy varies significantly across the UK. Some volunteers only visit members of their own faith group; others visit inclusively. Improved volunteering models can achieve several positive outcomes relating to workforce diversity, but there are also risks associated with the way volunteers and selected and used. Given the subtlety of the issues we have set out some explicit statements relating to volunteering before going on to consider their role in workforce diversity.

CHCC Positional Statements

1. We believe that Chaplaincy volunteers are a valuable resource in the delivery of inclusive chaplaincy services within healthcare settings; they can add a richness to the diversity among a team but **must complement and not supplant the role of employed Chaplains.**[11]

[11] Many chaplaincy services across the UK will comprise of small teams where the possibility of having a broad range of diversity is limited. In these circumstances, volunteers can be used effectively to add significant value and inclusivity for service users with specific religious needs being supported. In larger teams, this may further expand into the more nuanced cultural and social aspects of diversity within faith and belief traditions such as African Christian communities. The role of a chaplain is that of a skilled autonomous practitioner who brings a level of training, expertise, and experience in assessing and delivering the various aspects of patient care, *whilst volunteers may assist in the delivery of that care, they should not be used as a solution to any gap in service provision.*

2. Every team (apart from lone workers) should aspire to have paid chaplains from diverse faith and belief backgrounds, delivering an excellent service for all. When faced with diverse patients they should **not** just build a team that responds to diversity through **volunteers or external faith community referral**.

3. Clear guidance should be developed to enable team audits allowing a review of the nature of their service delivery and whether the service is equitably designed in its use and support of volunteers.[12]

4. Ideally, volunteers should be skilled in a range of ways to support the delivery of Chaplaincy services and **not be simply limited to faith and belief specific support to patients** of the same religion or culture (except perhaps in particular circumstances). This will enable a more inclusive service.

5. Volunteering opportunities should be inclusive in terms of access and ways of working. Apart from widening the pool of those able to contribute, teams should also look for creative opportunities for aspiring chaplains to develop their skills and build pastoral experience - such as volunteering opportunities for those explicitly seeking future employment. This group will require additional training or development opportunities to enable them to make the most out of their time volunteering and set them up in good stead.[13]

6. No volunteers should be put in position without completing training and induction from the Chaplaincy team: **it is not enough for people simply to be approved by the hospital volunteer services or and external body (e.g. faith/belief group).**

[12] This is not a one size fits all solution nor should it simply be mapped onto local demographics, but should actually explore the nature of the service, local circumstances, understanding gaps in provision and inclusion needs. This will likely have significant variance in outcome across chaplaincy sectors as well as geographic regions but is grounded in an intentionality towards inclusive practice. Demand often builds from service awareness; where services are ineffectively designed, gaps in provision and inclusion may not be apparent. Where volunteers are being used to enhance service provision, this should be seen as an opportunity to identify further service needs and working towards the development of employment opportunities.

[13] As a significant focus of Chaplaincy provision is to transcend a model focussed on serving those whose are like-minded or co-religionist, restricting development opportunities among volunteers in this way goes against the grain of chaplaincy provision and could impact on workforce talent pool from which future chaplains will emerge.

7. Chaplaincy volunteering is often emotionally and spiritually challenging, so clear role descriptions as well as effective training and ongoing support should be available to all. **Supervision should be given to volunteers on a frequent basis.** Given this, there are only so many volunteers a team can safely have.

8. Opportunities for volunteering should **be inclusive by design and communicated effectively across the local community**, including in the language used. Advertisements via NHS or other local systems are not always adequate.[14]

9. The designation of 'Honorary Chaplain' to include highly skilled volunteers is supported in the NHS England guidance, but needs to be embedded as a key, consistent role, not as an honorific: this is for reasons of patient safety as well as being a means to providing an entry route into the profession.

10. National work is desirable to establish the role, scope and standards for those operating as 'Chaplaincy Volunteers' and 'Honorary Chaplains'. Ideally, we would be consistent in the use of these two terms.

    The title 'Volunteer Chaplain' is not to be used under any circumstance.[15]

What does good look like?

- Volunteers from diverse communities who feel welcomed and appreciated. A broad diversity includes socio-economic, cultural, disability, gender, age, religion and more. There may need to be explicit acknowledgement of the

[14] Volunteer opportunities should be communicated effectively across communities to enable diverse volunteers to engage. Chaplaincy may need to be explained in creative and effective ways to help those who are not clear what it is.

[15] Limited workforce development has led to an unfortunate divergence across the UK in regard to terminology and roles, as well as some outliers in terms of pay and use of volunteers. The term 'volunteer chaplain' is unhelpful and inappropriate as it implies the roles of a Healthcare Chaplain, and a volunteer are interchangeable. We follow NHS England in recommending the term 'Honorary chaplain' to denote those few (such as a religious sister) who are suitably trained and able to work as an unpaid chaplain in a limited remit, operating (and recruited/trained/supervised) at equivalent to a Band 5 as a minimum. This does not change the fact that our amazing volunteers should all be viewed and treated as part of the team.

insights such diversity brings, particularly where such diversity is under-represented within the chaplaincy team.

- A clear process for encouraging volunteers to claim expenses for their travel etc. There is a cultural attitude that volunteering your time includes paying for any expenses that occur. This creates a bias towards the wealthy: to maintain a feeling of parity amongst volunteers it is important to encourage them to claim.
- Opportunities that are inclusively designed with adequate investment in time and resources for recruiting, training, developing, supervising and supporting.
- A clear set of standards and expectations for volunteers and Chaplaincy teams.
- A clear entry route and development opportunities for volunteers wanting to enter the profession.[16]
- A service where volunteers are adding value to the team: 'complementing not supplanting'.
- A clear tool to audit chaplaincy volunteering, guarding against excessive reliance on volunteers to deliver core services.
- Faith and belief literacy among chaplaincy managers: this is a key component in overseeing diversity particularly where their faith or belief community is not represented within the chaplaincy team.
- Managers should verify whether individuals whose roles is identified with a specific faith or belief are in good standing with their respective faith and belief networks or possess any accreditation they claim.

Barriers to good volunteer systems include:

- lengthy entry processes with unnecessary barriers,
- recruitment from a limited number of local faith and belief communities.
- inadequate engagement or weak communication with paid chaplains.

As many chaplaincy teams have limited capacity to manage volunteers, it may be, for some, that developing volunteers remains an aspiration but is not achievable.

Voluntary Services Departments will be partners on this agenda, including training opportunities which may not be specific to chaplaincy but relevant to working in a healthcare environment. National initiatives should also be shared locally.

[16] For some people, volunteering may simply be a way of giving back, but others will be looking to enter the chaplaincy profession. For the latter, departments need a training or development package that enables them to make the most out of their time volunteering and sets them up in good stead to seek employment.

We are clear that **chaplaincy teams should manage chaplaincy volunteers**, and indeed may be best placed to oversee those offering volunteer roles that seem intimately related**. All 'spiritual care' related roles should be managed directly within the chaplaincy service**. We offer robust training and clear supervision to address the emotional toll that chaplaincy volunteering can take. Concerns should be raised if parallel 'pastoral visitor' or 'emotional support' roles or similar are created within an organisation, however well intended, to ensure all work within an organisation's spiritual and pastoral care policy.

3: Inclusion and the recruitment process

Current position

Anecdotally, the chaplaincy profession still remains predominantly Christian across the UK, albeit proportions seem to have changed. Even with teams which do not identify chaplains by faith tradition (such as in Scotland), this appears to be the tradition of origin of most team members, especially among full-time post holders and lead roles. Healthcare Chaplains from other faith and belief traditions are more likely to be found in part-time or bank chaplaincy roles, or indeed in 'Honorary Chaplain' roles, albeit there are some positive and notable exceptions that have become more common over the last 10 years. This means that a critical reflection on recruitment practices is vital.

As stated above, the College takes it as a given that greater inclusion will lead to a stronger workforce so long as inclusion is not valued above the quality of the individual appointment.

Problems and challenges

1. Several areas related to advertising and recruitment (as well as training and development within posts) need improvement to support inclusion and facilitate diversity, but there is little or no resource to support this on a national level.

2. There is a relatively slow turnover of chaplaincy posts. If we seek more rapid change in the workforce profile, we will need to be proactive in improving our recruitment processes – and in doing so need also to reflect on age diversity, given the current older age profile of chaplains.

3. We want to ensure organisations advertise roles and shape recruitment paperwork in an inclusive manner. There should always be evidence of an Equality Act impact assessment if a specific faith or belief group is to be recruited.

4. Many healthcare organisations do not understand modern chaplaincy services and therefore may misstep in recruitment, with practices such as:

    - Hospital managers relying on their contacts and networks to guide them on application and appointment processes and thereby perpetrating the preferment of one faith tradition over others.

    - Teams leading recruitment for a new lead, thereby choosing their own manager.

    - Trusts and Chaplaincy Leads being unaware of, or unwilling to use, UKBHC advisors.

    - Use of 'legacy' job descriptions which embed faith (usually Christian) biases.

Such issues lead to inconsistencies and embed bias in the process.

5. Healthcare organisations have still been known to contact their local Church of England/ Church in Wales diocese for guidance. This is inappropriate and perpetuates a preference towards Christian appointments and the perception that the Chaplaincy profession is Christian in nature. Posts should not be restricted to Christians unless it is a genuine occupational requirement (GOR) and follows an Equality Act Assessment. Normally, interview panels should be drawn from (as appropriate): a professional advisor, a senior chaplain from within the NHS Trust, other relevant chaplain (sometimes from another Trust), HR representative, a patient representative, and a healthcare professional from another discipline. It is not appropriate to have someone there from a faith/belief group unless an Equality Act assessment has clearly demonstrated that need.

6. In teams where the lead is of a certain tradition- it is important that great care is taken not to amplify mono-culture by repeatedly recruiting from the same broad tradition/gender/ethnicity etc.
7. Budget restrictions have a huge impact for several reasons:
    a. Smaller teams are more likely to focus on employing established and experienced chaplains, which will slow down the diversification on the workforce.
    b. Teams that are over-stretched or working at capacity due to financial constraint will likely be less able or willing to invest in the development of chaplains of other faith or belief traditions as this would not be considered a primary objective. Consequently, chaplains from diverse communities may not get the opportunity to gain the experience necessary to secure a substantive chaplaincy post.
    c. A belief that on-call provision should be predominantly Christian will bias all appointments.
    d. To increase diversity, minority faith applicants cannot be limited to applying for very part-time or bank roles with insufficient financial security.

What does 'good' look like?

- An established best practice for advertisements, job descriptions and person specifications. In particular, this means looking at any requirements that may be excluding candidates such as 'contributing to the Sunday service rota', or, more fundamentally, a single faith-based on-call system.
- A shortlisting process that ensures that trusts are not discounting suitable candidates because they lack formal theological qualifications. This is particularly noticeable where minority faith and belief communities may approach Chaplaincy without formal qualifications but with significant pastoral experience.
- There should not be a faith community representative on the interview panel when the post is open to candidates of all faiths and beliefs. Caution should be exercised if it is felt that a faith representative is necessary on any panel and a

clear rational developed as to why this might be necessary. Everyone should consider issues of unconscious bias and perceived unfairness, including those selecting the interview panel and shaping the process.

- Interview questions and scenarios should be shaped to be fair for candidates from different faith and belief traditions, but remain unapologetically focussed on recruiting high-quality chaplains with relevant experience. For example, use of 'in your previous ministry' or other phrases linked to a particular tradition, should be avoided. However, it is right and proper to ask explicitly 'in your previous chaplaincy experience…" if the post expects such experience. An applicant without chaplaincy experience will, and should, be at a disadvantage to a candidate with such experience.

4. Role Development and Progression

Current position

Career progression varies across the nations. In England and Wales, the few development opportunities are usually only feasible for holders of full-time Chaplaincy posts or those with independent means. Chaplains from minority communities are often in part-time roles that make them less able to access resources for development or career progression. Furthermore, the reality is that part-time chaplaincy posts are often focussed on service delivery with very little scope for personal development. This is a barrier in the development and progression of these individuals.

There are several training courses, most of which have some cost attached. Chaplaincy teams are generally hard-pressed to fund training opportunities for staff, and part-time staff are less able to avail themselves of the opportunities as the perceived return to the hospital is deemed significantly less.

Problems and challenges

Some part-time chaplains aspire to a full-time career within chaplaincy, whilst others are quite satisfied with the hours they have. Part-time chaplains may find they are

excluded from decision-making processes of their teams because such decisions are understood mainly to impact full time staff.

Part-time chaplains may be less likely be given responsibilities, for example being part of multidisciplinary teams, or leading on specific projects, thus limiting their experience and development.

Chaplaincy teams are often small, and they have very limited budgets. This leaves a gap for investment in workforce planning and service development.

What does 'good' look like?

- A clear system of career development through which a chaplain can develop a wide range of skills and experiences.
- Training courses that develop chaplains' skills in research, leadership, staff management, finance, HR and planning.
- Access to regular CPD (continued professional development); whether these are held virtually by chaplains across the UK relating to chaplaincy practice or opportunities led by other healthcare professionals. We recommend that the profession adopt a fixed minimum of CPD hours a year per chaplain and makes some element of CPD mandatory.
- Opportunities within hospitals to shadow or sit on various advisory boards, interest groups and end of life planning.
- Opportunities for responsibility and leadership in planning, delivering and evaluating projects, and in training and managing volunteers.
- Opportunities to participate in recruitment processes, from shortlisting to interview.
- Development posts which blend chaplaincy experience and areas of service development, project work and progression. The creation of chaplaincy development/training posts may be a means of enabling a clear entry route into Chaplaincy leadership. Some NHS bodies use an Agenda for Change, Annex 21 entry route into chaplaincy, which creates the opportunity for Chaplains entering the profession with development needs to be put on a lower pay scale for a limited period as they are entered into a structured training programme

designed to give them the skills or qualifications required by the role. Upon completion, they are moved onto their full-pay scale. This is warmly welcomed and is not a difficult HR process to set up.

- A fast-track process for chaplains with natural leadership abilities, to enable them to progress into chaplaincy leadership and contribute to the strategic direction of the profession. For those in the NHS this may be through leadership development programmes that help develop management skills within Chaplaincy.
- Straightforward and affordable pathways for all chaplains to be involved in chaplaincy professional bodies so they can develop an overarching and strategic understanding as well as contribute towards the development of the profession.
- Opportunities for research: chaplains wishing to conduct research do not have any clear pathways in which they can develop or specialise. We are aware of a few Trusts and Boards with posts at Band 7 or above that include a research element, but these are a tiny minority within the profession. This is a source of regret: research yields valuable resource and information and helps in the future development of the profession

5. Communication and Definitions

Current position (including regional and model variations)

The definition and scope of the profession need clarification. Both the titles used, and the understanding of the care Chaplaincy delivers vary in geographical regions as well as across Acute, Mental Health and Hospice settings. This variance influences the model of Chaplaincy implemented, the design of chaplaincy provision and the subsequent issues around diversity, inclusion and workforce planning.

Further research is needed into the perceptions of patients and communities, in particular the express understanding of what service chaplaincy provides, who it is provided by and who the service is for. Other terms, such as pastoral and spiritual care, are also commonly misunderstood. It is likely that a better understanding and

awareness of what a “chaplaincy service” delivers will increase demand for the service across all communities, which will create impetus for an increasingly diverse service.

Problems and challenges

The historical origins of the word ‘chaplaincy’ and its Christian heritage has maintained a perception, reinforced by earlier models of service provision, that chaplaincy is a service ‘led by’ Christians and serving ‘mainly’ the Christian community.

The UKBHC is the voluntary registration body with oversight over the profession known as ‘Healthcare Chaplaincy’ although it must be noted that chaplaincy is regrettably not yet a regulated profession. This still leaves considerable flexibility over how we describe what we do, with a number of contenders such as, ‘spiritual care’, ‘Pastoral Team’ or ‘Pastoral, Spiritual and Religious care’. The challenge is to agree a way forward, and to popularise a better understanding of Chaplaincy that works across nations and different healthcare sectors; as well as considering the communication needs of diverse faith and belief communities.

Any change of name would need a consensus between the professional groups and the employers, and it must also make sense to service users. There is some risk in individual teams and locations going it alone with re-branding what is a registered profession.

What does ‘good’ look like?

- Flexibility in language around the description of the service, while maintaining the professional title of ‘healthcare chaplain.’ CHCC does not believe, at present, that there is an urgent need for Chaplaincy to go through a re-branding exercise, although this is an open question for the future.
- Chaplaincy centres that are not designated ‘The Chapel’ when their role and function is wider.
- A communication strategy to shape the understanding of Healthcare Chaplaincy, its work and place within healthcare and the wider population.

6. Professional Registration and competencies

Current position

Chaplaincy's professional framework includes a code of conduct, core competencies, and registration on the voluntary professional register of the UK Board of Healthcare Chaplaincy; accredited by the Professional Standards Authority. The UKBHC aims to ensure that there is consistency in good and safe practice across chaplaincy provision. This is necessary to enable standards alongside diversity.

Problems and challenges

At present, registration on the UKBHC register is voluntary, with perhaps 80% of paid chaplains *not yet registered*. As registration ensures evidence of professional experience and of continued CPD, this means that, for a significant number of teams, we have no assurance with respect to continued training and learning. At worst, this means poor practice will not be identified. At best, it means chaplaincy departments can too easily operate in silos with little contact with the rest of the profession. Continuing in this way seems likely to further the marginalisation of some departments and poorer patient care.

The process of professional registration needs to be inclusive, without presenting barriers to people applying from diverse faith and belief communities. We also need models of accreditation that can adequately reflect existing competencies that have been gained outside of postgraduate certificates and degrees - yet do not simply open the title 'Chaplain' up to anyone wishing to use it. We support a portfolio route into chaplaincy where agreed competencies can be measured.

Different faith and belief communities may approach the delivery of spiritual, pastoral, and religious care from varying theological models and social structures, especially in the case of formal academic education, courses of study and lived experience. Reviewing the requirements of all registration pathways (as well as training and education) so that they are sensitive to different faith and belief communities will ensure that the registration process is inclusive.

Faith and belief communities also diverge when it comes to the nature of leadership in spiritual care: academic qualifications may not feature significantly, and spiritual care may not be viewed from the lens of a professional service or defined role but as an extension of a compassionate spiritual life. It is worth exploring barriers that discourage chaplains from applying to the professional register, whether this is from the perspective of diversity and inclusion or something different. Diversity is also relevant to the evidencing of skills and competencies for registration which should be open to the experiences of members from diverse communities.

In addition, the age profile of the chaplaincy profession could be examined: whilst it is common to have experienced nurses working at Band 6 in their mid-20s, this is unusual in chaplaincy posts. We could compare the age profile of Heads and Deputy Heads of Chaplaincy with advanced nurse practitioners and modern matrons, for example. There is huge amount of work to be done - but it must be recognised that the UKBHC does not get central funding or any large sums from registrants to do the level of research required.

What does 'good' look like?

- A diverse, Chaplaincy profession that is formally registered by the UKBHC.
- Clear ways to access the profession, with a wide variety of academic entry points and a coherent schema for assessment of prior experience.

We feel that this simple statement reflects our ambition and would support a wide diversity of differing faith and belief groups. Furthermore, an open and inclusive registered body would place the onus on chaplains, just as other healthcare professions, to maintain and evidence training and development as part of CPD. This would ensure that all Chaplaincy teams work to the same set of professional standards and do not become isolated either from the wider profession or their Trusts. It may also prevent the potential for dominance by any faith or belief group.

7. Authorisation and Endorsement

Current position

To begin with, *terminology* is a challenge: endorsement, licensing, authorisation, accreditation may have different meanings to different groups or in different contexts. For brevity, we will use the term 'endorsement' here.

Endorsement of individual chaplains by faith or belief groups is currently recommended in the NHS (England) Chaplaincy Guidelines and expected in Wales and Northern Ireland, but not in Scotland. When in place, it provides the institution with some reassurance regarding *belief-based* competencies which they may not be equipped to measure or assess through standard recruitment processes. It is required, at present, to be registered with UKBHC- but it is clearly *distinct* from registration.

Problems and challenges

Within faith and belief groups, there are a multitude of standards and processes for authorisation or endorsement. Some groups provide specific training in the delivery of pastoral, spiritual, and religious care (for example, this forms a part of Anglican ordination training), while others may solely take a view regarding an individual's beliefs and associated practices. This will inevitably remain.

Endorsement cannot and must not take the place of a thorough recruitment processes and the assessment of skills, competencies, and experience by employers. The duty to ensure the best candidate is employed sits with the employer. The use of an experienced UKBHC adviser also helps ensure a candidate is both employable for the role described (they will not choose *between* employable candidates). Endorsement should only be used for a very particular purpose, when a role requires the delivery of religion specific or belief-based care. Historically- it has been used for a much broader purpose, and this is a problem as the process is not fit for this purpose.

Endorsement in recent years has not been considered at all relevant in some chaplaincy models, where practitioners are not be appointed specifically to provide religious/belief based care. **It is clear to us that within such models, there needs to**

be other mechanisms to ensure posts do not dissolve into more general well-being or psycho-social support posts, and that it is the role of the UBHC to ensure this is in place. Where endorsement is not sought as part of the recruitment process, consideration must be given to how the institution can otherwise be assured of the sincerely held and well thought out worldview of practitioners, whether religious or non-religious. It is this depth that affords the profession a very different sphere of impact from related professions.

Caution is needed in situations where endorsement is not in place for a preferred candidate (who has a role involving religious care) or when endorsement is withdrawn for an individual already in post. Attention is drawn to the case of Canon Jeremy Pemberton in this regard, and overall, services should take specialist advice to consider whether endorsement is essential for the individual to undertake the tasks required of the role. This said, extreme care must also be taken to ensure that a *loss* of endorsement is fully understood and *not* taken as simple grounds for ending employment. In many cases such endorsement can be regained with a different body after a period of grace is allowed (this is the position set out by the UKBHC which we are in full agreement with).

What does 'good' look like?

- We believe in a workforce of healthcare chaplains who have strong personal belief and value positions, held with integrity, and invested in before and throughout their working life.
- It is for the UKBHC to oversee the safety of the profession, and the requirement of religious/belief endorsement (for registration) sits with them. We are supportive of any move by the UKBHC to improve clarity about the requirement for endorsement.
- **In situations where a chaplain is delivering religious care as part of their role, we believe that endorsement should be maintained, or introduced if not yet in place.**
- In situations where a role is formally limited to spiritual and pastoral care (the individual is not permitted to carry out religious acts associated with positions of authority, use religious titles etc.) we support the UKBHC as it seeks to find a

parallel option to evidence a strong personal belief and value position that enables them to practice with depth and integrity.

- We believe each belief tradition offering endorsement should have a clear sight of the role description before confirming such endorsement is in place. The Network for Pastoral, Spiritual, and Religious Care in Health (NPSRCH, or The Network) has produced a guide to endorsement, covering the contacts and procedures for seeking confirmation of endorsement for each of its member groups, and explaining what each group undertakes in order to award endorsement. This is a helpful starting point for understanding how endorsement contributes to a robust recruitment process and sets out the process for confirming whether a candidate is endorsed by each of the faith and belief groups.
- An employer may not be aware of matters that are important to faith and belief communities, including particular internal dynamics, when judging the suitability of a candidate. The institution should be guided by their Equality Impact Assessment for each appointment in deciding whether the ability to perform particular rituals is required, and then seek advice from the endorsing authorities as to whether candidates are permitted to perform those.

8. Community Engagement

Current Position

One would suppose that good community engagement would begin with each chaplain maintaining healthy links with their own faith/belief community or network. This certainly cannot be taken for granted at the present time. Indeed, during the emergence of chaplaincy as a profession it was evident that we attracted many who were not finding support or hospitality within their own tradition for a number of reasons. Despite any such tension, Chaplaincy recognises its duty to build robust relationships of trust with regular and transparent lines of communication with faith/belief networks relevant to their base of work.

Without sufficient steps to foster community engagement within the chaplaincy profession, it is likely that the pool of talent from which potential volunteers,

chaplains and honorary chaplains can be recruited will remain static and diversity will not flourish.

Different forms of healthcare chaplaincy have different opportunities and challenges around community engagement. Some teams already have a dimension of community outreach. Community chaplaincy is particularly well-placed: in areas where healthcare chaplaincy is becoming established in GP surgeries, health centres, Primary Care Network hubs, pharmacies, and even sports clubs. There is greater scope to relate to the immediate locality rather than chaplains/volunteers who commute to or between acute hospitals, hospices or mental health units. Tertiary sector chaplains face the particular challenge of a regional and even national catchment of patients/service users, as well as those from the locality.

Problems and challenges

- Limited chaplaincy team resources in terms of staffing can mean that chaplains become wholly focussed on patients/service users, carers and staff within the institutions which they serve.
- Out-dated job descriptions often emphasise an inward-looking institutional focus.
- Community faith/belief leaders can have a limited understanding of chaplaincy, for example, seeing chaplaincy as co-terminus with the pastoral/religious care which they deliver. This brings a risk of misunderstanding both of work carried out within the institution and any efforts to deliver spiritual care in community.

What does 'good' look like?

- Frequent and intentional engagement with local faith/belief leaders and networks with a view to dispel misunderstanding and support the recruitment of a more diverse voluntary, and eventually paid chaplaincy workforce.
- A two-way flow to this engagement, depending on the type of chaplaincy: e.g. inviting local faith/belief leaders into Trusts/Boards for educational events, EDI events, inter-faith week etc; but also, chaplaincy teams going out to community

faith/belief events, e.g. local Iftars, Holocaust Memorial Days, Humanist events etc.

- Chaplaincy job descriptions that include an element of community engagement.
- Clear reference to the 'gatekeeper' role of chaplaincy in policy and role description, to ensure the professional boundary setting is in place.

9. Staff Support

Current position

The support of staff and volunteers has been part of healthcare chaplaincy in all its forms from its inception. Due to capacity constrains often patient or service users' needs are prioritised; chaplains can therefore struggle to meet the needs of staff in the way they would wish. The COVID-19 pandemic has brought the provision of pastoral, spiritual, and religious care for staff into sharper focus. Some services have managed to get charitable funding for fixed-term, or on-going provision through business cases. Others have been able to appoint or ring-fence staff support chaplains from core Trust funding. There are numerous models and ways of working across the United Kingdom, and it is to be welcomed that support of staff is seen as a vital part of modern healthcare chaplaincy.

Problems and challenges

There are several blocks and challenges in getting a safe, effectively resourced offer for staff:

- Lack of understanding of what chaplaincy to staff involves means it can be difficult to advocate for resources to deliver safe, consistent, and sustainable care. Counselling and psychology are better understood.
- One clear feature of chaplaincy support is that we do not seek to pathologise the human condition when facing difficult life events. Another is that we are flexible and responsive in our paradigms of working. We also feel that we can deliver can bring better outcomes for people and better use of limited resources. Such strong arguments for our work are not clearly set out in any

agreed way nationally, which makes it harder for each Trust or Board to understand any business case.

- Many chaplains do not have sufficient time in their roles to specifically support staff. Conversely, many staff do not have time in their roles to seek support.
- There is inequitable provision across the heath sector, some have well-resourced offers to staff and other places where there is little or no support.
- As with patient support, some cannot see past the stereotype and would see chaplaincy as just for the religious. Work needs to be done to ensure all feel included and can access support.
- Data sets and metrics need to be developed as a profession to allow for reflection of practice and to determine what excellent quality care looks like. Often staff support data is not collected. In the NHS maxim, if it is not documented it did not happen. As a profession, we need to urgently attend to demonstrating what we do, and shouting out about it so the careful, compassionate, and responsive care does not just go under the radar.
- Many NHS organisations are multi-site, or over a large geography, meaning consistent, accessible care can be a challenge. Technology can mitigate some of this but is not the total solution.

What does 'good' look like?

- At its best, staff chaplaincy brings something unique and precious to the support and care for staff and volunteers alike. Our flexibility, ability to listen, reflect upon, and produce creative responses is our great asset.
- We need to have this value set out clearly in much greater detail than we have at present - with robust research put in place to evaluate benefit.
- Chaplaincy for staff and volunteers must be relational. In places where staff chaplaincy is flourishing, there are strong relationships; chaplaincy is visible and accessible across the organisation. Senior leaders know team members, know the worth of chaplaincy, and trust the team when something significant occurs to deliver care corporately or individually.

- Staff chaplaincy should help mark significant times in individuals or the national life through ceremonies or services.
- Bereavement care is a key element of the chaplaincy offer to staff, whether this be personal bereavement, the death of a colleague or patient/service user. Services should have the capacity and the skills to support people through what can be complex and challenging times; for example, when someone has died suddenly or taken their own life in the team.
- The availability of places of quiet and/or prayer in what can be busy unpleasant environments that allow people to look within or transcend themselves. Space that is not rest space or a “wobble room” but that is welcoming and allows people space to be. There has to be awareness that staff may want spaces that are staff-specific so they don’t run the risk of appearing vulnerable in public.
- Core to staff support is allowing every staff member or volunteer to know and feel they are unique and of value. This has particular benefit in our post Covid-19 situation. Chaplaincy at its best allows space to connect with the things that shape and give value to their lives. It allows everyone to come as they are, and to receive compassionate support and care or simply to be.
- We would like to see the staffing recommendations set out by various bodies in 2023 taken seriously by organisations across the UK, and the application of safe staffing principles in chaplaincy supported by all NHS bodies.

Section Four: Conclusions

There is a great deal to do in the next few years if we are to achieve greater diversity and a fully inclusive profession. The scale of the challenge is illustrated by the many strands of work set out above. We have tried throughout this document to indicate what the College sees as 'best practice' in each area. Taken together, these steps will bring about the radical evolution required.

We believe that our **core positional statements** offer a foundation for chaplaincy profession that is inclusive and diverse- and can deliver a broad, effective chaplaincy service. It requires a strong focus on a workforce that is effectively trained and resourced as well as soundly grounded in a personal worldview.

Whilst we are not proposing a simplistic 'one size fits all' picture of chaplaincy, we *are* looking for **greater professional discipline, conformity and collaboration across the profession and a move towards the inclusive paradigm**. There is a real risk to the profession (and confusion for patients and staff colleagues alike) when chaplaincy departments work out their own models without reference to the wider profession.

We have outlined key areas of development, but have not attempted to proscribe best practice on all the potential issues in the workforce (such as the impact of chaplains wearing religious iconography at work, use of 'scrubs', use of religious titles etc). Both nationally and in our local context, we must be more keenly aware of such matters and ensure what we do is based on patient and staff need. More research in this area would be welcome given the emotive nature of such issues.

We believe teams must **actively seek to collaborate with other teams as well as the wider profession**: greater diversity is less likely when teams adopt 'silo' working, and lone working is perhaps the greatest risk of all. In addition to the diversity benefits- there are number of other clear benefits to close partnerships and collaboration, and these are better formed proactively by us as a profession that when organisational mergers force our hand.

We have not examined, as originally intended, wider diversity issues (such as disability or sexual or gender orientation, for example). In part, this was a matter of

capacity on the part of the College. Of all other outstanding diversity issues, we remain most concerned about the age profile of working chaplains: complex entry routes, lack of funding for training and the prior experience required all make entry routes difficult for younger candidates. We need to address this as a profession in the near future.

We also acknowledge that, in considering this area, we have been hindered by a lack of basic information; the NHS has no adequate measure as to how many chaplains that it employs. We are further hampered by a lack of quality research into any number of aspects of health and social care chaplaincy.

Despite such limitation, we believe that the emerging profession can and will diversify, flourish and evolve to meet the needs of patients and staff well into the 21st century. We commend this report to our members and all those managing chaplaincy provision.

Appendix 1: Stakeholders

Clearly, the College members are the most important stakeholders as far as we are concerned. The CHCC holds our responsibility for chaplaincy workforce development and best practice in partnership with many other Chaplaincy bodies. This list of stakeholders is not exhaustive:

UKBHC UK Board of Healthcare Chaplaincy

NPSRCH Network for Pastoral, Spiritual and Religious Care in Health (sometimes called 'Network'- England only)

AHPCC Association of Hospice and Palliative Care Chaplains

ACGP The Association of Chaplaincy in General Practice

NIHCA Northern Ireland Healthcare Chaplains Association

The Chaplaincy Forum for Pastoral, Spiritual and Religious Care in Health (sometimes called 'Forum' for short, England only)

Scotland has a strong working relationship in place between a dedicated 'NHS Scotland Chaplaincy Professional advisor' and the Professional Leadership Group (PLG) made up of lead Chaplains

Wales also has a lead chaplains' group with an active strategic role

We consider relevant 'Stakeholders' to include any other body that might have a view on Health and Social Care Chaplaincy, such as NHS bodies, Integrated Care Boards, service user groups and wider faith and belief groups.

Appendix 2: Terminology

In this paper we have used a variety of terms. This is how we understand them:

Chaplain: We recognise that other names are sometimes used locally for the role but we have chosen to use *Chaplain.* This encompasses the 2023 NHS England Guidelines which uses "Healthcare Chaplain" and the NHS Scotland '2023 Scottish Framework (which uses "Registered Chaplain"). We intend to encompass anyone working in the profession.

Visit: This encompasses all encounters with people who use our services.

Faith and Belief: This is used to encompass all world religions, spiritual groups, humanism, and non-religious beliefs.

Inclusive chaplaincy post: This refers to a post open to individuals of any recognised faith or belief position, but still assumes that the individual post-holder is well-grounded in a faith or belief system. It is a shorthand descriptor for the purposes of this paper and used to distinguish from posts designated as 'Roman Catholic Chaplain, 'Humanist Chaplain' etc. *"Inclusive" is not meant as a title to be used*: we prefer that all chaplains are known simply as 'Chaplain' (or 'Registered Chaplain' (Chaplain in Scotland). We have chosen to use 'inclusive' rather than the term '*generic'*, which is often misunderstood.

Honorary Chaplain: We recognise this can have two meanings, both valid:

(a) Someone working as a chaplain whose primary employer/supervising body is external (under an honorary contract).
(b) Someone operating and recruited/trained/supervised at the level of a paid who is nonetheless not paid and registered as a Volunteer.

Chaplaincy Volunteer: *Chaplaincy volunteers* are a valuable part of the team, and carry out a variety of roles *excluding those that should be done by a paid Chaplain* (such as formal spiritual care assessment and on call). Along with the UKBHC *we do not support the use of the term* "Volunteer Chaplain" at all. Anyone carrying out the work of a Chaplain unpaid (who has the relevant skills to do so) should be designated as an "Honorary Chaplain" and must be provided with relevant training and supervision at Band 5 level or above.

Appendix 3: Contributing Authors

Many individuals (both members of the College and beyond) have contributed greatly over the last few years to the creation of this document. Both Kartar Bring and Graham Peacock took turns in co-ordinating and editing. Simon Harrison worked on several early and later draft versions and several other members of the OPC supported with specialist knowledge and copy editing.

We are deeply grateful to ALL who contributed (listed below). This paper is published as **the work of CHCC OPC & represents our considered opinion**, explicitly recognising that elements of it will not represent the views of any individual involved in drafting:

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Graham Peacock

Ben Rhodes

Clare Elcombe Webber

Ricarda Witcombe