SUBMISSION BY THE MULTI-FAITH GROUP FOR HEALTHCARE CHAPLAINCY TO THE ENQUIRY BY THE ALL-PARTY PARLIAMENTARY GROUP FOR HOSPITAL CHAPLAINCY – OCTOBER 2008

Introduction

1. This paper sets out the evidence which the Multi-Faith Group for Healthcare Chaplaincy (MFGHC) is submitting to the enquiry launched in August 2008 by the All-Party Parliamentary Group for Healthcare Chaplaincy (APG). The focus of these comments relate to the English NHS although some reference is made to other parts of the UK wherever this is helpful.

2. The paper is set out in three main sections concerning the current state of chaplaincy-spiritual care (paras 4-30); the direction which the MFGHC considers should now be taken (paras 31-39) ; and the challenges such progress would have to overcome (paras 40-49). In the penultimate section, the MFGHC seeks to set out its summary answers to the questions raised by the APG (paras 50-55).

3. In the final section (paras 56-63), the MFGHC restates its proposals for change and improvement to healthcare chaplaincy services.

Where are we now?

Chaplaincy-spiritual care policy and its implementation

4. The most recent chaplaincy policy[1] was issued by the Department of Health (DH) in November 2003. The policy had been drafted by a Joint National Multi-Faith Working Party established by the Secretary of State in 1997 following a conference on multi-faith healthcare chaplaincy. The policy which covered appointments to chaplaincy posts; confidentiality and data protection; volunteers in chaplaincy-spiritual care; worship and sacred spaces; training and development; bereavement services; emergency and major incident planning and a framework for calculating total chaplaincy units was well received by chaplains, chaplaincy bodies and the NHS.

5. Since the issue of the policy, implementation has been left to local health authorities in accordance with the approach set out in Shifting the Balance[2]. There has been no further enquiry from DH about progress, and implementing this policy was not included within the national performance management framework. The English style of managing this issue was thus in stark contrast to that in Scotland where a central monitoring and reporting process was established.

[1] NHS Chaplaincy: Meeting the Religious and Spiritual Needs of Patients and Staff; Guidance for managers and those involved in the provision of chaplaincy-spiritual care; Department of Health; 2003
[2] Shifting the Balance: The next steps; Department of Health; 2002

6. Effort was made in 2004 by the DH PPI Branch, which had the central responsibility, to devolve aspects of operational management for chaplaincy to the lead chaplaincy workforce body (NHS Yorkshire and the Humber). In 2006, NHS Yorkshire and the Humber gave up this responsibility and the NHS Chief Executives review group did not assign this responsibility elsewhere. In late 2007, an internal review in the Department of Health concluded that chaplaincy-spiritual care should be managed with issues of religion and diversity.

7. The MFGHC view is that the Department of Health has not led the implementation of the policy issued in 2003 effectively and that the NHS has not taken this responsibility locally. As a result, the important proposals for establishing multi-faith chaplaincy have not been adequately managed within the NHS and this is to the detriment of patients and other users.

Chaplaincy-spiritual care workforce issues

8. The English national workforce strategy[3] was issued by South Yorkshire Workforce Development Confederation (SYWDC) in November 2003. This was prepared the Caring for the Spirit NHS Project (hosted by SYWDC) with input from chaplains, the healthcare professional bodies, other confederations and the chaplaincy bodies. A period of formal consultation with interested parties took place in the summer of 2003. Subsequently, the Project published advice and guidance on a minimum dataset for spiritual healthcare; a strategy for continuing professional development; a review of some theoretical models of healthcare chaplaincy service and practice; chaplaincy collaboratives; and commissioning for chaplaincy-spiritual care.

9. Following a review of national workforce projects by SHA Chief Executives in 2006, the Project ended its implementation path some four years earlier than expected. There was some disappointment in this ending point as the organisational development work to develop chaplains and their teams in chaplaincy collaboratives was only just starting. No SHA would accept the national lead for the chaplaincy workforce relinquished by South Yorkshire SHA and the majority have not committed effort to sustain the chaplaincy collaboratives.

10. The MFGHC view is that this development work was ended prematurely and such an ending is effectively a waste of resources given the investment which had been made by the authorities in South Yorkshire. As a result, the broader aims of the Project especially those concerned with organisational development and standards of practice could not be achieved followed through effectively.

[3] Caring for the Spirit: A strategy for the chaplaincy and spiritual healthcare workforce; South Yorkshire WDC; 2003

Quality standards for chaplaincy-spiritual healthcare

11. The DH agreed a set of quality standards for the NHS in 2005[4]. These were divided into core standards and developmental standards, the former being essential and funded and the latter being for achievement over time. To reduce the number of standards, many were clustered together. Despite protests against the exclusion of chaplaincy-spiritual care from the set of core standards, it was included only as a developmental standard clustered with other beliefs and preferences.

12. In 2006, The MFGHC published for discussion with chaplains a set of standards[5] which mirrored those set for the NHS but tailored them to spiritual healthcare. These have been endorsed by chaplains and chaplaincy bodies and will be issued for consultation with SHAs in 2009.

13. The MFGHC view is that there should be a core NHS standard for chaplaincy-spiritual care which recognises the importance of spiritual healthcare to peoples' health and well-being.

Occupational standards for chaplaincy-spiritual healthcare

14. The Chaplaincy Education and Development Group comprised of the four main chaplaincy bodies agreed a statement of occupational/ vocational standards in 1992 and these were updated in 2002[6]. Subsequently, they were mapped to the NHS KSF[7] statement with a relatively strong fit but the Caring for the Spirit NHS Project was not able to afford (the £70,000 required) to develop a statement of National Occupational Standards for chaplaincy-spiritual care. In Scotland, the NES has published a set of capabilities[8] but these have not been agreed more widely.

15. The MFGHC view is that a set of National Occupational Standards is necessary if chaplaincy is to be recognised as an essential NHS professional service.

---

[4] Standards for Better Health; Department of Health; 2005
[5] Standards for Spiritual Healthcare; The Multi-Faith Group for Healthcare Chaplaincy; 2006
[6] Healthcare Chaplaincy (occupational/ vocational) standards; Chaplaincy Education and Development Group; 1992 (updated in 2002)
[7] The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process; Department of Health; 2004
[8] Spiritual and religious care capabilities and competencies for healthcare chaplains; NHS Education for Scotland; 2008

Authorisation of chaplains by faith community bodies

16. The MFGHC is working with its constituent faith community members to develop with each an authorisation[9] process for their healthcare chaplains which can be led and managed by the faith community. For the Christian and Jewish faith communities, these processes already exist and the remaining seven faith communities are seeking to complete their arrangements by the year-end. The MFGHC will publicise these new arrangements when they are completed.

17. The MFGHC view is that completing the development of authorisation processes in each faith community is important but is probably only the first step in this development. Individual faith communities will need to review their own progress and priorities and then as components of MFGHC to review and where necessary change the emphasis it gives to its work with these bodies and for healthcare chaplaincy more generally.

Funding for chaplaincy-spiritual care

18. Chaplaincy-spiritual care is funded by the NHS through the revenue allocation to health authorities and via the central allocation for hospital chaplaincy.

19. The funding requirement of chaplaincy teams by NHS bodies is based on the formula approach included in the annex of the 2003 policy statement. The formula approach was increased in 2003 and the NHS was expected to achieve the increased investment in chaplaincy over the three years of the local development plan. In this way, the policy of implementing multi-faith chaplaincy teams could be achieved.

20. With the passage of time, and changes in structure and policy imperative, the funding of chaplaincy-spiritual care has been eroded. Chaplain posts have been lost[10] and the consolidation of funding and workforce has prevented the development of balanced and funded multi-faith chaplaincy teams. There are some exceptions but generally the position is less satisfactory than was intended by the policy initiative.

21. The central allocation for hospital chaplaincy is a small (£170,000) allocation managed by the DH to support the central administration of faith communities. Its use was reviewed[11] in 2004 when an additional full-time post was agreed for Muslim chaplaincy with the balance of the allocation used by the remaining six faith communities and the MFGHC itself.

---

[9] Authorisation is the process whereby faith communities judge the development and maturity of their ministers of religion.
[10] According to research conducted by Theos in late 2007
[11] Report of a Review of Department of Health Central Funding of Hospital Chaplaincy; Department of Health; 2004 (The James Report)

22. In the years 2005 to 2007, this arrangement worked well but, since the administration of funds reverted to the DH (from NHS Yorkshire and the Humber), there have been delays in allocating funds and a lack of communication from the officials concerned.

23. The MFGHC view is that both the central and the local funding for chaplaincy-spiritual care needs to be made more transparent. In the NHS, chaplaincy-spiritual care is a distinct clinical service yet it is treated as less important than many minor hotel services without clarity for budgets, workforce issues or performance standards. At the Centre, the lack of clarity and communication is both demoralising and frustrating giving the impression of a lack of attention and a lack of interest.

Education for chaplaincy-spiritual care

24. The Caring for the Spirit workforce strategy made several proposals for developing education and training including developing a statement of what chaplains need to learn derived from the NHS KSF[12]. Using this basis, the introductory course for newly appointed healthcare chaplains developed by the chaplaincy bodies to 2002 has been used as the basis for entry-level courses for use in the world faith chaplaincies involved since that time.

25. In recent years, the educational issues have been complicated by several factors including the development of a new statement of capabilities in Scottish chaplaincy which reflects chaplaincy practice there (rather than in the UK generally); the development of a curriculum and training scheme for chaplains employed in public institutions[13] by the Department for Innovation, Universities and Skills and the Department for Communities and Local Government without any involvement by the healthcare chaplaincy bodies; the formation of an educational board by the chaplaincy membership bodies without the involvement of the faith communities; the failure of HEIs and chaplaincy bodies (yet) to agree a curriculum for healthcare chaplaincy; and the lack of educational support to chaplaincy education and training both nationally and locally.

26. The MFGHC view is that this fragmented approach to common issues makes progress in the faith communities new to chaplaincy more difficult and therefore slower. At the same time, the NHS has not enabled or facilitated the education of these NHS staffs. As a result, the development of multi-faith chaplaincies has been prevented and provision for those in the world faith communities has relied on unskilled workers or on chaplains of other faiths. This state of affairs is at odds with the policy direction set out in 2003.

[12] Knowledge and Skills in Spiritual Healthcare; South Yorkshire SHA; 2004
[13] Qualification in Faith Community Development; NIACE; 2007

Regulation of chaplaincy-spiritual care

27. Healthcare chaplaincy has been a valued NHS service since the NHS inception. Healthcare chaplains are professionals in their community who have chosen to give their skills to the NHS. Despite this long history of service delivery by professional practitioners, healthcare chaplains have not been accorded the status of healthcare professionals. This has been seen by some as detrimental to the service provided in chaplaincy-spiritual care and, as a result, the chaplaincy membership bodies are seeking to develop their own status as healthcare professionals.

28. The work of healthcare chaplains is complex because their work requires a significant knowledge and grounding in their faith. This formation of the chaplain is undertaken by the faith community which authorises them and is based initially on their faithfulness. The faith community which develops "its" chaplains also regulates them in order that the laity can be sure that they are receiving religious and spiritual care as they expect. As a result, the regulation of chaplains as healthcare professionals requires either two regulators (faith and NHS) or a new regulatory body which combines the two (and conforms to best practice in voluntary regulation).

29. In the years since 1948, the faith perspectives of society have changed. The world faiths have become better established in the UK so that the 2001 census could record 71.8% Christians and 5.4% non-Christians. At the same time, the number of those who say they are not following a specific faith has increased to 15.1%. There is thus a need for healthcare chaplaincy both to reflect the new profile of faiths within the community and for chaplains to comprehend a wider perspective of faiths and spirituality. How these new approaches are received by users will determine the extent to which any regulatory regime can work satisfactorily.

30. The MFGHC view is that healthcare chaplaincy should be seen as a professional service and that recognising chaplains as healthcare professionals would greatly assist the delivery of chaplaincy-spiritual care. At the same time, the regulation issues for such professionals are complex and can best be handled by the NHS working with the faith communities to develop a new voluntary regulatory scheme.

Where do we want to be?

NHS standards

31. The MFGHC proposes that the NHS should commit itself to determining and implementing a standard for healthcare chaplaincy as a core NHS service to be provided in all healthcare setting where NHS contracts operate including those in the independent and social care sectors. Such a standard should be instigated in 2009-10 and should support the policy guidance issued in 2003 and subsequent progress set out in the Caring for the Spirit NHS Project.

Educational curriculum

32. The MFGHC proposes that the NHS Institute for Innovation and Improvement should be tasked to assist in the formulation and agreement to an educational curriculum for healthcare chaplaincy in line with the NHS KSF and taking account of current progress. The intention should be to complete this work during 2010.

Professional status

33. The MFGHC proposes that the department of Health should review the list of agreed healthcare professionals and consider adding healthcare chaplaincy. This would enable their involvement with multi-disciplinary teams to be endorsed and, in some instances, recognised. Additionally, it would enable chaplains to be treated with the status which their work deserves in regards to data protection issues.

34. The MFGHC recognises that "adding healthcare chaplaincy" to the list of healthcare professions does not fulfil the requirements for regulation which the NHS requires. Further work will be necessary by the chaplaincy membership bodies and regulatory issues below will also need resolution.

Regulation

35. The MFGHC proposes that healthcare chaplaincy professionals should be regulated by a new regulatory body formed between the NHS and the Faith communities. Such an arrangement would need to conform to current best practice in regulation and be able to be endorsed by the Council for Healthcare Regulatory Excellence.

36. The MFGHC is establishing a working group of chaplaincy stakeholders under an independent Chair to examine regulatory issues in more detail and to make firm recommendations by June 2009.

Finance

37. The MFGHC proposes that the NHS should review the implementation of the formula approach to chaplaincy workforce levels set out in 2003 in light of changes to the NHS shape and structure heralded in Lord Darzi's review and seek to enable multi-faith chaplaincy services in each PCT locality.

38. The MFGHC proposes that the central allocation for hospital chaplaincy should continue to be administered by the Department of Health but that it be increased to enable all nine world faiths to fund a full-time officer at Grade 5 or an equivalent sum. Implementing this arrangement should be achieved over five years and should be reviewed annually to ensure that the allocation of such funding remains appropriate for NHS services. .

39. The MFGHC proposes that the MFGHC should continue to be able to apply for funding from the central allocation until such time as it can be funded either by subscriptions or by regulatory activity.

Challenges to progress

Evidence base for efficacy of chaplaincy-spiritual care

40. Clinical services in the NHS, of which chaplaincy aspires to be one, are expected to be able to demonstrate evidence that their services are efficacious. The evidence-base for chaplaincy is weak in that the discipline of research and testing has not fully been applied nor is there a long history of such analysis or endeavour.

41. Chaplains have available both the outline of a research strategy and also the encouragement of recently adopted competences in research to help their development of the evidence base in support of their work. The broad timeframe of five years surrounding other proposals above should also enable this evidence to be gathered and presented.

Government commitment to multi-faith chaplaincy

42. The MFGHC is focused in its work on England and, for the time being, maintains a watching brief over developments in Wales. It is fully aware of the different Governmental arrangements in the UK countries and is concerned that the progress in chaplaincy-spiritual care development may reflect these differences.

43. In brief, the management process in England is focused on a few management priorities which are rigorously pursued to the exclusion of less important issues which appear to include chaplaincy. In Scotland, the managerial process is less devolved and there is room in the priority list for the (very successful) development of chaplaincy-spiritual care. In Wales, Ministers and Officials indicate that the forthcoming chaplaincy strategy will be implemented rather than being left as guidance. In Northern Ireland, significant support is given to healthcare chaplains through a central allocation for professional development.

44. Such a summary as that above can only skim the surface of an issue but the MFGHC is worried that, in England, there is no interest in sustaining or developing healthcare chaplaincy within the Department of Health or the senior NHS echelon. There is some evidence of patient, staff and user interest in this service and its neglect is regrettable.

Chaplaincy leadership

45. Faith communities have developed a managerial style of their own which exhibits leadership but which differs to that in common parlance and may eschew the behaviours of the business world. Thus, those developed and nurtured within faith communities may not adopt the NHS leadership model without considerable encouragement and training. For this reason, chaplains may not respond to leadership challenges readily and collectively although many will do so from their managerial experience.

46. Generating a leadership position for chaplaincy therefore involves several different interests and may need to draw is a wider range of people and structures to achieve coherence and legitimacy. To date, this has not been possible in England and progress towards the objectives set out by the MFGHC will be correspondingly slower.

Funding issues

47. Although chaplains are not solely concerned with funding, progress on the ground and in delivering services to users can only move forward with supportive finance. Chaplaincy is not thought to be a "high-cost" specialty but there is a minimum requirement (set out in the policy guidance which is not always being met now.

48. Chaplaincy is thought to contribute to health and to well being. Certainly, a professional service which cares for all the patients and all the staff is likely to be of value to improving morale and enforcing caring values. Examining how to add value to the current investment should therefore be a useful exercise for the NHS.

49. Without further help, the central bodies for the world faiths will not be able to maintain their impetus towards the provision of safe and proficient healthcare chaplain

Responses to the specific areas of enquiry identified by the All-Party Group

Identifying the policy context and its implementation in light of commitments to a personalised, equitable NHS working to reduce health inequalities

50. The MFGHC considers that the policy guidance issued by the Department of Health in 2003 needs to be implemented fully within the NHS. The absence of a spiritual dimension to holistic care within the English NHS is striking and surprising. In order to safeguard spiritual healthcare, a new standard for chaplaincy-spiritual care should be agreed so that this care in guaranteed.

Identifying progress in the development of good practice, and instances in which change may be needed

51. The MFGHC considers that there are examples of good practice in most chaplaincies across the UK. The absence of co-ordinated implementation of the policy guidance and the premature halting of the Caring for the Spirit NHS Project has made this progress patchy and partial. Users and members of the chaplaincy and spiritual healthcare workforce are confused by the apparent lack in providing excellent spiritual care within the NHS.

Reviewing the potential benefits of NHS chaplaincy becoming a commissioned service

52. The Caring for the Spirit NHS Project made proposals for chaplaincy to be a commissioned service in light of the cut-backs which Trusts made in chaplaincy services arising from the financial challenges of 2006. This report set out in detail why chaplaincy should be treated as a clinical service rather than a purely voluntary add-on to support services. The report was submitted to the Department of Health in December 2007 but no response has been received to date.

Reinforcing the current multi-faith dialogue, while considering the ideal balance between multi-faith and faith specific approaches.

53. The policy guidance issued in 2003 was quite specific in its intention to create and support the development of multi-faith chaplaincy teams in which all Faiths would have equal status. The Department of Health needs to determine the extent to which this aim has been achieved and take steps to rectify any failings.

Making recommendations for future local and national policy and strategy

54. The MFGHC considers that there is confusion within the English NHS about Ministerial support for spiritual care and that progress is slow because the Top Management has failed to indicate any sense of direction and pace of change. As a result, the consensus which led to the need for additional policy guidance in 2002 has evaporated and no clear support for religious and spiritual needs is evident.

55. The MFGHC supports the need for a new direction which would be best signalled by the commitment to a standard for chaplaincy-spiritual care and a clear mandate for this to be given priority in the near future

Summary of Proposals

56. The NHS should commit itself to determining and implementing ***a standard for healthcare chaplaincy as a core NHS service*** to be provided in all healthcare setting where NHS contracts operate including those in the independent and social care sectors. Such a standard should be instigated in 2009-10 and should support the policy guidance issued in 2003 and subsequent progress set out in the Caring for the Spirit NHS Project.

57. A set of ***National Occupational Standards*** is necessary if healthcare chaplaincy is to be recognised as an essential NHS professional service. The Department of Health should draw up a plan to assist in this development by 2012.

58. The NHS Institute for Innovation and Improvement should be tasked to assist in the formulation and agreement to ***an educational curriculum for healthcare chaplaincy*** in line with the NHS KSF and taking account of current progress. The intention should be to complete this work during 2010.

59. The Department of Health should review the list of ***agreed healthcare professionals*** and consider adding healthcare chaplaincy. This would enable their involvement with multi-disciplinary teams to be endorsed and, in some instances, recognised. Additionally, it would enable chaplains to be treated with the status which their work deserves in regards to data protection issues.

60. Healthcare chaplaincy professionals should be regulated by ***a new regulatory body formed between the NHS and the Faith communities***. Such an arrangement would need to conform to current best practice in regulation and be able to be endorsed by the Council for Healthcare Regulatory Excellence

61. The NHS should ***review the implementation of the formula approach*** to chaplaincy workforce levels set out in 2003 in light of changes to the NHS shape and structure heralded in Lord Darzi's review and seek to enable multi-faith chaplaincy services in each PCT locality.

62. The ***central allocation for hospital chaplaincy*** should continue to be administered by the Department of Health but that it be increased to enable all nine world faiths to fund a full-time officer at Grade 5 or an equivalent sum. Implementing this arrangement should be achieved over five years and should be reviewed annually to ensure that the allocation of such funding remains appropriate for NHS services.

63. The policy guidance issued by the Department of Health in 2003 needs to be ***implemented fully within the NHS***. The absence of a spiritual dimension to holistic care within the English NHS is striking and surprising. In order to safeguard spiritual healthcare, a new standard for chaplaincy-spiritual care should be agreed so that this care in guaranteed.

Conclusions

64. The MFGHC welcomes the review undertaken by the All-Party Group and is pleased to have the opportunity to submit this written evidence. Members of Council and the Honorary Officers are ready to give oral evidence if required.

65. The MFGHC is concerned about a number of issues the most important of which is about people's understanding and valuing chaplaincy-spiritual care. There is evidence that all those in healthcare settings whether as patients or as staff understand their own spirituality and that their spiritual needs require to be cared for more effectively when they are themselves within a healthcare system. Our evidence is focused on producing a better chaplaincy service for all in the NHS and other healthcare settings.

66. The Council is grateful to those who gave of their time to contribute to and to comment on this evidence submission.

October 2008