CHCC COLLEGE OF HEALTH CARE CHAPLAINS

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Towards Greater Diversity in the Healthcare Chaplaincy Workforce

CHCC Workforce Development Guidance

July 2024

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Preface

This guidance was requested by members at our AGM prior to Covid19. For obvious reasons, it has taken over three years to produce. Drafting and re-drafting has been the work of many members. We are especially grateful to those individuals listed in the appendix who gave so much of their time.

During the spring of 2024, a draft was circulated widely across the profession, and we were delighted to receive considered feedback at our engagement events to further improve this final published document. As is stated (repeatedly) below, complex guidance only makes sense when it is read as a whole; looking at individual sentences or paragraphs in isolation can easily give a misleading picture.

At its heart, this document recognises that significant change is required to ensure chaplaincy is fit for the future of healthcare, and that there is no simple 'one size fits all' paradigm for a profession such as ours.

Simon Harrison
CHCC President

Introduction

There is a clear need for greater diversity across the health and social care chaplaincy workforce. The College of Health Care Chaplains (CHCC) strongly believes that increasing workforce diversity will enhance the profession and the service we deliver.

There has been little investment by the NHS in chaplaincy workforce development across the UK. We also face a huge shortfall in funding overall, alongside inconsistencies in education, training and recruitment and a proliferation of localised models, roles, and titles, to name but a few of the challenges.

Despite all this, recent years have witnessed several positive developments in healthcare chaplaincy, particularly in terms of professionalisation and registration. There has also been a gradual but notable diversification within the workforce, which is warmly welcomed. Nevertheless, there is much more to do and genuine UK-wide workforce transformation cannot occur in isolation but needs the collaborative effort of all stakeholders.

Historically, models of Christian ministry shaped much of chaplaincy recruitment and provision. Many feel that this created a bias against the perceived competency of other faith and belief communities in delivering chaplaincy even when posts were presented as open to all applicants. Much has changed in this regard but progress towards fully open posts has been sporadic and is not universal. Entry routes remain unclear, experience requirements are vague and **workforce diversity in terms of faith and belief remains inadequate across all parts of the UK.**

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. Yet amidst such innovation **we must not lose sight of the unique contribution that good chaplaincy makes in health and social care.** If we are to avoid defining our profession in ways that are too narrow (or even obsolete), we need to be able articulate our service in ways that our institutions can understand.

The CHCC believes that the long-term solution is for healthcare chaplaincy to become a *fully regulated profession across the UK* with a shared understanding of what good looks like. It is still too easy for teams and individuals to function in self-defining ways without reference to any common professional standards or oversight. This increases the risk of poor practice and risks the whole profession being side-lined within a fast-moving health and social care world. Clear self-understanding as a regulated profession with consistent high-quality delivery will go a long way to mitigate this risk.

One: What does *good* look like?

1. Key positions

Please consider the following 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 and extends beyond questions of faith/belief status to the *widest* understanding of inclusion. Team diversity will not significantly impact on the skills, abilities and professional competencies of any *individual* chaplain, but **greater diversity within each team will improve the quality of care delivered and have a further impact across the profession as a whole.** The wealth to be found within the deeply rooted lived experiences of chaplains from diverse cultural, religious and belief traditions should enhance all that we do from the shape of direct care to the research or reflective practice that lies behind it.

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 a depth of faith or belief and a commitment to ongoing nourishment to be an essential part of all recruitment across the UK.

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 **spiritual, pastoral, and emotional care can be delivered safely and effectively without requiring 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 point three above, we would **still argue strongly for a rich diversity within larger teams in terms of culture and belief and the employment, recruitment and monitoring required to achieve this.** Good chaplaincy understands the depth of spirituality within faith and belief communities and traditions and **should 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 multicultural population.[4] Such a team will not deliver the best of health and social care chaplaincy either outside of faith and belief practice or within.

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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, 5th-7th September 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 or remains suitable to be, whatever qualifications or experience they may hold. It is a challenging premise to translate into best practice but nevertheless we believe it to be essential.

2 This statement is an important one to make. It expressly challenges the suggestion that chaplaincy is always 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 nor helpful). The rich diversity to be found within traditions and beliefs and the uniqueness of individuals undermines any such presumption. Patients or staff may prefer support from someone who shares their gender or their broad worldview or sense of humour and so on – despite a different faith/belief system. It is 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 while respecting their unique needs and preferences. In situations with specialised care needs (such as specific religious rituals) or strong patient preferences (such as a request for non-religious support) it remains important for chaplains to refer patients to colleagues or safe external agencies who can provide the most suitable care.

3 See UKBHC capabilities and competencies.

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

5. **There is no 'one size fits all' shape for chaplaincy despite our need for greater consistency.** The UK has different governments, each shaping health and social care with varied cultural contexts. There are radical differences between lone working and working within a large team, between specialist settings such as a hospice or mental health, and between contexts such as inner-city London or the Isle of Bute. We need to be clear about models of working but must always allow for contextual variety.

6. **CHCC favours the adoption of a broadly inclusive model over a *representative* model of service along with an understanding of its limitations.** We recognise that an inclusive model is far from perfect both in the shape of care offered and its impact on the pace of our journey towards a diverse chaplaincy workforce. Nevertheless, we believe it currently offers the better model of care when adapted to meet local and service specific needs and can also deliver workforce diversity when the right attention is given to the workforce development process.

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 or 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 our 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 that these seven positional statements help focus our work and our collaboration with relevant stakeholders as we diversify the workforce and improve chaplaincy provision for patients and staff alike.

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5 The College works as closely as it can with other professional bodies and stakeholders. It nominates one director onto 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, the Association of Hospice and Palliative Care Chaplains and works closely with NHS Wales and NHS Scotland whenever it is able.

2. What does *good* chaplaincy look like?

Alongside these broad principles **we need to have a clear vision of what good *looks like* if we are to effect the right changes in our workforce** – or at least understand what our profession should look like in 10 years' time. This cannot be a complete picture of best practice, but some key elements that need to be in place, resource permitting:

- A service that has evolved significantly from our historical focus on primarily supporting patients with faith-based needs to an inclusive profession delivering high-quality spiritual care to those most in need: staff, patients, relatives and carers.
- A healthcare profession with a coherent model of working that is clearly understood by service users, colleagues, and stakeholders alike.
- A service embedded within NHS commissioning and contracts of service and 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 along with a strong volunteer program to enrich 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 of professionals who are **deeply rooted and grounded within the security of their personal faith or belief systems** and are well supported to remain so.

Two: Reflections on models and paradigms

This section offers wider reflections to support and further explain the key positions in Section One.

1. Two paradigms

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 practice, 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 focused 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, or unclear in any such association). At worst, the approach risks limiting the breadth of our provision with excessive attention paid to the faith or belief of the chaplains or those of shared faith among patients and staff.

Inclusive chaplaincy models seek to create a level playing field for all communities with regard 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 perpetuate established bias and may not ensure greater diversity among staff due to a number of other recruitment and societal factors.[6] It would take a scoping study across a geographical region where such practice is common (for example Scotland) looking at the demographics of those in post to see whether such inclusive practice has brought about greater diversity within the profession in terms of ethnicity, gender, belief, faith, tradition and so on. 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.

2. 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 the specific needs of the service and the local community.

Inclusive models should reduce the privileging of one group over another in terms of employment or delivery so long as we monitor effectively for hidden bias and discrimination.

As we go forward, it is important to work together as a profession nationally with openness to the insights inclusion and diversity may bring to our care and our paradigms.

Idiosyncratic teams which evolve in their own way with little reference to the wider profession do offer some value (especially if change is considered with a research framework in place) but also create risk both for the profession and for patients.

We are keen to encourage smaller teams to find peer support and share resources and best practice with other local 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 proactively offer support to smaller teams.

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

The College believes that in the long term it is necessary that **all models are underpinned by appropriate research into best practice** rather than any team, NHS, or governmental multicultural or secularisation agenda.

In some settings (small teams, mental health, hospice, etc) the inclusive model is the only possible model, as a representative correlation between the faith or belief of the workforce and local demographics is clearly meaningless.

Many teams in England are moving towards an inclusive model but **the CHCC remains concerned that a sizeable number of advertisements for chaplaincy posts are not genuinely open to candidates of all faiths and beliefs.**[7]

The College is also currently working on a position paper relating to on-call provision. 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 will be addressed with some urgency in that guidance.

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 representative thinking when open recruitment does not bring about diversity.

Example: In a diverse and multicultural city, a large acute hospital has operated open recruitment to all posts for several years but finds itself with every chaplain rooted in a Christian tradition despite a local population with 30% self-identifying as Muslim. It needs to address this, no matter how inclusive the recruitment model preferred by the local team or the NHS. External referral to the local Muslim community can deliver some of the patient support required but the team cannot pretend to have the depth of cultural understanding required to deliver the best spiritual and pastoral care. We would expect the lead chaplain to take proactive steps to understand why the team has the demographic it has and seek to lead change, in line with UK-wide equality legislation.

3. Sector-specific reflections

Mental-health chaplaincy

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

Hospice chaplaincy

Hospice chaplaincy is not typically based upon a representative model but has specific challenges around the expectation of the need for end-of-life rituals that may strongly influence decisions on recruitment if there is an inpatient role.

7 According to frequent surveys by the NPSRCH.

Hospices often look to encourage greater diversity and inclusion with many advertised posts focusing 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 clearly 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 what we would recognise as best practice in the profession. It is incumbent on CHCC to work closely with the AHPCC to address this with some urgency.

Chaplaincy in GP surgeries and community chaplaincy

These are both emerging areas of health and social care chaplaincy with evolving paradigms in play. Work can be focused primarily on listening in pre-planned one-to-one encounters or deeply embedded in multi-disciplinary team care plans. Chaplaincy recruitment and delivery is typically framed inclusively, although in some areas it may tie in closely with faith-based volunteer provision to provide additional support. There have been a number of experimental models in England whereas 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 (Association of Chaplaincy in General Practice) is also working hard to build the paradigm for chaplaincy in a primary-care and community context. This area may be of all areas least suitable for a representative paradigm.

4. Different models across the UK

The 'English model' (acute)

This is not really a model as such. To the extent that there is a common pattern, many English Trusts seem keen to retain features of a representative model. Monitoring by the NPSRCH (Network for Pastoral, Spiritual and Religious Care in Health) suggests that an inclusive approach still only applies to a minority of posts advertised.[8] While the appointment of faith-specific posts may be justified based upon the local demographics of the patient population or on-call demands, such recruitment is sadly 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 a trend towards advertisements with open rather than faith-based posts. While 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 continu to do so exclusively and faith and belief groups occasionally put pressure to ensure some posts continue to operate this way.[9] In addition, local on-call requirements can compromise any desire to operate inclusively (this is discussed more fully in Section Two: 2 and Section Three: 3).

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

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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.

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.

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). 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.

NHS Scotland's recent National Framework has built on but not changed this fundamental paradigm of working.

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 means that in many areas there can be a stronger 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 affecting certain boards which require individual solutions.

The 'Northern Irish model'

Chaplaincy in Northern Ireland is mostly denominationally based with few chaplains from a non-Christian background. Most paid chaplains work part time. Unlike most of the rest of the UK, some chaplains may be funded by individual denominations as well as the HSC. A very few do work with a recognised inclusive role and management roles are integrated. The HSC resources CPE, PGCerts, and other chaplaincy training through the NIHCA.

Better and worse models

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 inpatient settings. Inclusive models are also clearly much more appropriate in mental health, community and (mostly) in hospice settings.

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

Comprehensive data on the demographics of chaplains working in different settings and with different patterns of working would help to gauge the level of existing workforce diversity, investigate whether there are clear trends and identify the steps needed to improve diversity across chaplaincy volunteers, substantive chaplaincy posts, and leadership posts. In-depth research is also needed into service delivery as a whole.

Such research needs to consider the following questions:

- Do these models genuinely foster a diverse workforce in practice?
- 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)?
- What are the strengths and weaknesses of these models?
- Would a different model improve diversity and inclusion?
- Are there unintended consequences in changing the model?
- How does the emergence of community chaplaincy fit with these models?
- What listening models are used?
- Do we let these models emerge and develop, or should we support a dominant model?

It is also necessary to consider who should fund and resource research into chaplaincy models.

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[10] It seems anecdotally that most paid hours are 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.

Three: Key areas for development

This section was perhaps the most difficult to draft. There are many interconnected workforce issues that require development on a local, regional, and national level. To keep things as simple as we can, we have chosen to focus on a specific set of workforce themes following a consistent template for each. It is 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 and 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 without stripping something vital and unique from the workforce.

Historically it was clear that entry into chaplaincy was especially favourable to faith leaders of certain Christian traditions, who were deemed automatically safe and competent to deliver chaplaincy and spiritual care simply due to prior formation and training in ministry. Such a model was reinforced by the three-fold division of funding across most of the UK (in the not-so-distant past) into Free Church, Anglican, and Roman Catholic posts. It was assumed that such Christian ministers could meet the needs of most patients (who would be Christian or with a Christian cultural background) and then incidentally could provide broad pastoral and spiritual care fo people of all other faiths and beliefs. Although the situation has changed radically, this legacy still has an impact across the UK. Advertisements sometimes still 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 other regions 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 an imam or an experienced Buddhist practitioner is not coterminous with that of a Christian minister in training, pastoral experience, or community expectation. 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 a false presumption of skills and competencies.

All this points to a stronger role for registration and more significantly, robust, accredited education (such as PGCert and CPE) such as has been developed by several universities and accredited by the UKBHC. However, 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 achieved.

What does good look like?

- An approach that not only reflects the experiences of individuals and operates 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 to provide chaplains with the core skills, competencies, and insights needed to work effectively across all faith and belief traditions.
- Prior training 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 the clear expectation of all employers.
- Band 5 roles which include funding for the education to make Band 6 roles accessible not only for 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 permanent 'assistant chaplains'** (sic) within the NHS at Band 5 or below – nor indeed within hospices or other sectors.
- Appropriate remuneration. **It is completely unacceptable for hospices or private-sector providers to match medical and nursing salary grades yet seek to avoid appropriate remuneration for spiritual-care delivery.**
- 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 are 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]
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 referrals to external faith communities.**
3. Clear guidance should be developed to enable team audits allowing regular review of service delivery and whether the service is equitably designed in its use and support of volunteers.
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 where this is explicitly evidenced due to particular circumstances).[12]
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 those aspiring to work as chaplains to develop their skills and build pastoral experience. This group will require additional training or development opportunities to enable them to make the most out of their time volunteering.[13]
6. Nobody should begin a volunteer role without completing training and induction from the chaplaincy team: **it is not enough for people simply to be approved by hospital volunteer services and/or an external body (e.g. their faith/belief group).** Any voluntary activity that is distinctively religious or spiritual in its nature must be overseen by the chaplaincy team and we would expect organisations to write this clearly into their policy and protocols.
7. Chaplaincy volunteering is often emotionally and spiritually challenging. Appropriate management of volunteers therefore implies clear role descriptions, effective training, and ongoing support. **Supervision should be given to volunteers on a frequent and regular basis.** These requirements are likely to limit the number of volunteers a team can safely manage.

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11 There is inevitably limited diversity in very small chaplaincy teams. In these circumstances, volunteers can add significant value and enable the needs of service users with specific religious needs to be 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. Chaplains are skilled autonomous practitioners applying their training, expertise and experience in assessing and delivering the various aspects of patient care. *While volunteers may assist in the delivery of that care, they should not be used as a solution to any gap in service provision.*

12 This is not a 'one size fits all' solution nor should it simply be mapped onto local demographics but should explore the nature of the service, local circumstances, gaps in provision, and inclusion needs. Significant variance is likely between chaplaincy sectors and between 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 develop employment opportunities.

13 Restricting development opportunities among volunteers to the like-minded or co-religionist goes against the grain of chaplaincy provision and could impact on the workforce talent pool from which future chaplains will emerge.

8. Opportunities for volunteering should **be inclusive by design and communicated effectively across the local community.** This includes attention to 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.* We need to be consistent in the use of these two terms.

11. **Chaplaincy teams should manage chaplaincy volunteers,** and indeed may be best placed to oversee those offering related volunteer roles. **All roles related to spiritual care 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 they all work within an organisation's spiritual and pastoral care policy.

12. **The title 'volunteer chaplain' is not to be used under any circumstance.[15]**

Problems and challenges

- 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.
- Chaplaincy teams with limited capacity may mean that developing volunteers remains an aspiration but is not currently achievable.

What does *good* look like?

- Volunteers from diverse communities being actively recruited and feeling 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 insights such diversity brings, particularly where such diversity is under-represented within the chaplaincy team.
- A clear process that encourages volunteers to claim expenses. 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.
- Inclusively designed opportunities with adequate investment in time and resources for recruiting, training, developing, supervising and supporting volunteers.
- 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]

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

15 Limited workforce development has led to an unfortunate divergence across the UK regarding 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 (recruited, trained and supervised) at the 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.

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.

- A service where volunteers are adding value to the team, complementing and not supplanting.
- The use of 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 the faith or belief community is not represented within the chaplaincy team.
- Verification by managers that volunteers identified with a specific faith or belief are in good standing with their respective faith and belief networks and possess any accreditation they claim.
- Voluntary Services Departments work as partners on this agenda offering training opportunities which may not be specific to chaplaincy but relevant to working in a healthcare environment. National initiatives should also be shared locally.

3. Inclusion and the recruitment process

Current position

Anecdotally, the chaplaincy profession remains predominantly Christian across the UK, despite increasing numbers of chaplains from other traditions. Even where teams do not identify chaplains by faith tradition (such as in Scotland), most team members, especially full-time post holders and lead roles, come from a Christian background. Healthcare chaplains from other faith and belief traditions are more likely to be found in part-time or bank roles or as honorary chaplains, although positive and notable exceptions have become more common over the last ten 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

Advertising, recruitment, training and development within posts all need improvement to support inclusion and facilitate diversity, but there is little or no resource to support this on a national level.

There is a 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. In doing so we need also to reflect on age diversity, given the current older-age profile of chaplains.

Organisations do not always advertise roles and shape recruitment paperwork in an inclusive manner. There should always be evidence of an Equality Impact Assessment (EIA) if a specific faith or belief group is to be recruited.

Insufficient understanding of modern chaplaincy services by organisations sometimes leads to inappropriate practices such as:

- Hospital managers relying on 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.

Healthcare organisations still sometimes contact their local Church of England/Church in Wales diocese for guidance. This is inappropriate and perpetuates 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 Impact Assessment (EIA). Normally, interview panels should be drawn from (as appropriate): UKBHC professional advisor, senior chaplain from within the NHS Trust, other relevant chaplain (sometimes from another Trust), HR representative, patient representative, and healthcare professional from another discipline. It is not appropriate to have someone present from a faith/belief group unless an EIA has clearly demonstrated that need.

In teams where the lead is of a certain tradition it is important that great care is taken not to repeatedly recruit from the same broad tradition. The same applies to gender, ethnicity, etc.

Budget restrictions have an enormous impact for several reasons:

- Smaller teams are more likely to focus on employing established and experienced chaplains, which will slow down the diversification of the workforce.
- Overstretched or financially constrained teams may not see the development of chaplains from other traditions as a primary objective, potentially limiting the ability of chaplains from diverse communities to gain the experience necessary to secure a substantive chaplaincy post.
- A belief that on-call provision should be predominantly Christian will bias all appointments.
- 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. This includes 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 Trusts or Boards 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.
- Interview panels that do not include faith community representatives when the post is open to candidates of all faiths and beliefs. Caution should be exercised at the suggestion of inviting a faith representative and a clear rationale 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 that are shaped to be fair for candidates from different faith and belief traditions but remain unapologetically focused 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. The recommended alternative is "in your previous chaplaincy experience" if the post expects 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 focused on service delivery with very little scope for personal development, which constitutes a barrier limiting development and progression.

There are several training courses, most of which have some cost attached. Chaplaincy teams are 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 organisation is deemed significantly less.

Problems and challenges

Some part-time chaplains aspire to a full-time career within chaplaincy, while others are quite satisfied with the hours they have. Part-time chaplains may find they are excluded from decision-making processes in their teams because such decisions are understood mainly to impact full-time staff.

Part-time chaplains may be less likely be given responsibilities such as being part of multi-disciplinary teams or leading on specific projects, thus limiting their experience and development.

Chaplaincy teams are often small with limited budgets. This leaves an investment gap 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) including virtual and in-person opportunities across the UK whether organised by chaplaincy organisations or other healthcare professionals. We recommend that the profession adopt a fixed minimum CPD hours a year per chaplain and make some element of CPD mandatory.
- Opportunities within the organisation to shadow or sit on various advisory boards, interest groups and multi-disciplinary groups such as 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 resources 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. The titles used and the understanding of the care chaplaincy delivers vary across geographical regions as well as between acute, mental-health, and hospice settings. This variance influences the model of chaplaincy implemented, the design of chaplaincy provision and subsequent issues around diversity, inclusion and workforce planning.

Further research is needed into the perceptions of patients and communities, in particular their explicit understanding of what a chaplaincy service comprises and by whom and for whom it is provided. 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 alternatives used in practice such as “spiritual care”, “pastoral team” or “spiritual, pastoral and religious care”. The challenge is to agree a way forward and embed a better understanding of chaplaincy that works across nations and 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 must also make sense to service users. There is some risk in individual teams and locations going it alone with rebranding 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 rebranding exercise, although this is an open question for the future.
- Chaplaincy centres that are not designated as “chapel” when their role and function is wider.
- A communication strategy to shape the understanding of healthcare chaplaincy, its work, and its 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 (UKBHC), which is accredited by the Professional Standards Authority (PSA). The UKBHC aims to ensure that there is consistency in good and safe practice across increasingly diverse chaplaincy provision.

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 considerable 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 lead to poorer patient care.

The process of professional registration needs to avoid presenting barriers to people applying from diverse faith and belief communities. We need models of accreditation that adequately reflect existing competencies that have been gained outside of postgraduate certificates and degrees and yet do not simply open the title *chaplain* 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. 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. For some, 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 all barriers that discourage chaplains from applying to the professional register. Methods of evidencing skills and competencies for registration should be open to the experiences of members from diverse communities.

In addition, the age profile of the chaplaincy profession should be examined. It is common to have experienced nurses working at Band 6 in their mid-twenties, but this is unusual in chaplaincy posts. We could compare the age profile of heads and deputy heads of chaplaincy services with modern matrons and advanced nurse practitioners, for example. There is huge amount of work to be done and yet it must be recognised that the UKBHC receives neither central funding nor substantial registration fees to fund the level of research required.

What does *good* look like?

- An inclusive and diverse chaplaincy profession with its workforce 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.

An open and inclusive registered body would place the onus on chaplains, like 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 within their organisations. It may also prevent the potential for dominance by any individual faith or belief group.

7. Authorisation and endorsement

Current position

To begin with, *terminology* is a challenge: "endorsement", "licensing", "authorisation", and "accreditation" may have different meanings to different groups or in different contexts. For brevity, we will use the term *endorsement* here to describe the authorisation of chaplains by a body external to chaplaincy.

Endorsement of individual chaplains by faith or belief groups is expected in England ("where possible"), 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. Endorsement does not necessarily provide evidence of chaplaincy competencies in general, which need to be evidenced by other means such as registration with UKBHC.

Problems and challenges

Within faith and belief groups, there is a multitude of standards and processes for authorisation or endorsement. Some groups provide specific training in the delivery of pastoral, spiritual and/or 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. These differences will inevitably remain.

Endorsement cannot and must not take the place of 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 advisor helps ensure a candidate is employable for the role described. (The advisor will not help a panel to choose between employable candidates.) Although historically endorsement has been used in recruitment to indicate employability, the process is not fit for this purpose. Endorsement should only be used to indicate authorisation and competence to deliver religion-specific or belief-based care.

Endorsement in recent years has not been considered at all relevant in some chaplaincy models, where practitioners are not appointed specifically to provide religious/belief-based care. **It is clear to us that within inclusive models of working, there need to be other mechanisms to ensure posts do not dissolve into more general wellbeing or psychosocial support posts. We see it as the role of the UKBHC to ensure these are 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 quite 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. In such cases, services should take specialist advice to consider whether endorsement is essential for the individual to undertake the tasks required of the role. Extreme care must 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 (the position set out by the UKBHC with which we are in full agreement).

What does *good* look like?

- 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.
- The UKBHC effectively overseeing the safety of the profession and ensuring any necessary requirements for religious/belief endorsement are met for registration. We are supportive of any move by the UKBHC to improve clarity about the requirement for endorsement.

- **Endorsement being maintained or introduced if not yet in place in situations where a chaplain is delivering religious care as part of the role.**
- An inclusive acceptance of strong personal belief and value positions that enable a chaplain to practice with depth and integrity in situations where a role is formally limited to spiritual and pastoral care, i.e. where the chaplain does not carry out religious acts associated with positions of authority, use religious titles, etc. We support the UKBHC as it seeks to find suitable and relevant ways to evidence this.
- Each faith and belief tradition offering endorsement having clear sight of the role description before confirming such endorsement is in place. The Network for Pastoral, Spiritual, and Religious Care in Health (NPSRCH) 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 the relevant faith and belief groups.
- Each institution being guided by their Equality Impact Assessment (EIA) for each appointment in deciding whether specific faith-based practice or ritual is required and subsequently seeking advice from the endorsing body as to whether candidates are authorised to provide it. When judging the suitability of a candidate, an employer may not be aware of matters that are important to faith and belief communities including particular internal dynamics.

8. Community engagement

Current position

Good community engagement begins 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 anecdotally reported that chaplaincy posts often attracted those who were not finding support or hospitality within their own tradition for a number of reasons. Despite such tensions, chaplaincy recognises a duty to build robust relationships of trust through regular and transparent lines of communication with relevant faith/belief networks.

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 often greater scope to relate to the immediate locality than for chaplains and volunteers who commute to or between acute hospitals, hospices or mental-health units. Tertiary sector chaplains face the challenge of a regional and even national catchment of patients and service users, as well as those from the local area.

Problems and challenges

Limited chaplaincy team resources in terms of staffing can mean that chaplains become wholly focused on patients/service users, carers, and staff within the institutions which they serve, and out-dated job descriptions often emphasise an inward-looking institutional focus.

Community faith/belief leaders can have a limited understanding of chaplaincy, sometimes for example, seeing chaplaincy as coterminous with the pastoral and/or religious care which they themselves 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 misunderstandings and support the recruitment of a more diverse voluntary and paid chaplaincy workforce.
- A two-way flow to this engagement, depending on the type of chaplaincy. For example, local faith/belief leaders may be invited into Trusts/Boards for educational events, EDI events, inter-faith week, and so on. Also, chaplaincy teams may go out to community faith/belief events such as 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 descriptions, to ensure appropriate 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 constraints, often patients' 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 UK, and we welcome seeing support of staff as a vital part of modern healthcare chaplaincy.

Problems and challenges

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 often better understood. Consequently, there is inequitable provision across the heath sector; some have well-resourced offers to staff and in other places there is little or no support. While many chaplains are not resourced with sufficient time to specifically support staff, many staff do not have time in their roles to seek support from chaplains. Many NHS organisations are multi-site, or cover a large geography, meaning consistent, accessible care can be a challenge, especially for small chaplaincy teams. Technology can mitigate some of this but is not the total solution.

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. Our experience is that we can deliver better outcomes for people and offer better use of limited resources than some of the alternatives commonly offered. Such compelling 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.

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 effectively communicating it so that our careful, compassionate and responsive care does not fly under the radar.

What does *good* look like?

- A staff-support offer which exhibits the strengths of chaplaincy in its flexibility and its ability to listen, reflect upon, and produce creative responses. At its best, staff chaplaincy brings something unique and precious to the support and care for staff and volunteers alike.
- Clear communication within the organisation of chaplaincy's role in supporting staff, evidenced by robust research to demonstrate and evaluate benefit.
- Strong relationships with chaplaincy 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 both corporately and individually.
- Significant times for teams, individuals, the local community or the nation being marked through ceremonies or services.
- Accessible and responsive bereavement care, whether this be personal bereavement or the death of a colleague or patient/service user. The chaplaincy service 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.
- The availability of places of quiet and/or prayer that allow people to look within or transcend themselves. Space should be provided that is not rest space or a 'wobble room' but that is welcoming and allows people to find a space just to be or a sacred space. Staff may want spaces that are staff-specific, in order to maintain boundaries with patients and service users.
- Every staff member or volunteer knowing and feeling that they are unique and of value. Chaplaincy at its best offers the 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.
- 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.

Four: Conclusion

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 a chaplaincy profession that is inclusive and diverse in order to deliver a broad and effective chaplaincy service. It requires a strong focus on a workforce that is appropriately trained and resourced as well as soundly grounded in a personal worldview.

While we are not proposing a simplistic 'one size fits all' picture of chaplaincy, we are looking for **greater professional discipline, consistency and collaboration across the profession and a coordinated 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 prescribe best practice for all the potential issues in the workforce (such as the impact of chaplains wearing religious symbols at work, wearing scrubs, use of religious titles, etc). Both nationally and in our local contexts, 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. These are better formed proactively by us as a profession than forced by organisational mergers.

We have not examined, as originally intended, wider diversity issues (such as disability or sexual and gender identity, for example). In part, this was a matter of capacity on the part of the College. Of the 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 combine to make entry routes difficult for younger candidates. We need to address this as a profession soon.

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

Despite these limitations, we believe that the emerging profession can and will diversify, flourish and evolve to meet the needs of patients and staff well into the twenty-first century. We commend this report to our members and all those managing chaplaincy provision.

Appendices

Appendix 1: Stakeholders

Clearly, College members are the most important stakeholders as far as we are concerned. The CHCC holds 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 "the 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 "the 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 (ICBs), 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 is in accord with NHS England's 2023 NHS Chaplaincy guidelines (which use "healthcare chaplain") and NHS Scotland's 2023 National Framework (which uses "registered chaplain"). We intend the term chaplain 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, philosophies and worldviews.

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 is used to distinguish from posts designated as "Roman Catholic Chaplain", "Humanist Chaplain" etc. **"Inclusive" is not meant to be used as a title:** we prefer that all chaplains are known simply as chaplain (or registered 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:

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

Many people (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 coordinating and editing. Simon Harrison worked on several early and later draft versions and several other members of the OPC supported with specialist knowledge and editing.

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

- Andrew Bradley
- Kartar Bring
- Lindsay de Wal
- Paul Graham
- Simon Harrison
- Fran Kissack
- Mark Newitt
- Graham Peacock
- Ben Rhodes
- Stewart Selby
- Clare Elcombe Webber
- Andrew Williams
- Ricarda Witcombe

Appendix 4: CHCC membership

The CHCC (College of Health Care Chaplains) is a professional organisation for chaplains of all faith and belief groups. It is open to all recognised healthcare chaplaincy staff, paid and voluntary, and to those with an interest in chaplaincy. If you are interested in finding out more about the CHCC including information about the benefits of membership and subscription rates, please follow the link below:

Find out more about membership of CHCC
https://www.healthcarechaplains.org/about/become-a-member/

www.healthcarechaplains.org

www.unitetheunion.org

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