Healthcare Chaplaincy Guidelines Review

Recommendations

March 2019

V4
Contents

Background 3-8
- Review process
- Summary of the key findings of the survey
- Recommendations

Recommendations 9-19
- Specific to the 2015 Chaplaincy Guidelines
- General recommendations
- Recommendations for system leaders
**Background**

The NHS Chaplaincy Guidelines published in 2015 provided a description of good practice in chaplaincy care for the NHS in England. The document responded to changes in the NHS and wider society and attempted to broaden the understanding of religious, spiritual, and pastoral care within a work context. The guidelines also recognised the development of chaplaincy in a range of specialities including General Practice and in areas such as Paediatrics and Palliative Care. Research and innovation were also affirmed as important areas for chaplaincy both for improved practice and as a basis for commissioners to understand better the benefits of chaplaincy and spiritual care.

As such the guidelines of 2015 has provided a strong focus for chaplaincy within the NHS and the efforts of those who undertook the task of developing the guidelines must be recognised.

In January 2018 - three years after the guidelines were published - NHS England commissioned NHS Employers to work with partners and stakeholders – including NHS chaplains and managers - to review the impact of the guidelines. In addition, NHS Employers were tasked with suggesting ways of revising the guidelines (considering those impacts and in line with equality considerations) in order to help improve support for patients, carers, family members, volunteers, and other people accessing NHS services and staff across the health service.

The purpose of the review and subsequent activities was as follows:

- To help review the existing guidelines and address whether the best practice outlined in the existing guidelines was up to date and fit for purpose;
- To understand and address how organisations have integrated growing equality considerations within healthcare chaplaincy and identify where more work needs to be undertaken to address inequalities of provision;
- To share and learn about best practice in the field of healthcare chaplaincy that could be considered for inclusion in the proposed revised guidelines;
- To develop a series of recommendations to support a revision/rewrite/refresh of the 2015 guidelines in 2019-20.

**Review process**

The review process commenced in April 2018 and utilised an evidence-based approach – comprising of scientific / research evidence, organisational data (drawn primarily from the Electronic Staff Record system and Staff Survey data), the expertise and judgment of practitioners and managers and the views of stakeholders. This process included a series of engagement techniques to capture both the patient perspective - as well as the experiences of staff working in the NHS. The review process – and the associated engagement techniques – also allowed us to capture and collate the experiences and views of NHS chaplaincy from a variety of perspectives – including chaplains themselves, LGBT staff, members from minority faiths and belief/non-belief groups and managers amongst others. For more details of the activities/discussion that took place please click on the links below:
1. Two national workshops involving predominantly chaplains from all backgrounds were held involving 80 participants.

2. Specific workshop for patients and patient representative and separately those from minority faiths and belief/non-belief groups consisting of 80 participants.

3. National survey targeting commissioners, directors, chaplains, managers and equality specialists which resulted in 252 responses.

4. Separate task and finish groups addressing (a) out of area chaplaincy provision for and minority faiths and belief/non-belief groups (b) LGBT & people of faith.


6. Attendance at quarterly meetings involving the Healthcare Chaplaincy Forum for Pastoral, Spiritual and Religious Care (forum) and separately the Network for Pastoral, Spiritual & Religious Care (network).

7. A consultative group was set up involving the chairs or nominated representatives of both the forum and the network as well as patient representatives & NHS England to help provide specific advice to the review of the chaplaincy guidelines.

8. NHS England have attended events and meetings held and hosted by NHS Employers and provided ongoing support and guidance.

9. A webpage was developed to ensure the NHS were kept up to date with the project and associated activities. This web page has been publicised and promoted through NHS Employers and other communication channels.

Limitations of the review process

The intention from the outset was to ensure that the process was inclusive. The survey undertaken engaged with a wide variety of parties ranging from managers to chaplains. Yet at the same time responses from patients and patient representatives (despite our best efforts) were not as high as we would have liked.

At the same time the two workshops organised in November and December 2019 were attended predominantly by chaplains.

Therefore in 2019 we undertook positive action measures to ensure minority faiths and belief/non-belief groups as well as patients and patient’s representatives. This involved facilitating two specific workshops to ensure their view were heard.

The review highlighted the need to undertake further work to engage chaplains of all backgrounds as well as other key stakeholders in the system who can play a crucial role in (a) integrating future guidelines into their work; (b) supporting the delivery of chaplaincy within the NHS; (c) influencing the chaplaincy profession; and (d) looking at ways of integrating the impact of chaplaincy services within the governance processes of the NHS – including the inspection processes of the Care Quality Commission (CQC).

Language and terminology

The process of the review has highlighted the lack of consensus and a wide divergence of views in even some of the most fundamental terms involving the chaplaincy guidelines. These include things like the agreed-upon definitions of
religion, pastoral care, faith, chaplaincy and spirituality – and how minority faiths and belief/non-belief groups are accommodated within these definitions within the context of equality, diversity and inclusivity.

Therefore, in the shaping of the following recommendations we have attempted to be inclusive and appropriate in the use of certain terminology associated with the phrase “chaplaincy” – in order not to offend or undermine or under-estimate those diverse views.

Summary of the key findings of the survey

As mentioned above under the review process, in addition to the engagement activities, NHS Employers also undertook an online survey. The following is a summary of the key findings from the survey:

A total of 252 responses were received, including from NHS staff, volunteers and patient representatives. The responses covered different types of NHS Trusts and organisations, spread across eight regions in England. Acute trusts (specialist and non-specialist) were heavily represented in the data, with 58.73% of responses coming from that sector. The lowest responses came from the Clinical Commissioning Groups and Ambulance Trusts, which only had 3 responses each (representing 2.38% of total responses).

Key themes reflect a convergence around the language used in the guidelines and other barriers to its effective implementation. These are detailed below:

a. **Perception of non-inclusion:** There was a sense that the religion-based roots of chaplaincy may be preventing non-religious patients and service users from even considering chaplaincy services. In addition, there was also a strong view that the term “chaplaincy” was closely associated with the Christian religion – and that this may also be preventing those from minority faiths and belief/non-belief groups from considering using those services. The language of the guidelines was also felt to put emphasis on religiosity rather than spirituality and pastoral care. An example given was that part of the guidelines state that ‘it is important to note that some people who do not belong to a religion or belief can also access and fully utilise chaplaincy services’ – which some felt could be regarded as non-inclusive because it portrays faith-based service as the default, with spirituality and pastoral care as additional services that could be accommodated. Free text analysis revealed this position to be common place in practice.

b. **Time constraint:** There was a common belief that limited time was allocated to chaplaincy support. The current practice of calculating time allocation on a ratio basis was argued by some to result in a shifting of focus from a person-centred approach to a box-ticking exercise.

c. **Inconclusive data on patient data:** There was a thread throughout the survey of people feeling that the guidelines are unclear as to whose responsibility it is to record and audit patients’ religious, pastoral and belief information. Due to the lack of ownership, such ambiguity could affect the pursuit of accurate data on patients’ belief and religious (or not) inclination. There was also a feeling that where accurate data is obtained, the smooth transfer of this information to
chaplaincy services, even on patient request, could arguably be prevented or hindered by the Data Protection Act – and other related regulations.

d. Chaplaincy Guidelines: knowledge of content and strategy: Regarding a general understanding and implementation of the NHS Chaplaincy Guidelines, the data revealed that a large number of respondents had limited knowledge of document content and implementation strategy. On the question of how confident respondents were that their organisation had integrated key findings from the equality analysis document, 61.66% of respondents, were clearly not confident, on whether there existed an action plan or strategy to support mainstreaming of the guidelines – with only 36.84% respondents answering ‘Yes’. In addition, 49.62% had no knowledge of whether the work on the guidelines was integrated as evidence as part of the Equality Delivery System (EDS2).

e. Chaplaincy Guidelines: the individual and the organisation: Data in this section reveals the guideline has had a positive impact on organisations and other stakeholders, such as staff, patients and other service users.

f. Patient and service user care: equality, safety and compassion: 80.17% respondents, agreed that the existing provisions on patient care contained in this section of the guidelines were in accordance with best practice.

g. Staff organisational support: informed, competent, critical: 81.90% respondents agree that provisions of the existing guidelines on staff religious and pastoral care, is in accordance with current best practices.

h. Key components for an effective chaplaincy service: 80.70% of respondents agreed that the existing guidelines provisions on key components necessary for an effective chaplaincy, was in accordance with current best practice.

i. Chaplaincy volunteers: 85.09% of respondents agreed that the provisions of the existing guideline were in accordance with current best practice.

j. Chaplaincy service staffing: 75% of respondents agreed that the guideline’s provisions on general staffing ratio and the record and audit of users’ religion and beliefs, were in accordance with current best practice.

k. Chaplaincy in acute care: 69.64% of respondents agreed that provisions of the existing guidelines on staffing requirement and time allocation within this area of chaplaincy care, is in line with current best practices.

l. Chaplaincy in mental health care: Addressing this question on staffing requirement and time allocation in a mental health setting, 70.64% of respondents agreed that provisions of the existing guideline are in accordance with current best practices.

m. Chaplaincy in GP services: 66.97% of respondents agreed that the provisions in this section as it relates to staffing recommendations for primary care chaplaincy, including maintenance of a clearly defined process for patients and other users to access the chaplaincy are up-to-date

n. Chaplaincy in palliative care units: 73.58% of respondents agreed that the provisions of the section – as pertains to staffing, chaplaincy support for patients and their families, and chaplains’ administrative responsibilities – are in line with current best practices.
o. **Chaplaincy in paediatrics units:** 77.36% of respondents agreed that the guideline’s provisions – for enhanced training to enable chaplains in this context provide support to patients and their families and staffing to be in accordance with specialist palliative care – are in line with current best practices.

p. **Chaplaincy & Information Governance:** 77.67% of respondents agreed that the provisions – as it relates to the request and management of patient and user spiritual and pastoral data – is in accordance with current best practices.

q. **Chaplaincy & Research and Development:** 83.50% of respondents agreed that the provisions of this section, on the training and development needs of chaplains, is in line with current best practices. Only 16.50% were not in agreement.

**Recommendations**

This paper reflects the findings from the series of activities that were undertaken to support the review of the guidelines. The activities systematically reviewed each section of the 2015 guidelines.

Therefore, the recommendations that are set out in this paper will follow the same approach and provide **specific recommendations for each section of the existing guidelines** as outlined below:

- Introduction
- Patient and Service User Care: equality, safety and compassion
- Staff and Organisational Healthcare Support: informed, competent & critical
- Key Components for an Effective Chaplaincy Service
- Volunteers in Chaplaincy
- Chaplaincy Staffing
- Chaplaincy in Acute Care
- Chaplaincy in Mental Health Care,
- Chaplaincy in General Practice
- Chaplaincy in Specialist Palliative Care
- Chaplaincy in Specialist Paediatric Care
- Chaplaincy in Community Care
- Information Governance
- Training, Development & Research

In addition, this paper will also include **general recommendations** including addressing key equality considerations as follows:

- Continue to Integrate equality analysis within future revised Healthcare Chaplaincy guidelines and wider chaplaincy provision
- Mainstreaming Healthcare Chaplaincy Guidelines within existing NHS enablers such as the NHS Equality Delivery System, Quality Accounts and CQC standards
- Promoting the importance of service improvement, staff and patient voice within the Healthcare Chaplaincy Guidelines
Finally – and considering the recently published Long Term Plan - this paper will also outline **recommendations for system** leaders (e.g. primarily influential bodies who could act as key **enablers** in the system) who could help take forward a revised version of the 2015 guidelines. This will include reference to the following key bodies:

- NHS England
- NHS Improvement
- NHS Employers
- NHS Business Authority & Electronic staff records (ESR) team
- Care Quality Commission
- Health Education England (HEE)
- Healthcare Chaplaincy Forum for Pastoral, Spiritual and Religious Care forum)
- Network for Pastoral, Spiritual & Religious care (network)
- UK Board of Healthcare Chaplaincy
- College of health care chaplains
- Association of Hospice & Palliative Care Chaplains.
- Patients Association
- Healthwatch
- National Voices
- Faith action
- VCSE Health & Wellbeing Alliance
Recommendations

Specific recommendations for each section of the 2015 guidelines

1. Introduction section of the 2015 guidelines

a) What's in a name / title?: A clearer and broader understanding of the term ‘chaplaincy’ and the role of chaplains is required. Despite the 2015 guidelines seeking to promote inclusion by expanding previous definitions of chaplaincy, the term still appears to have a strong religious connotation, closely associated with Christianity. With the constantly growing number of people that identify as non-religious and / or from minority faiths or beliefs – as shown in the equality analysis document – there is an increasing chance that more people would be excluded from accessing the service because of the religious connotation attached to the word chaplaincy. In addressing the same matter, NHS Scotland replaced the word chaplaincy with the more inclusive ‘spiritual care’. NHS England should consider undertaking further consultation around changing the title of the proposed revised guidelines to a title that better reflects the role and duties of a modern service that aims to meet patient and staff pastoral, spiritual and religious needs e.g. Pastoral, Spiritual & Religious Care Guidelines. In addition, consider the alternate argument that any future guidance which is meant to apply to the chaplaincy profession, needs to retain the name of the profession, however it also needs to address the breadth of what chaplaincy engages in, such as cultural care and existential care which are hardly mentioned in 2015

b) Distinguishing between the delivery of chaplaincy and chaplaincy as a profession: The new guidelines needs to be clear when it is discussing the chaplaincy profession and when they are discussing the delivery of chaplaincy and religious spiritual and pastoral care to staff and patients.

c) Chaplaincy and continuing professional development (CPD): It is recommended that the introduction includes a strong commitment to supporting the continuing professional development of chaplains and how such interventions can contribute to the healthcare team’s professional education, training and research programmes. Future guidelines should also highlight the key role that learning development, organisational development and human resource management specialists can play in the CPD of chaplains or associated roles and how the chaplaincy department functions.

d) Chaplaincy and endorsement: Future recommendations should include the need for NHS organisations to have in place clear and proactive procedures and processes around how they endorse chaplains through their respective faith communities This includes clear statements in relation to issues such as defining objectively terms like ‘good standing’.
e) The aim should be to help to ensure that this process is not unduly complex. Again, learning development, organisational development and human resource management specialists could and should play a key role in supporting this area of work.

f) **Inclusive language and practice**: It is recommended that the revised guidelines and language is inclusive - recognising the Christian based roots of chaplaincy but equally recognising the interests of people from minority faiths or non-religious faiths or beliefs who would might prefer terminology that references (for example) spiritual and pastoral support. Therefore, the title of any future revised guidelines and content should reflect the needs of everyone i.e. pastoral, spiritual and religious. Feedback indicates that future guidelines need to consider being increasingly person-centred as opposed to religion-focused. This highlights the importance of expanding the training of individual chaplains to cover pastoral, spiritual and religious care, where possible. Currently, however, the guideline is more focused on taking incremental steps towards inclusion through an acknowledgment of the support for non-religious patients and users – rather than taking active steps to limit the differences amongst chaplains and promoting versatility and flexibility. At the same time, it must be recognised and acknowledged that there is a tension between the move towards generic working where roles are focused on professional care irrespective of religious belief affiliation and an attempt to match the demographic of patients and local communities. Critical to all of this is how chaplaincy becomes understood as a service for people of all faiths and beliefs - and guidance on how organisations can support this would be very welcomed and (in our view) strengthen any future document.

g) **Policy**: This section needs to be updated to reflect the wider focus on health care and not just the NHS in response to the wider integration of health and social care. In addition, the section needs to make explicit reference to the Long-Term Plan and the focus on:

a) Improving out-of-hospital care (primary and community services)
b) Reducing pressure on emergency hospital services
c) Delivering person-centred care
d) Not exclusive but a focus on mental health and well-being.
e) Digitally enabled primary and outpatient care
f) A focus on population health and local partnerships through ICSs

Chaplaincy has traditionally revolved around a large hospital context. The Long Term Plan includes an emphasis on primary medical and community services and this is likely to have an impact in terms of the chaplaincy models of the future

h) **Chaplaincy and staff health and well-being**: A reference to how chaplains can play a key role in the staff health and well-being agenda would provide a
strong statement that the chaplaincy service is there for staff as well as patients, carers and their family.

i) **Chaplaincy and equality:** An overriding principle of future revised guidelines should be reference and emphasis on the importance of reported compliance with the public sector equality duty as it relates to chaplaincy department. The duty covers age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation. In summary, chaplaincy department and - by default - revised guidelines should have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Future guidelines should include reference to the need to ensure that those who work on chaplaincy matters have the capability to look at and report on the impact of chaplaincy departments on people sharing the above 9 protected characteristics. They should also consider the need to avoid or mitigate against any negative impact on any group. The tool often used in the public sector to help this process - such as an equality analysis or equality impact assessment - should be highlighted, and NHS organisations should be encouraged to use / adopt them where appropriate. In addition, tackling health inequalities - as part of a wider focus on fairness and social justice – needs to be captured and recognised as part of the contribution of chaplaincy department in helping organisations to meet their duties under the Equality Act.

j) **Chaplaincy and safeguarding:** Feedback and discussions highlighted: the key role chaplains and chaplaincy departments can play in terms of safeguarding and promoting the welfare of children and young people and protecting vulnerable adults at risk from abuse or the risk of abuse. In addition, the review process also highlighted the important role chaplaincy departments play in the safeguarding and reporting of abuse - for example, abuse suffered by LGBT people linked to faith, or people accused of apostasy. This area has real synergy with the national work being undertaken in relation to endorsement and appropriate screening of chaplains by faith organisations.

(j) **Chaplaincy and complexity:** Future guidelines should advance greater awareness and understanding of the complexity and fluidity of a patient or staff members’ identity. Levels of observance and identification with specific religion or belief group practices may vary due to a variety of reasons,
therefore the emphasis should be on each person being treated as an individual.

(k) Out of area and general provision for people of minority faiths & belief/non-belief Groups: Feedback revealed provisions for people from people of minority faith & belief/non-belief Groups was increasingly reactive and referral led. This in turn also raises the question of quality assurance. It is therefore recommended that future guidelines encourage organisations to have clear procedures in place that outlines how they proactively plan and manage service provision to help support people of minority faiths & belief/non-belief Groups

(l) Guidelines and status: In the absence of the guidelines being mandatory future guidelines should consider outlining links with the Care Quality Commission’s (CQC) inspection regime in terms of how the CQC assess well led, care, effective, responsive and safe domains.

(m) Measuring impact: The chaplaincy department is a key business unit of an NHS organisation and reference to a tool such as the Patient Reported Outcome Measure of Spiritual Care would help organisations to be able to measure impact and support good practice – including minority faiths & belief/non-belief groups
2. Patient and Service User Care: equality, safety and compassion

a) Holistic care: The language of this section should be inclusive, patient and staff centred and reflect the language of the modern NHS and the need to stress patient/staff centred pastoral, spiritual or religious care.

b) Patient and staff friendly guidelines: Future guidelines should include a version that is both patient and staff friendly with the aim of making both parties aware of the role of chaplaincy and how using the service is all part of the staff experience or experience of care. This should include some guidance on the importance of using different and various communication methods and mediums to convey different messages to different audiences.

c) Policy: To give the future guidelines strength, reference should be made to how chaplaincy provision and practice supports the aims of the Long-Term Plan and contributes to the quality agenda.

d) Multi-disciplinary team working: Reference to working in teams across the organisation will help advance the key role of the chaplain and the wider team.

e) Spirituality and pastoral care: More emphasis should be placed on spirituality and pastoral care and the needs of those from minority faiths and belief/non-belief groups.

f) Out of area minority faith/non-religious faith provision faith provision: Some reference should be outlined in the guidelines within this section of the need to have clear processes in place to cater for those from minority faiths and belief/non-belief groups. This relates to non-Christian beliefs in general – and is particularly pertinent when patients are out of area with little or no access to religious or non-religious services they would have received nearer to home.

g) Safeguarding procedures: Future guidelines should include some reference as to how chaplaincy departments could play a role and better exercise its duty of care in safeguarding and promoting the welfare of children and young people and protecting vulnerable adults at risk from abuse.

h) Measuring impact: To measure impact and better demonstrate added value, chaplaincy departments should be encouraged to adopt patient reported outcomes measures.

i) Equality and inequalities: Explicit reference should be made to the need for advancing equality and addressing inequalities of access and chaplaincy provision in line with the Equality Act (2010) as demonstrated in the equality analysis that underpins the 2015 guidelines and any subsequent analysis. The above Act helpfully explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
• Recognising and taking action to encourage more civic engagement with minority faiths and belief/non-belief groups thus addressing possible provision that may be disproportionately low.

3. **Staff and Organisational Healthcare Support: informed, competent & critical**

   **(a) Role definition:** The role of the chaplain needs defining in the guidelines and terms such as “multi faith chaplaincy”, “faith-based chaplaincy” and “generic chaplaincy” also need to be defined.

   **(b) Chaplaincy department and definitions:** Future guidelines should include definitions of: pastoral care, spiritual care, religious care, multi faith chaplaincy, faith-based chaplaincy and generic chaplaincy. In addition, an attempt should be made to provide some support to help define terms such as “religion or belief”, “minority faiths”, “non-religious” and “humanist” or minority faiths & belief/non-belief groups

   **(c) Locating chaplaincy and influence:** The present guidelines state that the chaplaincy departments should sit alongside allied health professionals or similar clinical groupings. It is recommended that organisations should be encouraged to locate chaplaincy as part of the nursing and patient experience directorate and that a board level champion should take corporate responsibility to ensure maximum influence.

   **(d) Chaplaincy competency and endorsement procedure:** This section should include an outline of general competency requirements and models that organisations could adopt for chaplaincy staff in relation to the endorsement procedures of those bodies with responsibility for sanctioning chaplaincy appointments.

   **(e) Promoting ethical and reflective practice:** Reference to ethical practice and how this guides decision making and the importance of supervision and time for reflective practice should be considered.

   **(f) Service improvement and chaplaincy development:** The role of the chaplain should be strengthened through knowledge and application of service improvement methods to support the quality and improvement agenda as well as wider research addressing the role chaplaincy can play is both patient and staff health and wellbeing.

4. **Key Components for an Effective Chaplaincy Service**

   **a) Business planning:** Basic reference to key business tools such as business planning, budgeting, staffing and evaluation in this section will support better practice

   **b) Variations in set up and practice:** The model of effective modern-day chaplaincy defining its purpose and value should be highlighted to help determine what ‘good looks like’.

   **c) Recruitment and selection:** An outline of the need to undertake a recruitment process that meets the demographic of the population the trust
serves and encourages the HR department to be part of the recruitment process should be emphasised. This includes the need for an equality analysis. In addition, more detailed direction should be provided to support HR in the recruitment process for chaplains. For example, a clear direction on steps for the chaplaincy accreditation process. An obvious link needs to be made with the work of the Professional Advisors panel and the advice and support they can provide HR department from the start of the recruitment process and selection.

d) **Research and practice**: Recent publications that have reviewed chaplaincy could be included to provide information and support:
   - C Swift. *Hospital Chaplaincy in the Twenty-first Century.*
   - C Swift, M Cobb, A Todd. *A Handbook of Chaplaincy Studies.*
   - D Savage. *Non-Religious Pastoral Care.*
   - J. Bryant, *The Integration of Minority Faith, Groups in Acute Healthcare Chaplaincy*

   e) **Chaplaincy development**: The continuous professional development of chaplaincy should be highlighted.

f) **Equality**: This section should reaffirm again the importance of compliance with the Equality Act 2010 as detailed above in section 1 (e) and the ability of a chaplaincy department to be able to demonstrate compliance annually.

g) **Relationships with wider workforce**: Reference should be made to the increasing need for chaplains to work as part of multi-disciplinary teams.

h) **Standardisation and value**: Reference to the CQC standards may support chaplaincy departments to demonstrate added value - particularly in terms of how chaplaincy supports the safe, effective, responsive, caring and well led domains of the CQC inspection framework.

i) **Measuring practice and adding value**: Reference to the work on the *Patient Reported Outcome Measure of Spiritual Care* would help organisations measure impact and support good practice.

j) **Annual report**: A chaplaincy department should be encouraged through future guidelines to develop an auditing process and communicate an annual report demonstrating and evidencing practice and value. This reflects data which suggest that implementation of the guideline provisions may be low due to the absence of accountability.

5. **Volunteers in Chaplaincy**

   a) **Training volunteers**: The training available on appointment, induction and further development and refresher training should be referenced including shadowing and other forms of personal development.

   b) **Diversity of chaplaincy volunteers**: Reference should be made to the need to be mindful and to take active steps to ensure diversity of chaplaincy volunteers in line with local population demographics as not the only solution but part of the solution. Where appropriate, endorsement should be sought from the relevant religion or belief community with reference to appropriate screening and endorsement procedures and taking on board safeguarding requirements.
6. **Chaplaincy Staffing (Acute Care, Mental health, General Practice, Specialist Palliative Care, Specialist Paediatric Care, Community Care)**

   (a) Further discussions should be undertaken addressing the use of a formula-based approach to staffing levels. Other approaches should also be considered - for example, staffing levels based on evidence from local conditions. The present guidelines do not reference 7 days working or on call arrangements. The review provides an opportunity to promote 24/7 chaplaincy provision and local agreements.

   (b) Evidence from discussions has indicated the need to clarify the differences in understanding in the terms ‘Community Healthcare Chaplaincy’ and ‘Chaplaincy in General Practice’.

7. **Information Governance**

   a) **Data collection and accuracy**: The revised guidelines need to reaffirm the importance of regular data cleansing to ensure greater accuracy.

   b) **Access to patient data**: A clear statement on the need for chaplains to have access to patient data to help them provide appropriate support should be considered. It should be noted that an information governance guidance document has now been published. This document should provide clarification on access to patient data.

   c) **Effective referral and consent**: A pathway outlining the process of an effective referral process including training required and consent to accessing data should be considered with obvious GDPR requirements.

   d) **Caldicott provision**: Reference to this in the new guidelines and the role of chaplains should be considered.

   e) **Chaplaincy and lone working**: future guidelines should encourage consideration of chaplains who operate as lone workers and appropriate frameworks and standards should be highlighted to support NHS trusts.

8. **Training, Development and Research**

   a) **Learning and development**: The guidelines should consider reference to the key role of learning and development departments and their responsibility to support the chaplaincy workforce.

   b) **Research**: Opportunities to integrate chaplaincy provision within research per se should be encouraged as well as a commitment for specific research on chaplaincy.

**General recommendations**

In addition, the following are general recommendations including addressing key equality considerations as follows:
9. Supporting the development of a modern & diverse chaplaincy

k) Distinguishing delivery & the chaplaincy profession: The new guidelines need to be clear when it is discussing the chaplaincy profession and when they are discussing the delivery of chaplaincy and religious spiritual and pastoral care to staff and patients.

l) Re-write of the future guidelines: It is recommended that responsibility for the revised guidelines remains with NHS England and the task is undertaken working closely with the key partners and stakeholders who have helped shape these recommendations.

m) Future chaplaincy models: Support should be provided to help diverse parties to address the future model of chaplaincy in line with the NHS Long Term Plan and the latest research and practice. This is so important if an inclusive service is to be developed, which responds the changing needs of today. In addition, alignment with models in Scotland Wales and Northern Ireland should also be a clear consideration, as we may get to a point when chaplains are not able to move freely between the countries because of the diversification of understanding of the profession.

10. Integrating equality analysis and wider chaplaincy provision

a) Developing capacity: Consideration should be given to providing opportunities to develop awareness, understanding and the applicability of equality considerations and diversity and inclusion within chaplaincy practice.

11. Mainstreaming/action planning and the Healthcare Chaplaincy Guidelines

a) Joint working: Consideration should be given to how we can better promote and advance closer working between chaplaincy departments, line managers, HR departments and learning development specialist and service/quality improvement leads. This joint working should focus on HR practice such as for example job descriptions of members of chaplaincy departments, continuous professional development/endorsement and addressing key processes such as referrals and good governance.

b) NHS Equality Delivery System, Quality Accounts & CQC standards & NHS Long Term Plan: Opportunities should be provided to develop awareness, understanding and the applicability of chaplaincy and how it can provide evidence to support the organisations responsibilities under EDS2, Quality Accounts and CQC standards and the NHS Long Term Plan.

Finally, the following recommendation target key enablers in the system who could help take forward a revised version of the 2015 guidelines.
12. Recommendations for system leaders

a. **Joint endorsement**: To support the system to “own” and take responsibility for the future revised guidelines, it is recommended that the following key systems / system leaders are asked formally to support the new guidelines and promote their use in their work and the work of those they represent and support:

i) **NHS England / NHS Improvement**: Continue to raise the profile of chaplaincy provision and continue to support the link between chaplaincy, patient experience, staff experience and equality, diversity and inclusion. Focus in particular on influencing the role of chaplains but also how chaplaincy is delivered.

ii) **Integrated care systems**: The introduction of integrated Care Systems (ICS) provides an opportunity to look at ways of looking at chaplaincy provision and future guidelines and way of working, collaboratively, between a range of health and social care organisations, to help improve people’s health through chaplaincy provision.

b) iii) **Patients Association, Healthwatch, National Voices, Faith Action and any other partners**: Patient led organisations and champions for people who use health and social care services can use their remit and reach to help shape and communicate any future guidelines. In addition, these organisations should be encouraged to advocate the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

c) iv) **Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance**: The Voluntary Community and Social Enterprise (VCSE) Health and Wellbeing Alliance (HW Alliance) is a key element of the Health and Wellbeing Programme. The HW Alliance is partnership between voluntary sectors and the health and care system to provide a voice and improve the health and wellbeing for all communities.

d) v) **NHS Employers**: Use their role as the NHS representatives on workforce to ensure the link between chaplaincy and health and well-being and use their remit and reach to engage with HR, learning and development specialists and equality leads across the NHS to raise understanding, awareness and capacity to carry out culture change. Work with NHS England / NHS Improvement colleagues to better integrate religion or belief considerations into mainstream workforce tools such as EDS2, WRES and WDES and patient focussed tools such as the SOM.

e) vi) **NHS Business Authority and Electronic Staff Records (ESR) Team**: Review the categories that are used to collect data on staff and their religion or belief.
f) vii) **Care Quality Commission**: Work with relevant parties to explore ways of integrating chaplaincy provision within the inspection regime.

g) viii) **Health Education England (HEE)**: Address the work already undertaken supporting chaplaincy work on endorsement, education and wider continuing professional development. This work has the possibility of contributing for example to HEEs work on education, end of life care, workforce strategy, volunteers and patient care.

h) ix) **Healthcare Chaplaincy Forum for Pastoral, Spiritual and Religious Care (forum) and Network for Pastoral, Spiritual & Religious Care (network)**: Both bodies can play a crucial role in addressing key areas of the guidelines as well as encouraging use and evaluation of the impact of the guidelines.

i) x) **UK Board of Healthcare Chaplaincy**: The board has a crucial role integrating future guidelines in terms of their role to develop professional standards of practice.

j) xi) **Association of Hospice & Palliative Care Chaplains**. Represent hospice and palliative care chaplains seek to identify and promote good practice. In addition, be an agent of professional development, provide professional support and fellowship, promote links with the constituency of palliative care and promote links with relevant church bodies and faith communities

k) xii) **College of healthcare chaplains**: The college has a crucial role to promote the guidelines as part of their aim to promote the professional standing of chaplaincy and supporting their members, both nationally and within health and social care organisations.