

CHAPLAINCY COLLABORATIVES

Introduction and background

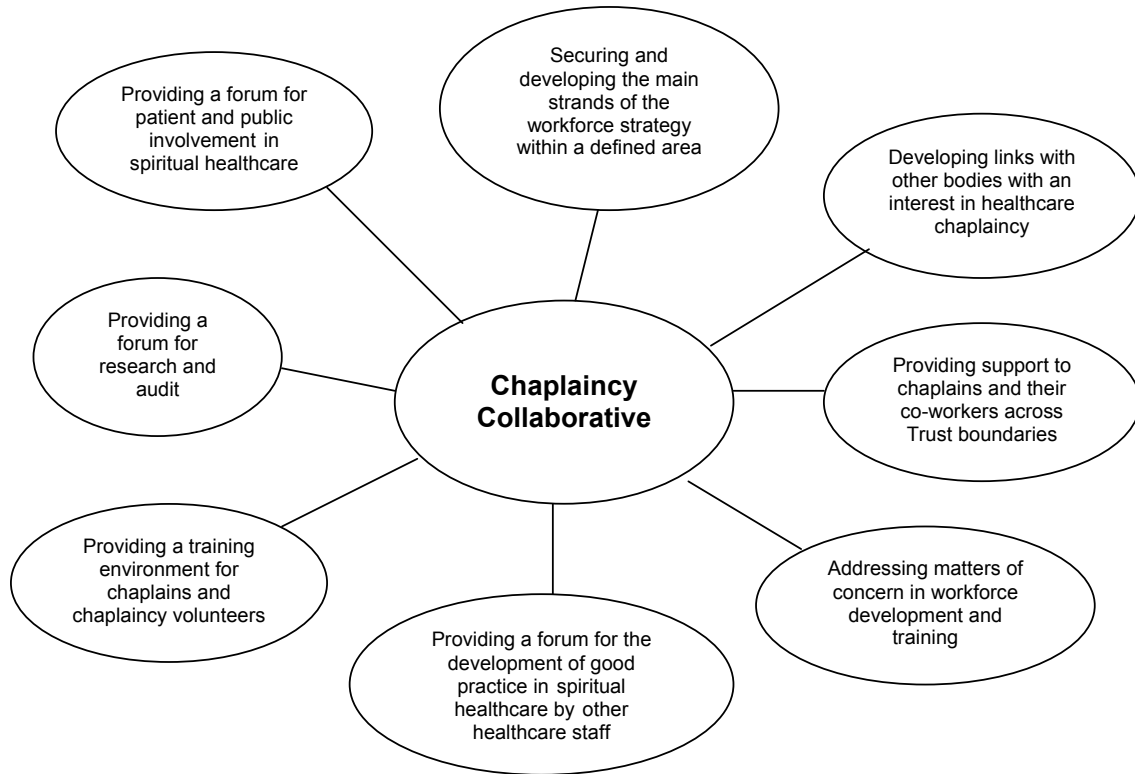
- 1 The spiritual healthcare modernisation agenda set out in the *Caring for the Spirit* workforce strategy proposed the formation of chaplaincy collaboratives as a means of supporting and securing the development of spiritual healthcare within the English NHS. This paper sets out this proposal in more detail so that chaplains and their management colleagues can be sure of the value which this proposal can bring.
- 2 The implementation of the workforce strategy offers opportunities to chaplaincy staff, and those who manage them, to plan ways in which a deepening awareness and understanding of spiritual healthcare could be provided and sustained within the spiritual healthcare workforce and among all healthcare staff. Such opportunities will involve the chaplaincy workforce in close collaborative working with other healthcare staff both in the workplace and in their respective training institutions.
- 3 Opportunities will also emerge for closer collaboration with the training establishments of the world faith communities in order that those who train 'ministers of religion' may consider a broadening of their training curriculum in order to provide for the vocation to healthcare chaplaincy. Additionally, given the increased emphasis upon patient and public involvement in NHS life at local and regional level, a consideration of how members of these significant groups could be included within the work of a chaplaincy collaborative is fitting.

The purposes of a chaplaincy collaborative

- 4 The purposes of a chaplaincy collaborative are to provide support and facilitation to aspects of the development agenda for spiritual healthcare including the following:
 - Providing the means of securing and developing the spiritual healthcare modernisation agenda within a defined and agreed area such as an SHA or PCT.
 - Providing a forum in which audit and research (*Caring for the Spirit* paragraph 62, 63), and education and training (paragraph 111, 122) can be enabled by a wider body of expertise and experience across Trusts.
 - Providing a forum for the development of good practice in spiritual healthcare, its understanding and its provision by all healthcare staff.
 - Helping to ensure progress in addressing matters of concern in workforce development and training and assuring occupational standards in each health and social care area (*Caring for the Spirit*, paragraph 131).

- Developing linkages with educational providers and faith organisations and with other chaplaincies to resolve problems which require a larger critical mass and greater expertise than that found within individual Trusts.
- Providing a training environment for trainee chaplains and chaplaincy volunteers using locally and nationally agreed training resources
- Providing a forum for patient and public involvement in relation to spiritual healthcare where that interest is raised by a forum which is local and not intrusive.

5 These ***purposes of a chaplaincy collaborative*** are summarised in the diagram below



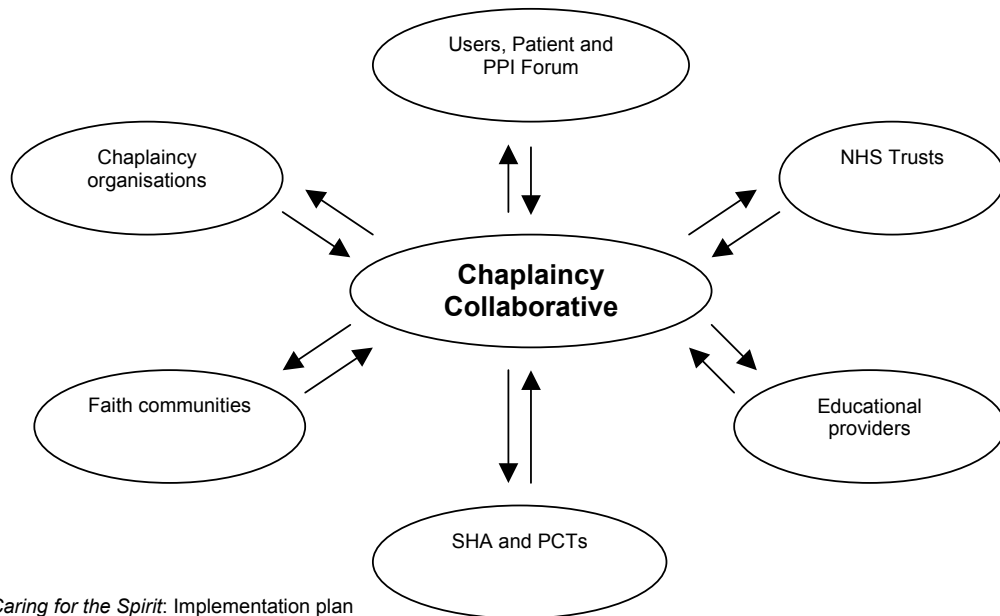
Size of a chaplaincy collaborative

- 6 While the workforce strategy did not define the size of a collaborative, discussions undertaken by the Lead Chaplains indicate that there is merit in considering the span of a collaborative to echo that of an SHA in order to encompass as many different chaplaincies as possible.
- 7 There are already some groups of chaplains which refer to themselves as a chaplaincy collaborative. In the main such groups are interest groups providing a forum for mutual support and the sharing of some good practice. Some of these groups have a dual role by being a regional section of the College of Health Care Chaplains. None of these forums involves any of the stakeholders mentioned above. While some extend over a large area many are small groups of chaplains who come from just a few Trusts and who represent a particular type of chaplaincy e.g. those working within Acute Trusts.
- 8 Mental health chaplaincy is not well represented within these informal forums, although chaplains within mental health tend more naturally to group together for support and the sharing of good practice. It will be clear from this paper that chaplaincy collaboratives will be very different in membership, role and task from the chaplaincy 'interest' groups, extending the interest and partnership beyond the present framework of the chaplaincy workforce.
- 9 The proposed SHA size will be a significant factor in funding bids made via the Workforce Development Directorate. It would also harmonise with the SHA/ WDD strategic role, creating for the first time the opportunity to develop an area-wide strategic agenda for spiritual healthcare. There would also be opportunities to develop links with the AHP/ Therapies workforce who are already represented at this level.
- 10 In some of the more dispersed areas, a smaller collaborative (PCT span) might also be viable. This might present a more local ethos which will be attractive to some but there might be insufficient numbers of chaplains to maintain viability in relation to the various purposes of a collaborative cited above.
- 11 Those groups already in formation, and attending to such matters as good practice, research, training programmes etc could become collaboratives, thus preventing unnecessary duplication of meetings. However it will be important in these circumstances to seek to widen the membership of such a group to include a greater diversity of chaplains from different types of Trust.
- 12 Chaplaincy collaboratives need to be robust in terms of size and span and also viable in terms of accessibility. Given these parameters, varying sizes of chaplaincy collaborative will be possible reflecting local/regional constraints and conditions. However, it will be essential for all the components of a chaplaincy collaborative to be present in each case.
- 13 While this new pattern for chaplaincy collaboration is far larger than anything with which chaplains have worked hitherto, a crucial emphasis is that the work (i.e. the spiritual healthcare modernisation material) is owned by healthcare chaplains as a means of change, development and service provision. It is expected that every chaplain should be able to take part in a chaplaincy collaborative although chaplaincy teams might choose to send representatives on an interest/rota basis.

- 14 In addition it is appropriate for the collaborative to be afforded recognition of and authority for its role and task by the SHA, thus assisting in the raising of the profile of healthcare chaplaincy in each area and securing the work in each area.

Characteristics of a successful chaplaincy collaborative

- 15 The workforce strategy and the discussions to date suggest several characteristics which together will help collaboratives be successful.
- The collaborative is built on a geographical area which encompasses a range of chaplaincies sufficient to sustain a training programme both academically and experientially. Following NHS boundaries is logical in order to coincide with development initiatives, funding streams and to ensure coherent approaches to holistic services.
 - Trusts and SHAs recognise and authorise collaboratives as a significant part of the professional development of the spiritual healthcare workforce. This development activity is thus seen as derived from the NHS’ investment in quality and can be managed within established WDD frameworks and other best practice.
 - The establishment of collaboratives is lead by the Lead Chaplains for the *Caring for the Spirit* NHS Project with membership of collaboratives drawn from a wide base including colleagues from other bodies who can support the developments taking place.
 - The collaborative faces inwards towards the Trusts and the chaplaincy services and outwards to the faith and academic / educational communities at local and regional level. Chaplains already work across boundaries into local faith communities and collaboratives will be likely also to match this.
- 16 The **network of relationships engaged in by chaplaincy collaboratives** is summarised below:



- 17 Collaboratives will be characterised by the following behaviours and outputs:
- Increased security and confidence arising from the formal recognition of the purposes and role within the SHA.
 - Progressive sharing of good practice among a greater diversity of healthcare chaplains matched by
 - Greater cohesion and consistency in the training of all chaplains and chaplaincy volunteers.
 - Improved support to the members of the spiritual healthcare workforce both mutually and in their developing links with the WDD for national workforce issues, training and development.
 - Better levels of communication and engagement with the health community will follow the involvement in this initiative by academic and training institutions for other healthcare staff.

Structure, Membership and support

- 18 A plenary structure (with a Convenor) lends itself well to this task with a regularity of meetings, say, every 2 – 3 months. The work will be closely focussed on topics and on topic groups thus allowing for specialty interests. It will be necessary to establish terms of reference to facilitate the work of the collaborative.
- 19 Membership is open to all who might be interested although this will be predominantly chaplains, other members of the spiritual healthcare workforce, other healthcare staff, and others working with partnership bodies.
- 20 The Workforce Directorate could be approached to fund a small amount of secretarial time in support of the Convenor.

Conclusion

- 21 Chaplaincy collaboratives provide a flexible and appropriate mechanism for supporting the development of chaplains and the modernisation of spiritual healthcare. SHA support for this approach indicates that the NHS is confident that this development can be fostered successfully.

Caring for the Spirit Project Team

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