

Caring for the Spirit NHS Project
Workstream on the future shape
and structure of spiritual healthcare

WORKING PAPERS

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July 2007

A Background

1. Each of the nine major world faith communities is represented in the *NHS* community, whether as health-care professionals or as patients. The provision of chaplaincy is seen by these faith communities as part of the support and pastoral care of those who adhere to their particular expressions of faith and a link with the communities from which they have come. The primary emphasis of chaplaincy in the *NHS* is therefore pastoral, spiritual and religious care and is not evangelistic.
2. Modern practice in the *NHS* sees the welfare and care of both patients and staff in a holistic context where spiritual, mental and physical health are interwoven and interdependent. The provision of chaplaincy has historically been seen as part of the response of the *NHS* to this holistic approach.
3. It is also the case that patients who claim neither to profess nor practise any religious faith can, at times of personal vulnerability, find themselves faced with questions which challenge them to consider deep and ultimate questions about life and death or their relationships with loved ones. For staff, such questions have a significant impact on the essence of care within the relationship with the patient.
4. Though not a medical professional, the chaplain is uniquely qualified to accompany people as they navigate the uncertain territory in which they find themselves when confronted by illness, either their own or that of those for whom they care, and to comfort and support the bereaved. This is both challenging and rewarding for the chaplain who, like all other professionals in the *NHS*, is part of the total care that should be available to all users of the service.

Introduction

5. The purpose of this work is to provide guidance to commissioners about chaplaincy-spiritual care provided in healthcare settings
6. Chaplaincy-spiritual care has always been available to patients and staff in healthcare settings. Since the inception of the *NHS* in 1948, the provision of this care has become more developed and the Department of Health has issued guidance about such care from time to time. The most recent policy guidance¹ covers a range of topics but gives particular emphasis to the development of chaplaincy-spiritual care on a multi-faith basis¹.

¹ Currently, the understanding of multi-faith chaplaincy in healthcare is that it includes members of the nine world faiths i.e. Bahá'ís, Buddhists, Christians, Hindus, Jains, Jews, Sikhs, Muslims and Zoroastrians

7. With the development of the NHS along the lines set out in Commissioning a Patient-led NHSⁱⁱ, the traditional models and organisation of chaplains within hospital-based teams would benefit from review. In particular, the approach set out in the Local Hospitals Projectⁱⁱⁱ that services should be de-coupled from institutions suggests that service providers and commissioners need to reflect how best to offer and provide services which are patient-led².
8. In response to these challenges, the Caring for the Spirit project group based within NHS Yorkshire and the Humber established a small workstream group to consider the future shape and structure of spiritual healthcare. The group has been led by Revd Kevin Skippon, Chaplaincy Services Manager, Derby Hospitals NHS Foundation Trust and the membership is set out overleaf.
9. The group has met on several occasions between October 2006 and May 2007 at Derby Hospitals Faith Centre. Discussions have focused on developing a series of working papers to do with commissioning chaplaincy services including proposals for a new service model related to the new NHS.
10. Post May, the workstream group intends to prepare a draft guidance document for discussion with commissioners during the July/ August period.
11. In parallel, the group will undertake a listening exercise on this draft pamphlet during June-August with chaplains for whom the working papers will also be made available. This listening exercise will also seek to identify the challenges which implementation poses for managers and for members of the spiritual healthcare workforce.
12. A final guide to the commissioning of healthcare chaplaincy services will be completed and published in September 2007.

² Much benefit is derived by patients, carers and staff who do not initiate contact with chaplains. Proactivity (ad hoc encounters, "being there" etc) on the part of chaplains often results in effective and timely pastoral and spiritual care which if left to a purely patient-led model would not happen at all.

Membership of the workstream group

Rev Paul Bentley	Nottinghamshire County Teaching PCT (also providing links to the work being undertaken by Trent chaplaincy collaborative on benefits of chaplaincy)
Rev James Blackman	Derbyshire Mental Health Services
Rev George Cobb	Association of Hospice and Palliative Care Chaplains
Rev Peter Davey	Derbyshire County PCT
Revd Debbie Hodge	Free Churches Steering Group within CtE
Rev Martin Kerry	Caring for the Spirit NHS Project
Rev Fr Paul Mason	Guy's and St Thomas NHS Foundation Trust
Imam Abdullah Shahjan	Derby Hospitals NHS Foundation Trust
Rev Kevin Skippon	Derby Hospitals NHS Foundation Trust
Ms Geraldine Stamp	Derbyshire County PCT
Rev Mark Stobert	College of Health Care Chaplains
Ven. Robin Turner	Diocese of Southwell and Nottingham
Mr Tim Battle	Caring for the Spirit NHS Project

Rev Ken Wright (Cumbria PCT) provided links to the work being undertaken by the Cumbria chaplaincy collaborative organisation and policy.

Rev Peter O'Driscoll (Basildon and Thurrock University Hospitals Foundation NHS Trust) provided links to the work being undertaken by the East of England chaplaincy collaborative on value for money.

B What chaplains offer

How do we define this?

13. Healthcare chaplaincy resources all those activities which directly and indirectly provide pastoral, spiritual and religious care of patients and staff.
14. The key purpose of chaplaincy is to help individuals and groups in a healthcare setting to respond to spiritual and emotional need and to the experiences of life and death, illness and injury, in the context of a faith or belief system.^{iv} Chaplains have particular expertise in enabling others to access the resources of that person's particular religious/spiritual tradition.
15. Chaplains also have expertise in handling **the spiritual and existential issues** which often arise at times of crisis. Amongst these issues are the fears of an uncertain future or of impending death; loss of function or loss of independence; or the loss of a loved one. Sometimes, a crisis may cause people to question fundamentally their understanding of the universe and their place in it. Chaplains can help people to address these existential questions.
16. **Pastoral care** is usually considered as the ministry of care and counseling provided by pastors, chaplains and other religious leaders to members of their group (church, congregation, etc). In healthcare, however, this ministry of care is often given to a member of another group and to many who belong to no particular group. It is offered not only to patients and carers but also to staff.
17. **Spiritual care** is care given in connection with an individual's beliefs about their spiritual life and about their life journey. This approach assumes that all human beings are spiritual beings who have spiritual needs throughout their lives³. Spiritual care is provided irrespective of the recipient's personal conviction or life orientation.
18. **Religious care** is given in the context of the shared religious beliefs, values, liturgies of a specific faith community. Whilst spiritual care is not necessarily religious, religious care, at its best, is always spiritual⁴.

People with no religious affiliation

19. As indicated above, religious care is one aspect of the spectrum of spiritual care. Accordingly, chaplains spend most of their time with people who do not share their beliefs or who hold no religious affiliation. The most recent examination of chaplains' work^v concluded that work in spiritual care predominated over that in religious care.

³ Taken from the DH policy guidance 2003 page 6

⁴ Taken from *Guidelines on Chaplaincy and Spiritual Care in the NHS in Scotland SEHD, October 2002*)

20. Chaplains also work with members of and leaders of faith communities which are not within the nine major world faiths. The knowledge and skills required of chaplains undertaking this valued and personal chaplaincy service are sometimes underestimated. Examples would include serving as ambassadors for the NHS within local faith communities, and providing facilities for very small faith communities to support members of their community when in a healthcare setting.

Caring for the institution

21. Chaplaincy has responsibility for helping the institution it serves to reflect the thoughts and feelings of the whole organisation at times of disaster/ loss/ crisis and change/ celebration. Examples of this work include staff support, group facilitation, and special services or ritual for special occasions. This concept of corporate spirituality is noted in commercial business organisations also⁵.
22. Chaplains also have a role in evaluating and, where appropriate, challenging the moral and ethical implications of decisions and ways of working adopted in the healthcare organisation. This may involve, but is not limited to, working on ethics committees.

The unique role of the chaplain

23. The National Workforce Strategy for chaplains^{vi} states that chaplains are unique among health professionals in that their caring task primarily focuses upon religion and spirituality. Chaplains are experts in religious belief, knowledge and practice and have developed a deep understanding of spirituality and life's journey. Thus, chaplains engage with the diverse spiritual and religious needs of patients, carers and staff.
24. Chaplains have to deal with some of the most difficult human experiences that result from illness, injury and traumatic life experience. They are often uniquely placed to relate to people in these circumstances, to discern their needs, and to provide forms of pastoral care. Chaplains also nurture well-being, foster hope and support people through the transitions that accompany a period of ill health. Consequently within the health care team a chaplain can become a key professional for a patient and an important link with carers, other agencies and the wider community.
25. Chaplains are also representatives of their faith communities. They must therefore be learned in the ways of the faith community and knowledgeable about the basis for its decisions and guidance. In this aspect of their work, chaplains seek to embody the faith community's ethos and teachings appropriately.

⁵ Notably Leo Buscaglia 1972; Sharon Drew Morgan 2003; Barbara Heyn 2006; Sonia Stojanovic 2006;

26. An important adjunct to this role is the chaplain's ability to represent the spiritual and religious embodiment of faith for other people. This can lead the observer to project on to the chaplain their views and expectations which can be simple or complex, clear or confused, placid or angry. The chaplain is able to explore the spiritual needs of the individual in a meaningful and relevant way without compromising their integrity.

Chaplains as a resource to the healthcare organisation

27. In understanding the relationship of spirituality to health care, chaplains recognise that values, meanings and beliefs play an important role in the life and work of the health care organisation. This distinctive perspective enables chaplains to be a resource to the hospital/service as an organisation and provide insights into a wide range of issues.
28. Chaplains work throughout the organisation and move easily across professional boundaries. They are therefore in a position to be able to listen to the stresses and strains of the organisation, to be an affirming and supportive presence, and to be a powerful reminder of the vocational and ethical aspects of care.
29. The specialist education and training received by chaplains and their experience in working with people in challenging situations is a distinctive educational resource to healthcare organisations. Chaplains can contribute to training and development across staff groups and in a number of important subjects including communications, religious and cultural diversity, and bereavement care. In addition, chaplains offer placement opportunities to students; provide input into the academic work of a health care organisation; and collaborate in research programmes.
30. Chaplains provide effective links between the healthcare organisation and faith communities. They support the move to wider public involvement and representation in the NHS and enable the provision of services that are sensitive to the needs of particular communities. Chaplains can facilitate community-based pastoral care as many chaplaincies use trained volunteers from local faith groups.

C How chaplaincy-spiritual care is delivered to users

31. Chaplains deliver their service to users in four ways: as a therapeutic conversation on a one to one basis or with small groups; as a therapeutic presence during periods of tension/ crisis and stress; as a ministerial leader of formal rites and rituals, whether of their faith group's liturgy or of their own construction to meet particular needs; and through enabling others to meet spiritual needs in patients and carers.
32. Different chaplains work to different practice models and this will affect the emphasis within these three approaches.

Chaplaincy as therapeutic conversation

33. The assessment of spiritual needs is performed by visiting an individual or group, often after a formal referral either by the patient or by ward/ department staff. Usually, the chaplaincy department will have a system of ward and department visiting whereby patient referrals can be identified or collected. In smaller healthcare settings, these systems may be more informal and immediate.
34. The chaplain will respond according to the nature and urgency of the need. Several conversations of varying lengths may be necessary over a length of time which may extend for the patient's stay in hospital.
35. Conversations with staff users are either on a one to one basis or in support group settings. One to one discussions usually take place away from the work location and may address issues where the individual's personal life impinges on their work. Discussions in support groups deal with challenging clinical situations such as bereavement, traumatic incidents and external issues.

Chaplaincy as therapeutic presence

36. A physical presence can bring calm to a distressing situation and chaplains will assess whether their presence can be beneficial in tense and stressful situations. The chaplain offers an environment of care which transcends the purely material requirements of healthcare.
37. Some aspects of presence involve touching the patient. Those associated with rites and rituals are very significant in religious terms for the patient, the chaplain and the carers. A most obvious example is the rite of anointing used in Christian faiths which may also use the laying on of hands/ blessing/ prayer of healing. Both are intimate expressions of faith with which chaplains are experienced and expert.

Chaplaincy as therapeutic leadership of rites and rituals

38. Chaplaincy is also delivered through rites and rituals. Christian users may want “to pray, read from Scripture, take communion, worship, read the liturgy and/ or have the clergyman/ chaplain perform a recognisable rite for them or with them”⁶. The other world faiths also have rites and rituals for individual or group expression.
39. These rites and rituals may be undertaken on a one to one basis or within acts of communal worship. Regularity of worship will relate to user and clinical preferences and requirements, but most chaplaincy teams organise communal worship on a weekly basis. In addition, chaplains may devise appropriate rituals specific to the needs of the healthcare context, such as a service of Blessing and Naming for a stillborn baby.

Chaplaincy as therapeutic enabling

40. Chaplains are a small workforce within the NHS yet serve all patients and staff. Achieving such reach within organisations involves the leadership of an informal team of carers comprised of healthcare staff and lay volunteers. These healthcare staff provide spiritual care confidently and competently via direct training and by discussion and collaborative working provided by the professional chaplaincy.
41. In addition to the members of the wider spiritual healthcare team, chaplains also rely on the support of trained chaplaincy volunteers drawn from the faith communities locally. These volunteers are also trained and supported by the professional chaplain. Estimates in the 2002 survey of chaplaincies suggested that there were some 10,000 chaplaincy volunteers in the NHS.

Organisation and delivery of the chaplaincy service

42. In most Acute and Mental Health Trusts, chaplaincy services are led by a senior chaplain usually supported by a small team. In Primary Care Trusts, the provision is more irregular and no pattern is evident⁷. The number and range of chaplains is based on the faith profile of users in the Trust⁸. The majority of current chaplains are in Christian traditions with a small number of Jewish chaplains. There is a growing numbers of Muslim chaplains and small numbers of other world faith chaplains.

⁶ Taken from reference V

⁷ This finding emerged from the survey of PCT chaplaincies by the Lead Chaplains for the Caring for the Spirit Project in 2005

⁸ The current policy guidance (2003) which links bed numbers and religious adherence to chaplaincy requirements needs to be updated. Additionally, there is some evidence that chaplains in world faiths other than Christianity have not been recruited in accordance with these ratios.

43. Chaplaincy should be available over the full 24 hours. Currently, several Trusts have had to withdraw funding for out of hours cover and are planning to reinstate it over time.

D Chaplaincy – spiritual care standards

Standards for Better Health

44. The NHS does not yet provide chaplaincy in accordance with NHS standards.
45. The current NHS proxy is in development standard D2 as a standard for spiritual needs.

Patients receive effective treatment and care that conform to nationally agreed best practice, particularly as defined in National Health Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery; take into account their individual requirements and **meet their physical, cultural, spiritual and psychological needs** and preferences; are well-co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.”

46. Monitoring of adherence to this standard will be through the Healthcare Commission’s work on privacy and dignity.

Quality standards

47. The standards issued to NHS Bodies in 2006^{vii} by the Multi-Faith Group for Healthcare Chaplaincy were a comprehensive statement to match the NHS Standards for Better Health to chaplaincy-spiritual care. The standards are set out in clusters of related standards under headings including service delivery and training; care environment; food and dietary requirements; protection for children and vulnerable adults; consent and patient confidentiality; management and staffing; and audit and review.
48. The Multi-Faith Group has set out 32 standards which have been consulted upon with chaplains and chaplaincy bodies. The Multi-Faith Group intends to consult further with NHS Bodies once the current (2006-07) reorganisation of NHS roles and structures is completed.

Occupational and vocational standards

49. A statement of the occupational standards in healthcare chaplaincy was first published in 1993 on behalf of the Churches and chaplains and was updated in 2002. The standards are accessible at www.mfghc.com. This statement links into the Knowledge and Skills Framework published by the Department of Health as part of the agreement to *Agenda for Change*.
50. The occupational standards describe the performance expected in a given work role. Each of the components of a work role is described in terms of the outcomes that should be achieved, and the range of situations in which a competent practitioner would be expected to be able to perform. Finally, for each element, the knowledge which underpins satisfactory performance of the role is stated.
51. Trainers may use the statement of standards to design training which develops the competence of candidates in line with the requirements of the standards. Such training may be developed to enable candidates to learn or refresh skills or may cover knowledge-based aspects either about the standards or about factors which underpin them. Knowledge of the standards is thus essential for trainers and also for chaplains and their managers who determine training and development needs.
52. Managers may use the structure and content of the standards to develop an overview of chaplaincy work and the various roles and job descriptions within it. They will also be able to determine standards of performance and to appraise the performance of staff. The standards can also be used to identify development and training needs and to support recruitment and selection of candidates.

E Professional aspects of chaplaincy-spiritual care

53. Chaplaincy is not included amongst current healthcare professions although many chaplaincies are managed within the same framework as the allied health professions. The chaplaincy membership bodies are committed to a process of professional voluntary registration as the precursor to any statutory application⁹.
54. Chaplains are expected to adhere to their faith community's **code of conduct** for its priests and ministers. These codes are available from the faith communities themselves. Variants, which chaplains follow additionally can be obtained from the chaplaincy membership bodies¹⁰.
55. Chaplains are expected to work within the statement of **occupational/vocational standards** (available www.mfghc.com). This is a widely agreed document within chaplaincy and represents best practice in chaplaincy. These vocational standards relate directly to the NHS KSF but do not yet have the status of National Occupational Standards.
56. Chaplains are expected to undertake **continuing professional development** as part of their commitment to NHS life-long learning. The strategy which chaplains follow is that published in 2005 by South Yorkshire SHA^{viii}. Chaplains who are members of the chaplaincy membership bodies also undertake CPD in accordance with portfolio guidance issued by the bodies' Chaplaincy Academic and Accreditation Board at www.caabweb.org.uk/
57. In addition to the above expectations, chaplains need support and guidance in discharging their roles and responsibilities. This may include **spiritual direction** which is the process whereby some chaplains engage with and may be sustained in their own faith development; and may also include appropriate **professional supervision** whereby their individualised caseload is monitored and guided by a senior and experienced professional practitioner.

⁹ Letter from the President, CHCC, dated 26th February 2007

¹⁰ The College of Health Care Chaplains' code of conduct has been widely adopted as specific for healthcare chaplaincy.

F A new service model for chaplaincy

58. For chaplaincy-spiritual care to be delivered in a consistent and systematic way, reliable service models are required that are driven by user needs; enable best practice; are consistent with wider organisational structures; and are predicated on a realistic level of resources. These models need also to embody the flexibility inherent in the way chaplains and users may first interact.
59. Current practice in primary care, mental health and acute services healthcare chaplaincy¹¹ was examined to identify generally applicable **characteristics of the current service models**. These characteristics are tabulated below:

CHAPLAINCY PRACTICE \ CHARAC-TERISTICS	Primary care chaplaincy	Mental health and learning disability chaplaincy	Acute service chaplaincy
	Community and institution based	Community and institution based	Institution based
Caring for Patients	Some 24 hr bed-based care in community facilities including bereavement care, coupled with care for people at home. Providing some continuity of care for those discharged home. Emerging partnership with chaplains in secondary care. Increasing numbers of patients with long-term conditions and end of life issues within a home-based community setting.	Providing care in hospital wards, day hospitals, community residential facilities and various types of community mental health teams. Emphasis is given to multi-faith care and the constraints of a secular setting. Encouraging healthy and positive aspects of religion and spirituality in order to improve mental health. Concerned to avoid imposition of religious activity in people with learning disability.	Service focused in support of 24-hour care with shorter acute episodes. Significant emphasis on care to those facing challenges and crises arising from sudden onset ill health. Providing support through presence/ "being there" advocacy, enabling and encouraging spiritual health. Care given across traditions and across the world faiths locally. Support to patient experience group

¹¹ This examination has not included healthcare chaplaincy in relation to the prison medical service for which the NHS has recently accepted responsibility. Currently, it is assumed that chaplaincy in these institutions is provided by the Prison Service.

CHAPLAINCY PRACTICE CHARACTERISTICS	Primary care chaplaincy	Mental health and learning disability chaplaincy	Acute service chaplaincy
	Community and institution based	Community and institution based	Institution based
Caring for Carers	<p>Providing support (including bereavement support) for friends, and family affected by the patient's illness. Supporting staff providing aspects of spiritual care to community patients.</p> <p>Linking with community groups such as Hospice-at-Home, MacMillan Nurses etc.</p>	Input to service user and carer groups as necessary.	Developed service for carers includes support in times of crisis as well as advocacy and setting direction. Spiritual care includes increased exploration of religious dimensions to life.
Caring for Staff	Supporting staff in community-based institutions and in community-based teams where accessed.	Supporting staff working in relative isolation within the community. Supporting staff in supporting staff. There may be less emphasis on voluntary working in a mental health setting.	Included in Trust staff support structure handling personal and work-related issues. Providing safe, trusted and confidential support as well as advocacy, training and education.
Caring for the Organisation	Supporting corporate development. Weak formal linkages with GP services although referrals increasing. Maintaining sacred spaces as appropriate.	Involvement in emergency planning, ethics, working lives and diversity issues as necessary.	Providing support to corporate expression of loss, grief and emotion through events such as memorial services and also services of celebration. Engaging with equality and diversity issues. Providing ethical guidance and promoting spiritual care and well-being.
Caring for the wider community	Maintaining liaison with faith communities locally. Providing training for community-based volunteers and helpers including the introduction of healthcare pathways with voluntary and community groups.	Maintaining liaison between community mental health teams and faith communities	Providing liaison with local faith communities and "sharing the caring" with local ministers and priests. Ensuring Trust excellent public relations are maintained.

CHAPLAINCY PRACTICE	Primary care chaplaincy	Mental health and learning disability chaplaincy	Acute service chaplaincy
CHARACTERISTICS	Community and institution based	Community and institution based	Institution based
			Facilitating good community relations through the development of interfaith services and links with Social Services and local support organisations and charities. Looking outwards to develop partnerships.
Caring for Students	Teaching aspects of chaplaincy-spiritual care to community staff, chaplains and local ministers, local faith-based groups.	Educating and supporting community health teams about spiritual care.	Providing training and private tuition and support for personal and work-related issues. Providing access to library facilities, religious ritual and work experience.
Driver/ Determinant	Provider-arm of PCT.	Mental Health Trust	Foundation NHS Trust

60. The result of this consideration is the identification of the characteristics of the current service model for chaplaincy-spiritual care set out below:
- Primarily focused on the needs of patients and carers
 - Supporting staff working in healthcare facilities/ premises/ teams
 - Supporting the organisations of the NHS/ Faith communities
 - Working within the wider community to develop links with other local institutions for health, education and social care
 - Sustaining education and training for staff, students and partner organisations.
- What is lacking is clarity about who sets the agenda for this service.

The impact of commissioning

61. In line with common practice, chaplaincy services are not commissioned but are provided by Trusts and NHS Bodies in accordance with policy guidance (reference 1). This ratio-based approach is not as sensitive to local determination as other approaches and also views chaplaincy as a quality add-on rather than as part of holistic services incorporating mental, physical, spiritual and psychological need.

62. The new service model for chaplaincy therefore should capture the effective aspects of service as currently delivered but also should be commissioned locally in line with other health services. The differences are highlighted in the table below:

	Current Chaplaincy service model	Proposed chaplaincy service model
Determination	Provided in accordance with policy guidance and local agreements	Commissioned by PCTs with other healthcare services
Service area	Linked to healthcare institutions	Focusing on geographical areas and populations
Demand drivers	Related to ratios established in 2003	Driven by User and Patient experience
Educational framework	Developed according to locally identified needs and by chaplaincy engagement within the Trust	Related to curriculum development through HEIs
Research framework	Developed according to locally identified needs and by chaplaincy engagement within the Trust	Related to evidence base published in 2007

63. Changing the current service model to incorporate the commissioning aspects of the new NHS completes the proposed new service model for chaplaincy-spiritual care. A representation of this proposed new service model is included at the end of this paper.

Implementing changes in chaplaincy provision

64. The following steps are thought to be necessary to bring the new service model into being:
65. The SHA/ PCT commissioning the chaplaincy service identifies proposals for change and discusses these within the current NHS provider network and within the Church/ Faith Community network so that the proposals for introducing a new service model are understood and agreed. [Reviewing service provision, Inclusion within PCT Prospectus]
66. The SHA/ PCT commissioning the chaplaincy service resources and appoints a Commissioning Chaplain to advise on issues of implementation and to oversee the work associated with bringing the new service into being. [Designing Services]
- The Commissioning Chaplain establishes a peer group of chaplains and managers locally who can support the determination of the size and nature of the chaplaincy service; the standards to which it should work; and the educational framework to support the human resources deployed. [Shaping the structure of supply]

- The Commissioning Chaplain works with (and may need to establish) a forum for faith communities locally at which issues of spirituality, faith and religion can be discussed and differences resolved within a healthcare context. [Shaping the structure of supply]
 - The Commissioning Chaplain convenes a user forum comprised of chaplaincy users, chaplains, faith community representatives and local people with an interest in chaplaincy services to provide a focus for local determination of the nature and characteristics of the chaplaincy service. [Seeking public and patient views, Assessing needs].
67. The Commissioning Chaplain prepares a plan for chaplaincy which identifies the “products” to be provided agreed with chaplains; the staffing arrangements agreed with faith communities; the standards of the service agreed with the user forum; and the costings/ resource profile agreed with commissioners. [Deciding priorities]
 68. The new service commences from a date agreed by the parties involved. [Treatment/ activity]
 69. Arrangements for monitoring performance and progress are activated with the user forum to brief commissioners. [Managing performance]
 70. Appropriate changes are introduced to respond to feedback from performance management, user comment and peer review assessment. [Reviewing service provision]
 71. These steps fit with the commissioning cycle for health services included in Health reform in England - update and commissioning framework: annex - the commissioning framework published in July 2006.

G Chaplaincy-spiritual care products and output

72. Chaplains have not found it easy to describe their work in quantifiable terms. Although chaplains work in groups and communal settings, the majority of their time is spent in one to one discourse tailored to the individual for whom they are caring. There are outcomes from this work expressed as feelings and apparent in behaviours. Measuring these changes is currently imprecise.
73. Nevertheless, chaplains have sought to provide data about their work in accordance with guidance about the need for data^{ix}. This guidance is recent and its understanding and implementation by chaplains has taken time. The guidance is also about a minimum requirement and this has been aimed at the majority of the chaplaincy workforce which is part-time in NHS employment and not resourced for data gathering by the NHS.
74. Set out below are the results of a small survey of chaplains undertaken in order to find data which would allow a description of what they do in a typical week. Data was gathered from 15 different chaplaincies and averaged to show what that typical week comprised and what was done. This week is expressed in terms of the minimum data set and there are notes below the table which explain some particular aspects.

In a typical week Minimum data set category	Range from survey	Average value chaplains in acute services	Average value chaplains in mental health
Number and duration of initial episodes of spiritual care categorized as being either routine or emergency	2 – 32 initial episodes taking 1 – 7 hrs	25 initial episodes taking 5 hrs and 30 mins	8 initial episodes taking 5 hr 20 mins
Number and duration of continuing episodes of spiritual care categorized as being either routine or emergency	2 – 45 continuing episodes taking 2 – 11 hrs	23 continuing episodes taking 6 hrs and 20 mins	19 continuing episodes taking 6 hrs
Number and duration of religious services in ward/ prayer room/ chapel	2 – 12 religious services taking 1 – 6 hrs and 30 mins	8 religious services taking 3 hrs and 30 mins	2 religious services taking 2 hr 30 min
Number and duration of funerals ¹²	0 – 12 funerals taking 30 mins – 6 hrs and 30 mins	2 funerals taking 2 hrs and 10 mins	1 funeral taking 1 hr
Duration of time spent in multi-disciplinary team meetings	45 mins – 5 hrs and 20 mins	1 hr and 50 mins	1 hr and 50 mins
Duration of time spent "being there" categorized by location within the hospital/ setting	2 hr and 45 mins – 20 hrs	11 hrs and 5 mins	12 hrs and 45 mins

¹² It is likely that the shorter periods relate only to the taking of the funeral itself whilst the longer periods also reflect preparation time including pre and post-funeral visiting etc.

In a typical week Minimum data set category	Range from survey	Average value chaplains in acute services	Average value chaplains in mental health
Duration of time spent in training Trust staff not members of the chaplaincy department	15 mins – 2 hrs and 30 mins	1 hr and 5 mins	1 hr and 20 mins
Duration of time spent in activities categorized as continuing professional development	15 mins – 6 hrs	1 hr and 50 mins	1 hr and 35 mins
Duration of time spent in staff/ chaplaincy team meeting	30 mins – 4 hrs	1 hr and 40 mins	2 hrs and 20 mins
Duration of time spent travelling between sites	0 – 4 hrs	1 hr and 20 mins	3 hrs
Total hours recorded		36 hrs and 20 mins	37 hrs and 40 mins

75. Some caution is necessary about the data presented here. The sample is small and the range of data wide indicating that there needs to be further testing of the averages. At the same time, the averages themselves seem reasonable to those contributing data and to the small group of chaplains to whose work this survey was a contribution. No attempt has been made in this survey to categorise activity by location or in time frame and the survey did not cover “what was not done” i.e. the time between tasks and admin time generally.
76. The conclusions drawn from this data are only as strong as the data itself. In relation to this survey it is possible to conclude as follows:
- The chaplaincy working week is occupied by several different activities all of which relate to the health and well being of the users;
 - The majority of chaplaincy time (76-78%) is spent in direct delivery of spiritual care to users (initial and continuing episodes, religious services, funerals and “being there”);
 - There are differences in the pattern of the working week between those working in acute care and those in mental health.
77. The data about initial and continuing episodes reflect the urgent nature of acute services with an emphasis on initial diagnosis whilst in mental health the emphasis is on continuing care and less on an initial intervention. The average duration of an episode of care in acute services was half that in mental health (14 mins in acute compared to 28 mins in mental health) implying a significant difference in the nature of these episodes.

78. Although providing religious services is very important to both the user and the chaplain, it is a small part (10%) of the chaplain's time in acute and mental healthcare¹³. Less emphasis is given to collective worship in acute services than is the case in mental health. At the same time, chaplains in acute services may spend much of the "religious" time providing sacramental observance for users at ward level.
79. The amount of time spent on "religious" activity will vary between acute and mental health settings because of the view that religion and spirituality are linked positively and negatively to mental health. Thus, in mental health settings, exploring religious issues with patients is an important priority for the chaplaincy. There are other differences between chaplaincy in different healthcare settings not highlighted here.
80. Funerals remain a most important part of the care chaplains provide to users. In addition to the actual event, chaplains are intimately involved in planning the liturgy and discerning the families' views and feelings to this end. The funeral is often the end point in a relationship formed with users on admission or through a period of crisis during a hospital stay. Both staff and carers benefit enormously in the closure which this event provides for those affected by bereavement.
81. "Being there" is a purposeful activity reflecting the chaplain's sense of where their time is needed and the importance attached to "presence" by faith communities. It can include being present in ITU or A&E at times of pressure/ stress but also includes just being available within the office or near the chapel at times of crisis/ anxiety for the hospital. This is not purely the length of time that the chaplain spends at work nor is it a balancing figure to make up the total.
82. Chaplains do not work alone and rely on others to understand spiritual care and to deliver care on a routine basis. Such delivery requires education and training and this will encompass cultural issues as well as faith-based aspects. Chaplains educated overseas may also be involved in wider education programmes as part of the Trust's general approach to diversity.
83. As professionals in healthcare, chaplains give a significant part of their time to continuing professional development.
84. Inevitably, chaplains become involved in meetings, be they for team co-ordination, the planning of wider projects or as part of care planning within multi-disciplinary teams. This involvement is important for the contribution chaplains make in specialist spiritual care and also as support to those within the wider healthcare team who may provide spiritual healthcare throughout the day and night.

¹³ In a part-time PCT context, the provision of religious services takes up a much higher proportion of time because the weekly services still take as long whether the chaplain is working one day or a week or five. The proportion of an individual's time could therefore reach 20%.

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