

**Health Care Chaplaincy
and
The Church of England**

**A Review of the work of
the Hospital Chaplaincies Council**

February 2010

19 February 2010

To: The Rt Revd Michael Perham
Bishop of Gloucester

Dear Bishop Michael,

In the summer of 2009, in your capacity as Chair of the Church of England's Hospital Chaplaincies Council, you asked me to Chair a review of the Council and its current work. You were concerned that, in a rapidly changing context – in the Health Service, the Church and in society more widely – the church should be able to think clearly about its ministry and mission in the context of the National Health Service. You were also concerned at the long-standing tensions and antipathies between different bodies working amongst, and claiming to represent, health care chaplains. You asked me to assemble a small group to see what could be done to focus the church's resources on this work in more effective ways.

This has not been an easy task! The small review group has had to get to grips with the complexities and uncertainties of health care policy and the wider issues around the multi-faith and secularisation agendas. We have also been conscious that tensions amongst chaplains' organisations go back a very long way, which suggests that there are no simple and quick answers. We have, nevertheless enjoyed our task and trust that this report goes some way towards clarifying future priorities for the Church's work in this area. Whilst we cannot, of course, make recommendations to bodies outside the Church of England, we hope that our report may suggest ways in which others might move if they share the goal of effective chaplaincy for patients and staff in future years.

I want to convey my thanks, through you, to the other members of the review group. The Revd Prof. Stephen Pattison and the Revd Mia Hilborn have worked imaginatively and tirelessly to master all the complexities and work creatively with them. The Revd Dr Malcolm Brown has supported us as Secretary to the group. Many others, as you will see, have made time to meet us and share their perspectives on the issues. This has indeed been a collaborative effort.

Because our review has entered into contested waters, and because our recommendations are unlikely to be welcomed by all concerned, I think it is important for me to stress the absolute impartiality with which the members of the group approached their task. Where sectional interests are so deeply entrenched, suspicions about motives and influence are perhaps inevitable, but the creative way the group worked transcended any partisan position. We are, I need hardly add, wholly unanimous in offering you this report.

Yours sincerely



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1. The Review Group

Dame Janet Trotter (Chair)	Chair of Gloucestershire Hospitals NHS Foundation Trust
The Revd Professor Stephen Pattison	Professor of Religion, Ethics and Practice, University of Birmingham.
The Revd Mia Hilborn	Head of Spiritual Health Care and Chaplaincy Team Leader, Guy's and St Thomas' NHS Foundation Trust Chair of the College of Healthcare Chaplains, London Region.
The Revd Dr Malcolm Brown (Secretary)	Director of Mission and Public Affairs, The Archbishops' Council.

The Terms of Reference of the review group are to be found in Appendix 1. The review did not set out to be a comprehensive “solution” to all the questions arising for healthcare chaplaincy today, nor did it attempt to set directions for the chaplaincy work of other Christian denominations, other faith groups or organisations independent of the Church of England. This report, therefore, is primarily a set of organisational recommendations to the Church of England. Clearly, the consequences of organisational changes by one church will be felt across the wider field of healthcare chaplaincy, and the review group has done its best to consult widely enough to understand the likely impact of what is proposed. However, the limits of the group’s remit were clear and the report is intended, first and foremost, for those with responsibility for supporting chaplaincy within the Church of England.

Key Principles

The Review Group has reflected at length on the challenges and opportunities facing chaplaincy in healthcare today. Our report and recommendations reflect the following principles which form the starting point of our work:

- A. **We wholeheartedly support the principle of chaplaincy within public institutions.** Religious belief remains widely held and highly significant in society and is an aspect of people's identity which is often under-recognised. The first objective of chaplaincy is to meet the religious needs of patients and staff in the NHS. The second is to seek the good of the institution itself.
- B. **We support healthcare chaplaincy as an integral component of the churches' ministry and mission.** All clergy and ministers need support when encountering hospitals and healthcare institutions in the course of their work. Chaplains have an important ministry to the church in this way.
- C. **Chaplains are called by God to understand their work in terms which are, as far as possible, intelligible in both an NHS and an ecclesiastical setting.** They therefore need knowledgeable and dedicated support from the church.
- D. **There is a need for national-level engagement between the Church of England and the issues arising in chaplaincy, including ethics and healthcare policy.**
- E. **All that can be done together should be done together with other churches, faith communities and interested bodies.** Resources, both in the NHS and the church, are scarce and divided voices are likely to muddy the waters. Unnecessary duplication of resources or confusion of structures is unhelpful. There are ecumenical, financial and strategic issues here.
- F. **The Church of England needs to be clear which essential tasks it alone can do.** The specific role of the Church of England in relation to healthcare and chaplaincy belongs in-house.
- G. **The scale of the changes currently taking place in the NHS require the church to review its ways of working and of supporting chaplains so that the religious needs of patients are best served.**
- H. **A balance needs to be struck between the national and local/diocesan structures of the Church of England in supporting chaplaincy.**
- I. **There is a creative tension to be found in all ministry which connects with both the church and the world beyond the church.** Healthcare chaplains handle this tension all the time.

3. Mapping the Territory

HCC and its work.

1. The National Health Service, one of the largest employers in the country, is full of people for whom faith of one sort or another is part of their motivation for working where they do. Many of these are Christian, others are not. There is as much diversity of belief in the NHS as in society at large. But religion, faith and belief remain important, if often under-recognised, in making the NHS what it is today.
2. Since the foundation of the National Health Service in 1948, chaplains have been integral to hospital structures and understood to play a valued part in the care of patients and the support of staff.
3. In health care, as in other aspects of national life, perceptions of the Church of England as the “default” church for the English have changed since the Second World War. Whilst the CofE retains its commitment to the spiritual welfare of all the people, the nation is much more consciously plural in religious terms. This situation is reflected in health care chaplaincy where Anglican representation remains much larger than that of any other religious bodies, but where chaplaincy is consciously ecumenical and increasing understood in multi-faith terms.
4. At the beginning of 2010, there are some 425 full time, and approximately 3,000 part time, chaplains employed by the National Health Service (NHS). The salaries and pensions of full time chaplains are paid from the public purse through the structures of the NHS. Part time chaplains receive fees from the NHS for the chaplaincy work they undertake. There are also numerous volunteer chaplains of all denominations and faiths – more than we have been able to count.
5. Of these totals, 325 (over 75%) of the full timers and 1,500 (50%) of the part timers are Anglicans.¹
6. The greater proportion of non-Anglican chaplains come from other Christian denominations. Some sense of the diversity represented here is obvious from the fact that chaplaincy on behalf of the Free Churches involves some 21 different denominations. Chaplains of faiths other than Christianity number fewer than 8 full timers (all Muslims) and approximately 200 part timers.
7. The Church of England supports health care chaplains through the structures of the dioceses to which they are licensed and also, at national level, through the Hospital Chaplaincies Council based at Church House,

¹ These figures supplied by the Hospital Chaplaincies Council.

Westminster. The HCC dates back at least to 1952 when it was formed out of the pre-existing Hospital Chaplaincies Commission. This national support through the HCC is the subject of our review and of this report.

8. The Hospital Chaplaincies Council is constituted as a sub-Committee of the Mission and Public Affairs Council which, in turn, is part of the Archbishops' Council of the Church of England. The term "Hospital Chaplaincies Council" refers both to the committee of that name and to the overall portfolio of work carried out on behalf of that committee by the staff of the HCC. In this report, we will endeavour to distinguish these meanings wherever possible ambiguities may arise.
9. The remit of the HCC, and its current membership, are set out in full in Appendix 2. The Council meets twice a year, one meeting being of 24hrs duration. The current Chair is the Bishop of Gloucester, who is, *ex officio*, a Vice Chair of the MPA Council.

Staffing and Budgets

10. The staff of the HCC work within the Mission and Public Affairs (MPA) Divisional team. In the past three years there have been some changes to the staffing of the HCC. In 2007, the HCC staff comprised:
 - Chief Executive Officer
 - Training Development Officer
 - Training Coordinator and Webmistress
 - General Administrative Support (part time)At the end of 2007, the Training Development Officer retired from full time work but was retained on a part time basis until the end of December 2009, primarily to service the work of the Multi-faith Group on Healthcare Chaplaincy and the HCC meetings.
The General Administrative Support worker retired in October 2008 and was not replaced due to the pressure on all Archbishops' Council budgets.
11. Within MPA, a new post was created to work in the field of Medical Ethics and Health and Social Care Policy, linking explicitly to the work of HCC and drawing on chaplains for grass-roots experience and insights on various policy issues. The post was filled in January 2009.
12. As at 1 January 2010, the staff team working on HCC-related issues (with salary grades) thus comprised:
 - Chief Executive Officer (Full time - Band 1)
 - Training Coordinator and Webmistress (Full time – Band 6)
 - Medical Ethics and Health/Social Care Policy Advisor (Full time, but not confined to HCC issues – Band 2).
13. The HCC Chief Executive Officer resigned from his post with effect from 31 January 2010, so that post is currently vacant.

14. The Budget for HCC is a cost-centre within the overall budget for MPA. Putting together the staff costs of the Chief Executive, the Training Coordinator and Webmistress, and half the staff costs of the Medical Ethics and Health/Social Care Policy Advisor, plus the operating budget for the work of the HCC, the overall costs of the current HCC operation amounted to some £210,000 in 2009. Of this, staff costs were £203,900. HCC's training work, meanwhile, generated an income of just under £8,000.
15. Income in 2009 came partly from other churches in support of the ecumenical training support provided by HCC. Financial pressures on other churches have led to this income declining in recent years and the only contribution expected in 2010 is £4,000 from the Roman Catholic Bishops' Conferences towards training provision.
16. It should be emphasised that the Church of England receives no funding from the Department of Health towards its national support of chaplaincy.

Work Programmes

17. The work of the HCC is primarily carried out by the staff, acting in the name of the Council and drawing on the Council for advice and guidance. In practice, the staff have considerable discretion in designing and carrying out work programmes.
18. The Review Group put some questions about the work to the HCC staff and the response gives an overall picture of their current work.

Q1 How do you see your work – and HCC's work?

- Anglican chaplains are the largest chaplaincy group who are paid and pensioned by the NHS. There are some 320 whole-time chaplains and some 1500 part-time chaplains working in healthcare. Many of the estimated 10,000 volunteers in chaplaincy teams are Anglicans.
- Our work is HCC's work which is both strategic and operational. The HCC staff put into practice the decisions of the Council. The office handles the day to day issues which arise.
- The primary focus of our work is in providing pastoral and educational support to Anglican chaplains, their teams and their supporters (NHS employers, Church employers, Diocesan senior staff, the Archbishops Council and General Synod).
- Secondly, we put effort into the development of world faith chaplaincy in healthcare settings, and into sustaining multi-faith chaplaincy.

- Thirdly, we emphasise the need for linking with Government and other policy makers. It is our aim to bring influence to bear which will lead to establishing a legally enforceable provision and standards for healthcare chaplaincy

Q2 How do you view the state of chaplaincy in the NHS today?

- At this moment, chaplains across the NHS are ministering to patients, staff and relatives. In the most distressing and demanding of circumstances, chaplains are in situations where heroic medical intervention will save a life. They also stand alongside when there is no miracle but care can and must be given.
- We have concerns about the rise of the secular movement, particularly as the NHS is a secular organisation.
- The establishment of the All-Party Group has been a most helpful outcome to patient negotiation and networking over some years. We consider that this will balance the apparent lack of interest by Ministers and officials in sustaining spiritual healthcare within the NHS.
- We are concerned at the general lack of faithfulness amongst people – this is not something which we can address ourselves but does impact on the value set in society.
- The promotion of “generic” chaplaincy whereby chaplaincy is delivered by people who do not have a faith tradition is of concern as is the sidelining of the faith communities in discussions about the more general development of healthcare chaplaincy.
- We have not seen any evidence that the move towards the professionalisation of healthcare chaplaincy has gained general support with chaplains and managers.
- Little progress has been made by chaplains in research, data collection and efficacy and outcome measurement.

Q3 Is the role of HCC to support the NHS institutionally or individuals within the NHS?

- HCC supports the institutions and the individuals
- HCC staff provided the drive and organisation of the 50th and 60th celebrations of the NHS at Westminster Abbey.
- Individual NHS Trust executives/ managers/ chaplains are well supported. There is daily interaction between HCC and these people.

Q4 What is your assessment of the Multi-faith Group?

- The HCC assessment is that *the MFGHC* has made steady progress in supporting the world faiths in their aspiration to introduce healthcare chaplaincy for their communities. The Group is well placed to continue its work as an advisory body to the Department of Health and the recent availability of a small financial allocation from the DH is welcomed.

Q5. What were your key achievements in the last 3-5 years?

- Taking forward the policies / strategies of the HCC Council.
- Ensuring the continuation of chaplaincy education and training through establishing links with a Higher Education Institution to credit and authorize introductory training courses.
- Developing a significant strategy for delivering training to chaplains across the UK through local chaplaincy centres meeting locally-identified training needs.
- Sustaining the development of multi-faith chaplaincy in partnership with the Multi-Faith Group for Healthcare Chaplaincy from humble beginnings as a voluntary association of faith community representatives to its current position as an advisory body to the Department of Health
- Managing HCC's transitions within Church House and through the various changes in the NHS and at the DH of finance and governance.
- Supporting individual chaplains and NHS Trusts day by day.
- Reversing the decision by the Worcester Acute Hospitals NHS Trust to make redundant all members of its chaplaincy team in 2006.

Q6 What are your key objectives for the next 3-5 years?

- The HCC Council has endorsed a work programme in which these aims are included.
- Continue to strive towards the establishment of healthcare chaplaincy as an NHS legal requirement.
- Support the development of a clear statement about faith and spirituality between the faith communities and the NHS
- Work towards closer integration of healthcare chaplaincy within the purview of Dioceses
- Continue to support the MFGHC in its current work programme on authorization and regulation

- Continue to work towards partnership working with all bodies with an interest in healthcare chaplaincy
- Continue to seek the establishment of the network of chaplaincy education centres within England and Wales
- Maintain firm and improving links with the Department of Health after the 2010 election, leading possibly to the establishment of a chaplaincy branch in DH similar to those in other Government Departments.
- Support the All-Party Parliamentary Group in reaching conclusions on its review of chaplaincy in the NHS
- Supporting and sustaining the development of the healthcare chaplaincy workforce in response to the *Caring for the Spirit* strategy.
- Sustain and develop the work with ecumenical partners.

Q7 How do you spend your time pursuing these goals?

- (Ch Exec) Edward Lewis' time is mainly spent in maintaining contacts within the chaplaincy world at national level including senior staff at the Department of Health; members and staff of the All-Party Group; senior officials in faith communities and chaplaincy bodies; and in communication with chaplains on the ground.
- (Webmistress) Mary Ingledeu's time is spent in the office predominantly dealing with the continual updating and improvement of the HCC database (currently with some 2000 entries). The balance of her time is spent in preparing for training courses or in dealing with enquiries from delegates and chaplains
- (Training Development Officer) Tim Battle's time for HCC is spent in preparing for and servicing meetings of the multi-faith group and the HCC Council. This work for HCC finished in September 2009

Q8 How do you stay in touch with events in the NHS etc.?

- Through contacts with chaplains, Bishops' visits and personal visits to NHS Trusts and Diocesan senior staff.
- Through work associated with the Panel of National Assessors. This workload varies between and within years but generally there are some 40 appointments and 5 reviews every year.
- Through reading publications such as professional and faith-based journals and via PCT, HSJ and NHS Confederation bulletins and journals

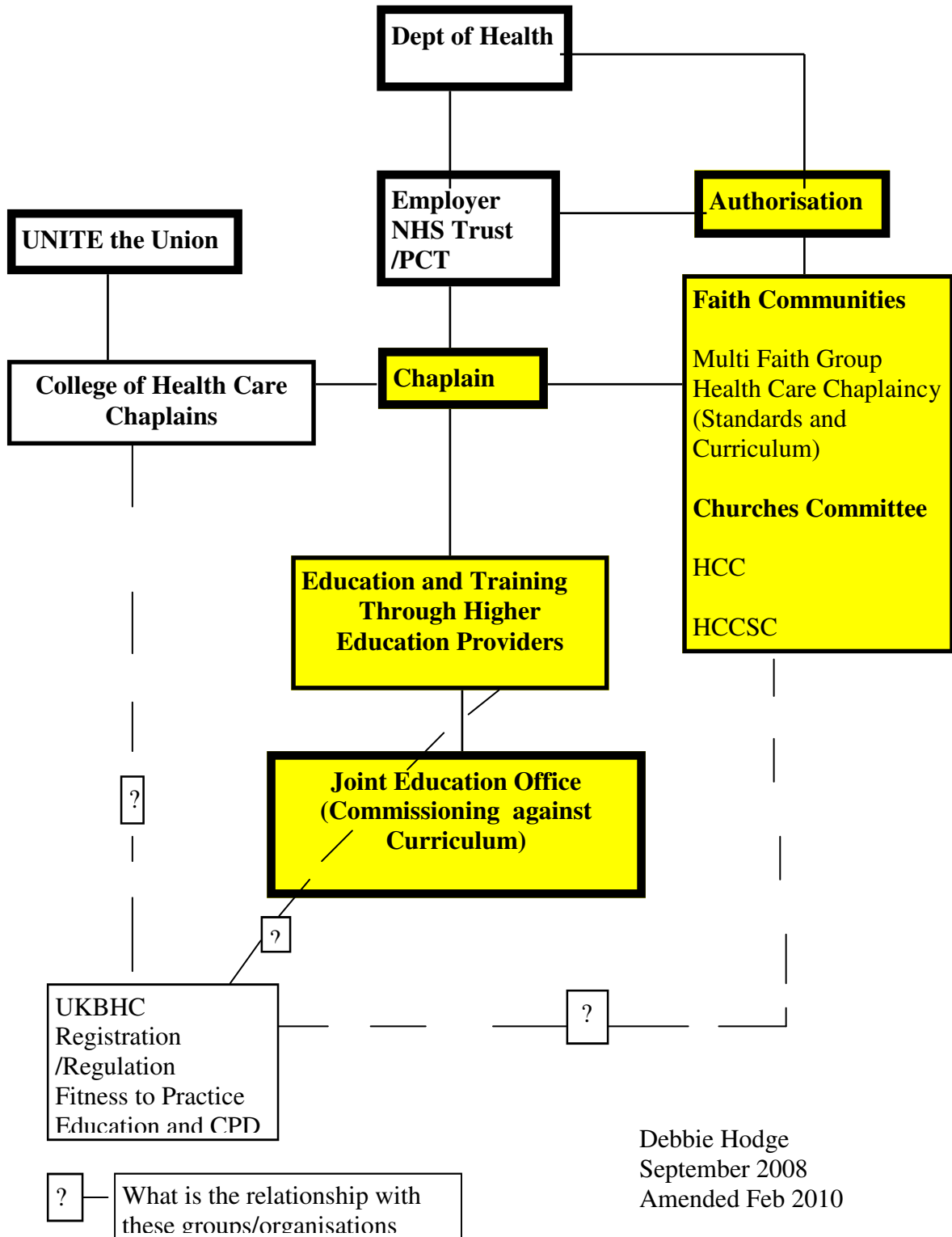
Other bodies in the field

19. We are indebted to the Revd Debbie Hodge (Secretary for the Churches' Committee for Hospital Chaplaincy at Churches Together in England) for the diagram below. This attempts to set out the main structural and institutional relationships around the chaplain. The shaded/coloured boxes represent the structures which are essentially accountable to the churches and faith communities.

20. It is worth noting at this stage the complexity of relationships and structures involved in healthcare chaplaincy. Although chaplaincy in health care is a much bigger affair than almost any other form of institutional chaplaincy, it is nonetheless a comparatively small operation to warrant such complexity. We shall return to this question at a later stage of our report.

Diagram 1

Outline of Chaplaincy bodies and structures relating to the Chaplain



Debbie Hodge
September 2008
Amended Feb 2010

Faith communities' structures

21. Looking at the structures owned within the faith communities (right hand box) it is clear that the set up is complex. Apart from the HCC, the relevant bodies include:
- *The Multi-faith Group for Health Care Chaplaincy* (MFGHC) [Founded 2003]. This body was set up following consultation with the Dept. of Health and acts as an advisory group to the Department. The current Chair is Manhar Mehta. The HCC Chief Executive Officer was Chief Officer (until his resignation in January 2010) and the former HCC Training Development Officer is the Administrator. We noted that, whilst the Chair rotates, other key roles have been occupied for a very long time by HCC staff and have not, in practice been shared between the faith communities. The efforts of the MFGHC are currently directed toward the regulation and accreditation of chaplains through their faith communities, all but two of the faiths having structures in place for this. There are 13 groups represented at the MFGHC.
 - *The Churches' Committee for Chaplaincy* is a coalition of Anglican, Roman Catholic and Free Church interests, constituted as a Co-ordinating Group of Churches Together in England (CTE). The Chair and Secretary are, constitutionally, always from different denominations. The Chief Executive and Chair of HCC are members on behalf of the CofE.
 - *The Health Care Chaplaincy Steering Group* is the Free Churches' body for the oversight of health care chaplaincy. It covers England and Wales. Debbie Hodge is its Officer.
 - *The Health Care Reference Group* is the Roman Catholic equivalent to the HCCSG and HCC. It was described by our Catholic respondents as a "think tank" for the Roman Catholic Bishops' Conference of England and Wales. It organises conferences, considers ethical and multifaith issues and supports people of faith in the NHS. The group has produced a number of highly respected publications on Roman Catholic approaches to health care chaplaincy.²

Trade Union and chaplain-led structures

22. On the left hand side of the diagram is the *College of Health Care Chaplains* [Founded 1992] which is a body affiliated to the Trade Union, *Unite*. As its trade union nature suggests, this is an association of chaplains, organised to pursue the interests of the members, and taking its place alongside other union structures working on behalf of health care staff. The CHCC offers support for chaplains, especially in situations of conflict in the workplace. It is "owned" by its members, who include many Anglican chaplains.
23. The CHCC has amongst its objectives the promotion of health care chaplaincy as a profession and, in support of this aim, seeks to offer

² For example, *What is a Catholic Chaplain?* – a handbook for non-Catholic NHS managers; *Care of Catholic Patients* – a handbook for nurses and others about the needs of Catholic patients.

appropriate professional development. The CHCC engages with the NHS on issues such as the terms and conditions of chaplains' employment.

24. CHCC is organised on a regional basis and its governing body is elected by the members.
25. We met with Revd Mark Stobert (Vice President of the CHCC) standing in for Revd Ann Aldridge (President) who was ill. Mark unpacked the CHCC understanding of professionalism within health care chaplaincy as being concerned with discipline and practice. Discipline referred to the whole question of authorisation of chaplains and their good standing within both the NHS and their own faith communities. Practice related to the areas of knowledge and understanding needed by chaplains which distinguishes them from clergy in other situations.
26. *The UK Board of Healthcare Chaplaincy* [Founded 2008] is a relatively new player in the field and has been added to the left hand side of the original diagram. The links with other bodies are deliberately represented with question marks since, in many cases, they have yet to be negotiated and tested. The UKBHC's relationship with the CHCC might have been represented more strongly since there are historic links, mainly in terms of the people involved, between the two bodies.
27. According to its website, the UKBHC's primary objects are to:
 - advance and disseminate the knowledge and practice of healthcare chaplaincy.
 - Define and develop professional standards of chaplaincy including education, training and continuing professional development,
 - Train advisers to support employers in the selection and appointment of health care chaplains,
 - Operate procedures to consider, investigate and assess the professional conduct of registered chaplains,
 - Maintain and develop systems to promote and accredit continuing professional development and the professional registration of chaplains.
28. We met with Revd Dr Derek Fraser from the UKBHC who explained that the initial link with CHCC had been a matter of expediency – processes were now in train to enable the UKBHC to be constituted independently of the trade union-based CHCC. The UKBHC's authority would come from its links with the professional bodies in health care chaplaincy such as the association of Hospice Chaplains, the Scottish Association of Health Care Chaplains etc. The mechanism whereby this authority would be secured remained unclear to us.

HCC and other chaplains' structures

29. The clear overlap in objectives between the UKBHC, HCC and MFGHC, especially in relation to the registration of chaplains and the provision of advisers for chaplaincy appointments, will be obvious. The poor state of

relations between the HCC (and because of its close links with HCC, the MFGHC also) on the one hand, and the CHCC and the UKBHC on the other, seems to have undermined any efforts directed to worthwhile consultation or cooperation.

30. HCC is a denominational body whereas the CHCC and UKBHC are open to all health care chaplains of any church, denomination or faith community. These bodies are not all trying to do the same thing on behalf of the same constituency. We came to the view that some of the tensions between them stem from the fact that the Church of England has always provided the largest number of chaplains in England and was, in many respects, first in the field in terms of national organisation.
31. It was natural that the Church of England, through the HCC, should at one time have led the way in relating to the NHS and government at national level on behalf of all chaplains. But the shifting pattern of ecumenical and multi-faith engagement in chaplaincy suggests that the Church of England must adapt to new and collaborative ways of working.
32. The lingering suspicion among some non-Anglicans that the HCC has not moved on from the period when the Anglicans led the field seems to fuel antagonisms. We are not convinced that this is a wholly accurate picture. But, for example, the pivotal role of HCC staff in the MFGHC suggests how such impressions become powerful.
33. We believe it is time to reconsider the ways in which HCC is simultaneously a denominational structure and, because of the Church of England's particular opportunities for national-level ministry, takes leading roles in support of health care chaplaincy in general.

The NHS and the Dept. of Health

34. As the employer of chaplains, the Health Service is an important factor in the way chaplaincy policy, and the work of chaplains, is evolving. We shall look at the health care policy context in a later section.
35. Health care chaplaincy is structured very differently from the chaplaincies paid for and organised by government in prisons and the armed services. Unlike those examples, health care chaplaincy is not a statutory provision (although HCC has been lobbying for this to be considered). So, whereas military and prison chaplains are coordinated in each case by a Chaplain General (who may or may not be an Anglican – if he/she is, they have the status of an Archdeacon) paid for and located within the relevant Ministry, health care chaplaincy is co-ordinated on behalf of the Dept. of Health (DoH) by one civil servant.
36. We met with the current holder of that office, Mr Barry Mussenden, who is Deputy Director, Equality and Partnership, within the Dept. of Health Policy and Strategy Directorate and reports to the Chief Nursing Officer.

37. Mr Mussenden's work is currently linked strongly with the government's Equalities agenda which sees Religion and Belief as a single strand, embracing not only the great world religions but secular beliefs also.
38. Until recently, the DoH has taken a relaxed approach to the question of how chaplaincy is delivered, and this is likely to continue. However chaplaincy has figured more prominently as religion has increasingly been perceived as a political issue framed in terms of essentially secular assumptions. Making provision for patients whose religious affiliations are increasingly diverse has tended to make chaplaincy a sub-set of the equality agenda, although we were informed that the limitations of this approach are recognised.
39. The DoH offers only limited and general guidance to Trusts on chaplaincy matters. (See the 2003 guidance document on the DoH website).³
40. The DoH, we were told, is reluctant to get into questions of regulating chaplaincy. Nor is it likely to set policies forcing Trusts to retain chaplains. The DoH is currently neutral about health care chaplaincy as a statutory provision on the model of prison or military chaplaincy. It was unclear whether a change of government would affect the general thrust of policy but there were no obvious signs that it would do so.
41. The Department attempts to relate to all the bodies which support and represent chaplains. It works with the MFGHC on questions of regulation and accreditation, but this is not an exclusive relationship – it also works with the UKBHC which is addressing the same issues. The disputes and tensions between bodies make the DoH's job more difficult but there is still a commitment to working with all. Nonetheless, the vehemence of the disputes encourages the Department as a whole to stand back from the issues around chaplaincy.
42. The problem was presented as being, not one of too many players on the field, but uncertainty about who represents whom. For example, it is not always clear how many members of some groups are active chaplains: there are questions about how representatives connect with practitioners.

Funding questions

43. Interestingly, the role of the Church of England as the largest source of chaplains, and as the first to structure and support this nationally, has had a downside for HCC. Anglican chaplaincy was already well-established, and in the majority, at the point when national policy in the NHS began to be more aware of religious pluralism and sought to put all chaplaincy on a more level playing field.

³

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4062016

44. Whereas chaplains themselves are paid for by the Trusts, there has been some DoH money available for organising chaplaincy, especially for supporting multi-faith and ecumenical developments. A DoH report commissioned in 2004 allocated a budget of £186,000 in the following proportions: Free Churches 25%; Jewish visitation service 25%; Muslim Spiritual Care 25%, with the remaining 25% distributed around the other members of the MFGHC.
45. So, whereas, for example, The Revd Debbie Hodge's post, working on behalf of the Free Churches and located at Churches Together in England (CTE), is paid for by the DoH, the HCC which has a comparable role for a much larger group of chaplains, gets no DoH money and is paid for almost entirely by the Church of England itself.
46. In addition to the funding above, the DoH has a small fund for projects (the Third Sector Partnership Fund).
47. In the current national financial context, it is unlikely that funding for chaplaincy will increase. On the contrary, especially at Trust level, there is likely to be considerable pressure on budgets and, hence, pressure on chaplains to justify their work on the basis of therapeutic evidence. The language of cost-effectiveness, evidence-based practice and targets is likely to become more powerful. Chaplains can point to the strong support for their work from patients and health care professionals, but these are not the people who determine budgets.
48. In terms of DoH funding for chaplaincy, it was suggested that the present total was so small that it does not make a lot of difference to the overall departmental budget. There is likely, however, to be pressure on all budgets and no area is likely to escape close scrutiny.
49. There is an anomaly in the lack of central DoH funding available to the Church of England for its work amongst the largest denominational group of chaplains. The idea of "pump-priming" money for other faiths and smaller churches is sound, but the time comes when such funding is looked upon more as payment for services which the Dept. wants to see happen. It is a fine judgement whether that shift in perception has already taken place, but we believe there is scope for greater clarity about whether the DoH is paying religious bodies to organise and support their chaplains or if the funds are in fact levelling an uneven playing field. Working with the DoH to clarify the policies on the national support of chaplaincy by the churches is an urgent task for the Church of England in this area.

Assessors' Panels

50. The DoH lays down guidelines for Assessors to take part in the appointment processes for a number of roles including optometrists, speech therapists, chaplains and others. These guidelines make provision

for the NHS to draw upon the knowledge of the bodies which accredit practitioners in those fields. The guidelines for appointing chaplains are, necessarily, non-faith specific.

51. As noted, the MFGHC has done a considerable amount of work to assist the different faith groups to set up their own structures for ensuring that candidates for chaplaincy posts are fit to practice on the terms of the relevant faith community.
52. The HCC has, for some time, operated a list of Church of England assessors, drawn mainly from the ranks of longer-serving health care chaplains. It is not clear to us how this list has been assembled and on what grounds the individuals concerned are selected. This lack of transparency has led some Anglican chaplains to resent the existence of the list and regard it with suspicion.

Training for Chaplains

53. Chaplains receive training of a variety of kinds. For instance, as staff within complex health care institutions, they will participate in training programmes alongside other employees. They may join in CME programmes with other clergy. We are concerned mainly with the training which addresses directly their particular role as chaplains.
54. Chaplains who responded to our questions listed HCC (especially in its partnership with St Michael's Llandaff) and the CHCC as sources of initial induction training. 56 mentioned the HCC/Llandaff route and 12 the CHCC provision.
55. St Michael's Llandaff has a Centre for Chaplaincy Studies which offers a variety of accredited courses, including an Induction programme for healthcare chaplains, an MTh in chaplaincy studies and facilities for PhD studies in chaplaincy subjects. The Centre offers programmes for chaplains in many contexts, not only health care.
56. HCC has also been involved in developing a Foundation Degree in Healthcare Chaplaincy at St Mary's University College, Twickenham (a Roman Catholic foundation).
57. These courses are both important in helping the emergence of chaplaincy as a distinct set of practices within ministry. They seem to be very highly valued by chaplains who have participated on the courses.
58. HCC has clearly been an important factor in helping these programmes to take off. The present role of HCC, mainly through the Training Coordinator and Webmistress, involves ensuring that chaplains are aware of what is on offer, responding to enquiries and referring applications to the colleges. The link between HCC and the colleges is one route whereby the colleges keep abreast of developments in chaplaincy at national level.

4. Theological Foundations of Chaplaincy

59. There is a good deal of literature on the theologies and ecclesiologies which underpin the practices of chaplaincy in different settings.⁴ Hospital, or health care, chaplaincy is an especially good example, since its practice embraces different theological approaches and, sometimes, the emphasis of one approach over another may be a source of tensions.
60. It is part of the vocation of all Christians, and especially clergy, to emulate Christ in seeking the wholeness of all people. Reconciliation and grace are at the heart of the *Missio Dei*. On this fundamental principle, the church's ministry has always embodied a commitment to healing and the very idea of hospitals as places of healing originates in the monastic ministry to communities. Until the 19th Century, all hospitals in England were religious foundations. Into the 20th Century, the church continued to be instrumental in founding and running hospitals. The presence of the church's ministers in hospitals is not a concession granted by a secular state but (as in the case of church schools) a link to the founding history and original purposes of many of today's hospitals.
61. Chaplaincy, in the sense of ministry to people or institutions defined outside a territorial framework of parish or diocese, is long established. Perhaps its origins lie in the Middle Ages with the chaplains to wealthy households whose task was to pray and say Mass for the family and its retinue. Whilst this kind of ministry may strike modern ears as elitist, it embodies an important truth, understood better in pre-modern times than today: that wealth and power constitute considerable spiritual danger and that, although a fallen world demands that some must deal in power and handle wealth, by so doing they place their immortal souls at risk.
62. This theological justification for special spiritual attention may not have survived the decline of Christendom, but many modern forms of chaplaincy echo the concern that some areas of human activity place people in spiritual jeopardy. The intense life and death decision-making which falls to many in the medical professions come into this category. Thus, the ministry of health care chaplains to those who bear onerous medical responsibilities and for whom ethical decisions may often be about averting the worst rather than embodying the unequivocal good, may have important connections to the earliest forms of chaplaincy.
63. To fulfil this model, chaplains need to be alert to the nature of the ethical decisions which healthcare professionals must make and be able to contribute to ways in which healthcare structures function as ethical institutions in society.

⁴ For instance: Giles Legood (ed.), *Chaplaincy: The Church's Sector Ministries*, London: Cassell, 1999.

64. A second model of chaplaincy dates from the early decades of industrialisation and the ensuing compartmentalisation of different kinds of activity coupled with greater geographical mobility. Put simply, it reflects the principle that, if some people are physically unable to get to church, the church must go to where the people are. This model is reflected in the nineteenth century Navy Missions, the industrial chaplains on oil rigs in the North Sea, agencies such as the Mission to Seafarers, military and prison chaplaincy. In all these contexts, clergy and lay ministers have offered the church's ministry to all people by being available to those whose work or circumstances placed them beyond the reach of the geographical parish system. There is a strong element of this rationale in the ministry of health care chaplains to patients, especially in activities such as ward communions, chapel services and counselling.
65. A third model was eloquently expressed to us by Bishop Christopher Herbert, a former Chair of the HCC. Here, chaplaincy embodies the theological truth that God is active in the world beyond the church, that God's concerns are for the wholeness of creation and not just the good of Christians and that the church needs to be constantly called back to these truths which it is perpetually at risk of neglecting. Bishop Christopher cherished his contacts with health care chaplains for their capacity to remind the church of the saving work of God within secular institutions and in the lives of many in the medical professions who may profess no faith of their own. On this model, an important element of the chaplains' work is a mission to call the church back to a serious, incarnational, understanding of a living God.
66. Putting these three models together, chaplains need to be thoroughly embedded in both the church and the health care institutions – and learn to live on the edges of both, embodying the tensions inherent in a commitment to both the ecclesiastical and the secular structures. The uncomfortable nature of this position is, perhaps, a testimony to its importance. It implies that the chaplain must be theologically acute, but also intensely well-informed (intellectually and emotionally) about how hospitals work and how the lives of health care professionals are moulded by the structures. It is simultaneously a pastoral calling, a work of translation between quite distinct conceptual vocabularies, a research programme for the benefit of the churches' understanding of God in the world, and a missionary vocation to call both church and world back to a vision of God's Kingdom.
67. Whilst the preceding paragraphs are in no way a comprehensive theology of chaplaincy, they serve to show that health care chaplains embody each one of the suggested models. Chaplains are essentially liminal people, learning to operate within, but never entirely subsumed by, the institutional church and the institutions of the Health Service. At times, they are more part of one "side" than the other, but the balance can swiftly move the other way. So, at the bedside of a dying patient, the chaplain is emphatically the church's minister, offering something that no secular agency can quite replicate. But on many occasions, the chaplain must be

known and trusted as an integral part of the health care team, able to speak the language, empathise with the complexities and be a bridge between the church's theological insights and the wisdom of the professionals.

68. Handling these ambiguities is not simple. It is easy to get the balances wrong: to undervalue the importance of the theologically distinctive insights which the chaplain is there to offer or to act as if the hospital regime revolves around spiritual imperatives; to defer to the perceived authority of medical knowledge instead of seeing medical staff as spiritually vulnerable by the nature of their calling.
69. Possibly because most ministry is lonely and most health care settings are collaborative, the chaplain may sometimes feel better understood in the hospital setting than in the church and come to see the church as a hindrance to mission rather than the source of his or her own vocation. Or the chaplain's identity within the church may mean that he or she becomes unable to empathise with the complexities, compromises and political imperatives which shape the practices of health care today. Most hold these extremes within a creative tension.
70. Almost all the chaplains who contacted our review understood these points and recognised the nature of the tightrope they walked daily. But we point out these basic theological, missiological and ecclesiological tensions because, in our view, approaches to their understanding lie behind some of the arguments and antagonisms within chaplaincy today. Like other disputes among Christians, the fact that the controversies are rooted in theology as well as politics or practice makes them all the more intractable.
71. However, the comprehensive nature of Anglican ecclesiology is an important factor when it comes to the chaplains of the Church of England and to the HCC.
72. The Church of England has always been committed to ministering to all the people of the nation and supporting the common good. This is reflected in the commitment of health care chaplains to the spiritual needs of all patients regardless of their religious affiliation or lack of it. The reality of religious pluralism dating, one might say, from the emancipation of Catholics and "dissenters" in the 19th Century, means that this Anglican vocation is not aggressively protected against others but acknowledges the role of chaplains of other denominations, churches and faiths. Indeed, many non-Anglican chaplains share a vocation to offer their ministry to all who wish to receive it. But it remains that the commitment to all is, for Anglicans, non-negotiable.
73. Moreover, the Church of England remains the Established Church. Despite the growth of secular structures and understandings, England is not a secular state. Although it may be a tiny part of any chaplain's role, their knowledge of health care issues informs the church's wider

engagement with politics and the state, including through interventions of the Lords Spiritual in the Upper Chamber. The combination of the Anglican offer of ministry to all and the Established Church's role in the political, cultural and institutional life of the nation means that chaplains are integrally concerned with the institutions and structures of health care and not only with the personal pastoral care of patients and staff. Again, this commitment may often be shared by chaplains of other traditions, but it is absolutely central to an Anglican understanding of chaplaincy.

74. As we shall see, these considerations form part of the background to our practical recommendations in this report.

5. What the chaplains told us

75. The Review group composed a short questionnaire designed to elicit the views of serving Anglican health care chaplains (Appendix 3). 490 questionnaires were sent, mainly to full time Anglican chaplains identified from the HCC database. 113 responses were received (a response rate of just over 23%).
76. The analysis of the questionnaires was handled by Sue Burrige of the MPA staff team, using the software programme, *Nvivo*. The results, presented graphically, are set out in Appendix 4. The group is indebted to Sue for what turned out to be a substantial piece of work.
77. The results are presented in the form of a model for each of the 8 questions which summarises the comments around subject areas (called nodes). Each node bubble includes the number of questionnaires which mention that subject area with the size of the bubble representing approximately the proportion of respondents who made each point.

Key points from the questionnaires

78. The responses to the questionnaires contain a considerable amount of material. However, the key points which bear most directly on this review are summarised below. Where possible, we have illustrated each point with a boxed quote from one of the questionnaires which epitomises the responses of a similar nature.
79. The respondents tend to fall into two camps. Firstly, there are those for whom their Anglican identity is seen as essential to their work and ministry. They tend to support HCC in some form or other, have gone to HCC initial training, have some anxieties about 'professionalism' and about CHCC's agendas and value their connection with their diocese. They want 'the wider Church' to understand and value their ministry.
- I would particularly value support and information about 'things Anglican'; such as the meaning and integration of 'priesthood' in relation to one's identity as 'Chaplain'...*
80. The other group tends to stress their identity as 'Healthcare chaplains' and tend to make less of an issue of their Anglican identity. They refer positively to CHCC. They place a high priority on
- We, as Chaplains, have not referred to ourselves as hospital chaplains for years. Many healthcare chaplains no longer have a 'hospital' to work out of. I have not found my work enhanced at all by HCC. I have found the College the main source of support both pastorally and professionally..*

professional development, the importance of being seen as Healthcare professionals and of having regular CPD.

81. However the two groups are united in their anxiety about the organisations purporting to represent hospital/healthcare chaplains and the seeming antagonism between them.

'The real problems have lain in the remit, boundaries and roles the different organisations have assumed'
'The central issue which has been so damaging to hospital chaplaincy over the last few years has been the breakdown in relationship between the CHCC and the HCC issuing in much confusion and stress for chaplains, no clear advocacy for chaplains/chaplaincy at a national level. .'
'The infighting is very sad and brings chaplaincy into disrepute. A lot of work is duplicated'.

Some headlines from the questions

82. (Q. 1) Supervision, pastoral care or support from the local bishop was the most common need expressed by respondents.

'good also for chaplains to have an annual meeting either with the Bishop, or with whoever has responsibility for hospital chaplaincy within the diocese – often an archdeacon – to enable us to keep more closely in touch, and to talk about issues arising'.

From this question and question 7 it would appear that respondents looked to the National Church for advocacy and the commissioning of research.

'support at the National level to do the strategic negotiation/communication/ governmental/links etc – the work that individual chaplains can't do'.
'there is a greater need for advocacy for chaplaincy and a greater need to articulate the purpose of chaplaincy and that presents a wonderful opportunity for the Church to do some fresh thinking and exercise leadership.
'The 'business case' language of the NHS is not well understood and we need national champions who can speak to NHS executives in a language they can understand'

83. (Q.3)When asked how might things be different, the most common suggestion was to simplify. If more than one body is to exist then there were pleas for clarification of roles and more collaboration.

'It would be better to have a single body that would be able to offer help, support, and insurance cover'.
'The best way to help me personally is to stop making me feel I have to choose. Its like picking sides in the playground'.

The numbers are not a particular distraction – the real problems have lain in the remit, boundaries and roles that the different organisations have assumed. ‘There must be greater desire to collaborate and share at national level. Times are changing in healthcare. I rather like the Armed forces model of chaplaincy’.

84. However several of the answers mentioned the question of representation with differing views of who should speak on their behalf.

‘However, any organisation seeking to oversee Chaplaincy as a whole has to be more than just a Chaplains organisation. Self-regulation has not had a good press of late (Bankers, MPs etc.) There are other ‘stakeholders’ to be considered, including the faith communities, the NHS itself and most importantly there needs to be room for the voice of patients/the public’.
‘This seems a waste of resources – especially as many of these groups seem to be made up of people with very little practical experience of whole-time Chaplaincy’.

85. In addition to the questionnaire to chaplains, we asked all the diocesan bishops for their views on the role of health care chaplaincy within their dioceses. In many cases, bishops delegated the response to their advisors on health care chaplaincy and most bishops who responded personally did so after consulting with their advisors. We received responses from the dioceses of: Guildford, York, Liverpool, Manchester, Worcester, St Edmundsbury & Ipswich, Lincoln, Sheffield and Leicester.
86. The responses from dioceses emphasised the good work done by chaplains and the importance of their work in the mission of the diocese. Most of the bishops who responded take pains to meet with their chaplains from time to time and to stay aware of the issues they face. In particular, the bishops recognised the chaplains as being “on the front line” between the church and secular institutions. It was clear that bishops feel better able to stay abreast of chaplaincy issues when there is a good co-ordinating chaplain or bishops’ advisor in post who is prepared to be proactive in linking chaplains to diocesan structures.
87. Many diocesan responses touched on the anxieties faced by chaplains in the context of health service financial pressures. This was connected to a suspicion that the role of chaplaincy is not well understood in many parts of the Health Service. Some bishops were aware of the desire amongst some chaplains (and in the College of Health Care Chaplains and the UKBHC) for a stronger professional identity for chaplains which could secure their position as health care professionals. The responses, however, did not explore the pros and cons of this approach in depth.
88. There was, however, a considerable amount of criticism of the ways in which the HCC goes about its work. Many bishops were aware of the institutional tensions and antagonisms between HCC and other chaplains’ bodies and deplored the inability to defuse the situation and work together.

89. One bishop's advisor argued that only a root and branch change to the arrangements for representing chaplaincy would get beyond the current "turf wars". It was argued that there needed to be a single ecumenical body, recognised by all the churches, representing all Christian chaplaincy.
90. There was a good deal of criticism of HCC. It was felt by some that HCC had failed to keep chaplains informed about its own business and that the membership of HCC was selected in ways which made it unrepresentative. The influence of the officers of HCC on the Multi-faith Group was also deplored by some respondents who felt that divisive attitudes were being imported into the MFGHC from HCC. Too much was felt to depend upon whether individual chaplains and others were favoured by HCC officers.
91. The power of these comments is not that they are a balanced and accurate picture of the current state of affairs (different protagonists would tell the same story differently) but that these views are being picked up by bishops who are in close touch with their chaplains. Without the robust support of a majority of the bishops, a body like HCC is very limited in its ability to do its work on behalf of the church.

What did they think should be happening?

92. Although the responses from chaplains and bishops gave a wide range of views, some areas of basic agreement are easily discernible from the analysis of the responses.
93. A significant number of chaplains wanted support from their diocesan bishop and saw the local church (which included the diocese) as the source of affirmation for the priestly character of their ministry. Whilst we heard some anecdotal evidence that some chaplains are "escapees" from the structures of the institutional church, and that some do not trust their bishops to understand the nature of their vocation to chaplaincy, this view was not strongly represented among the responses to our questions. On the other hand, it was clear that the actual support received from bishops and local church structures is patchy and that there is a desire for diocesan support to be improved.
94. A substantial number of chaplains looked to the national church for advocacy on behalf of chaplaincy and for training opportunities.
95. There was strong agreement that the present state of duplication and confusion between different bodies in the field was counter productive. Bad relationships between bodies constituted an embarrassment to many.
96. The pressures on the NHS, maintaining chaplaincy services in the face of financial cuts and the perception of an increasingly confident secularism

informing national health care policy, all figured strongly in the chaplains' responses and were echoed by many of the bishops. Chaplains felt that there was a significant role for the national church in seeking to influence policy matters in this area.

97. Several of the bishops also hoped to see a stronger Church of England voice on wider issues of health care policy.

6. The NHS Context for Chaplaincy

98. As we have undertaken our work we have taken cognisance of the significant changes taking place in the NHS, with more to come as financial pressures on public services bite. Appendix 5 is a Reflection from The Reverend Dame Sarah Mullally, former Chief Nurse: it sets out some of the historical perspectives and some of the current changes impacting on the NHS generally and chaplaincy specifically. The following paragraphs seek to provide a brief framework in which NHS chaplaincy operates.
99. British society has changed significantly since the NHS was created in 1948: it is now, for example, more plural in relation to ethnicity, religious allegiance and cultural expression: secularisation also has a firm hold on certain sections of society.
100. Research into social diversity has raised issues about plural outcomes from investment in the NHS and other public services. It is proven that those individuals in lower socio economic groups have poorer health outcomes than their counterparts in higher groups and that health is a major determinant of an individuals quality of life.
101. Societal changes have also had demographic consequences, both reflecting them and creating them. The birth-rate is increasing particularly among minority ethnic communities, there is significant demand for mental health services and the structure of society will change as increasing numbers of people over 65 years of age live longer. Many of this latter group will be living with long term and chronic conditions.
102. In 1948 it was believed that investment in the NHS in the short term would reduce health expenditure in the long term. This has clearly not proved to be the case in practice. It almost appears as if the higher the investment the more is the public expectation for additional resource.
103. Another factor affecting rising expectations of healthcare is advances in medical technology. Many premature and sick babies are now kept alive on a ventilator where, at one time, they would have struggled to gain independent life and advances in, for example, coronary, stroke and cancer care have given life and hope to countless patients. Additionally, the information revolution has encouraged patients and carers to take more control of their health: the concept of expert patients as co-workers with the medical profession is increasingly common with choice being offered where possible.
104. Diversity, rising expectations, medical advances and pressure on resources have led the NHS to respond in a variety of ways which impact not just on the context of the NHS chaplain but also the outworking of the role day by day.

105. One response has been to put the patient at the centre of healthcare and to recognise that the individual has a responsibility for maintaining their own health. The NHS will, therefore, increasingly support individuals with their health problems by offering more personalised services, accessible care in a variety of settings (e.g. GP surgery, supermarket, community setting, residential home) and hospitalisation when essential. In this scenario the NHS becomes less the traditional institutional provider of illness services and more the commissioner of appropriate services for a given population/group from, for example, charitable organisations, private providers, NHS Trusts and GPs. In creating contracts with such organisations the NHS will be commissioning on the basis of quality, proven benefit of the intervention, safety and value for money.
106. Such approaches are encapsulated in the NHS Constitution (2010) and recent Department of Health Documents. The Constitution sets out the roles, responsibilities and entitlements of the various players in the health field: human rights and equality legislation will reinforce aspects of this approach.
107. We were aware that we could not do justice to these major changes in a brief summary but draw attention to them because of our awareness that chaplaincy within the NHS cannot be isolated from them. Nor can chaplains be protected from the financial pressures without constantly reassessing their role and place within a modern NHS.
108. This should not be viewed as a call to retreat but as an opportunity for new thinking and fresh expressions. It may well be the time for new forms of chaplaincy partnership with ecumenical and multi faith partners; attention being paid to evidence based chaplaincy which emphasises the importance of spiritual well-being in health; embracing chaplaincy in a variety of healthcare settings and Dioceses recognising that a calling to such work is a special front line ministry requiring support, encouragement and appropriate training.
109. It is our belief that this anticipatory agenda can be pursued creatively via our recommendations.

7. The Strategic Dilemma

110. We have outlined the concerns which emerged from our questions to chaplains and bishops, and we have considered some of the key issues facing chaplaincy in the Health Service today. The question now arises: how should the church organise and deliver support to chaplains in health care in ways which address the issues and pressures they face? It is clear that this is the question which all the existing bodies in the field believe themselves to be addressing, although their strategies are often poles apart. The particular nature and role of the Church of England raises specific questions about the role of HCC and central church structures.
111. At the heart of the strategic dilemma is the dual nature of chaplains' accountability (to the NHS and to the church) and the many ways in which those relationships can be weighted in one direction or the other. It is clear that some chaplains see themselves as primarily health care professionals whilst others understand their vocation to be ministers of the church who work within a health care environment. It seems to us that different approaches to this tension are one of the key issues behind the antagonisms within health care chaplaincy today.
112. Behind the dilemma lies the spectre of secularisation. Many respondents with whom we spoke were clear that there are real anxieties about the "default" social model on which health care policy (and social policy more widely) is made. This often treats religious observance as essentially marginal and problematic. Chaplains may have good personal relationships with managers in the Trusts and Strategic Health Authorities within which they work but, even where this is the case, it is no guarantee of security within an NHS where financial resources are so strained. Chaplains must make the case for their work against a background which often sees no value in models of care which do not conform to instrumental and empirical understandings.
113. This is not, of course, a context unique to health care chaplaincy. In most areas of public life, the role of religion is contested and the churches are learning to speak of their work and mission in terms which are recognisable to those with no religious background at all. This is essential if the church is to have any purchase on national life and policies. A report commissioned by an Anglican bishop in 2008 concluded that, at the highest levels of government and the civil service, there is a deep lack of understanding of religions from within: traditional religious language is often, literally, incomprehensible among people with whom we need to communicate.⁵

⁵ (eds) Francis Davis, Elizabeth Paulhaus and Andrew Bradstock, *Moral, But No Compass: government, church and the future of welfare*, Chelmsford: Matthew James Publishing, 2008. This was a report commissioned by the Bishop for Urban Life and Faith, The Rt Revd Stephen Lowe.

114. It is little wonder, then that there is considerable pressure on chaplains to present their role and their work in a vocabulary which fits the imperatives of NHS managers. It is the language of professionalism rather than priesthood, of spirituality rather than religious traditions, and of authority and legitimacy which may be conferred academically but where spiritual authority is not recognised.
115. Yet the responses received from chaplains suggest that the majority of them understand that their vocation is not adequately described in such language. They remain committed to the church which sends them and continue, in contexts where it can be understood, to describe their work in the language of faith rather than that of management or therapy. Most seem aware of the risk inherent in adopting management or therapeutic terminology to describe and value their work, but they are also very aware of the concomitant risk of failing to do so. It is the tension between being co-opted into a secular mind-set on the one hand and being unwelcome and unable to practice as ministers of religion on the other.
116. We were struck by the divergence of approach between the Roman Catholics on the one hand and the representative of the UKBHC on the other. The Catholics understand professionalism only in terms of authorisation from a bishop. For them, ministry in a health care setting is an extension of the church's wider ministry. They do not regard chaplaincy as a ministerial specialism, but as one aspect of a generic priestly ministry. There is a strong residual focus on ministry to Roman Catholic staff and patients rather than to the institutions, although many Catholic chaplains work harmoniously in ecumenical or multi-faith teams. Overall, we gained a strong impression that the Roman Catholics were willing to offer chaplaincy within the NHS on the church's terms but not to compromise with concepts or values in the NHS which did not cohere with their own theology of ministry.
117. We especially noted the observation by Bishop Tom Williams, who headed the Roman Catholic group which met us. He felt that the Roman Catholic church had much to learn from other denominations about relating to the NHS and the Trusts as institutions. Although Bishop Tom did not connect the lack of such a relationship to the Catholic reluctance to interpret the role of chaplains in language which the health care institutions could appreciate, we could not help but think there was a strong connection.
118. In contrast, the representative of the UKBHC stressed the necessity, as he saw it, of presenting chaplaincy as a profession which could take its place alongside other professions in the NHS and which could justify itself in terms which focused on the measurable benefit to patients in words which were not dependent on religious sympathies. Although he also acknowledged the importance of chaplains retaining their connections with their churches, his enthusiasm for the

“professionalisation agenda” struck us as almost the polar opposite of the Roman Catholic position.

119. The question for the Church of England must be where, on the spectrum between these positions, should HCC be located?
120. At present, HCC has chosen to stand very close to the Catholic position. HCC staff have maintained that they stand for an authentic ecclesiology whilst the chaplain-led organisations are regarded as having sold the pass to a dominant secular agenda. This has been one of the sources of tension and dispute among the different bodies.
121. In this, the HCC position is not without merit. Secularisation, in society in general, not just in the NHS, is a major challenge to the churches’ traditional understanding of their social role. There is always a risk that those who learn to speak a new language, and spend most of their working lives in the places where that language is spoken, will come to forget (or at least, cease to be fluent in) their native tongue.
122. Our findings from the chaplains themselves suggest that this risk is appreciated and that chaplains have found their own ways of guarding against it. That does not quite dispose of the problem, since the deeper question is how a focus on professionalism in secular terms will change the balance between the chaplains’ NHS and church identities over a period of years.
123. However, we are also very aware of the Church of England’s fundamental role in relating to the institutions and structures of society. The difficulty found by the Roman Catholics in developing this side of their ministry is telling. An Anglican theology of mission also suggests the necessity of maintaining the language of faith alongside the language of “the world” – the best-selling report, *Mission-Shaped Church* bases its analysis of mission on precisely this tension and the need to hold both aspects together.
124. So, whilst we can see the rationale behind HCC’s current stance towards the “professionalization agenda” (and towards those who promote it), we do not believe that this approach has been fruitful, or is likely to be so.
125. Instead, we believe that HCC should be more Anglican in its approach. By this we mean being deeply conscious of the “both/and” aspects of mission which are, after all, grounded in the vocabulary of classic Christian orthodoxy where the Kingdom of God is both present and yet to come and Christ is both fully God and fully human. Anglican orthodoxy, holds holiness alongside engagement with the world, and combines the reformed focus on purity with the catholic focus on inclusivity. Anglican theology therefore reflects the theological attention to paradox well. We believe that HCC must help

equip chaplains to learn to speak the languages of the NHS and of the church with equal fluency and to maintain the constant tension (which so many chaplains reported to be at the heart of their lives and work) between Christian vocation and NHS employment. This is a necessity if chaplains are to be effective advocates for the interests of patients, both in the NHS and in the wider community context.

126. Of course the risk remains of chaplains retreating into the secular mind set of the NHS and losing their authenticity as members of the church. It remains the Church of England's responsibility, including that of bishops and bishops' advisors, to offer strong roots within the church for chaplains who are undertaking this front-line work. But it must be done in ways which chaplains can value and which recognises the tightropes they walk. It means attentive listening to the chaplaincy context and continuing to work with those who evaluate the dilemma differently. We repeat that most chaplains want to retain their roots in the church and not to jettison them. For the Church of England to allow itself to be portrayed as championing one side of a known dilemma, rather than helping chaplains to navigate the complexities, has been unhelpful.
127. This leads us back to the Key Principles articulated at the start of this report.

8. A New Remit for work among Anglican health care chaplains

135. We have come to the conclusion that HCC has tried to do too much and has therefore achieved too little. It has underestimated the extent to which collaborative working could offer more effective support for chaplains. HCC has made assumptions about the centrality of the Church of England's role in supporting all chaplaincy which we believe have been superseded by changes in the NHS and wider society, and has not kept up with the models of ecumenical and multi-faith team work which so many chaplains find creative and effective.

Recommendation 1: The Hospital Chaplaincies Council has not been functioning as effectively as it should. The church's structures for chaplaincy support need to be more flexible, collaborative and clear about the functions only the Church of England can undertake.

Hospital Chaplaincies Council, its Chair, and Episcopal support

136. The Hospital Chaplaincy Council, as a committee, includes members who bring considerable experience and expertise to the table. We value their input enormously. However the business of a committee is not always conducive to using their experience and expertise effectively. The current membership does not include a great deal of direct and recent chaplaincy experience.
137. The HCC committee is large and cumbersome for its purposes. We note that all Boards and Councils which operate under the auspices of the Archbishops' Council are being urged to reduce the number of the members and the cost of their activities quite drastically. We believe that a lighter, more flexible, structure, more obviously geared to utilising the expertise available in the church, should take its place. (We note the high regard with which the Roman Catholic Health Care Reference Group is held for its work on ethics and the fact that it is conceived as a think tank rather than a committee).
138. The HCC committee should, in our view, no longer be a constituted sub-group of the Archbishops' Council but should act as a reference group with the expertise to advise the church and its officers on matters of health care policy and chaplaincy issues. As this is a fast moving field, the areas of expertise required may change from time to time and this suggests a small core group working within a wider panel of experts who can be called upon when needed. Just as the Advisor on Medical Ethics has convened a reference group of ethicists and experts to advise him on issues such as assisted dying, beginning of life issues, and so on, we believe that the church will best be served by a small group of people with experience and expertise relevant to health care

policy and chaplaincy. The group should be convened for specific purposes, meet infrequently and conduct most of its business electronically. Some of the present members of the HCC would be obvious members of such a new grouping.

Recommendation 2: The present Hospital Chaplaincies Council should be replaced by a small reference group of members selected for their expertise on health care and chaplaincy issues. This group should conduct most of its business electronically.

139. The position of the Chair of the HCC, who is also a bishop and a member *ex officio* of the MPA Council, requires clarification. With the present HCC replaced by a reference group, we believe that there is a strong case for the work to be supported by a Lead Bishop for Health Care and chaplaincy issues. The parallel would be with the Bishop for Prisons who concerns himself with penal policy at national level, works with prison chaplains to give them episcopal support in addition to that of their diocesan bishops and argues the case for chaplaincy and its role. The parallel is not exact, as there is also a Chaplain General for prisons, but the present HCC staff fulfil a similar function on behalf of the church and this would continue with an AHCC as proposed.
140. We believe that the cause of health care chaplaincy would be well served if the Archbishops were to appoint a lead bishop for health care who had a particular remit for policy issues and for ensuring that chaplains' concerns are heard by the church. The lead bishop would not replace the diocesan bishop as the chaplain's first line of Episcopal support or pastoral care, but would have a role in encouraging all bishops to support their chaplains and possibly for mediation if a chaplain's responsibility to the NHS is in conflict with responsibilities to the diocese.
141. It is, in our view, important that the lead bishop for health care should be drawn from among the Lords Spiritual. Health care issues, and chaplaincy itself, are of great significance in the church's ministry and a Christian perspective needs to be emphasised in the legislative and deliberative processes. We do not believe that the lead bishop needs to be a member of the MPA Council.
142. There will need to be some negotiation with the NHS and DoH so that the role of the lead bishop is understood and enabled to engage at the right levels with senior staff concerned with health care and chaplaincy policies. This could be undertaken by the Director of MPA supported by the present Chair of the HCC, or by a lead bishop designate.

Recommendation 3: The Archbishops should be requested to appoint one of the Lords Spiritual as the lead bishop for health care and for chaplaincy issues in the NHS.

Recommendation 4: The lead bishop for health care should work with his fellow bishops to ensure that diocesan support and pastoral care for chaplains is more consistent and effective across the country.

Titles and roles

143. We believe that the Hospital Chaplaincies Council is not a title which adequately describes the proper roles which the Church of England requires in this field. It still implies a responsibility for chaplaincy as a whole and does not communicate the Church of England's position within multi-faith and ecumenical structures. Moreover, the focus on hospitals may be too narrow in the context of the complex structures of health care today.
144. We are not committed to any particular new title for the Church's work in this field. It may be sufficient that it is a part of the wider Mission and Public Affairs brief. For now, we suggest the title *Advisor for Health Care and Chaplaincy* (AHCC) to refer to the key staff member concerned.

Recommendation 5: The title Hospital Chaplaincies Council should be dropped and the key staff member with responsibility in this field should become the Advisor for Health Care and Chaplaincy within the MPA team.

The Church of England and Other Bodies in the Field

145. There is clearly a role for a body which brings chaplains of all faiths together to pursue common concerns. There is a similar need for Christian chaplains to find common structures for working on issues which affect them. Thirdly, there are occasions when Anglican chaplains need to operate together and present a common front. Only in the third of these instances is there a case for the Church of England assuming the lead on all occasions.
146. We therefore believe that the Church of England must have the capacity to be represented in multi-faith and ecumenical bodies – no doubt taking its turn alongside others to lead and service such bodies. It will also have a key role in working with dioceses to ensure that Anglican chaplains are linked to their ecclesial structures and connected to the wider work of the Church of England on issues of health care policy, medical ethics and so on. Ensuring this link should be part of the job description of the AHCC.
147. An important part of the role for the AHCC will be to play a full role in the Multi-faith Group and the Churches' Committee for Chaplaincy, so that the interests of the Church of England and its chaplains are fully represented in the ecumenical and multi-faith contexts.

148. In the case of the MFGHC, the CofE's representative should initiate discussion with the Chair and others to explore how roles such as Chief Officer and Administrator of the group do not become over-identified with any one religious or denominational group in future.

Recommendation 6: The Advisor for Health Care and Chaplaincy should play a full role in the Multi-Faith Group and the Churches' Committee for Chaplaincy alongside, and on the same terms as, members of other faiths and denominations.

149. We recognise that relations with the CHCC and UKBHC are especially poor. We have good reason to believe that responsibility for perpetuating the antagonisms lies on both sides. Restoring good relations will, therefore, need especial care and cannot be achieved entirely by unilateral action of any kind.
150. However, we believe that the Church of England is in a position to make the first overture by expressing its intention to restore good relationships whilst continuing to argue its case in contested areas. In this, the church would only be reflecting the position of many chaplains who are members of CHCC, may support in principle the objectives of the UKBHC, but do not necessarily share every policy or strategy which those bodies embrace. These are, after all, member organisations, and it is the responsibility of members to make their views and wishes known and acted upon.
151. The Church of England should indicate its support for the principle of member-led support bodies for chaplains. It should encourage Anglican chaplains to engage with the CHCC and to play a part in its policy-making and governance.
152. From time to time, the Church of England may find itself at odds with the chaplain-led organisations on matters of public policy. In such cases, it should be the role of the AHCC to express the church's views to the leadership of these bodies and to ensure that Anglican chaplains are aware of the reasons for the church's position. It should be the role of the Church of England to join in debates about chaplaincy (for instance, on the professionalization agenda) but not to run them or assume authority over member-led chaplains' bodies.

Recommendation 7: Chaplaincy networks such as the CHCC and UKBHC should be assured of the Church of England's willingness to work with them in future and its support for the principle of representative bodies led by, and accountable to, serving chaplains. Channels should be developed for the member-led bodies to be kept abreast of the Church of England's policies on health care and chaplaincy and for the church to be briefed on the activities of CHCC and UKBHC.

Accreditation and Support for Chaplains

153. We believe that the duplication of effort on the issue of accreditation has been damaging and wasteful of resources. Professional accreditation of chaplains should be structured to reflect the whole field of health care chaplaincy, thus cohering with the way the NHS understands chaplaincy to be a multi-faith and ecumenical provision. The UKBHC, despite the clumsiness with which it was set up, has an obvious role here.
154. At the same time, it is the church's job to ensure that those who engage in ministry on its behalf are in good standing and properly recognised by the church. There is a key role here for bishops who are responsible for licensing health care chaplains in their dioceses. We know, however, from the reports of chaplains, that diocesan support is patchy and contact with bishops (whether direct or through bishops' advisors) is somewhat hit and miss.
155. We believe that the proper model here is not that of a central "desk" but that of practitioner-led networks for Anglican chaplains. This is not intended to replace the national member-led CHCC but to offer a simple light-touch structure for Anglican chaplains to support each other and relate more effectively to the church through their dioceses and the National Church Institutions.
156. Some regional groups of Anglican chaplains exist already. It is rare, however, for the diocesan advisors responsible for liaising between chaplains and their bishops, to be connected to those groups. In some places, there is almost no local structure at all. One task of the AHCC will be to help establish regional groups for Anglican chaplains and including diocesan advisors. The right level of formality/informality will be crucial here. The main objective will be to enable chaplains to connect to the Church of England through their dioceses as well as through the AHCC, and to facilitate the exchange of good practice, especially in terms of proper support for chaplains.

Recommendation 8: The AHCC, with the support of the lead bishop, should work with chaplains in the regions, and with diocesan advisors, to establish networks for the sharing of good practice and support. These networks should be largely self-supporting once established.

Assessors' Panels

157. It is clearly important that NHS Trusts should be able to rely on authoritative information about the fitness to practice and good standing within the church of Anglican candidates for chaplaincy

posts. As ministers are licensed at diocesan level, the diocese is the correct level at which this form of accreditation should take place. However, dioceses will need some support in engaging with the NHS's appointment processes so that there is a complementary relationship between the church and the Trusts.

158. We believe that guidance should be produced by MPA, drawing on the DoH's own guidance and working in collaboration with the MFGHC and others bodies in the field, for the benefit of dioceses and those who may take part in appointment panels.
159. We do not believe that there needs to be a centrally-held list of CofE assessors. The manner in which this list has been compiled and used has been divisive and unhelpful. Instead, we believe that bishops, no doubt working closely through their diocesan advisors, should be free to nominate whoever they wish to panels appointing chaplains in their dioceses.

Recommendation 9: MPA should ensure that guidance is published nationally to help dioceses play a full part in the appointment of chaplains in their areas. The list of Assessors should be discontinued and bishops and diocesan advisors should appoint representatives to appointment panels for posts in their dioceses.

160. Negotiations between the churches and the Department of Health would be greatly assisted by a more collaborative and united relationship between the main bodies responsible for healthcare chaplaincy. The Department's allocation of funding to chaplaincy support structures does not, in our view, reflect the present needs of the churches and the AHCC, along with the lead bishop, and in close collaboration with the Churches Committee for Chaplaincy, should seek to open a conversation about this and other aspects of the churches' relationship to the Department.

Recommendation 10: The AHCC, working with the lead bishop and the Churches Committee for Chaplaincy, should work with the Department of Health to help clarify national policy about chaplaincy and seek to establish clear guidelines on the financial relationship between the Department of Health and structures for chaplaincy support.

161. The appointment of the Advisor for Medical Ethics and Health and Social Care Policy to MPA, with responsibility to work with HCC on medical ethics and health care policy, has given the Church of England the capacity to take a stronger role on ethical and policy issues in ways which involve and serve the chaplains. This is a relatively new post, and its significance to chaplaincy (and to HCC) has not yet been fully explored, but we expect this side of the work to grow and to be better linked to the constituency of chaplains in health care.

162. The boundary between health care policy and policies which affect chaplaincy is not easy to define. We believe, however, that the AHCC and the medical ethics and health/social care policy adviser should work together under the line-management of the Director of MPA to work collaboratively and apportion work and responsibility in a suitable way.
163. We note that the Church of England supports chaplains in Higher and Further Education through officers (based in the Education Division) who combine a responsibility for monitoring and responding to policy with support for chaplaincy in HE and FE. We believe that this is a suitable model for the support given to health care chaplains by MPA. There is scope in future for greater collaboration between Divisions in the support of chaplaincy in institutions where chaplains are not statutorily present.

Recommendation 11: The Medical Ethics and Health/Social Care Policy officer at MPA should continue to develop links with health care chaplains and address policy and ethical issues which arise in the chaplaincy context.

Recommendation 12: Further work should be done, within the Divisions of the Archbishops' Council, to create the most effective structures for addressing questions arising in all forms of public sector and institutional chaplaincy.

Training

164. We are delighted that the training programmes for chaplains run by St Michael's Llandaff and St Mary's Twickenham are now established and successful players in the field. We believe that these courses should be the primary sources of training for Anglican health care chaplains, although there is scope for regional training initiatives and other ventures aiming to address particular training needs.
165. HCC played an important part in helping these programmes to be established. The Church of England's chaplains are only one of the constituencies they serve. The proper role for the church now, is to ensure that chaplains are aware of the courses on offer. This means scaling-down the current HCC involvement in training and recognising that continuing professional development for chaplains is best provided by a mixed economy of training institutions. The network of regional representatives will have a useful role in disseminating information about training, not least, through word-of-mouth recommendation.

Recommendation 13: The Church of England centrally should not be involved in commissioning or running training courses for chaplains but should confine itself to co-operating with the successful courses at Llandaff and Twickenham.

9. Getting from Here to There

166. Some of the steps which we believe to be essential, if the Church of England's support for its health care chaplains is to be effective, have already been outlined in the recommendations above.
167. Some important moves have already been made. The job description for the MPA Advisor for Medical Ethics and Health/Social Care Policy is helpfully in line with the stronger focus on policy issues that we hope to see connected with the work of chaplains.
168. Through the work of the Webmistress and Training Coordinator, the support of healthcare chaplains has an experienced "face and voice" on the front line of queries and requests addressed to Church House. This post is now well integrated within the wider MPA support team.
169. The resignation of the Chief Executive Officer gives scope to recast the role into that described above as the Advisor for Health Care and Chaplaincy.
170. Until this can be done, the combined energies of the Webmistress and Training Coordinator and the Advisor for Medical Ethics and Health and Social Care Policy will give continuity to essential areas of day to day work and cover on policy developments which may be unpredictable. Both posts now come under the line management of the Director of Mission and Public Affairs who will be responsible for ensuring that essential roles are filled and the structures in place to implement the recommendations of this report.
171. The proper process for replacing the Hospital Chaplaincies Council with a reference group, and for appointing a lead bishop for health care and chaplaincy issues should be worked out between the Director of MPA and the present Chair of HCC.
172. We noted earlier the way in which policy and chaplaincy support are combined in the Education Division's work in HE and FE. We also noted the different structures of support for chaplains in prisons and the armed forces. We believe that there is scope for further work to explore the common issues in public sector chaplaincy and the ways in which structures of church support might evolve in future. It is clear to us that the separation of chaplaincies according to the sphere of public life which they serve is only part of the story – there are many issues, such as secularisation, which affect them all and where a common voice would be very welcome. There is scope for the chaplaincy support in health care, FE and HE, all of which is currently the responsibility of the Archbishops' Council, to collaborate more effectively. The new emphases in health care chaplaincy which we have recommended here

will, we think, help to make such discussions and future co-working take place.

In Conclusion

173. We recognise that our review process was short and aimed to point a way forward from a present, unsatisfactory, situation. Our report cannot be a final authoritative statement about the Church of England's involvement in health care chaplaincy. We hope that we have made a useful contribution to future directions and developments.

174. Chaplaincy in hospitals and other health care institutions is on the front line of the church's mission today. It is most regrettable that the tensions which chaplains face daily should have become the arena for antipathies among those responsible for supporting chaplains in their work. In so far as the Church of England has contributed to these breakdowns, we express our apologies to the chaplains whose work has been made harder as a result. Successive staff and members of the HCC have, over many years, contributed to work that is vital to the church's – and to society's – flourishing. In a rapidly changing secular context, it is right that the church's structures for supporting chaplains should adapt and change. We trust that, in offering this report and its recommendations, we have succeeded in showing the church's health care chaplains that the Church of England supports them, values them and seeks their flourishing.

10. List of Recommendations

- 1: The Hospital Chaplaincies Council has not been functioning as effectively as it should. The church's structures for chaplaincy support need to be more flexible, collaborative and clear about the functions only the Church of England can undertake.**
- 2: The present Hospital Chaplaincies Council should be replaced by a small reference group of members selected for their expertise on health care and chaplaincy issues. This group should conduct most of its business electronically.**
- 3: The Archbishops should be requested to appoint one of the Lords Spiritual as the lead bishop for health care and for chaplaincy issues in the NHS.**
- 4: The lead bishop for health care should work with his fellow bishops to ensure that diocesan support and pastoral care for chaplains is more consistent and effective across the country.**
- 5: The title "Hospital Chaplaincies Council" should be dropped and the key staff member with responsibility in this field should become the Advisor for Health Care and Chaplaincy within the MPA team.**
- 6: The Advisor for Health Care and Chaplaincy should play a full role in the Multi-Faith Group and the Churches' Committee for Chaplaincy alongside, and on the same terms as, members of other faiths and denominations.**
- 7: Chaplaincy networks such as the CHCC and UKBHC should be assured of the Church of England's willingness to work with them in future and its support for the principle of representative bodies led by, and accountable to, serving chaplains. Channels should be developed for the member-led bodies to be kept abreast of the Church of England's policies on health care and chaplaincy and for the church to be briefed on the activities of CHCC and UKBHC.**
- 8: The AHCC, with the support of the lead bishop, should work with chaplains in the regions, and with diocesan advisors, to establish networks for the sharing of good practice and support. These networks should be largely self-supporting once established.**
- 9: MPA should ensure that guidance is published nationally to help dioceses play a full part in the appointment of chaplains in their areas. The list of Assessors should be discontinued and bishops and**

diocesan advisors should appoint representatives to appointment panels for posts in their dioceses.

- 10: The AHCC, working with the lead bishop and the Churches Committee for Chaplaincy, should work with the Department of Health to help clarify national policy about chaplaincy and seek to establish clear guidelines on the financial relationship between the Department of Health and structures for chaplaincy support.**
- 11: The Medical Ethics and Health/Social Care Policy officer at MPA should continue to develop links with health care chaplains and address policy and ethical issues which arise in the chaplaincy context.**
- 12: Further work should be done, within the Divisions of the Archbishops' Council, to create the most effective structures for addressing questions arising in all forms of public sector and institutional chaplaincy.**
- 13: The Church of England centrally should not be involved in commissioning or running training courses for chaplains but should confine itself to co-operating with the successful courses at Llandaff and Twickenham.**

Appendix 1

The Terms of Reference of the HCC Review Group

1. The Review of the Church of England's provision in support of hospital chaplaincy has been commissioned by the Bishop of Gloucester who is Chair of the church's Hospital Chaplaincies Council. The Review group will report to the Bishop of Gloucester. Whilst the report is private to the bishop, the expectation is that he will make it public, in whole or in part.
2. There are a number of reasons why the time is ripe to review the work of the Church of England's Hospital Chaplaincies Council (i.e. the committee of that name and the work of the HCC Chief Executive and other staff)
 - **The shape of the HCC staff team at Church House has changed.** HCC is now working within the Mission and Public Affairs Division and one post in MPA (Rev'd Dr Brendan McCarthy) has been set up to encourage a greater degree of interaction between MPA and hospital chaplains on issues of medical ethics and social/health care policy. HCC now has a smaller support staff capacity.
 - **Issues affecting hospital chaplaincy are changing.** A more strident secularism appears to be informing aspects of health care policy and the position of chaplains in some PCTs is vulnerable. HCC needs to work closely with colleagues in MPA and elsewhere to ensure that the church's response to the secularist agenda is coherent.
 - **There are undeniable tensions between some of the bodies which represent hospital chaplains.** The question of whether hospital chaplaincy is primarily a profession within the world of health care, or a wing of the churches mission and ministry to society, is contested. In that it is both these things, the present structures do not seem well-equipped to hold the balance.
 - **There is a clear desire among chaplains across the country for nettles to be grasped nationally** and the breakdown in conversations involving the HCC, CCHCC, CHCC and UKBHC.
 - **The relative salience of ecumenical and multi-faith agendas in chaplaincy is changing.** Models of diversity, common in the NHS and PCTs, are less comfortable with the differences between churches and more likely to regard all manifestations of religion as equivalent.
 - **The Church of England is currently conducting a financial review --** and has indicated that hospital chaplaincy is an area of national work which might be done differently in ways which achieve savings.
 - **The CofE is also reviewing its structures --** and has raised a question over the future existence of committees such as the HCC.
3. The purpose of the review is for the Church of England to evaluate its central provision for hospital chaplaincy support and to consider how it should be provided in the future in relation to the wider network of bodies in the field.
4. Terms of Reference

The Review Group shall:

- Determine the best way for the Church of England's National Church Institutions to support Hospital Chaplaincy.
- Take into account the employment status of chaplains (including volunteer chaplains), the role of the bishop's licence and the diocese, ecumenical and multi-faith structures and sensitivities, and the roles of other bodies representing chaplains' interests.
- Explore the broader policy and operational context within which healthcare chaplaincy works.
- Bear in mind the work of other review processes currently active within the Church of England, especially the Financial Strategy Review and the Review of Structures.
- Consult with other interested bodies, calling for written evidence.
- Invite selected respondents to meet with the group to explore issues and ideas further.
- Address its recommendations to the Bishop of Gloucester, as the lead Bishop for Hospital Chaplaincy, who will determine how the group's recommendations will be disseminated and enacted.
- Where its recommendations bear implications for bodies outside the Church of England, consult with those bodies and, where possible, secure agreement about the proposed ways forward.

5. Proposed time scale for the review :

- September 2009 – review group convenes and agrees a process for its work.
- October—November 2009 – group collects submissions from interested parties and meets with key respondents.
- December 2009 – group draws its findings together and passes its recommendations to the Bishop of Gloucester.

Much of the group's work may be handled electronically but some 5—6 meetings will be necessary during the course of its work.

6. Membership of the Review Group.

The members of the group bring to its work significant experience of the NHS, of chaplaincy, of ethical issues and of the life and governance of the Church of England. They are

- *Dame Janet Trotter, Chair of the Gloucestershire Hospitals NHS Foundation Trust (Chair of the Group)*
- *The Revd Professor Stephen Pattison, Professor of Religion, Ethics and Practice in the University of Birmingham*
- *The Revd Mia Hilborn, Chaplaincy Team Leader in Guys and St Thomas' NHS Foundation Trust.*

+Michael Gloucester
Chair, Hospital Chaplaincy Council

Revd Dr Malcolm Brown
Director, Mission & Public Affairs

August 2009

Appendix 2

The Current Remit of the Hospital Chaplaincies Council

- (a) To consider questions of policy and practice relating to spiritual ministrations to patients and staff in medical establishments and community care programmes referred to it by the Archbishops' Council and/or the General Synod.
- (b) To provide information and advice to the dioceses in their negotiations with Health Authorities and Trusts on the appointment of hospital chaplains and on other National Health Service (NHS) matters; to visit and support dioceses involved in such negotiations; and to provide similar services to hospital chaplains in their relations with NHS management.
- (c) To respond promptly to enquiries from Chief Executives and Trusts regarding chaplaincy issues and the best practice for employment of Anglican clergy in the NHS.
- (d) To monitor and authorize, on behalf of the Church of England, the standards and content of training provided for hospital chaplaincy in cooperation with other Churches and chaplaincy organizations.
- (e) To work jointly with the Ministry Division in providing the personnel and expertise input from qualified chaplains in preparing theological students for their ministry to the sick in hospital and in the community.
- (f) To monitor matters affecting spiritual ministrations in all medical establishments and community care programmes, reporting to the Archbishops' Council via the Mission and Public Affairs Division and/or the General Synod as and when required.
- (g) To act as a liaison between the Department of Health and the Church of England on all questions relating to spiritual ministrations in medical establishments and community care programmes.
- (h) To contribute, in cooperation with the Community and Public Affairs team of the Mission and Public Affairs Division, to the ongoing theological reflections on contemporary medical, ethical and social issues.
- (i) To exchange information and advice in matters relating to hospital chaplaincy with other Christian Churches in the British Isles and abroad.

From: The Church of England Year Book 2010, pp.177—8

Current members of HCC (2005—2010)

Chairman

The Right Reverend Michael Perham

Vice Chairman

The Revd Professor D.Huw Jones, MA, MD MSc FRCP FRCR (Co-opted/General Synod) Postgraduate Dean – Eastern Deanery

Members

Dr Martin Elcock (General Synod)

The Revd Canon Nicholas Fennemore (Co-opted/General Synod)

Mr Simon Harrison, PhD (CHCC)

The Revd Canon Jane LLoyd, C.Chem, MRIC, Dip.Theol., (CHCC)

The Ven Douglas McKittrick, D Phil. (General Synod)

The Ven. Richard M.C. Seed, MA (General Synod)

The Revd Canon Glyn Webster, SRN PhD (General Synod)

Mrs Deborah Wheeler, BSc RGN (Co-opted/General Synod)

Miss Fay Wilson Rudd (General Synod)

From the Church in Wales

The Rev'd Nigel Griffin, BA (Swansea NHS Trust)

The Rev'd G Berw Hughes, BA (Ysbyty Gywnnedd NHS Trust)

Consultants

Mrs Jane Williams, MA (Theologian & Author)

The Rev'd Peter Sedgwick, MA, PhD (Cardiff University)

Appendix 3

The Questionnaire sent to Chaplains

Review of CofE National Support for Hospital Chaplaincy

- 1. What support, information etc. do you think hospital chaplains need from the Church of England? What support should be delivered locally (i.e. through the diocese, bishop etc.) and what should be delivered nationally?**
- 2. How is your work enhanced through contact with:**
 - a) The Hospital Chaplaincies Council?**
 - b) The College of Health Care Chaplains?**
 - c) The UK Board of Healthcare Chaplaincy?**
 - d) The European Network of Health Care Chaplains?**
 - e) The Multifaith Group for Healthcare Chaplaincy?**
 - f) Other relevant groups?**
- 3. Is the number of bodies representing Health Care Chaplaincy a problem for you in practice? How might things be ordered differently to help you personally and to support hospital chaplaincy generally?**
- 4. Did you received specific initial or induction training for your chaplaincy work? If so, from which body or institution? Do you receive specific Continuing Professional Development? If so, from which body or institution? What do you regard as the main training needs of hospital chaplains?**
- 5. Are you involved in Annual Appraisal? If so, who undertakes this appraisal?**
- 6. Do you work with volunteer hospital chaplaincy visitors? If so, how many are part of the chaplaincy team?**
- 7. What do you see as the biggest issue(s) affecting your ministry in the next 2—5 years? How might you be supported by the various organisations above in meeting the challenges and issues you identify?**

Please add any other comments which would be relevant to the review. If you need more space for your responses, please feel free to reply in another format.

Appendix 4

Diagrammatic representation of the Chaplains' responses

The files containing these diagrams are very large. Appendix 4 is therefore available in hard copy on request to The Rev Dr Malcolm Brown at MPA.

Appendix 5

A Reflection on Major Issues in the NHS Today

We are indebted to The Revd Dame Sarah Mullally, former Chief Nurse, for contributing this Appendix

1. The origins of hospitals in Britain can be traced back to medieval times when religious foundations established institutions such as St Bartholomew's Hospital, London and St Thomas's Hospital, London in the twelfth century. The advances in science and technology mean that both the health services and peoples' expectations of health care have changed over time and there are more changes underway in the NHS to which Healthcare Chaplaincy needs to respond: such changes are as a result of health policy and provision, the desire for care which is underpinned by evidence and research and a change in society which makes it more diverse and plural.

Changes in health policy and provision

2. The NHS was born on July 5th 1948 with the aim of providing a comprehensive range of services to all in need⁶. The original vision for the National Health Service (NHS) was based on the post war wish to defeat the five giants of oppression. This included the setting up of a welfare state in which healthcare was provided free at the point of delivery, providing cover from cradle to grave. Chaplaincy has been part of NHS provision since its inception.
3. Lord Darzi's report High Quality Care For All – NHS Next Stage Review ⁷ is the most recent government report to describe the changes facing society and healthcare systems around the world. He describes how the NHS in the 21st century faces a particular set of challenges: rising expectations; demand driven by demographics; the continuing development of our 'information society'; advances in treatments; the changing nature of disease; and changing expectations of the health workplace. The document concludes that these are challenges it cannot avoid and goes on to encourage the NHS to anticipate and respond to them creatively and systematically.
4. The report goes on to set out a vision of an NHS that gives patients and the public more information and choice, which works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe. It is an NHS which delivers high quality care for all users of services in all aspects, not just some.
5. The essence of Lord Darzi's report is that if the NHS is to move from quantity - more money, more clinicians, and more operations – to quality, healthcare

⁶ Ham, C., 2004, Health Policy in Britain, 5th edition, Palgrave Macmillan pg 5

⁷ Lord Darzi 2009 Lord Darzi Report - High Quality Care For All – NHS Next Stage Review
Department of Health

needs to become 'patient centered' with services redesigned around the patient and with personal choice a key component.

6. As has been noted the nature of healthcare has changed over time. Between 1900 - 1950 healthcare's concern was infectious disease, between 1950s - 2000 the concern was primarily heart disease and cancer. Beyond 2000 healthcare will be shaped by the increase in long term conditions and chronic disease amongst the population. Accessible services which fit with people's lives will increasingly be placed in local communities and not in general hospitals: this will mean people being diagnosed and treated while they are at home⁸ or in a community setting.
7. A corollary of this is that the questions about meaning and purpose that ill health so often raises will be asked at home or in the community not in hospital. The House of Bishops report⁹ suggests that people with chronic illness can often feel marginalised by both the NHS and the Church: this is an opportunity for the Church to respond and embrace people with chronic illness and view healing not just as a physical phenomenon but about the restoration of meaning to life¹⁰ : 'the restoration of the possibility of fulfilling the purpose for which we were created'¹¹ .
8. In creating a 'patient centred NHS' NHS organisations were encouraged by the Department of Health¹² better to understand patients and their needs. At the heart of a positive experience was whether they were treated as individuals with dignity and respect. People 'wanted to be treated as human beings and individuals, not just people to be processed, ensuring people always feel valued by the health service and are treated with respect, dignity and compassion.'¹³
9. At the heart of the 'patient centred' concept was the spiritual nature of an individual which can be seen in the revised version of the 'Patients Charter'¹⁴: 'NHS staff will respect your privacy and dignity. They will be sensitive to and respect your religious, spiritual and cultural needs at all times.' If Healthcare Chaplains align themselves with patients and provide a 'patient led' service they could seize the opportunity of demonstrating how their role contributes to the quality of a service which will influence how patients choose their hospitals in the future. However, the NHS organisation charged with responsibility for the development of Healthcare Chaplains recognised the challenge that existed to persuade healthcare organisations to show commitment to supporting the

⁸ The Department of Health, 2006, Our Health, Our Care, Our Say: A New Direction for Community Services, January, Department of Health.

⁹ House of Bishops, General Synod, Church of England, 2000, A Time to Heal: The Church of England's Report on the Healing Ministry, Church House Publishing, London pg 128

¹⁰ Pilch, J.J., 2000, Healing in the New Testament, Fortress Press, Minneapolis pg 141

¹¹ House of Bishops, General Synod, Church of England, 2000, A Time to Heal: The Church of England's Report on the Healing Ministry, Church House Publishing, London pg 129

¹² Department of Health/NHS, 2005, Creating a Patient-led NHS: Delivering the NHS Improvement Plan, 17th March, Department of Health.

¹³ Department of Health/NHS, 2005, Creating a Patient-led NHS: Delivering the NHS Improvement Plan, 17th March, Department of Health.pg 8

¹⁴ Department of Health, 2001, Patients Charter , Department of Health

spiritual needs of patients as an integral part of healthcare¹⁵. The NHS Constitution (2009) reinforces these themes as does the proposed single equality framework which seeks equality of access to health services for people for whom this is believed to be problematic, including faith and religious groups.

10. Spirituality for healthcare professionals is often only accepted as 'background noise': they often assume that it does not bear any real relationship to their central caring task¹⁶. Whilst healthcare professionals hope to deliver 'holistic care' in developments such as the 'nursing process'¹⁷ and by embedding concern for spiritual need in professional codes of conduct they have lacked clarity as to their specific role in the arena of spirituality¹⁸. For many spirituality does not fit the mould that has been carved by the medical model in western culture¹⁹ and has, as a consequence, been overlooked²⁰.
11. This has led to the spiritual aspect of care suffering from lack of interest and lack of attention in training: healthcare professionals often have a too narrow concept of spirituality and are uncertain about their own personal spirituality and religious beliefs and values. They also fear imposing personal beliefs on others and intruding on a person's privacy. There is evidence that nurses often wait for the spiritual need to be raised by a patient and only then do they refer them to the Chaplain²¹. This means that often spiritual care is being offered only to those people of faith²² rather than more generally being seen as part of the totality of a person's care.
12. It has been suggested that the ability of healthcare professionals to make an assessment of spiritual need could be increased by including in training an approach which allows them to become more aware of their own spirituality and limitations in this area²³. To achieve this, healthcare professionals need to have the opportunity to articulate their spiritual narrative, understand something of the narratives of faith communities and have confidence to recognise and support the spiritual care of those in their care²⁴. However, the reality is that this rarely happens – yet this could be an opportunity for Healthcare Chaplains.

¹⁵ South Yorkshire NHS Workforce Development Confederation, 2003, Caring for the Spirit: A Strategy for the Chaplaincy and Spiritual Healthcare Workforce, NHS.

¹⁶ Swinton, J., 1998 'Healing Presence: Reclaiming Friendship as a Pastoral Gift', in Contact, 126, pp2-7.

¹⁷ Roper, N., Logan, W. and Tierney, A., 1996, The Elements of Nursing, Churchill Livingstone, Edinburgh, pg 56

¹⁸ Robinson, S., Kendrick, K., and Brown, A., 2003, Spirituality and the Practice of Healthcare, Palgrave Macmillan.

¹⁹ Ross, L., 1994, 'Spiritual Care; The Nurses Role', in Nursing Standard, April 12, Vol. 8, No. 29, pp33-37.

²⁰ Govier, I., 2000, 'Spiritual Care in Nursing: A Systematic Approach', in Nursing Standard, January 12, Vol.14, No.17, pp32-36.

²¹ Charters, P.J., 1999, 'The Religious and Spiritual Needs of Mental Health Clients' in Nursing Standard, March 17, Vol. 13, No. 26, pp 34-37.

²² Wordsworth, H. A., 2001, Parish Nursing – A Mission Opportunity for Local Churches in England?, Dissertation for MA Theology in Applied Theology, Spurgeon's College pg 57

²³ Ross, L., 1994, 'Spiritual Care: The Nurse's Role' in Nursing Standard, April 13, Vol. 8, No. 29, pp33-37 pg36

²⁴ Robinson, S., Kendrick, K., and Brown, A., 2003, Spirituality and the Practice of Healthcare, Palgrave Macmillan pg236

13. The National Institute for Mental Health in England is at the forefront of developments within spirituality in the NHS and set up a spirituality project in September 2001 in response to users and carers increasingly saying that spirituality was of vital importance in their lives²⁵. The Institute recognised the growing importance of the 'whole person' where spiritual needs should be considered alongside physical, psychological, emotional, cognitive and creative aspects. It also recognised the increasing body of research which indicated that spirituality is a major factor in people's recovery by giving them a personal sense of meaning, identity and providing community support²⁶.
14. As the NHS drives towards a more patient centred service Healthcare Chaplaincy needs to be avowedly patient centred while also acknowledging wider concerns. It also needs to support spiritual needs as defined by patients, support other healthcare staff in a variety of settings and encourage faith ministers' in communities where increasing numbers of people will be assessed, diagnosed and treated.

A more diverse society

15. In 2003 the Department of Health in its guidance NHS Chaplaincy: Meeting the Religious and Spiritual Needs of the Patients and Staff gave a clear message that in the context of a changing NHS spiritual care had to modernise as part of the NHS responding more sensitively to the culturally and spiritually diverse nature of the communities it serves²⁷. A definition of spirituality which had historically been dominated by the clergy and by the western Christian Church tradition was no longer seen to be relevant in a diverse and plural society²⁸.
16. Typically hospital chaplains have been Christian ministers and have either been employed to work full time for the hospital or take on some part time sessions as part of their parish ministry. Their management was shared between church and hospital and their role as representative of the church in the organisation went largely unquestioned. The way chaplaincy was configured in any one hospital tended to be a consequence of local circumstances.
17. Modern Healthcare Chaplaincy is now increasingly concerned not only with serving and supporting those with specific religious beliefs and practices but also those with no religious beliefs and practices.
18. In society there has been a general loss of a Christian narrative and the decline in the corporate expression of faith has been demonstrated by the decline in churchgoing. Whilst people may be becoming less religious it would be wrong

²⁵ Gilbert, P., 2006, 'Breathing Space', in Community Care, (1106), January 19th-25th, pp36-37.

²⁶ National Institute for Mental Health in England, 2003, Inspiring Hope, Department of Health.

²⁷ Department of Health, 2003, NHS Chaplaincy: Meeting the Religious and Spiritual Needs of the Patients and Staff, Department of Health.

²⁸ Hollins, S., 2005, 'Spirituality and Religion: Exploring the Relationship', in Nursing Management, Vol.12. No. 6, October, pp22-25 pg 22

to suggest they are becoming less spiritual or that they no longer search for transcendence or spiritual fulfilment²⁹.

19. Religion has become separated from spirituality and it is this that has led to a broader definition of spirituality³⁰ to mean a more diffuse human need, broad enough to accommodate the uniqueness of all individuals, patients and nurses irrespective of particular belief, values or religious orientation³¹.
20. It can refer to the essence of human beings as unique individuals. ‘What makes me, me and you?’ So it is the power, energy and hopefulness in a person. It is life at its best, growth and creativity, freedom and love. It is what is deepest in us - what gives us direction and motivation. It is what enables a person to survive bad times; to be strong; to overcome difficulties; to become themselves.³²
21. This development of a broader definition has done two things. Firstly, it means that the Christian Church no longer has unique access to the language of spirituality. The post modern era has given birth to a mosaic of ideas and stories where Christianity is no longer the dominant force³³ but where the sacred still exists.
22. Secondly, it means that Healthcare Chaplains are becoming generic brokers of spiritual care. For some this appears like ‘dumbing’ down the Christian message and a move towards the lowest common denominator³⁴. ‘It is my belief that the effective abandonment of a particular charismatic theistic spirituality in favour of a generic consumer ‘spirituality’ may lead to the long term impoverishment of all concerned’³⁵. Pattison believes that rather than Christian Chaplains seeing themselves as generic brokers of spiritual care of all kinds they should hold on to what people find useful – the lived experience of dwelling within a historic religious tradition recognizing that Chaplains can only minister out of their own narrative³⁶. Rather than answering inclusiveness by eliminating distinctive faith communities Christian Healthcare Chaplains need to be ‘confident inhabitants of particular faith traditions who are prepared to dialogue.’³⁷
23. Healthcare Chaplains are employed by the NHS and serve a diverse population and should, in my view follow a more generic model of spirituality: building up

²⁹ Swinton, J., 2001, Spirituality and Mental Health Care, Jessica Kingsley Publishers pg 11

³⁰ Swinton, J., 2001, Spirituality and Mental Health Care, Jessica Kingsley Publishers pg 11

³¹ McSherry, W., 2000, Making Sense of Spirituality in Nursing Practice, Churchill Livingstone Press, Edinburgh.

³² Bradford NHS Trust, 2001, Document on Spiritual Well Being – Policy and Practice, NHS.

³³ Thwaites, J., 2000, The Church Beyond the Congregation, Paternoster Press, Cumbria. Pg23

³⁴ Pattison, S., 2001, ‘Dumbing Down the Spirit’, Chapter 2 in Orchard, H., (ed) Spirituality in the Healthcare Context, Jessica Kingsley Publishers, London.pg 39

³⁵ Pattison, S., 2001, ‘Dumbing Down the Spirit’, Chapter 2 in Orchard, H., (ed) Spirituality in the Healthcare Context, Jessica Kingsley Publishers, London pg 29

³⁶ Lyall, D., 2001, ‘Spiritual Institutions?’, in Orchard, H., (ed) Spirituality in the Healthcare Contexts, Jessica Kingsley Publishers.pg51

³⁷ Pattison, S., 2001, ‘Dumbing Down the Spirit’, Chapter 2 in Orchard, H., (ed) Spirituality in the Healthcare Context, Jessica Kingsley Publishers, London: pg 40

the capacity of the NHS to meet the spiritual needs of the patient and provide expert spiritual advice and support ³⁸.

A desire for evidence

24. Along with the NHS becoming more 'patient centred' there is growing evidence that suggests faith and spirituality impact on health outcomes. Healthcare Chaplains, as yet, do not have a specific evidence base that both protects and extends their work. Although historically there was an assumption that healthcare chaplaincy in the name of religion had an obvious relationship with suffering and recovery, the change in understanding of religion and the distinction between religion and spirituality requires that healthcare chaplains are more robust in their approach to their evidence base.
25. In November 2003 South Yorkshire NHS Workforce Development Confederation published a strategy for the chaplaincy and spiritual healthcare workforce ³⁹. Part of this strategy was to commission a review of literature to assess the state of the evidence base in UK healthcare chaplaincy prior to the formulation of guidance for chaplaincy research. It sought to provide practitioners and others with evidence to inform practice, add to the knowledge base of researchers and practitioners in the field of healthcare chaplaincy and stimulate healthcare chaplaincy research.
26. Healthcare Chaplains are being asked to show that what they do results in desired outcomes for those they work for: patients, families, staff, the organisation and the community. This requirement is linked to resource allocation. The urgent question is can chaplaincy articulate how it expedites the healthcare journey for those who are recipients and providers of health care.

Concluding Remarks

27. The provision of healthcare is changing; policy from the Department of Health is encouraging the NHS to be more 'patient centred' with care being provided in the community. Healthcare professionals often neglect people's spiritual needs and there is increasing evidence that faith does contribute to positive health outcomes.
28. Among other things Healthcare Chaplains need to align themselves more with patients and demonstrate how they contribute to improving people's experience of the NHS. The Church and faith communities need to engage with healthcare on an agenda of 'wholeness' and 'personhood' within a variety of healthcare settings.
29. Parts of the NHS such as the National Institute for Mental Health Excellence are taking hold of the agenda but the model of spirituality for them and increasingly for Healthcare Chaplains is a generic one. Healthcare Chaplains need to

³⁸ Mullally, S.E., 2005, 'Healthcare Chaplaincy and the NHS – Finding a Common Language', at The Bishops Advisors on Healthcare Chaplaincy Conference, 15th June.

³⁹ South Yorkshire NHS Workforce Development Confederation, 2003, Caring for the Spirit: A Strategy for the Chaplaincy and Spiritual Healthcare Workforce, NHS

provide support to an increasingly multiracial / faith community and support other healthcare professionals to build up their capacity to meet the spiritual needs of patients and carers. They need to provide expert support and advice to parish ministry and community faith leaders who will increasingly find they are supporting people who are being assessed, diagnosed and treated at home.

30. In the future Healthcare Chaplaincy will be characterised by patient choice, generic and faith based chaplaincy and community and NHS accountability⁴⁰.

⁴⁰ Follard, M., 2005(b), 'Looking Forward – Health and Chaplaincy', at the Multi Faith Group for Hospital Chaplain's Conference, 6th June.

Appendix 6

List of respondents

The following met with the Review Group.

The Revd Edward Lewis	HCC Chief Exec.
Mr Tim Battle	HCC (part time)
The Revd Prof. Huw Jones	Vice Chair HCC
The Rt Revd Christopher Herbert	Former Chair, HCC
The Revd Dr Derek Fraser	UKBHC
The Revd Mark Stobert	College of Health Care Chaplains
The Revd Debbie Hodge	Churches Together in England
The Rt Revd Tom Williams	Catholic Bishops' Conference
Fr John Gorman	Catholic Hospital Chaplain
Fr Paul Mason
Fr David Potter
Fr Peter Scott
Mr Barry Mussenden	Dept. of Health

The following contributed to the work of the Review in writing:

The Bishop of Grantham	
The Bishop of Guildford	
The Bishop of Leicester	
The Bishop of Manchester	
The Bishop of St Edmundsbury and Ipswich	
The Bishop of Sheffield	
The Bishop of Wakefield	
The Revd Canon Ian Ainsworth Smith	Diocese of Bath and Wells
The Revd Prof. Paul Ballard	
The Revd Neil Gray	Diocese of Manchester
The Revd Canon Dr Ian Lovett	Diocese of Liverpool
The Revd Clive Parr	Diocese of Worcester
The Ven Richard Seed	Archdeacon of York
The Revd Dr Christopher Swift	Leeds
The Revd Canon Dr Andrew Todd	St Michael's College Llandaff
The Revd Dame Sarah Mullally	Former Chief Nurse

113 serving chaplains

The Multi-faith Group for Healthcare Chaplaincy was approached to meet with the review group, but it appears that the correspondence was not received.

A number of other respondents were approached but were unable or unwilling to make a response.