**The Catholic Bishops' Conference of England & Wales**
**Healthcare Executive Group**

# Catholic Healthcare Chaplaincy

*Guidelines for the Church and Chaplaincy Employers 2018*

## *A Statement of Best Practice*

***A companion volume and other supplementary material will be produced on theological, clinical and training issues***

August 2018

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# FURTHER MATERIALS

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# Foreword

The work of healthcare chaplaincy and spiritual care remains, despite many changes in the world of health and care, of constant relevance.

Both the Welsh and English services within our National Health Service have in recent times revised their Chaplaincy guidelines and the growth of good scientific evidence around the value of chaplaincy interventions for staff, service users and their loved ones means that it is an opportune time to revisit and revise our guidelines.

We welcome the opportunity to work in partnership with all agencies, NHS and non-NHS, who employ healthcare chaplains, to ensure that high quality spiritual care plays its part in ensuring we care for our population.

The constant value of healthcare chaplaincy is that it provides a supportive presence in the midst of healthcare, helping people make sense of the health issues and the care they receive, and for Catholics addressing what our faith says, and having the ministry of the Church present for us at time of health challenges, is an important part of our faith and practice, and a legitimate expectation.

A new feature of this guidance is that it is available online only, so those reading and using it can find the most appropriate sections quickly, and it contributes to our commitment to sustainability.

**+ Right Revd Paul Mason**
Lead Bishop for Healthcare
Catholic Bishops' Conference of England and Wales

# Pope Francis on Healthcare Workers

When we suffer we are never alone because God in his merciful love for us embraces even the most inhuman situations in which the image of the Creator present in every person appears blackened or disfigured. That was what it was like for Jesus during his Passion who took on every human suffering, every anguish, out of his love for us.

Jesus's Passion is the greatest school for whoever would like to dedicate their lives to caring for their sick and suffering brothers and sisters. Experiencing the sharing of this fraternal love for the suffering opens us to the true beauty of human life including its fragility.

When caring for life, we must recognise the dignity and value of every single human being, from conception until death. Mary, Jesus' mother, welcomed life on behalf of us all and for the advantage of all and has very close personal links with the Gospel of Life.

I urge you to see the figure of Christ present in the poor, the suffering, the unwanted children, in people with physical and psychological disabilities and in the elderly.

***Pope Francis***
*speaking to the Pontifical*
*Commission for Healthcare workers*
*24 March 2014*

# Pope John Paul II on Health Care Ministry

The deep interest which the Church has always demonstrated for the world of the suffering is well known. In this for that matter, the Church has done nothing more than follow the very eloquent example of her Founder and Master.

In fact, over the course of the centuries the Church has felt strongly that service to the sick and suffering is an integral part of her mission, and not only has she encouraged among Christians the blossoming of various works of mercy, but she has also established many religious institutions within her with the specific aim to fostering, organizing, improving and increasing help to the sick.

In her approach to the sick and to the mystery of suffering, the Church is guided by a precise concept of the human person and of their destiny in God's plan…Illness and suffering are not experiences which concern only humankind's physical substance, but humankind in its entirety and in its bodily-spiritual unity. For that matter, it is known how often the illness which is manifested in the body has its origins and its true cause in the recesses of' the human psyche.

Illness and suffering are phenomena which, if examined in depth, always pose questions which go beyond medicine itself to touch the essence of the human condition in this world … For the Christian, Christ's redemption and his salvific grace reach the whole person in their human condition and therefore reach also illness, suffering and death

***Pope John Paul II***
*Apostolic Letter Dolentium Hominum*
*Establishing the Pontifical*
*Commision for Healthcare Workers*
*1985*

# Pope Francis on the value of Health Care

"How I would wish that we Christians could be as close to those who are ill as Jesus was, in silence, with a caress, with prayer. Sadly, our society is tainted by the culture of waste, which is the opposite of the culture of acceptance. And the victims of the culture of waste are those who are weakest and most frail; and this is indeed cruel. How beautiful it is instead to see that in this hospital the smallest and most needy are welcomed and cared for. Thank you for this sign of love that you offer us! This is the sign of true civility, human and Christian: to make those who are most disadvantaged the centre of social and political concern."

***Pope Francis***

*Visit to Prokocim paediatric hospital*

*Poland, July 30, 2016*

# 1. The Catholic Faith Community in England & Wales : Numbers, Identity & Beliefs

### *To be a Catholic*

1.1 To be a Catholic means, essentially, to be part of a faith community whose identity is informed and supported by a common tradition, common structures and common rites. This does not mean that all Catholics are entirely uniform. There is a wealth of liturgical, spiritual and cultural traditions included in Catholicism. There are Western or Latin Rite (sometimes called Roman) Catholics which many people in the UK will have some familiarity with, but there are also Greek or Oriental Rite Catholics whose worship and practices have much more in common with Orthodox Christians than Western or Latin Catholic Christians. (Syro-Malabar)

1.2 Even within Western Catholicism, there are many different national cultures. English and Scottish Catholics have different national patron saints, and even different customs around funerals, for example. Being a Catholic is a lifelong journey – even for those who leave or are alienated from the Church and engage with it intermittently. The lived experience of a Community following the example of Jesus Christ, sustained by the Holy Spirit and shaped through common belief, sacred scriptures and sacred rites is an inalienable part of Catholic identity. The central act of Catholic Worship – the Eucharist, or Mass – is an act done in Community, as are all Catholic Rites of passage from birth to death.

1.3 For Catholics, illness, as all of life, is something which the entire Catholic community is involved in. Catholics are taught that at times of illness they should expect to receive the prayers of the whole church, the support of family, friends and loved ones, and the ministry of the sacraments brought by clergy and other designated ministers. Catholics expect that they can access the Rites of their Faith Community and keep a live connection with that even and especially when in hospital. The ill or dying Catholic is upheld in the prayers of the Community and even rites like bringing Communion to Catholics in hospital are a means of keeping the person linked to the worshipping, living community.

1.4 An effective understanding of Catholic healthcare Chaplaincy in today's NHS requires a clear understanding that it is Chaplaincy from a Faith Community and that for Patients and Staff alike the Law upholds the right of Catholics to access their Faith Community's rites and support. This right in Law is recognised in NHS Policy in both England and in Wales including the NHS Charter and the Equality Act 2010.

1.5 Government's own figures taken from the 2011 Census indicate[i] that 8.3% of the population of England & Wales, on average, are Catholics. The Bishops' Conference of England & Wales estimates that there are 4.1 million

Catholics in England & Wales. This picture varies from area to area. In the North West 25% of the population have some link with the Catholic Faith. In Liverpool it is in excess of 50% Therefore a minimum of 8% of people in any hospital's catchment area are likely to be Catholics, even though some of those may have little live connection with the Church. Many Catholics return to a deeper practice of their faith at times of crisis, and hospitalisation is such a time. As will be seen below, the importance of providing for the spiritual and religious needs of this proportion of the population is recognised within NHS policy in England and Wales.

1.6 The Catholic population is, according to research[1] over-represented in the health and care workforce, compared to their representation in the general population. This is at least in part testament to the fact that Catholics explicitly see service to others as a core part of their mission. This has important implications for NHS employers and other care employers as they try to harness the good will and engagement of their employees and maintain good performance.

1.7 For Catholics, access to the ministry of the Church, and in particular the Sacraments, is an essential part of life. While in an ecumenical perspective, pastoral support and sharing in prayer and reading of the Bible is supportive and welcome, there are some particular aspects of their faith that can only be supplied by other Catholics who are appropriately trained and mandated by the Bishop.

1.8 Many Sacraments – some of the most sacred religious rites for Catholics - can only be administered by ordained clergy. Sacraments such as the Eucharist (often called Holy Communion) can be brought to hospital by a duly trained Special Minister, who may be a lay person or member of a religious order or community. The religious needs of Catholics can only be met to a limited extent by non Catholics.

1.9 The Church teaches that "sick people are not left to combat their illness alone.[ii]". Doctors, nurses, other healthcare professionals, social workers, chaplains and visitors in Catholic teaching take on a duty to do "whatever they deem necessary" to help the sick person "both physically and spiritually.[iii]" The Church also teaches that "When they do this they are fulfilling Christ's command to visit the sick, for it was Christ's intention that the whole person should be their concern and that they should offer both physical relief and spiritual comfort." Caring for those who are ill is, therefore, a direct participation in the ministry of Jesus Christ.

1.10 The Church teaches that baptised Catholics who are able to receive communion are obliged as part of their faith to ask for the sacramental ministry of the Church when sick. This means they should ask to receive the religious rites of their Church while in hospital. Not making arrangements for Catholic patients to be able to receive such support, should they wish it, can

[1] Stephen bullivant's researcg

therefore become a source of major anxiety to them and will directly and deleteriously impact on their health and healing. Catholics acknowledge that:

> The *Catechism of the Catholic Church* clearly states the priority with which Jesus held the care of the sick and dying as a component of his ministry and life: "Christ's compassion toward the sick and his many healings of every kind of infirmity are a resplendent sign that 'God has visited his people' (Luke 7:16) and the Kingdom of God is close at hand."[*Catechism of the Catholic Church (CCC)* #1503] Jesus sought healing for the entire person -- spirit, soul, and body. His compassion for the sick and dying was such that he even identified with them in both word and deed. And the *Catechism* states: "His preferential love for the sick has not ceased through the centuries to draw the very special attention of Christians toward all those who suffer in body and soul. It is the source of tireless efforts to comfort them."[*CCC* #1503][iv]

1.11 Catholics in common with other Christians believe that they are following the example of Christ in healing the sick and in praying for health. In particular the New Testament urges Christians when sick to call for the ministry of the Church, and the ministers are to pray over the person, and anoint them with oil. (James 5: 14-15.) While for Catholics illness unites us to the suffering of Christ, the Church teaches that it is equally "part of God's plan that we should combat all illnesses and prudently seek the blessings of good health.[v]" Catholics, unlike some other Christians, have specific sacramental rites for the sick, which follow the injunction of the New Testament with anointing. In particular, the sacraments of Reconciliation and Eucharist often play an important part in Catholic sacramental ministry to sick people.

### *Understanding the role of the local Bishop in Healthcare Ministry*

1.12 Ministry to those who are ill, for Catholics, is in a special way the particular concern of the Bishop, who is essentially the chief Pastor in his Diocese. The Chaplain, who exercises a publicly appointed or mandated ministry, exercises this with and on behalf of the Bishop. This is a point which needs to be understood by the NHS and chaplains within it, because the entire work of a Catholic Chaplain's ministry is conducted within this context.

1.13 The Catholic Chaplain cannot minister without the sanction of the Bishop. Indeed, the Chaplain's role would make little sense unless it was exercised as a participation in the ministry of the Bishop. In civil and in church (canon) Law the Catholic Chaplain, whether an ordained or lay person, is essentially an *agent* of the Bishop. It is the Bishop who has a particular duty to ensure visits to members of the Catholic faith community are undertaken and this includes to those who are sick. Catholic Teaching holds[vi] that:

> In the field of physical and mental health, each Pastor in his diocese proclaims the Gospel with the help of persons qualified in the pastoral care of the sick. Healthcare occupies a special place in our society. Medicine and healthcare which are both centred on the person and being near to people in time of suffering awaken in the heart of the Christian the image of the compassionate Christ, the Physician of Body and Soul, and calls to mind his authoritative words in the Church's mission: "Cure the sick" (*Mt* 10:8).
>
> Organizing and continually promoting pastoral activity in this area are a priority in the heart and life of the Bishop.

1.14 This is the essential context of Catholic healthcare ministry. Understanding this context makes it easier to understand the particular theological and organisational approach of the Catholic faith community, and why this requires a context of joint working between Bishop, Chaplain and the NHS.

1.15 The Church, in working with the NHS, seeks to develop a relationship of collaboration with the NHS, which is at once organisational and profoundly theological, reaching to the heart of the sacramental and pastoral presence of a living, worshipping, faith community. Catholics regard ministry to the sick as a sacred obligation. It is fitting that the Bishop has a central role in this, and that the Bishop and NHS together exercise their common duty to the work of health and healing.

# 2. The Policy & Legal Framework for NHS Catholic Chaplaincy Today

### *Current Guidance & Legislation*

2.1 Current NHS Policy in Both Wales and England recognises the need for chaplaincy, and sets down some principles for NHS employers in particular to deliver this. We will not repeat these here, but, as stated and welcomed in the *NHS Chaplaincy Guidelines 2015* for England, this document provides specific contextual guidance for Catholic chaplaincy.

2.2 Two principle models seem to exist for Catholic Chaplaincy in the NHS:

> The model whereby the NHS Trust employs Chaplains (and accredits volunteer Chaplains) who are treated as employees or accredited volunteers
>
> The model of Service Provision, whereby the Trust reaches a Service Level Agreement with the Ordinary (Bishop) who then provides a service of Chaplains to hospitals. This model is often used to deal with out of hours needs for Chaplaincy.

2.3 Whatever model is used, guidance and legislation exists in England & Wales which puts the importance of Catholic Healthcare Ministry in context for the NHS. Most recently this guidance includes NHS Chaplaincy Guideline 2015 *Chaplaincy: Meeting the Religious and Spiritual needs of Patients and Staff*[vii]

2.4 These documents recognise that there is an obligation flowing from the Human Rights Act 1998 and the Equality Act 2010 to provide proper arrangements which enable the Catholic faith community (as with other faith communities) to meet the religious and spiritual needs of Catholic patients and Catholic staff. The Equality Act 2010 adds impetus to the need for NHS bodies to ensure provision for Staff.

2.5 *NHS Chaplaincy (2015)* for England states that:

- *The NHS Charter* provides national standards for respect for privacy and dignity, religious beliefs and people's spirituality. Meeting the varied spiritual needs of patients, staff and visitors is fundamental to the care the NHS provides."
- "The Human Rights Act, introduced in October 2000, enshrines in law the right of the individual to religious observance. This underlines the need for NHS Trusts to provide appropriate world faith representatives and worship spaces for faith communities within the healthcare population."
- The Equality Act 2010 includes religion or belief as a protected characteristic in the provision of services and employment.

2.6 The Care Quality Commission Key Lines of Enquiry, and recent NICE guidance on care towards the end of life, and cancer recognised the importance of meeting the spiritual and religious needs of patients:

2.7 In short, Policy and legislation recognises that meeting the spiritual needs of patients and staff is part of providing effective healthcare and that NHS agencies and the Catholic faith community should work together to ensure that the proper religious and spiritual needs of Catholic patients and Catholic staff are taken into account in planning and are provided for.

2.8 To this end, NHS Trusts and employers are expected by NHS policy to be able to build effective relationships with their local Catholic faith community for the provision of Chaplaincy. Normally these arrangements are through the person of the local Diocesan Bishop, whose representative and agent is any properly appointed or mandated Catholic Healthcare Chaplain. Chaplaincy appointments should be made in conjunction with the Faith Community.

2.9 In Canon Law, the law of the Church, the competent authority to appoint a Chaplain is usually the Diocesan Bishop, known technically in Canon Law as The Ordinary.

2.10 Under the same Canon Law, the local bishop has the legal right of ecclesiastical appointment and discipline of ministers in his Diocese, including those which an NHS trust appoints as Chaplains. This is recognised in NHS Policy concerning the role of National Assessors for Chaplaincy Appointments.[viii].

2.11 The difference between appointment and mandate needs to be made clear. When a local Ordinary appoints a Chaplain the appointment includes all that is necessary in terms of faculties (ecclesiastical permissions) to function as a Chaplain as far as the Church is concerned.

2.12 This is true not just for clergy but, for lay people (including non-ordained religious), where a category of ministry commonly known as Mandated Lay Ministry, exists within the authority of the local Ordinary. This means that Catholic Healthcare Chaplains must hold recognition or appointment from **both** the NHS Trust, or other Healthcare organisation (e.g. a hospice) **and** the local Ordinary. In practice, most Bishops will appoint a Bishop's Healthcare Adviser (BHA) on chaplaincy. This is usually a serving Catholic Chaplain but not always. NHS Trusts will often have most contact with the Adviser.

2.13 The guidelines in this document have been devised to support the Ordinary, the Bishop's Adviser (several of whom have contributed to this document) and the NHS in working together as effectively as possible.

2.14 The Church also seeks to take seriously the training and formation of its chaplains. That is another reason why this document has been created.

2.15 The context of governance and management of ministries within the Catholic Church continually develops, with arrangements for regulating, appraising, supporting and developing people for ministry being reviewed to ensure ministry is the best it can be for today's world. The context for education and supervision of those who undertake healthcare ministry,

specifically chaplaincy, has developed as the profile of skills and competencies needed has become increasingly formalised and complex.

2.16 This current statement, then, seeks to clarify some key aspects of the legislation, policy context and theological background for Catholic Chaplaincy today. It is intended to help:

- NHS Agencies in understanding how the specific nature and context of Catholic Faith and Practice affects the set up, management and development of Catholic Chaplaincy.
- Ordinaries in working more effectively with the NHS and Chaplains. The pattern of this varies from diocese to diocese, and while some local variation is important, there is also room for some national standards of good practice.
- Chaplains in relating their ministry to best practice from the NHS and the Church.
- The Catholic Community in playing its part in working with the NHS to meet its spiritual and sacramental needs, and in working ecumenically in relation to chaplaincy as a whole.

### *Best Practice From Guidance and Legislation*

2.17 The role of a Catholic Chaplain in the NHS essentially involves a legal relationship between the Catholic Church in the person of the local Ordinary (i.e. the local Bishop) the NHS, the local Catholic Faith Community and the Chaplain. The local Ordinary makes the ecclesiastical appointment and authorises or mandates in ecclesiastical terms. The NHS either makes an employment appointment (where the Chaplain is an employee) or through a Service Level Agreement (SLA) with the Diocese which arranges Chaplains to provide a service. The Chaplain acts as the agent of the local Ordinary.

2.18 An SLA, where it exists, does not and should not isolate the Catholic Chaplain from the rest of the Chaplaincy Team. The SLA is a mechanism to make the provision of Catholic Chaplaincy more effective for the needs of patients and staff.

2.19 As with Clinical Governance in the NHS, so in the context of the Catholic Community a Chaplain, to be effective, must be held in trust and good faith by those who work with them. This is just as important for sessional, part-time, lay and religious who are Chaplains as it is for full-time and ordained Chaplains.

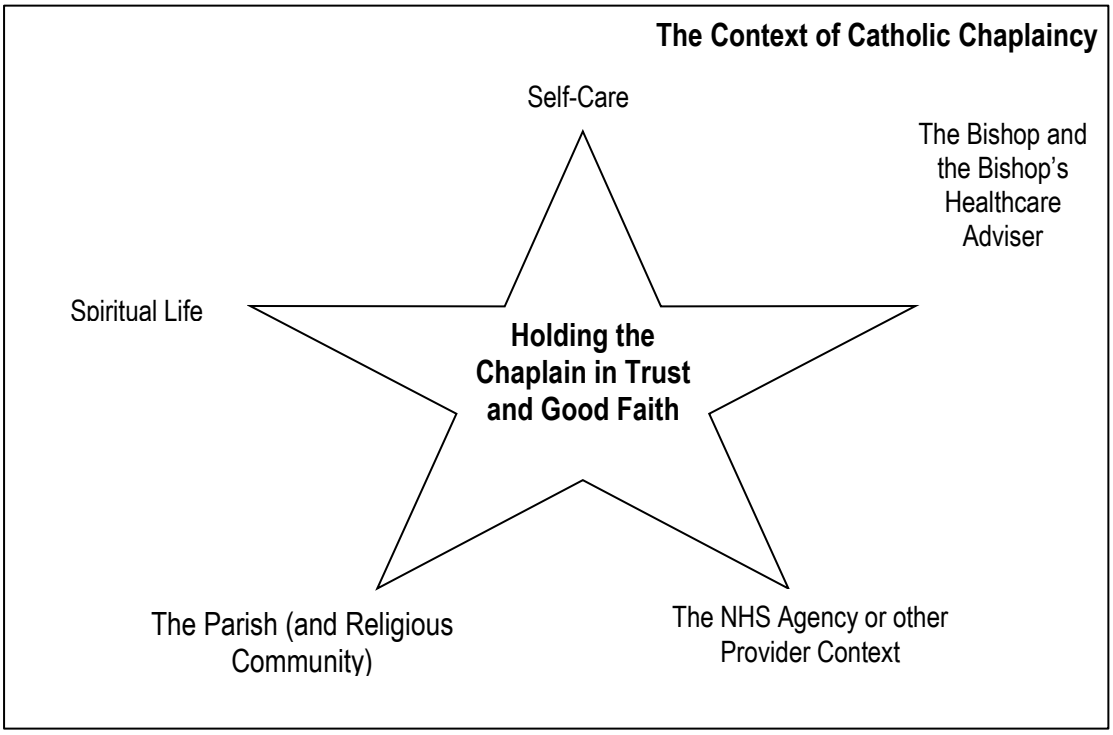
2.20 The role of the Bishop's Healthcare Adviser is important to consider in relation to how Chaplains operate. The Advisor often acts as lead on negotiations with the NHS, and may perform a variety of roles from being lead manager for relationships with the Strategic Health Authority or NHS Trust through advising on pastoral care, formation (development) and appointment of Chaplains, to having a strategic and administrative overview of all aspects

of Catholic Chaplaincy in a Diocese. Negotiations between the Bishop's Adviser will usually be the way in which NHS Trusts work with the Bishop. Ensuring, then, that the role of the Bishop's Adviser is recognised both as an administrative and strategic function and as a pastoral function assessing need for chaplaincy and supporting Chaplains in their ongoing formation (development) and role delivery is an important aspect of making joint working between NHS Trusts and the Church a reality.

2.21 But even where full-time, dedicated Catholic Chaplains exist, the role of the local Ordinary and wider Catholic faith community is important in Catholic Canon Law. This is because the local Ordinary appoints, mandates/authorises and disciplines clergy and all those (laity and religious included) who exercise a public ministry on behalf of the Church. The NHS Trust makes a civil employed appointment or accredits someone as a volunteer (in the case of unpaid chaplaincy volunteers.)

2.22 This need not be too complex a relationship. It needs to balance a range of priorities in a manner analogous to the seven pillars of clinical governance. In particular, the Spiritual Life and effective Self-Care (stress, boundaries, role-life balance etc) for the Chaplain are crucial. NHS agencies need to work with the Chaplain and the Bishop to ensure that their role can be effective, safe and accountable. This is shown in graphic form in the figure below. Problems arise when Chaplains become, for whatever reason, isolated from either parish/faith community or the NHS structure. A proper holding in trust requires holding being a part of the faith community and a part of the NHS in proper balance.

**Figure 1: The Context of Catholic Chaplaincy**



2.24 This raises points about ecumenical context and part-time chaplains. Catholic Chaplains work in an ecumenical context with other faiths. Three important points derive from this:

- First, It is important to approach this effectively and realistically, realising that Catholic Chaplains can and do minister to those of other Christian traditions and other religions, and vice versa, but there are specific religious boundaries which in the end entail that some faith communities can only be ministered to by those of their own faith. *NHS Chaplaincy Guidelines 2015* recognises this and NHS trusts should take this into account in their planning. The Church's Law, custom, practice and theology sets this down very clearly as a part of Catholic belief. Even if, for example, one non-Catholic denomination says "we have the same understanding of anointing and holy communion as the Catholics" that is not acceptable to a Catholic and the Catholic's right to have their specific needs respected is upheld by the law.

- Second, the arrangements for how the Catholic Church and NHS work together to protect the public and ensure Catholic Chaplains are effective means the relationship between the Faith Community and the Chaplains needs to be clearly articulated.

- Third, the issue of part-time Chaplains needs to be considered effectively. Given that many Catholic Chaplains are part-time, constraints of time will exist on their ability to take part in management and Chaplaincy team activities, with the concomitant detrimental consequences of becoming isolated from the Chaplaincy team and wider initiatives. The NHS policy frameworks allow for extra time to be built into Chaplaincy contracts so that part-time chaplains can take part in the wider ecumenical and team aspects of NHS Chaplaincy. NHS Trusts need to carefully consider this when allocating time and contracts.

2.25 The aspects of best practice for Catholic Chaplaincy, therefore, can be divided into those impinging on the person and practice of the Chaplain (deriving from theological, pastoral, sacramental and clinical governance contexts) and those impinging on appointment and management of the Chaplain. The person and practice of the Chaplain is dealt with later in this document.

2.26 Similarly, the Church expects that Chaplains will fulfil their obligations to meet those essential aspects of good practice which enable effective working in a healthcare context. This includes but is not limited to for example infection control and safeguarding training as well as other mandatory training. An acceptance of the need to work within reasonable and appropriate reporting structures is expected by all healthcare settings, and working within this is also expected by the Church of its Chaplains.

2.27 The table below deals with the aspects of best practice for appointment and management of the Chaplain, and seeks to relate them to the requirements of legislation and policy. Trusts and Local Ordinaries should

work together with Chaplains to ensure that these standards for best practice are met. Where an SLA model exists, these principles should be included in the SLA.

**Table 1: Best Practice: The Expectation of Guidance and Legislation**

| Issue | Best Practice | Legislation & Policy Engaged |
|---|---|---|
| A Memorandum of Understanding would enable a clear relationship on both sides. If an SLA is adopted, an MoU may be unnecessary | Bishops and the NHS Trusts in their Dioceses should agree a Memorandum of Understanding of key principles in operation of Catholic Chaplaincy. This already operates well in several NHS Trust areas and a template will be made available as part of the work of *Keeping Faith.* | Human Rights Act 1998<br>Equality Act 2010<br>The NHS Five Year Forward View<br>NHS Chaplaincy Wales Guidace<br>The NHS Charter<br>*NHS Chaplaincy: Meeting the Religious and Spiritual needs of Patients and Staff*<br>NHS Equality and Diversity Schemes |
| Arrangements for Appointment and Management | Trusts should have arrangements with the local local Ordinary (the Bishop) for appointment of RC Chaplains to meet the needs of the population, including part-time and lay Chaplains. | |
| Data Protection | Trusts must assess and facilitate the need for RC Chaplains to access data on patients so they can meet patients' needs<br>*This can help avoid risks to Trusts from litigation by patients and staff that their religious needs are not considered* | NHS Charter<br>Public Sector Equality Duty<br>NHS Equality and Diversity Scheme |
| Provision of and access to Chaplain for Patients | Trust must facilitate access to RC Chaplaincy for RC Patients in order to meet their spiritual and religious needs<br><br>*This is set down in the 205h Chaplaincy Guidelines* | NHS Charter<br>Public Sector Equality Duty<br>NHS Equality and Diversity Scheme |

| | | |
|---|---|---|
| Provision of and Access to Chaplain for Staff | Trust must facilitate access to RC Chaplaincy for RC Staff. | *NHS Charter*<br>*NHS Chaplaincy: Meeting the Religious and Spiritual needs of Patients and Staff*<br>Public Sector Equality Duty to staff |
| Inclusion | Catholic Chaplains should be able to play a full part in the Spiritual Care Team Playing a full part requires Catholic chaplains to look at the wider picture of healthcare chaplaincy, its structures, aims and purposes. | *NHS Chaplaincy: Meeting the Religious and Spiritual needs of Patients and Staff* |
| Development | Chaplains develop to meet standards of effective practice | |

# 3. Essential elements for effective Relationships: Chaplain, Bishop and NHS

3.1 The Catholic Chaplain, whether ordained, lay or religious; full-time or part-time, is an agent of the Bishop, and derives their legitimacy to minister from his authorisation. This means, that in law, there is

1. The Relationship between two Principals (i.e. Bishop and NHS Trust) to deliver a Chaplaincy Service, expressed through the joint appointment (ecclesiastical and NHS) of the agent : the person of the Chaplain.

2. Where there is an employment of Chaplains, the relationship of employment between the Chaplain and the NHS Trust
    a. For arrangements where lay volunteer Chaplains are used, and who are managed by the Trust, the legal relationship of volunteering which many NHS trusts are used to applies
    b. "Bank" Chaplains are often useful to provide out of hours and sickness cover. The employment model can be cumbersome for this and some Dioceses operate an employment model for "office hours" chaplaincy and an SLA for "bank" chaplaincy.

3. Where there is a Service Level Agreement Model, the Church is a service provider. The Church here appoints and the NHS accredits. An SLA arrangement sits well with the fact that the NHS Trust and Bishop are both Principals.
    a. For arrangements where lay volunteer Chaplains are used within an SLA, they are appointed and managed by the Church and accredited by the NHS Trust.
    b. Where an SLA model exists, many Trusts regulate and accredit individuals through the use of Honorary Contracts, a mechanism well used in the NHS.
    c. SLA models offer advantages in managing "Bank" Chaplains because where a bank of chaplains are accredited, the entire bank can be accredited simply by the Trust and deployed by the Bishop or Chaplain to meet need.

4. The relationship of agency between the Chaplain and the Bishop, which is the same regardless of whether a Chaplain is employed by an NHS Trust or accredited by them under an SLA.

3.2 This position is not new. The fact that employed Chaplains are essentially joint appointments (the Bishop appoints ecclesiastically and the NHS Trust makes the NHS appointment) is, as has been said above, recognised by NHS guidance. Deriving from the Law of Agency in England & Wales, a Chaplain acting on behalf of a Faith Community (i.e. *de facto* appointed by one) acts as an agent of their Faith Community.

3.3 As such, a legal relationship exists between the NHS trust employing the Chaplain *qua* Chaplain and the Faith Community. This is in addition to any employment relationship existing between the NHS Trust and the Chaplain and any employment/agency relationship existing between the minister and their faith community as Minister. This can be perceived as an interweaving network of duties of care, trust and confidence. The Chaplain has a duty to both the NHS Trust and Licensing Church Authority, who owe duties to her/him whether from Employment Law or ecclesiastical law respectively.

3.4 Equally, the Ordinary (local Bishop) as the Church Authority who issues the authorisation, and NHS Trust owe each other a duty. Other bodies involved in formation of Chaplains (e.g. educational bodies, Trades Unions, professional associations etc) are essentially Third Parties to this relationship. They may owe the Chaplain, the Church or the NHS Trust a duty of care (e.g. to ensure the training they provide is adequate or the representation and services they offer are effective) but they are still third parties outside the core relationship.

3.5 Giving effect to the particular nature of joint working with the local Ordinary is something which many NHS Trusts have recognised for some time, and *NHS Chaplaincy* recognises and continues this understanding. There are, however, a number of aspects of good practice which will make the relationship between the Chaplain, the NHS Trust and the Bishop clearer and smoother if they are outlined from the beginning, and contained in any Memorandum of Understanding as suggested in Chapter 2 above. These are outlined in the table below.

3.6 We suggest that it is good practice for the Bishops' adviser to develop with local NHS Trusts appropriate memoranda of understanding outlining these aspects of good practice and making clear arrangements for the management and provision of Catholic Chaplains locally. The table below suggests a framework for issues to be addressed in such a memorandum. A template Memorandum will be made available as part of the work of implementing this document. (See Appendix)

**Table 2: Dimensions of Good Catholic Chaplaincy Practice and Responsibility**

| The local Ordinary (the Bishop) | Jointly | The NHS Trust or Hospice |
|---|---|---|
| | **Governance Arrangements** | |
| Arrangements for appointment, management, development and care of Chaplains as Church appointees<br><br>Advisers can be helpful here since it is very difficult for bishops to be up to date with the nature of hospital chaplaincy | Memorandum of Understanding between Agency and Diocese | Effective systems for appointment and management of RC Chaplains compliant with policy above |
| **Good Standing** | | |
| Ecclesiastical Good Standing – discipline, checks, parish community | Protection of children and vulnerable adults through both Bishop and NHS applying their policies | NHS Good Standing – effective recruitment and selection within NHS policies |
| **Knowledge and Skill** | | |
| Theological Knowledge and Competence | Ensure relevant and ongoing training and professional development. | Healthcare setting knowledge and competence; mandatory training for healthcare setting |
| Technical and professional knowledge in sacramental situations | Technical and professional knowledge in pastoral situations | Technical and professional knowledge in clinical policy, patient rights, NHS policy and clinical governance etc |
| **Role-Life Balance and Self-Care** | | |
| Health, Pattern of Life, Personal boundaries, maturity of intra and interpersonal growth | Not just amount of time spent but ability to have personal time, personal development and formation | Occupational Heath and Safety including stress, vaccinations etc Being able to work across Christian traditions and other religions |

| | | |
|---|---|---|
| Prayer & Spirituality, Faith Development and discipleship | Good working conditions | Personal attributes within Person Specification |
| Self-Discipline according to canon law and Church expectations | Good working conditions | Discipline within NHS code of conduct<br>Clinical Supervision |

3.7 We also suggest that it is good practice for each local Ordinary to maintain a Register of those appointed and/or mandated to Chaplaincy whether ordained, religious or Lay. This should be open to NHS Trusts to check. This would usually be done by the Bishop's Healthcare Adviser.

3.8 The Church will present a substantive Chaplain (clerical or lay) with a formal letter of appointment – which must be presented to any NHS trust in which a Chaplain seeks to work. There should be some form of commissioning Rite or service within the faith community and/or NHS Trust for them. This derives from the fact that such ministries are part of the public ministry of the Church, and should be seen to be so.

3.9 In recent years, the healthcare field has seen professionalisation among a range of roles. This has included development of Codes of Conduct, creation of professional bodies and the increasing importance of education and training. There have been several such efforts in the field of Chaplaincy.,.. There is no statutory framework agreed by the NHS beyond the 2015 guidelines for England and the Welsh guidelines. There is equally no statutory registration body or standard. The overarching framework in the absence of any statutory framework for registration, remains a joint relationship between the local Ordinary (Bishop) and the NHS Trust.

**The Role in Canon Law of the Chaplain and the Local Ordinary**

3.10 Canon law is the code of law which governs the workings of the Church and the people it appoints to roles in its name.

3.11 It is important that the Bishops' Advisers and local chaplains themselves draw this to the attention of NHS Trusts as an added dimension of governance aimed at ensuring safety and integrity of practice. It is important to note that the local Bishop can remove chaplains where needed.

## Third Parties, Professional associations and registers in the Chaplaincy Relationship

3.12 Professional associations can be valuable sources of support for Chaplains, but they do not replace the authority of the Ordinary. A Catholic chaplain must be authorized by an Ordinary (the local bishop) as well as appointed by the healthcare setting.

3.13 The sets of roles and responsibilities around chaplaincy management, deployment and development sit properly in part with the Churches, in part with the relevant NHS Trusts and in part with educational bodies. There is also a need for a body which represents the employment and conditions rights of chaplains, in the same way that a Trade Union does.

3.14 The Church has no objections to Chaplains joining Trades Unions such as Unison, Unite or others, indeed this may provide valuable access to support. Church law does not allow priests to take leadership roles in Trades Unions. It should be noted that under its current status the College of Health Care Chaplains is part of Unite, a recognized Trade Union, and any employer requiring membership by a Chaplain is in effect acting contrary to the prohibition introduced by the Employment Act 1990 and the Trade Union and Labour Relations (Consolidation) Act 1992

3.15 The UK Board of Healthcare Chaplaincy is a voluntary register which recognises standards. The Department of Health confirmed in 2010[2] that this is voluntary and employers cannot require membership. At the same time, the Register does not replace the role of the Ordinary in either church or civil law. Discernment of whether registration is advantageous for a specific chaplain is a matter for discernment between the Chaplain and the Bishop's Adviser. Their chaplaincy cannot be made contingent on that registration, nor can it be enforced upon them.

3.16 Chaplains will be part of the indemnity, public liability and employers' liability insurances of their employing NHS Trust. . They may additionally seek professional indemnity insurance through a body such as the Institute of Healthcare Management or other body, but although this would be good practice, is voluntary.

3.17 The management and discipline of a Chaplain *qua* Chaplain is legally the subject and focus of the relationship between the local Ordinary and the NHS Trust only. All other bodies are essentially third parties to this. While the work of these third parties may have a bearing on practice and fitness to practice, it is not in their gift to decide this, but is the prerogative of the local Ordinary and NHS Trust only.

[2] This was confirmed in a letter from David Nicholson to all NHS Chief Executives in "The Week"

3.18 While Chaplains who are members of any of these bodies should adhere to the codes of conduct of these bodies, and while complaints about Chaplains *by virtue of being* members of these bodies may be properly considered by those bodies, these bodies do not decide the fitness of the Chaplain to be a Chaplain. Where a Chaplain is disciplined or struck off by a professional body of which s/he is a member, the proper course is for the NHS Trust and local Ordinary to consider the implications of this through their own policies and procedures.

3.19 A Code of Conduct exists between several chaplaincy associations and bodies, which some NHS Trusts have sought to incorporate into advertisements or conditions of employment[ix]. The Bishops support in principle the idea of a Code of Conduct which Chaplains can sign up to, and which helps them place their chaplaincy practice in a proper theological, ecclesial and clinical governance context. The Bishops of England and Wales, confirmed by Government's understanding, regard it as purely voluntary and it does not in any way intervene in the rights of NHS Trusts and Bishops to appoint and discipline Chaplains. In practice the Church has its conduct requirements and all healthcare settings now have their own conduct or acceptable behavior policies which are mandatory.

3.20 If there are concerns on the part of a healthcare setting about chaplains' practice, it is important to contact and seek advice from the BHA before it gets to the stage of capability or disciplinary. If a capability or other procedure is started against a chaplain the BHA should be engaged as a matter of urgency.

# 4. The Care of Catholic Healthcare Staff

4.1 The Catholic Church holds both that we should strive to enjoy good health and combat illness, and that we should care for the sick as Christ did. In fact, the Church teaches that involvement in a health profession is a vocation of great importance, because it directly follows the ministry of Christ.

4.2 For Catholics, involvement in healthcare as a profession and vocation is very often a means of living out their Christian commitment. Their ethos of care, quality and service stems from their faith-inspired values. It is seen as a ministry, following the life and example of Jesus. The Pontifical Council for Health Pastoral Care, a central agency of the Catholic Church, puts it in this context:

> The activity of those engaged in health care is a very valuable service. It expresses a profoundly human and Christian commitment, undertaken and carried out not only as a technical activity, but also as one of dedication to and love for one's neighbour. It is "a form of Christian witness." ' "Their profession calls for them to be guardians and servants of human life."[x].

4.3 Given the recent NHS programmes of recruiting staff from overseas, especially countries such as India, Poland, Spain and the Philippines where there is a high proportion of Catholics, there are wards and units in the NHS today where the largest faith group among the staff is Catholic.

4.4 It is not surprising, then, that Catholic staff will be a presence in many NHS Trusts and premises. The care of such staff, in particular ensuring they can access the life of their worshipping faith community, is important to both the NHS Trust (especially in light of the Equality Act 2010 and to the Catholic Chaplain. Effective working between the two can deliver benefits for patients, the Trust and the staff themselves.

4.5 Working in healthcare requires Catholic staff to manage the boundaries between their personal and professional roles. Seen positively, this can help them cut through the artificial dualities of physical/spiritual or psychological/spiritual. But it can also engender a real tension, particularly when ethical issues arise for the staff member. Access to a chaplain during these situations will be particularly important. It should be recognised that the particular moral tradition of the Catholic Church and the Church's own long history in the field of bioethics entails that a Catholic Chaplain is often felt by such members of staff to be an essential need.

4.6 The Catholic Chaplain, , has several significant roles in relation to healthcare staff, which directly impact on NHS Policy:

- Supporting staff in expressing and developing their faith and continuing *formation* or development in that faith
- Providing pastoral care and a link with the faith community

- Providing a mechanism of social support for isolated catholic staff and staff in general, especially those who have come from other countries to work in the NHS
- Supporting staff in developing and safeguarding their own clinical and professional practice by working through ethical and other issues effectively
- Supporting staff in local processes for shaping local policy in a way which reflects their specific needs (e.g. non-participation in abortion, understanding catholic reservations about some genetic technologies, etc.) This is an important aspects of the teaching role of the Chaplain.
- Providing a mechanism for ongoing development of staff in relation to their understanding of how their faith forms a value base for their work.
- Supporting effective self-care in healthcare workers
- Equipping healthcare workers with ethical and theological tools to understand their practice
- Equipping healthcare workers – Catholics and non-Catholics alike – to understand and respond sensitively to the needs of Catholic patients as required in *Standards for Better Health D2.*

4.7 NHS Trusts, and especially Chaplaincy teams within them, and Catholic Chaplains should work together to ensure that their Human Resources policies and their day to day practice supports these functions, in order to reap the benefits of them for staff and patients alike.

4.8 In particular, the needs of Catholic Healthcare staff who have come from other countries to work in the NHS needs to be understood. They may have religious needs which are different to many other staff, even among other Catholic staff employed by a Trust, due to particular cultural reasons.

4.9 In such circumstances the NHS Trust and Chaplain can facilitate access to particular Chaplaincies which exist in Dioceses for people from different countries, and access other support. Ensuring contact with the Trust Chaplain and accessing wider resources can be crucial in ensuring staff work well, and can be a part of meeting the best practice standards in *Improving Working Lives.*

# 5. Lay Chaplains and Ministers

5.1 Increasingly, Lay People and members of Religious orders (sometimes colloquially referred to as sisters, nuns, brothers or monks) perform Chaplaincy ministry roles. This may vary from being appointed as Catholic Chaplains or Assistant Chaplains to being volunteersbringing Holy Communion to those in hospital. Where Lay People or Religious are Chaplains, they too are mandated (authorized) by the Bishop and will need to have access to ordained clergy for sacramental ministry which is proper to clergy.

5.2 Lay Chaplains can be paid or may be volunteers and can be appointed to substantive chaplaincy posts. More is said about paid chaplains below. *NHS Chaplaincy guidelines and Welsh guidelines* makes specific reference of the use of Volunteers in Chaplaincy to help meet the needs of faith communities. If there is a substantive lay chaplain there should be provision made for sacramental care for Catholics.

5.3 Some NHS Trusts, where large numbers of lay volunteer ministers of Holy Communion visit people, regulate these through their accredited volunteering arrangements. This is good practice. A number of common elements of good practice volunteer chaplaincy assistants have been found through experience to work well:

- There is a dedicated person who supports the volunteers
- Volunteers are formally recruited, trained and deployed
- The HR Department is involved in this process
- Volunteers can access support and supervision
- Where an SLA exists, the volunteers are part of the arrangement if they are to be used
- Volunteers have out of pocket expenses remunerated and are able to access training
- Volunteers should have appropriate DBS checks
- Volunteers have a personal development plan
- Volunteers are brought together in groups for ongoing development on a regular basis

# 6. Contractual and Financial Issues

6.1 *NHS Chaplaincy Gudelines 2015* makes it clear that NHS Trusts should agree with Faith Communities a framework which allows for the Faith Community to meet religious and spiritual needs appropriately, and equitably. It does not, however, work out all the contractual and financial issues covering NHS Chaplaincy. Elsewhere in this document the following solutions are suggested to these issues:

- A Memorandum of Understanding between the Bishop and the NHS Trust (a template of which will be supplied) agrees key principles (Tables 1 and 2, Chapter 3)
- The Bishop and NHS Trust will need to work together, especially through the Bishop's Adviser (Chapter 3)
- Some Dioceses apply a Service Level Agreement (Chapter 3)

6.2 Financial constraints mean that many NHS Trusts have put in place a system whereby there is variety of provision for in-hours (daytime weekday) provision, and sometimes too limited provision of a "generic" (which may be non Catholic) out of hours provision.

6.3 The guidelines also state that if there is more than one call out for a particular faith community per week then the Trust should make specific call out provision for that faith It is important to ensure that units of time are calculated into Catholic Chaplaincy on a basis which reflects call out need so provision can be maintained, and that NHS Trusts understand why Catholic Chaplaincy needs to reflect call-out arrangements because of pastoral and sacramental needs that cannot properly be met by "generic" chaplains. This should be negotiated within the Memorandum of Understanding.

6.4 For Catholics, it is an essential aspect of pastoral care that in urgent situations or when facing major procedures and a chaplain is called for, an ordained Catholic priest administers sacraments to them. No other person can do this. Catholics have a right to this under the NHS Equality policy and under human rights legislation.

6.5 These issues should be approached by NHS Trusts at senior level, to establish properly a framework of equity for call-outs. It should be borne in mind that the need for call outs may be greater than would be anticipated by the sheer size of the Catholic Population. 9.6 Catholics because of their distinct religious needs and expectations often expect support from the Chaplains out of hours. Many trusts will find the bulk of their call outs are for Catholic patients

6.6 All of this means that a way has to be found of ensuring that the need for on-call for Catholics is equitably addressed. There are several models which can be used to resolve this tension:

1. A proper needs assessment in line with both English and Welsh guidelines is worked through between the Bishop's Healthcare Adviser and the NHS Trust, the outcomes of which are integrated into the Memorandum of Understanding, and is worked into the NHS Trust arrangements, with roles and responsibilities for both the local Ordinary and the NHS Trust determined for provision of out of hours work.

2. Where a Service Level Agreement is operated, the local Ordinary arranges cover for out of hours work) For "office" hours chaplaincy, appointments and a calculation into the framework of sufficient units for chaplaincy proceed as normal and for out of hours a Service Level Agreement is developed whereby conditions and paying out of hours on-call staff which is paid. A designated person organises the rota of on-call chaplains who are accredited by the Trusts and make the payment. Where this has happened so far experience suggests that it reduces administrative burdens on the NHS Trust, is governed by an SLA so both parties have clear rights and duties (including protection of children and vulnerable adults) and it has presented financial benefits in relation to meeting *Agenda for Change,* according to feedback from several NHS Trusts.

# Glossary of Useful Terms

**Anointing** - The administration of oil, specially blessed by the Bishop, to the head and hands of a person. Oil is traditionally associated with strength and cleanliness, and anointing is a part of many Catholic Sacraments across life. Baptism, Confirmation, Ordination and the Sacrament of the Sick all include anointing with such oil, termed Holy Oils.

**Auxillary Bishop** – a Bishop appointed to assist a Diocesan Bishop in his Ministry

**Bishops' Conference** – a National Body which represents all Catholic Bishops in that country and which comes together to agree key policy issues for the Catholic Faith Community in that country. England & Wales and Scotland each have their own Bishops Conferences.

**Canon Law** – The constitutional and governmental principles which guide the Catholic Church in its life and ministry. http://www.vatican.va/archive/ENG1104/_INDEX.HTM Courts of Law in England & Wales have traditionally regarded Canon Law as having authority for the Catholic Faith Community.

**Chaplain** – A priest, deacon, religious or layperson duly recognised by the Diocesan Bishop and NHS Trust, working to meet the spiritual and pastoral needs of patients and staff

**Diocesan Bishop** – the Bishop duly appointed and recognised as having jurisdiction and oversight in his Diocese. The term Bishop derives from the Greek episcopes, meaning overseer.

**Diocese** – a geographical territory, overseen by a Bishop, usually consisting of a few counties. This is further divided into parishes.

**Eucharist –** the sacrament in which Christ is present and is received under the appearances of bread and wine. The word Eucharist also refers to the act of worship in which the bread and wine are received, often referred to by Catholics as Mass. Receiving the Eucharist is often called receiving Holy Communion.

**Extraordinary Minister of the Eucharist** - a religious or layperson duly authorised by the Church to bring the Eucharist (Holy Communion) to people unable to participate in the Church's normal celebrations.

**Extreme Unction** – an outdated term for sacraments offered to a sick person. See Sacraments below

**Formation** - in this document is the initial and ongoing development of a Chaplain to do their role, but also the development of Catholic healthcare staff in their life, faith and work. *Formation* is not just academic or professional training, but is wider. It includes development in a spiritual and personal

sense. Formation is seen as a means of bringing together all the aspects of *forming* or developing a person for discipleship and living their particular vocation and ministry, be that as a Chaplain, a nurse, a doctor or a healthcare assistant.

**Holy Communion –** see Eucharist

**Last Rites** – Another term which although outdated is often colloquially used to denote the visiting of a person when thought to be in some danger of death, to administer the sacraments of Reconciliation (Confession), Eucharist (Holy Communion) and the Sacrament of the Anointing of the Sick (anointing with oil, sometimes called extreme unction.) The Sacrament of the Anointing of the Sick (see below) is actually intended to be used more broadly than in extreme situations. Relatives, families or the person themselves often express a concern that Last Rites have been administered.

**Mass –** see Eucharist

**NCSC** - National Catholic Safeguarding Commission http://www.catholicsafeguarding.org.uk/ orofessional advice on best practice in child protection, and among other functions organises appropriate screening and background checks for the Church.

**Ordinary** – the person who in church law is the competent authority for a Catholic population. For almost all NHS purposes this will be the Diocesan Bishop.

**Parish** – the smallest level of organisation of the Catholic faith community, usually equivalent to a village or several electoral wards of a large town or city.

**Parish Priest** - A Priest duly appointed by the Bishop to be in charge of a parish.

**Religious** – A woman or man who has taken vows (normally of poverty, chastity and obedience) and lives within the rule and customs of their religious congregation (e.g. Franciscan, Benedictine)

**Rosary** - An iterative prayer designed to help Catholics reflect on the life of Christ and the role of Mary as modelling God's call to us. This is usually prayed with the aid of a string of beads, known as a rosary. The prayer involves repeating specific prayers while meditating on an aspect "mystery" of Christ's life and using the beads. Rosary beads have religious significance for Catholics both for the prayer and because they are often blessed. Since many Catholic receive them as gifts they often have great sentimental significant too. Rosary beads are often twined round the hands of a dead Catholic to symbolise their prayer and journey through life.

**Religious Superior** – The person who has oversight of their religious community (e.g. a house of religious sisters, brothers or priests.)

**Sacraments** – Sacred Rites and celebrations which are a vital part of Catholic life. For most healthcare purposes these include Baptism, Eucharist (Mass, Holy Communion), Reconciliation (Confession), Confirmation, Sacrament of the Sick (sometimes outdatedly called Extreme Unction) and Marriage. Many of these may only be celebrated by a priest.

**Sacred Scripture** – Catholics, like many other Christians, believe the Bible, comprising Old and New Testament is their Sacred Scripture.

**Sacrament of the Sick** – Technically this is the Sacrament of the Anointing of the Sick. A rite which Catholics expect to receive when ill, especially before undergoing theatre procedures or when seriously ill. The priest brings Oil specially blessed for the Sacrament and anoints the person on head and hands with prayers. Oil is traditionally associated with strength, so it is a sign that the patient is being given strength for the journey, whether that be towards healing or towards death. The sacrament of the sick is often associated with other sacraments such as Reconciliation (Confession) and Eucharist. When the Eucharist is brought as part of the Sacrament of the sick it is called Viaticum. Catholics believe this practice derives directly from Sacred Scripture, in *The Letter of St James, Chapter 5, verses 14-15.*

**Vatican** - The term commonly used to refer to the seat of the Pope and his *curia* or administration in Rome. The word Vatican really refers to the Vatican Hill on which the Vatican City State is built.

**Viaticum** – meaning “food for the journey”, this is the name given to the Eucharist when administered to a dying Christian.

# References

[i] *Report of a review of Department of Health Central Funding of Hospital Chaplauncy*. London : Department of Health (2004)

[ii] Sacred Congregation for Divine Worship (1972) I*ntroduction to the rite of anointing and pastoral care of the Sick*, 4

[iii] Sacred Congregation for Divine Worship (1972) I*ntroduction to the rite of anointing and pastoral care of the Sick*, 4

[iv] Bishop of Dallas (2002) *Pastoral Letter on the Care of the Sick.* *http://www.cathdal.org.cnchost.com/Pastoral%20Letter%20Care%20of%20Sick%20Dying%20121802.htm*

[v] Pope Paul Vi (1972) *Sacram unctionem infirmorum*

[*vi*] *The Bishop: Servant of the Gospel*. *Declaration of the Tenth Synod of Bishops.* Rome: Libreria Editrice Vaticana, 2001

[vii] *NHS Chaplaincy. Meeting the Religious and Spiritual needs of Patients and Staff.*London : Dept of Health, 2003

[viii] Dept of Health (2004) Assessors for the appointment of clinical scientists, hospital optometrists, clinical psychologists, child psychotherapists, hospital chaplains and speech and language therapists 29 october 2004 http://www.dh.gov.uk/assetRoot/04/08/21/12/04082112.pdf

[ix] Eg See a recent advert for Chester on www.jobs.nhs.uk

[x] Pontifical Council for Health Pastoral Care *Charter for Catholic Healthcare Workers.* Rome : 1995

# Further Materials

The following materials to support implementation of this guide will be developed and made available by the Bishops' Conference, on the website:

1. Companion guidance on theological and clinical role, training and formation of Chaplains

The following further materials to support implementation of this guide will be developed and made available by the Bishops' Conference, available on request from the address below:

1. A sample Memorandum of Understanding between Bishop and NHS Trust (will be available on request from address below)

2. Sample Job Descriptions

3. A Sample Service Level Agreement between Bishop and NHS Trust -

4. A Sample Assessment/Appraisal and Continuing Formation tool for Catholic Chaplains

5. Guidance and sample training programmes for Lay Chaplaincy Assistants and Volunteers

For further information and to obtain copies of these contact

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