

Editorial

The Challenge of Change

Meg Burton¹

Editor in Chief
meg.burton@gmail.com

As I write, the UK is less than three months from leaving the European Union, Donald Trump is being Donald Trump in the USA and all over the world change is happening, both within individuals and in society at large. Change can be a challenge.

As the largest employer of chaplains in the UK, the NHS in England produces guidance about the practice and deployment of chaplains to provide spiritual care across all of its services. The NHS Chaplaincy Guidelines (2015) are currently being revised. Questions are being asked: What is the role of the chaplain? Is chaplain the correct title for us? When we think about where the majority of people are treated, and where most people die, where should most chaplains be deployed? Should chaplains be paid for by Trusts/Health Boards or, if more are to work in community settings, should they be paid by those who commission the services?

It is often said that people do not like change, but change happens continually, whether we like it or not, to us as individuals as well as to the societies in which we live and work. The articles in this issue of *Health and Social Care Chaplaincy* all speak of change in one form or another, and you may find some of it challenging.

Whilst acknowledging that “appropriate spiritual care provision for all NHS patients is a statutory requirement and part of the NHS’s own contract of care” Susannah Cornwall, in her article, suggests that spiritual care for trans people “has the potential to improve wellbeing and outcomes for a group whose mental and physical health is known often to be threatened and precarious” and should be an imperative (Cornwall 2019). She

1. Meg Burton is an ordained Methodist Minister and Editor in Chief of *Health and Social Care Chaplaincy*. She has recently retired as Lead Chaplain for Rotherham, Doncaster and South Humber NHS Foundation Trust and is Joint Secretary for Healthcare Chaplaincy for the Free Churches Group, based in London, UK.

envisages a future where spiritual care is integrated within direct care provided by healthcare professionals, with additional care from specialist chaplains where desirable. The findings from the Modelling Transgender Spiritual Care project suggest a need for additional training and resourcing in gender identity care for chaplains, which has implications for budgets and commissioning, as well as increased accountability for fulfilling the statutory requirement for spiritual care in the NHS. A challenge indeed!

A continual problem, certainly in UK hospitals, is how do other members of the hospital staff know what services we offer and how many of them realize that we are there to support them, as well as the patients and their carers? Victor Sulaiman and Harrie Cedar, in their research article, have explored this issue, especially with regard to how our services are accessed if staff themselves are not aware of us and the roles we play within a hospital. This affects not only how effective we can be but also limits the offering of our services to patients and carers, thus, potentially, not being able to meet their spiritual and/or religious needs. They found that circulating their questionnaire immediately raised staff awareness of chaplains and the wide range of services they offer, but only on the unit in which the research was undertaken. They conclude, therefore, that much work needs to be done if staff in all areas are to be able to access chaplaincy services, both for patients and carers and for themselves.

Martin Skinner and Eileen Cowey begin their research article, by asserting that “Increasing religious diversity makes spiritual care more complex in healthcare settings” (Skinner & Cowey 2019). As they point out in their introduction, all UK healthcare staff are required to offer people spiritual care (UKBHC 2009; The Royal College of Nursing 2011; Gordon *et al.* 2011) but increasing religious diversity in the UK makes this more complex because there are a greater variety of needs to respond to. This review explores the experience of adults from minority religious groups in UK healthcare contexts by investigating primary research studies published from July 2007 to September 2017. They remind us that there is no such thing as “one size fits all” when supporting people from a particular faith group, that each of us is a unique individual with our own particular religious/spiritual needs, and conclude that all healthcare staff would benefit from on-going training concerning the delivery of quality individualized spiritual care to people from minority religious groups.

When we consider the question of where chaplains are best deployed, one of the best examples in the UK is in the community, working with mental health patients. Alan Gibbon and Debbie Baldie, in their research article, show us how effective Community Chaplaincy Listening (CCL) is by using the PROM (Patient Reported Outcome Measure). The PROM was designed

to generate evidence for the efficacy of specialist spiritual care and builds on the original Scottish study by Snowden and Telfer (2017). It is also being used to evaluate chaplaincy in Europe through the recently established European Research Institute for Chaplaincy in Healthcare (ERICH).

The final article in this issue of the journal, by Daniel Grossoehme, is based on a presentation he gave at the 15th Consultation of the European Network of Health Care Chaplaincy (ENHCC) in June 2018 at Blankenberge, Belgium. Here he reflects on his 25 years' working as a health care chaplain in a paediatric setting. He shares with us the challenges he has faced, both personally and professionally, the different experiences he has shared and the joy of being part of this great calling. Do we, too, find that we "grapple with theology at the bedside" more in chaplaincy than we do in parish? Do we find that people's understanding of God is "too small"? As we read his reflection, I am sure we will find ourselves reflecting on our own time in health care chaplaincy.

I hope you find much to feed you in this issue.

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