



SPIRITUAL CARE & CHAPLAINCY

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Dear Colleague

SPIRITUAL CARE

Purpose

1. To provide revised guidance on spiritual care in the NHS in Scotland.

Summary

2. The Spiritual Care Development Committee (SCDC) was asked to review the implementation of HDL 76 (2002). Revised guidance based on the SCDC report's recommendations is attached as Annex A. The SCDC report, which includes a copy of the previous guidance, is attached as Annex B and is also available at

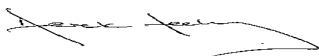
<http://www.nes.scot.nhs.uk/spiritualcare/publications/default.asp>.

Action

3. Chief Executives are asked to ensure that this guidance is brought to the attention of all appropriate staff and, in particular, to ensure that:

- they have appointed a senior lead manager for spiritual care;
- their Board's spiritual care policy is updated in light of local need and the attached guidance;
- their spiritual care/chaplaincy service is resourced to provide the necessary service throughout the year on a twenty four hour basis. Where this level of service is not currently provided an action plan showing how and when this will be achieved should be developed.

Yours sincerely



DEREK FEELEY

CEL (2008) 49

17 November 2008

Addresses

For action

Chief Executives, NHS Boards
and Special Health Boards

For information

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Directors of Nursing, NHS Boards
Directors of Human Resources,
NHS Boards
Scottish Health Council
Chaplaincy Organisations
NHS Chaplains
Faith/Belief Communities
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GUIDANCE ON SPIRITUAL CARE AND CHAPLAINCY IN THE NHS IN SCOTLAND

Introduction

1. This guidance is drawn from, and should be used in conjunction with, the attached report¹ of the Spiritual Care Development Committee (SCDC) on the development of Spiritual Care and Chaplaincy services within the NHS in Scotland. The SCDC is the national forum for discussion among faith communities, belief groups, healthcare staff, chaplaincy associations, the Equalities and Planning Directorate of NHS Health Scotland and the Healthcare Chaplaincy Training and Development Unit.
2. The SCDC report, which is written with a view to encouraging development in this area, is firmly based on the policy set out in HDL 76 (2002) which recognised the major changes taking place within Scottish society; described the essence and practice of spiritual care in ways which took account of such changes among people with and without any faith commitment; and signalled a significant movement in the understanding and practice of spiritual care and chaplaincy in NHS in Scotland.
3. The report commends NHS Boards on the work done to implement HDL 76 (2002) and affirms the understanding that spiritual care is a necessary and integral part of the whole person care offered by the NHS in Scotland.
4. The report identifies a number of ongoing development actions and the SCDC will continue to work with NHS Boards on these actions. The report's recommendation number is identified where appropriate in the following guidance.

Spiritual and Religious Care

5. It is widely recognised that the spiritual is a natural dimension of what it means to be human, which includes the awareness of self, of relationships with others and with creation.
6. The NHS in Scotland recognises that the health care challenges faced by the people it cares for may raise their need for spiritual or religious care and is committed to addressing these needs.

Spiritual care is usually given in a one to one relationship, is completely person centred and makes no assumptions about personal conviction or life orientation.

Religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community.

Spiritual care is not necessarily religious. Religious care should always be spiritual.

Spiritual care might be said to be the umbrella term of which religious care is a part. It is the intention of religious care to meet spiritual need.

¹ see Annex B and http://www.sehd.scot.nhs.uk/mels/hdl2002_76.pdf

Relationship with Healthcare

7. Among the basic spiritual needs² that might be addressed within the normal, daily activity of healthcare are:

- the need to give and receive love
- the need to be understood
- the need to be valued as a human being
- the need for forgiveness, hope and trust
- the need to explore beliefs and values
- the need to express feelings honestly
- the need to find meaning and purpose in life.

8. The need for spiritual care demonstrates that people are not merely physical bodies requiring mechanical fixing. People find that their spirituality helps them maintain health and cope with illnesses, traumas, losses and life transitions by integrating body, mind and spirit. People, whether religious or not, share deep existential needs and concerns as they strive to make their lives meaningful and to maintain hope when illness or injury affects their life.

Research and Evidence Base (Item 1.5 of SCDC Report)

9. Literature reviews show there to be a growing body of evidence as well as a healthy critical analysis of research in the realm of spirituality and religion. Many of the behaviours associated with faith and belief can be shown as beneficial to well-being.

NHS Boards are asked to:

- **promote research which broadens and enlightens the evidence base for the efficacy of spiritual and religious care in health (Recommendation 3); and**
- **continue the development of professional and research documents, journals and activities, both within Scotland and, where possible in a UK context, which will enable the advancement of NHS Chaplaincy towards self or national registered health profession status (Recommendation 22).**

Principles of Spiritual Care Services

10. The principles of all spiritual care services provided by the NHS are that the service should:

- be impartial and accessible to persons of all faith communities and none and facilitate spiritual and religious care of all kinds;
- function on the basis of respect for the wide range of beliefs, lifestyles and backgrounds found within the NHS and Scotland today, in particular in relation to age, gender, ethnicity, sexual orientation, disability and religion/belief;
- value such diversity;
- be a significant NHS resource in an increasingly multicultural society;
- be a unifying and encouraging presence in an NHS organisation;
- never be imposed or used to proselytise;
- be characterised by openness, sensitivity, integrity, compassion and the capacity to make and maintain attentive, helping, supportive and caring relationships;

² Narayanasamy A (1991) *'Spiritual Care: A resource guide'* Lancaster Quay Books

- affirm and secure the right of patients to be visited (or not visited) by a chaplain or their faith representative by incorporating flexibility into the means of obtaining informed consent to spiritual care both at the time of admission and during a patient's time of treatment;
- be carried out in consultation with other NHS staff; and
- acknowledge that spiritual care in the NHS is given by many members of staff and by carers and patients, as well as by staff specially appointed for that purpose.

Spiritual Care Policies (Item 2.1 of SCDC Report)

11. The review indicated that all NHS Boards had produced a Spiritual Care Policy written with wide consultation among the health service and with the local community.

NHS Boards should ensure that:

- **a senior lead manager for spiritual care is appointed (Recommendation 5); and**
- **their spiritual care policy is updated in light of local need and this guidance (Recommendation 6).**

Spiritual Care Committees (Item 2.3 of SCDC Report)

12. Spiritual care committees are now established in most NHS Boards and have developed their work patterns to meet local need.

NHS Boards are asked to review the role and composition of their Spiritual Care Committee to ensure that it fulfils its primary function, of engaging with local faith communities/belief groups, thus enabling dialogue between health care staff, spiritual care providers and community groups. NHS Boards should also ensure that the work of the Committee continues and develops in the best way for each Board (Recommendation 7).

Healthcare Chaplaincy Training and Development (Item 2.5 of SCDC Report)

13. The Healthcare Chaplaincy Training and Development Unit now sits within NHS Education for Scotland (NES) alongside the training of other healthcare professionals. Its responsibilities include the provision of spiritual care advice to the Health Directorates and the NHS in Scotland; the provision of chaplaincy training; developing a qualification in chaplaincy; the production and use of chaplaincy service standards; and creating a capability and competence framework for chaplaincy/spiritual care. The Unit's national advisory role has seen it develop strong links with chaplaincy associations throughout the UK as well as with Europe (through the European Network of Healthcare Chaplains), the USA and Canada.

NHS Boards are asked to encourage:

- **inter-professional educational initiatives to enable a wider understanding of the context and meaning of Spiritual Care and its relationship to Health among all healthcare staff (Recommendation 2);**

- **education on equality legislation and promote a service which delivers spiritual care equitably to people of any or no declared faith community or belief group (Recommendation 4);**
- **use of the Chaplaincy Capability and Competency Framework³ in professional and personal development in relation to the Knowledge and Skills Framework (Recommendation 17).**

Standards for Chaplaincy Services (Item 3 of SCDC Report)

14. The “NHS Standards for Chaplaincy Services”⁴ document describes the seven main areas in which a spiritual care service is expected to operate. The document includes a rationale, a set of criteria by which a chaplaincy service could be described and self assessment questions.

NHS Boards should use the series of self assessment questions contained within the Standards as the audit tool for the review of the Spiritual Care Service within their area (Recommendation 10).

The Appointment and Employment of Chaplains (Item 4 of SCDC Report)

15. The integration of spiritual care within NHS Boards’ responsibilities has provided an impetus for change. In the past the initiative for chaplaincy appointments came largely from the faith communities and the Boards enabled this to happen. The responsibility for a spiritual care service now lies within the NHS. The present chaplaincy and spiritual care workforce is populated by several categories including: whole-time Chaplains; part-time Chaplains; Denominational or Faith Specific Chaplains; Sessional Chaplains; Honorary Chaplains; Volunteers; and Healthcare Staff. Partnership between Boards and local faith communities and belief groups is therefore essential.

- **NHS Boards should ensure that the spiritual care/chaplaincy service is resourced, in human, financial, accommodation and support terms, to provide the necessary service throughout the year on a twenty four hour basis. Where this level of service is not currently provided an action plan showing how and when this will be achieved should be developed. (Recommendation 21).**

NHS Boards should:

- **use business plans, cost benefit analysis and other relevant factors to determine the complement of spiritual care staff, ie not just the size of the unit or the number of beds (Recommendation 11);**
- **employ Spiritual Care Staff for their qualifications and pastoral abilities. Having or obtaining the new Certificate in Healthcare Chaplaincy, once established, should be a requirement for all new appointments (Recommendation 12);**
- **use an appropriate chaplain as a professional assessor when employing whole-time chaplains (Recommendation 14);**
- **require chaplaincy staff to work with the whole healthcare community, patients, carers and staff, providing spiritual care for all and either providing or facilitating the appropriate religious care for those requiring it (Recommendation 12);**

³ <http://www.nes.scot.nhs.uk/spiritualcare/resources>

⁴ http://www.nes.scot.nhs.uk/documents/publications/classa/010207nes_standards_final.pdf

- wherever necessary and practicable develop a system of honorary chaplains or faith/belief group representatives to respond to the religious or spiritual need specific faith community/belief group (Recommendation 15);
- consider appointing a paid chaplain on a denominational or single faith basis where a needs analysis shows that numbers and needs of a faith/belief community would justify such an appointment and they are not represented by an employee on the spiritual care team. Any chaplain working in this way would require the direct authorisation of the faith/belief community, but would also be accountable within the NHS to the Head of the Department of Spiritual Care at the Board (Recommendation 13);
- encourage chaplains within their spiritual care team to:
 - a. maintain their good standing with the faith community or belief group in which they have roots;
 - b. work harmoniously with those of the wide variety of faith and belief groups within Scottish society;
 - c. play a meaningful part in chaplaincy professional associations;
 - d. participate in continuous professional development through attendance at study days, conferences;
 - e. support the development of relevant research, courses and qualifications for spiritual care staff, volunteers and other interested staff, and the use of reflective practice and pastoral supervision (Recommendations 8, 9 and 16); and
- encourage co operation with other Allied Health Professions and to work as members of the multi professional healthcare team whenever possible (Recommendation 23).

Spiritual Care in the Community (Item 6 of SCDC report)

16. The majority of healthcare takes place in the community. Therefore, spiritual care must find its place in settings other than hospitals. This is perhaps most clearly seen in mental health services where fewer people require in-patient care. Consequently, several mental health chaplains are working in day centres and in the community as well as in their local hospital. This will increasingly be the norm as Community Health Partnerships become major providers of health care.

17. There is also interest in some GP practices in implementing better spiritual care through using the resources and partnership of local faith/belief communities. There needs to be close partnership between chaplains based in the community and those based in acute in-patient units. Such care must be exercised in as seamless a way as is possible.

NHS Boards are therefore encouraged to develop new ways of providing spiritual care to health service users in community settings (Recommendation 19).

Data Protection and Patients Confidentiality (Item 10 Of SCDC Report)

18. The NHS in Scotland is committed to providing spiritual and religious care to patients who wish it, as part of a holistic health service. In this it is in full agreement with the World Health Organisation who wrote in 1998, "Patients and physicians have begun to realise the value of "spiritual" elements such as faith, hope and compassion which emphasise the seamless connections between mind and body".

19. While patients have a right to receive appropriate spiritual care as part of their health care, they also have a right of confidentiality and data protection. NHS Boards have a duty to ensure that both of these rights are met. Achieving this balance requires good communication to improve the understanding of these issues by the healthcare staff involved throughout a patient's journey of care.

20. The legal position is that a patient's faith or belief stance is sensitive information that may only be made available to another party with informed consent.

21. However, while it is important that a patient's right to confidentiality is respected, it is also important to ensure that this does not result in a failure to provide patients with the available spiritual or religious care. In exceptional circumstances where informed consent is impossible to obtain, eg if a patient is unconscious or impaired, then the views of carers, and common sense, should prevail.

22. NHSScotland has received supportive guidance from the UK and Scottish Information Commissioner's offices to the effect that consent to make available information as to a patient's faith or belief stance, may be given by patients either in writing or orally at any time throughout the care process. The time of admission to hospital is important, but is not always the time when a patient's broader emotional or spiritual needs are evident.

23. It is important to recognise that such consent may be given by patients at any point of their health care journey and needs to be listened for rather than demanded. It may, for example be given to a chaplain through a decision to enter into conversation, providing the chaplain has indicated his or her role. What is important is that all NHS staff remain sensitive to patients' spiritual and religious needs and respond appropriately by making the necessary chaplaincy referral.

24. The needs and rights of members of faith communities/belief groups for appropriate care, often of a sacramental or religious nature, should not be underestimated and all staff should be aware of how important it is to offer to facilitate this by sensitively asking and seeking appropriate help.

25. The Healthcare Chaplaincy Training and Development Unit will make more information on this available for patients and staff through leaflets and other general information channels. Boards should also take steps, eg the use of patient experience questionnaires, to ensure that patients' spiritual and religious needs are being both properly assessed and addressed.

NHS Boards should ensure the right of patients to be visited (or not visited) by a chaplain or their faith/belief representative by incorporating flexibility into the means of obtaining informed consent to spiritual care both at the time of admission and during a patient's time of treatment (Recommendation 20).

Further Support and Assistance

26. Further advice and support on any of the issues raised in this guidance is available from Reverend Chris Levison, Chaplaincy Training and Development, NHS Education for Scotland, 3rd Floor, 2 Central Quay, 89 Hydepark Street, Glasgow G3 8BW. Email: anne.richardson@nes.scot.nhs.uk, Telephone: 0141 223 1443.

Patients and Quality Division
November 2008

Spiritual Care and Chaplaincy in NHSScotland 2008

Revised Guidance

Report and Recommendations

Revision and Update of HDL (2002) 76 “Spiritual Care in NHSScotland”

Dealing with progress and change since 2002 and making recommendations for the future

Report and Recommendations June 2008

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Revised Guidelines for Spiritual Care/Chaplaincy in NHSScotland

1. Purpose

This report is written to describe the present situation, with a view to providing guidance on ongoing developments, in the area of spiritual care and chaplaincy in NHSScotland. It is firmly based on the understandings and changes put forward in the previous guidance contained in HDL(2002)76 'Spiritual Care in NHSScotland' (attached as Appendix 1).

1.1 Context

HDL(2002)76 signalled a significant movement in the understanding and practice of spiritual care and chaplaincy. It recognised some of the major changes that had been taking place within Scottish society, and it described the essence and practice of spiritual care in ways which took account of such changes among people with and without any faith commitment. There are many who believe who do not belong to a particular faith or belief group; hence, for example the discrepancy between those who self nominate as Christian (around two thirds according to the census of 2001) and the much smaller number who regularly attend worship. Some might call our age 'Post Modern' but all would recognise that we have a greater variety of faith, culture and belief throughout all our social institutions than ever before. Spirituality, in the early part of 21st century Scotland has many outlets.

1.2 Equality Legislation

Throughout Scotland, the United Kingdom and Europe there have been legislative changes promoting the equality of human rights for people of every background. The Equalities Act of 2006 and the bringing together of commissions to form the single Equality and Human Rights Commission have created a robust legal framework against discrimination. Discrimination on the grounds of religion or belief is an offence under the law. NHSScotland through its work on Patient Focus and Public Involvement as well as Equality and Diversity has shown the importance it places on treating people as individuals. People have a right to be respected whoever they are and holistic care must be the aim of every member of staff in NHSScotland. More detail of the legislation may be found in the NHS document "Religion and Belief Matter – An Information Resource for NHS Staff".

Recent government documents "Delivering Care, Enabling Health" (Scottish Executive, 2006) and further articulation of "The Kerr Report" in "Better Health, Better Care" (Scottish Government, 2007) have emphasised the development of a patient focussed service which both improves care and upholds the rights of individuals.

1.3 Spirituality

It is widely recognised that the spiritual is a natural dimension of what it means to be human. The awareness of self, of relationship with others and with creation, the finitude of life, the search for meaning, for the transcendent, and the need to be acknowledged, accepted, valued and loved, are all parts of this dimension. Many have reported profound experiences of wonder, joy, inner peace, transcendence and connection to nature and others, in ways they can only describe as spiritual. Many

express these understandings and experiences through a belief system, by holding to a set of values, or through belonging with and participating in the life of a faith community.

“Among basic spiritual needs that might be addressed within the normal, daily activity of healthcare are:

- The need to give and receive love
- The need to be understood
- The need to be valued as a human being
- The need for forgiveness, hope and trust
- The need to explore beliefs and values
- The need to express feelings honestly
- The need to find meaning and purpose in life¹”

The broad word “spirituality” includes religion, and spiritual care includes pastoral care.

The definitions used in HDL (2002) 76 have been useful and a catalyst for much valuable discussion:

“Spiritual care is usually given in a one to one relationship, is completely person centred and makes no assumptions about personal conviction or life orientation.

Religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community.

Spiritual care is not necessarily religious. Religious care should always be spiritual.”

These have shown that this agenda involves everyone, but they did not attempt to show in full the relationship between spiritual and religious care. Spiritual care might be said to be the umbrella term of which religious care is a part. It is the intention of religious care to meet spiritual need.

‘Pastoral care’, another term commonly used, although having Christian roots, is now often used to describe the care given for the well-being of individuals and communities in a broadly spiritual context.

Those who are specialists in providing spiritual care are often known as chaplains, although in some settings they may be known as spiritual care providers. Following much discussion among faith communities and belief groups of differing type, it has been generally agreed that the word chaplain is acceptable across the spectrum. It is the duty of those who wear the title and those who work with them to ensure that the perception of their role is one of person centred care, acceptance and affirmation of those with whom they work. The remit of their work includes patients, their carers and health service staff. All health care staff are expected to provide spiritual care at an appropriate level. (HDL (2002) 76, Par 5 refers). It is acknowledged that many,

¹ Narayanasamy A (1991) ‘*Spiritual Care: A resource guide*’ Lancaster Quay Books

including families, carers, significant others, etc, all give care which may be termed “spiritual”. NHSScotland is committed to providing or facilitating spiritual and religious care with equal commitment to any within its care.

1.4 Relationship with Health

The need for spiritual care demonstrates that people are not merely physical bodies requiring mechanical fixing. People find that their spirituality helps them maintain health and cope with illnesses, traumas, losses and life transitions by integrating body, mind and spirit. People, whether religious or not, share deep existential needs and concerns as they strive to make their lives meaningful and to maintain hope when illness or injury strikes. Often this striving or searching leads towards deeply spiritual questions such as; “Why do I exist?”, “Why is this happening to me?”, “What will happen to me when I die?”. Institutions that ignore the spiritual dimension in their regular provision of care increase the risk of becoming, as one commentator suggested, only “biological garages where dysfunctional human parts are repaired or replaced” (Gibbons and Miller 1989)

In recent times several health care authors have put this into words in different ways, e.g.:

“Spirituality is part of health, not peripheral but core and central to it. It pervades our every thought and action, each caring moment. Spirituality and health are bonded to each other, inseparable companions in the dance of joy and sadness, health and illness, birth and death.” (Stephen Wright “Reflections on Spirituality and Healing. 2005)

“Traditional spiritual practices such as the development of empathy and compassion are being shown to be vital active ingredients, even prerequisites, in effective health care – in the carer and the cared for they build wellness and happiness. Effective and efficient health care must now (re)take into account these core values.” (David Reilly in foreword to Reflections on Spirituality and Healing. 2005)

The World Health Organisation has made many statements describing the need for holistic care and the integral nature of this spiritual dimension:

“Until recently the health professions have largely followed a medical model, which seeks to treat patients by focussing on medicines and surgery, and gives less importance to beliefs and to faith. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process. The value of such “spiritual” elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension, emphasising the seamless connections between mind and body.” (WHO 1998)

Spiritual Care and Chaplaincy in the NHS in Scotland

The Scottish Executive echoed this holistic meaning of healthcare by describing spiritual care as “an integral part of the health care offered”, and that spiritual caregivers (chaplains), are “members of the professional care team” (HDL (2002) 76 Par 20), providing in most cases a twenty four hour, seven days a week service.

“Illnesses are deeply meaningful events within people’s lives, events that often challenge people to think about their lives quite differently. Spirituality sits at the heart of such experiences. A person’s spirituality, whether religious or non-religious, provides belief structures and ways of coping through which people begin to rebuild and make sense of their lives in times of trauma and distress. It offers ways in which people can explain and cope with their illness experiences and in so doing discover and maintain a sense of hope, inner harmony and peacefulness in the midst of the existential challenges illness inevitably brings. These experiences are not secondary to the “real” process of clinical diagnosis and technical care. Rather they are crucial to the complex dynamics of a person’s movement towards health and fullness of life even in the face of the most traumatic illness.” (J. Swinton in Mark Cobb: *The Hospital Chaplain’s Handbook* 2005).

Major societal health concerns include: long term conditions, sexual health issues, obesity, stroke, cancer and depression. Much attention is being paid to self care and rehabilitation. These are all areas in which spiritual well being, self worth, motivation and the confidence of a caring environment are of crucial importance. The health and ill health of Scottish society will be significantly affected by the quality of caring relationships both within and without the Health Service.

1.5 Research and Evidence Base

There is an increasing level of research activity concerning the positive relationship between faith/belief and health. Evidence exists which shows that the vast majority of those who have a faith/belief which is shared and enacted within a faith/belief community obtain health benefits, resulting in less stress, better sense of self worth and of meaning in life. Life years are increased, disease is better coped with and healing can be enhanced. Developments in psychoneuroimmunology show that stress, low self esteem, lack of control, lack of coherence, as well as poverty, frequently have a negative impact on people’s health. (McEwan, Steptoe, Carlisle; *Glasgow Centre for Population Health Lecture Series* 2005-7).

In Scotland the research base has grown, including the significant ‘What do chaplains do?’ by Dr Harriet Mowat and Professor John Swinton and the Ethos Project led by Rev Bob Devenny. A number of chaplains have undertaken research as part of post graduate qualifications, and a course teaching methods of research in spiritual care is now established with a growing number of participants. “Religion and Belief Matter” as previously referenced also contains a summary of some research evidence. The recent study ‘The Potential for Efficacy of Healthcare Chaplaincy and Spiritual Care Provision in the NHS (UK)’, again by Dr Harriet Mowat, although commissioned in England, is also relevant to the Scottish context.

Literature reviews show there to be a growing body of evidence as well as a healthy critical analysis of research in the realm of spirituality and religion among which there is material of varying quality.

1.6 Abiding Principles

The principles of all spiritual care services provided by the NHS remain, and include that such services should:

- Be impartial and accessible to persons of all faith communities and none and facilitate spiritual and religious care of all kinds;
- Function on the basis of respect for the wide range of beliefs, lifestyles and backgrounds found within the NHS and Scotland today, in particular in relation to Age, Gender, Ethnicity, Sexual orientation, Disability and Religion/Belief;
- Value such diversity;
- Be a significant NHS resource in an increasingly multicultural society;
- Be a unifying and encouraging presence in an NHS organisation;
- Never be imposed or used to proselytise;
- Be characterised by openness, sensitivity, integrity, compassion and the capacity to make and maintain attentive, helping, supportive and caring relationships;
- Affirm and secure the right of patients to be visited (or not visited) by any chaplain;
- Be carried out in consultation with other NHS staff; and
- Acknowledge that spiritual care in the NHS is given by many members of staff and by carers and patients, as well as by staff specially appointed for that purpose.

2. Developments in Boards

As proposed by HDL (2002) 76 Chaplaincy and Spiritual care services have been brought within the structures of NHS Boards with greater clarity leading to increased accountability. Boards have designated an executive lead for spiritual care, often at Board level and a lead chaplain or head of service has been appointed. Boards vary in their internal organisation of chaplaincy and spiritual care services as do the names by which they are known in hospitals – Department of Spiritual and Religious Care (or Pastoral Care) is common.

2.1 Spiritual Care Policies

Each Health Board has produced a Spiritual Care Policy written with wide consultation among the health service and with the local community. These policies have been commented on and approved by the local Board of Directors. In Area Boards the local faith and belief communities were consulted so that there would be an appropriate awareness of local communities and belief groups while organising a spiritual care service which would be 'fit for purpose'. Special Boards, some of whom are spread through different areas and may not have direct patient contact, have written their policies with staff and client consultation of differing kinds.

2.2 Responsibility for Spiritual Care

Since its inception the NHS has upheld the need for hospital chaplaincy. The work of chaplains has increasingly involved the provision of spiritual care to those with little or no connection to a faith community while still providing religious care to those for whom it is appropriate. As the work has broadened to include increased staff support and education and as the integral nature of spiritual care has become understood as a core and necessary part of any health institution (which is required to provide whole person care), so there has been movement towards an acceptance that health

provision is enhanced by it. The Scottish Government Department for Health and Wellbeing and the Health Boards have come to understand spiritual care as a necessary part of health service provision which can take its place alongside the other core services of the NHS.

In the past it might have been said that the faith communities, in effect the main Christian Churches, were the bodies responsible for the provision of chaplaincy. The last few years have seen a shift whereby this role now lies with Health Boards who are creating new relationships with faith communities and belief groups to ensure that religious and spiritual care addresses the diversity of the local population. There is a new landscape of discussion and consultation emerging in which all parties have new roles to understand and viewpoints to hear. Faith communities and belief groups are being used as a resource for advice in training NHS staff and for delivering religious and spiritual care; appointments to vacant chaplaincy posts come from a wider range of faith communities and backgrounds. Board Spiritual Care Committees have been useful contexts for discussion, debate and development of the service. The Scottish Inter-Faith Council has made valuable and informed contributions to the process.

2.3 Spiritual Care Committees

Spiritual Care Committees are now established in most NHS Boards. These are chaired by a Board nominee and are made up of representatives of the spiritual care staff, including the lead chaplain, local faith/belief communities and groups, patient representatives, staff representatives and the spiritual care manager.

These committees have developed their own working patterns and vary considerably in how they run and how often they meet. They are largely advisory groups and provide a lively forum for discussion. They have a key role in the governance of a Board's Spiritual Care Policy and its implementation. They hear reports, plan events and, in some case, play an active part in recruitment. They are multi faith in character with denominations; belief groups (e.g. The Humanist Society of Scotland) as well as a variety of world faith groups playing a full part. Some are more active than others.

2.4 Departments of Spiritual and Religious (or Pastoral) Care

A Chaplaincy Service in an NHS Board will deliver spiritual and religious care in accordance with the Board's Spiritual Care Policy. Board Single System working can mean that there are several Departments of Spiritual and Religious Care (local terminology varies) working as a unified service and management / leadership structures will vary from Board to Board.

The Chaplaincy Service and its Departments in hospitals or units allow for chaplains working in specialities (e.g. Paediatrics, Oncology), to plan together, audit and develop the service. Priorities can be set and resources shared on matters such as training and education, for staff, volunteers, and the supervision of students. Leadership to the service creates greater cohesion and accountability for local service delivery. Creative use of the varied talents, skills and interests of all chaplains can provide a better service and offer development opportunities to practitioners.

2.5 Healthcare Chaplaincy Training and Development/Spiritual Care Advisory Unit

In order to provide and develop more standardised and appropriate training opportunities for healthcare chaplains and spiritual care providers, the Healthcare Chaplaincy Training and Development/Spiritual Care Advisory Unit was established by the Scottish Executive Health Department in 2001. Alongside developing training for chaplains the Unit was required to promote and resource the writing of Spiritual Care policies by health boards and to report on progress to the Scottish Executive Health Department (SEHD).

There continues to be a clear relationship between person or patient centred spiritual care, the Patient Focus Public Involvement, and the Equality and Diversity agendas. The Unit has been involved in the religion and belief strand of the six areas of diversity. This has now been largely taken on by an Education project looking at the religion/ belief strand developing towards a single Equalities Unit, now housed within NHS Health. The Scottish Health Council has taken over much of the monitoring and reviewing aspects of the work concerning spiritual care policies and their implementation and impact within health board areas.

Following an initial trial period the Unit was made permanent and became part of NHS Education for Scotland. Thus, in keeping with government policy, the training of spiritual care providers has become better integrated alongside the training of other healthcare professionals. This has also made more explicit the need for spiritual care awareness in the training and development of other health care professionals.

The Unit now has responsibility for the provision of training, developing a qualification in chaplaincy, the production and use of service standards and creating and disseminating a capability and competence framework for chaplaincy/spiritual care. The Unit has a national advisory role and has developed strong links with chaplaincy associations throughout the UK as well as with Europe (through the European Network of Healthcare Chaplains) the USA and Canada.

An advisory group, the Chaplaincy Training Advisory Group (CTAG), was established in 2005 to work with the Training and Development Officer in the provision and planning of training and educational events and opportunities.

3. Standards for Chaplaincy Services

The "Standards for NHSScotland Chaplaincy Services" document was produced by a working group and, following consultation, has been ratified by the three professional chaplaincy organisations; the Scottish Association of Chaplains in Healthcare (SACH), the College of Healthcare Chaplains (CHCC Scotland Branch) and the Association of Hospice and Palliative Care Chaplains (AHPCC Scottish Branch).

These standards describe the seven main areas in which a spiritual care service is expected to operate. The document includes a rationale, a set of criteria by which it could be described and a series of self assessment questions by which an audit of the service can be undertaken. They have been well received by boards and chaplaincy managers.

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The areas are as follows:

Spiritual and Religious Care Needs: describing the task of the service as identifying and responding to those who have such needs. There has to be understanding by staff of spiritual and religious need, their similarity and difference. Assessment may require to be taught and good referral systems put in place.

Access to Chaplaincy Services: by which all patients, carers and staff have access to the service. This requires good written material with verbal back up and a clear way of checking that the appropriate information is given at the right time and with adequate explanation concerning the nature of the service. This will involve not only the admission procedure but during the patient pathway and an out of hours “on call” service.

Partnership with Faith Communities and Belief Groups: describing how chaplaincy services should work in partnership with faith community and belief groups to ensure the appropriate provision of religious and spiritual care for patients and their carers. Many patients appreciate visits by their own faith/belief group representatives and the service is expected to facilitate this when asked and when appropriate. An up-to-date and comprehensive contact list must be available. The service should also have easily accessed information to hand to help staff understand the particular needs they may encounter of those from faith and belief communities of many kinds. (e.g. *Multi Faith Resource for Healthcare Staff*).

Support for Staff: the chaplaincy service is expected to offer personal and professional support to staff and volunteers as part of its provision. Good relationships require fostering so that those who are undergoing stress or difficulty will be able to make use of such pastoral care which is confidential, empathetic and helpful.

Education Training and Research: the chaplaincy service is committed to supporting the continuing professional development of chaplains, and contributes to the healthcare team’s professional education, training and research programmes. Those within the specialist chaplaincy team have responsibility for their own development, for the developing evidence base of the profession and for offering opportunities to other healthcare staff to develop their understanding and skill as spiritual care providers.

Resources: the health service unit or board in which the service is housed has responsibility to ensure that adequate resources are provided for proper service delivery. Such resources include quiet spaces for counselling and worship, adequate opportunity for initial and on going training, administrative support and access to professional associations, faith community/belief group of choice and supportive supervision. There must be appropriate and adequate chaplaincy provision in keeping with the needs of patients, their carers and staff, including a 24/7 service.

Involvement in major Incident and significant events: chaplaincy services have a significant contribution to make at times of major event, incident or disruption within the health service. This could be a national event, a disaster or the death of a member of staff. Coping with major change such as hospital closure, dealing with numbers of relatives or a communal need, are all times where the chaplaincy service may play a valuable and valued role.

A Self Assessment Tool has been provided along with the Chaplaincy Services Standards Document. This tool enables the service to be audited so that priorities can be set and the strengths and challenges of a particular service seen and addressed. Appropriate questions are listed alongside each standard and answers, evidence and comments are asked for.

Health Boards are strongly advised to make use of this service standards document as a means of auditing and developing their spiritual care service.

4. The Appointment and Employment of Chaplains

The integration of spiritual care within Health Boards' responsibilities has provided an impetus for change. In the past the initiative for chaplaincy appointments came largely from the faith communities and the health boards had official advice to enable this to happen. The responsibility for a spiritual care service now lies within the NHS. Partnership between Health Boards and local faith communities and belief groups is essential. The present chaplaincy and spiritual care workforce is populated by several categories including:

Whole-time Chaplains: Directly appointed and employed by Health Boards with Agenda for Change banding and responsibility to develop their work in accordance with the Knowledge and Skills Framework. Employed to work with the whole healthcare community, staff, patients and carers, such chaplains are appointed to deliver and facilitate spiritual and religious care as appropriate.

Part-time Chaplains: Appointed by the health boards on exactly the same terms as whole time chaplains but with proportionate hours.

Denominational or Faith Specific Chaplains: appointed jointly by the faith community and Health Board but not generally direct employees of the health service. These have a particular responsibility for those of their own faith community. They work as part of the chaplaincy service and appointments will be made by local arrangement between the Health Board and the faith community.

Sessional Chaplains have historically been appointed to "an office" by their denomination without employment status and usually with a whole community role (even if assigned to set wards).

Honorary Chaplains represent a particular faith or belief group and are called upon when needs arise, with expenses paid. Such representatives are appropriately trained and subject to normal appointment procedures for chaplaincy volunteers.

Volunteers: trained to work within the parameters of the spiritual care policy and the Health Board's volunteer policy. They are normally assigned and supervised by a chaplain.

Healthcare Staff: expected to provide spiritual care as appropriate, to know the importance of listening, to show respect and sensitivity for those of all faith/belief groups in accordance with spiritual care policy and to make appropriate referrals.

Appointments are now made through standard NHS procedures and in accordance with needs provision and the health board establishment. The amount of chaplaincy provision will be decided in relation to needs assessment and the expectations and activities of the service. Guidance is available in the Chaplaincy provision section of this document.

The professional chaplaincy associations have a common Code of Conduct and it is strongly advised that chaplains and volunteers work within the parameters of this Code.

It is important that all chaplains as part of their employment contract must either have undertaken or be committed to undertake the basic induction training course as delivered by the NES Healthcare Chaplaincy Education and Training unit. A new postgraduate certificate of chaplaincy is planned and this or an equivalent qualification will be essential training for future entry into the profession. Continuing Professional Development (CPD) is expected to a level similar to other healthcare professions.

It should be noted that visiting Ministers, Priests, Rabbis, Imams etc are not chaplains but should be given access to those patients who wish their presence when it is convenient for the patient, the ward and the 'faith or belief' visitor. The department of spiritual and religious care has a responsibility to offer advice and facilitate this activity where appropriate.

4.1 Composition of Spiritual Care Department Staff

Chaplains will normally be appointed on the basis of their qualifications, pastoral skill and experience rather than any particular denominational or faith community basis. It is recognised however that it will help if the chaplaincy staff is equipped to provide for the spiritual and religious needs of a large proportion of patients, staff and carers. Where there is a particular need which is not catered for by the normal employment processes it is possible for the Board to seek an agreement with a faith community/belief group for a local service. Any such contract would mean that an appointment would be joint and the faith community/belief group and the Board would share a joint accountability for the service. Any chaplain working with this sort of agreement would be accountable to the head of department for his or her work within the institution and also to their faith community/belief group. The appointment would be by interview although there may be nomination arrangements.

It is understood that most faith communities/belief groups give pastoral or religious care through visiting their own adherents. It is the duty of the Spiritual Care Department to facilitate such visits. Any faith community or belief group may request

for one if its number to be recognised as the local contact/representative for the group or alternatively as an 'honorary chaplain' if such a system is in operation.

4.2 Whole-time and Part-time Chaplains

Several Health Boards have been amalgamating sessional or part time posts, thereby increasing the number of whole time posts. This is often in recognition of training needs, on-call responsibilities, professional development and the increased ability to integrate with other healthcare professionals. There will remain many areas where part time chaplaincy is seen to be preferable and more practical, particularly in some smaller healthcare units.

4.3 In Good Standing

The past assumption that all chaplains would be ordained clergy of recognised Christian denominations is no longer appropriate. Already several of the chaplaincy workforce are not ordained although Health Boards usually wish some of the team to have this recognition and ability to exercise the more common functions of ordination such as sacraments. It was felt that as a level of accreditation all chaplains should be "in good standing" with their faith community/belief group. As chaplains develop their professional credentials with a code of conduct, mandatory training modules and work towards regulation as a healthcare profession, and as they come from increasingly varied backgrounds, it is increasingly being questioned as to whether the description 'in good standing' is entirely appropriate as a condition of employment.

Where this form of accreditation is considered by a faith/belief community to remain a valid requirement for its clergy or practitioners to continue to practise a ministry in any setting, then there may become situations where a chaplain's conduct does not contravene a health board's employment policy, but would be in conflict with that community, and serious difficulties could arise. However it still remains as an area of understanding and trust between a patient, member of staff or carer to know that a chaplain is a bona fide member, representative or leader of the faith/belief community in which he or she is based. It is therefore recommended that health boards in appointment and review of chaplains take this seriously into account but do not regard it as being an over-riding factor when, by other professional standards and codes, the chaplain is still fit to practise.

In recent chaplaincy literature the need to be grounded within a faith community or belief group is seen as necessary, more for the individual chaplain's continuing pastoral and spiritual development and support, than simply as a form of accreditation.

Chaplains who are explicitly denominational (faith community or belief group) based in their appointment must have both the express authorisation of, and be in good standing with, their denomination, faith or belief community.

4.4 Use of Assessors

It is common practice for professions to use external assessors as part of the recruitment and selection process and this is recommended when Health Boards are filling a vacancy in their chaplaincy service. An assessor ought to be an experienced chaplain from a different Health Board and will bring a dimension of perspective and consistency to the interview and assessment of candidates. When the vacancy is in an area of specialised chaplaincy (e.g. paediatrics or mental health) the assessor ought to work in this field. As chaplaincy vacancies are relatively infrequent, the involvement of knowledgeable chaplains and human resources staff is important. The Spiritual Care Development Committee, through its executive officer, can provide names of suitable assessors. Work is being done on a UK basis to develop and train a panel of assessors who might undertake this work in the future.

5. Development of Healthcare Chaplaincy as a Regulated Profession

5.1 Registration

An initial notice of intention to apply for status as a registered health care profession has been made to the Health Professions Council, the UK body which regulates or recognises those professions who are or who wish to be a registered health care profession. This is a lengthy process which requires aspiring professions to demonstrate their unique body of knowledge, entry and training pathway, code of ethical practice and method of continuing professional development. Full registered professional status for healthcare chaplains, while not an immediate prospect, is being pursued.

The health service requires that the needs of individual patients or staff to be accommodated and taken into account with equal skill and compassion whatever a person's background and life stance happens to be. A particular and specialised area of training, practice and regulation has become necessary. The multi disciplinary team is now seen as the main unit of health care and the chaplain, the specialist spiritual care provider, is integrated into this team with his or her expertise and awareness enabling care to be more holistic or "whole" person.

Experience suggests that this more 'professional' approach is best achieved through the usual NHS educational channels, supplementing such training normally required and given by faith communities and belief groups themselves. There needs to be a degree of standardising. In the same way that spiritual care policies are in place to give people confidence that they will be treated consistently and well, so the training and regulation of the specialist spiritual care work force will give confidence in the quality and consistent approach of the chaplains. It is no less of a 'calling' to require specialist training, indeed it is one way of treating the idea of a calling seriously.

5.2 Capability and Competency Framework

Following the creation of Chaplaincy Service Standards, work has recently been completed in developing a "Spiritual and Religious Care Capabilities and Competences for Healthcare Chaplains" framework for those who are employed to deliver the service. This will guide the delivery of education and training and will help in the development of recognised professional qualifications in chaplaincy.

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The framework, draws on the 'Ten Essential Shared Capabilities' (DOH 2004) which encourages a multi professional understanding and approach:

- Working in Partnership
- Respecting diversity
- Practising ethically
- Challenging inequality
- Identifying the spiritual needs of patients, carers and staff
- Providing safe and responsive person- centred care
- Promoting best practice
- Promoting rehabilitation approaches
- Promoting self care and empowerment
- Pursuing personal development and learning

This framework includes the capabilities and competencies needed by a qualified and practising chaplain, grouped into a number of domains:

- Knowledge and skills for professional practice:
- Knowledge and skills for practice;
- Practising ethically;
- Communication skills;
- Education and training.

- Spiritual and religious assessment and intervention:
- Spiritual assessment and intervention;
- Religious assessment and intervention.

- Institutional practice:
- Team working;
- Staff support;
- Chaplain to the hospital or unit.

- Reflective practice:
- Reflective practice;
- Personal spiritual development.

In the future there will be information or frameworks corresponding to specialties (e.g. Mental Health, Paediatrics) and increased levels of responsibility, experience and qualification required of those in lead and management positions.

It is further planned to produce a capability framework, or related document, on spiritual care for all NHS staff.

These documents are linked to the Knowledge and Skills Framework and will aid the curriculum development for certificate, diploma and masters qualifications in healthcare chaplaincy. All newly appointed chaplains will, in the near future, be expected to hold the certificate in order to be a fully qualified chaplain. The opportunity of working towards a diploma or masters degree will be encouraged, in part, by the increasing requirement for continuing professional development.

5.3 Remuneration

The introduction of Agenda for Change (AfC) into the NHS has had an impact upon the pay, terms and conditions of Chaplains employed by the NHS, in common with all other staff groups. The Accommodation Allowance which had been paid to Chaplains had been converted into a long term Recruitment and Retention Allowance. The out of hours on call duties of Chaplains have been recognised and payment for this work will be made under new agreements. Remuneration is based on an evaluation of the post holders responsibilities, which is underpinned by a nationally agreed Local Job Evaluation System. Individuals will be assigned to an AfC Pay Band created to facilitate a fair and transparent pay structure for NHS staff.

The AfC Knowledge and Skills Framework (KSF) and Personal Development Plans (PDPs) provides a single, consistent, comprehensive and explicit framework on which individuals can develop within their post and will ensure that all NHS Chaplains are undertaking ongoing training and development to meet the demands of their post. In a similar way, the Spiritual and Religious Care Capabilities and Competences for Healthcare Chaplains describes the education and training required in order to perform in the role of a Chaplain.

6. Spiritual Care in the Community

The majority of healthcare takes place in the community. Therefore, spiritual care must find its place in settings other than hospitals. This is most clearly seen with regard to mental health where fewer people require in-patient care. Several mental health chaplains are working in day centres and in the community as well as in their hospitals. This will increasingly be the norm in the future as Community Health Partnerships become major providers of health care. There is interest in some GP practices in implementing better spiritual care through using the resources and partnership of local faith/belief communities. There needs to be close partnership between chaplains based in the community and those based in acute in-patient units. Such care must be exercised in as seamless a way as is possible.

7. Chaplaincy Associations

Chaplaincy Professional Associations are now firmly established. There are three main bodies in the United Kingdom at present. The Scottish Association of Chaplains in Healthcare (SACH) is the largest in Scotland. The College of Healthcare Chaplains (CHCC) is a UK organisation with a Scotland branch and is a professional section of the Amicus section of Unite, the trade union. The Association of Hospice and Palliative Care Chaplains (AHPCC) is UK wide and has a Scottish branch.

These associations have contributed much towards the development of the profession. They work closely together, have, for example agreed a common Code of Conduct, and share the aspiration that chaplaincy becomes a registered healthcare profession. The joint associations have formed a Chaplaincy Academic and Accreditation Board (CAAB) which has worked on standards, qualifications, entry levels, continuous professional development and other issues. Knowledge and Skills Framework outlines have been drawn up to assist understanding and review of chaplaincy posts, from entry to senior level.

In November 2008 the UK Board for Healthcare Chaplaincy (UKBHCC) was launched. This Board incorporates and supersedes the work of CAAB. It deals with Academic Standards, Professional Advisers, Professional Conduct and Professional regulation.

8. Relationship with UK, European and other Chaplaincy Organisations

Throughout the past 15 years there has been regular contact between chaplains/spiritual care providers throughout the UK and Europe. The Scottish Churches' Committee on Healthcare Chaplaincy, established in 1994, acts on behalf of the member churches of Action of Churches Together in Scotland (ACTS) and is responsible for monitoring and promoting the provision of healthcare chaplaincy in statutory, voluntary and private contexts. The Churches' Committee for Hospital Chaplaincy is a co-ordinating group of Churches Together in England with responsibility for representing the churches on matters of hospital chaplaincy to the Department of Health. In 1997 this committee initiated the formation of the Multi-Faith group for healthcare Chaplaincy. The Training officers and Church representatives of England, Scotland and Ireland maintain contact and hold occasional meetings where progress and issues are exchanged. There are some variations in the practice of spiritual care and in training and support given. In Scotland we concentrate more on spiritual care which is a provision of the NHS and is for all, regardless of culture, faith belief or background. Elsewhere the denominational aspects are stronger and there is less commitment to those with no declared faith. In practice most chaplains, wherever they are, work to some extent in a generic way responding to the needs of any. In Scotland this approach is included in policy documents in a very explicit way.

The European Network of Healthcare Chaplains has developed from very small beginnings in 1992. The network holds a conference every two years and Scotland has played an important part in these proceedings. The network includes chaplains from Finland to Italy and from Iceland to the Ukraine. The practices vary considerably due to cultural and historical factors yet there is enough in common to make such gatherings meaningful and very worthwhile. Contact has been made with EU departments for whom such cooperation across the continent is seen as significant.

North American chaplaincy shares certain characteristics as well as differences with the Scottish model. A few have received part of their training in the USA or Canada and vice versa. A delegation visited a Canadian conference in 2004 to learn and share methods of training in particular Clinical Pastoral Education. (CPE) This has borne fruit and encouraged work with Glasgow Caledonian University in establishing and accrediting CPE Units for practising chaplains, healthcare workers and others involved in pastoral care.

9. Spiritual Care Development Committee

The setting up of Spiritual Care Committees in Boards enabled them to cater for local needs. It was also envisaged that some issues and discussions would best take place on a national basis and for that reason a national multi faith/belief group was brought together. The Spiritual Care Development Committee (SCDC) was first constituted on 12th June 2003 with the objective of, "the development of spiritual care in both understanding and practice in the NHSScotland". The SCDC undertook to further this by facilitating a common understanding of and support for spiritual care among

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faith/belief groups, chaplaincy bodies, patients, carers and staff. It is a means of consultation and co-operation between all such groups.

The Committee seeks:

- To provide advice to the Scottish Government Health and Wellbeing Directorate and NHS Boards about spiritual/religious care on behalf of all faith/belief groups, chaplains, patients, carers and staff with particular reference to the Guidelines on Spiritual care in NHSScotland HDL (2002) 76.
- To enable liaison between faith groups, chaplaincy groups, carers, staff and other health care groups in the discussion and formation of spiritual care.
- To help nurture the national debate and share good practice.
- To promote the highest quality of spiritual care with reference to nationally agreed standards.
- To promote adequate education and training for specialist spiritual caregivers to enable them to meet these performance standards and develop a programme for continued professional development. This is done by supporting the work of the Health Care Chaplaincy Training and Development Group.
- To assist both health care organisations and faith/belief communities in the appointment of appropriately qualified and authorised chaplains.
- To assist in the formation of working groups assigned to undertake specific tasks

The membership of the SCDG includes representatives of:

- World faith groups – Baha’i, Brahma Kumaris, Buddhist, Christian, Hindu, Muslim, Jewish and Sikh;
- Employers of chaplains/spiritual care givers: The Church of Scotland, Roman Catholic Church, Scottish Episcopal Church and Health Boards;
- The Scottish Churches Committee on Health Care Chaplaincy;
- The Scottish Inter Faith Council;
- The Humanist Society of Scotland;
- The Scottish Government Health and Wellbeing Directorate, Health Board Management, Health Care Staff, Health Councils and patient groups;
- Chaplaincy Organisations.

The work of the committee to date has been in line with these objectives and it has been a place for the sharing of information, the examination of issues affecting chaplaincy and spiritual care in NHSScotland, and the discussion of areas of commonality and difference in the understandings of different groups. It has acted as steering group for the Multi Faith Resource produced by NHS Education for Scotland (NES) and it has set up working groups such as the one asked to revise the guidelines in this document.

It is an important forum and provides a useful conduit of information between board spiritual care committees, faith communities/belief groups, chaplains, and the Scottish Government Health and Wellbeing Directorate. There exists a somewhat similar group in England and its retention and development is strongly recommended.

10. Data Protection and Patient Confidentiality

NHSScotland is committed to providing spiritual and religious care to patients who wish it, as part of a holistic health service. In this the Scottish Government Health and Wellbeing Directorate is in full agreement with the World Health Organisation.

There is increasing evidence that health outcomes for patients may be considerably enhanced when their beliefs and values, their social context and their relationships are fully taken into account within a clinical context. Increasing emphasis on Patient Focus within the NHS and a developing awareness of Equality and Diversity issues have brought patients' spiritual needs higher up the NHS agenda. To be treated in a culturally and spiritually sensitive way, within the context of their faith and beliefs, can be as important to patients as the meeting of their other physical or psychological needs.

While patients have a right to receive appropriate spiritual care as part of their health care, they also have a right of confidentiality and data protection. NHSScotland has a duty to ensure that both of these rights are met. Achieving this balance requires good communication, and an understanding by all healthcare staff involved throughout the clinical care process. It is important to ensure that over emphasis on privacy of information does not result in failure to provide patients with available spiritual and religious care. Similarly, patients' rights to confidentiality must be upheld where they do not wish information to be passed on to a spiritual/religious care provider. The legal position is that a patient's faith or belief stance is sensitive information that may only be made available to another party with informed consent. In exceptional circumstances where informed consent or otherwise is impossible to obtain e.g. if a patient is unconscious or impaired, then the views of carers, and common sense, should prevail.

NHSScotland has received supportive guidance from the UK and Scottish Information Commissioner's offices to the effect that consent to make available information as to a patient's faith or belief stance, may be given by patients either in writing or orally at any time throughout the care process. The time of admission to hospital is important but is not always the time when a patient's broader emotional or spiritual needs are evident. It is important to recognise that such consent may be given by patients (or staff members) at any point of their health care journey and needs to be listened for rather than demanded. It may, for example be given to a chaplain through a decision to enter into conversation, providing the chaplain has indicated his or her role. What is important is for all NHS staff to remain sensitive to patients' spiritual and religious needs and respond appropriately by making the necessary chaplaincy referral.

The needs and rights of members of faith communities/belief groups for appropriate care, often of a sacramental or religious nature, should not be underestimated and all staff should be aware of how important it is to offer to facilitate this by sensitively asking and seeking appropriate help.

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All patients should be informed at the time of admission, or at another appropriate time, of the spiritual care which is available within the NHS. Health care providers should think about how questions should be asked of patients. For example, it may be better to ask if a patient has a way of understanding life and illness and would like to have someone to talk with about this, before asking directly if they are part of any faith community or belief group. If they do formally record a religious faith or belief preference, they should be informed that, if they consent, this can be passed to the Department of Spiritual and Religious Care for use in providing them with spiritual care. Patients and staff should also be informed that the spiritual care team is happy to be consulted on any issue of concern.

Chaplains who form the spiritual care team are generally employed within the NHS and have a duty of confidentiality in terms of their employment contract. In addition, the Chaplaincy Associations have a mutual “Code of Ethical Conduct for Healthcare Chaplains” to which all members of these Associations ascribe. Access to patient information, the keeping of spiritual care departmental records and the use of that information must also conform to the Caldicott Committee Guidelines. All spiritual care volunteers should sign an appropriate local confidentiality statement.

It is proposed to make more information on this subject available for patients and staff through leaflets and other general information channels. Health Boards are encouraged to use patient experience questionnaires to ensure that patients’ spiritual and religious needs are being both properly assessed and addressed.

11. Chaplaincy Provision Levels

HDL (2002) 76 provided suggested ranges and ratios concerning the number of beds or people justifying one session of chaplaincy time, i.e. three and a half hours. It also included suggestions of time which may be spent by chaplaincy staff on other activities such as teaching, worship, sacraments, pastoral counselling, administration and head of department duties. As spiritual care and the chaplaincy teams who are the specialist spiritual care providers become more integrated as part of the holistic care and support offered to all patients, carers and staff, it has become increasingly clear that ratios on their own are no longer adequate.

Previous advice has suggested the number of beds and members of staff count towards one session of chaplaincy provision, which led to a baseline requirement that a District General Hospital of around 300 beds would require a whole time chaplain. Such an assumption and such criteria are no longer particularly helpful for several reasons, e.g:

(a) Patient stay times are generally shorter leading to a greater throughput of patients in wards than ever before. Those who are hospitalised for long periods are usually acutely ill and require high intensity care.

b) The spiritual and religious care service is now far more integrated into local service delivery structures and chaplains are regarded and used as professionals who offer a unique service alongside other healthcare professionals. The constant availability of chaplains to a hospital or unit is crucial to an effective spiritual care service.

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c) Chaplains are involved in delivering training and education on spiritual and religious care, bereavement, religious and cultural issues, etc, often working in conjunction with Practice Development and Training and Development staff.

d) Professional development, research, planning, record keeping, reviewing and developing the department with managers, have all become part of the service.

e) A strict interpretation of the European Working Time Directive will require a minimum of 3 whole-time chaplains in post in order to provide an out-of-hours service. Even in the smallest of units, one member of staff cannot work during the day and also provide an out-of-hours service.

f) Work with equality and diversity groups, spiritual care committees and other committee work is now expected of chaplains to a far greater extent.

g) Government documents and papers such as 'Religion and Belief Matter' have raised the profile and need for a planned and properly resourced spiritual and religious care service.

It is now commonly expected that senior or lead chaplains undertake roles involving the training, mentorship or supervision of students and volunteers.

Care in community which is being provided increasingly and especially by mental health chaplains does not relate meaningfully to bed numbers.

Managers within the NHS are increasingly requiring spiritual care departments to justify their staffing levels. In order to respond to this in a competent and meaningful way, the departments must learn to describe the work they do, and the benefit they bring to their clients. This must be done in ways comparable to other healthcare professions and understandable to those who make such staffing decisions amid numerous claims on finite resources. Each department should aim at producing a business plan which describes the value that dedicated spiritual care or chaplaincy brings to the whole institution and outlines the current activities, professional developments, service priorities, and the resources required to meet these priorities.

The diversity activity of chaplains is now supported by the Standards for NHSScotland Chaplaincy Services (2007) and by the Capability and Competence Framework for Healthcare Chaplains in NHSScotland (NES 2008). These documents describe what the service should consist of and what skills are required of chaplains.

The plan for each department should include a considerable degree of strategic and numeric information, including:

Organisation's role and mission - how does the spiritual care service contribute to the fulfilment of this? How does the institution relate to the local/national community and how does it perceive the place of spiritual and religious care in the workplace and in the care of individuals?

Institutional variables such as the acuity levels, how sick patients are, how far do patients have to travel, any particular faith or belief groupings, numbers of deaths per week.

Current spiritual care staffing with the variety of skills and training needed, the requirements of the service and departmental strengths, weaknesses, opportunities and threats (SWOTs).

Current activities including where time is spent, numbers of referrals and sources, teaching, pastoral care, protocols which require spiritual/pastoral care involvement, funerals.

On call requirements (see, e) above)

Identification of activities to meet priorities through effective assessment and documentation processes, effective referrals and tracking of activities in ways relevant to organizational goals, departmental scope and professional requirements. Production of a business plan with cost/benefit analysis.

An analysis of needs and a description of the service required will develop a picture of the level of staff provision necessary within a health board. It must also be acknowledged that where a spiritual or pastoral care service is well understood and pro active, the usage of the service increases dramatically (Allan and Macritchie, SACH Journal 2007).

12. Note on Publications

A number of documents have been written in the last few years, some of which are already quoted in this paper. Those most relevant to spiritual care in NHSScotland include:

Scottish Executive Health Department HDL(2002)76, *Spiritual Care in NHSScotland*.

Scottish Executive Health Department (2005), *Fair for All: The Wider Challenge*.

NHS Quality Improvement Scotland (2005), *Report of the Scoping Study Group on the Provision of Spiritual care in NHSScotland*

Mowat, H and Swinton, J (2005), *What do Chaplains do? The role of the chaplain in meeting the spiritual needs of patients*.

NHS Education for Scotland (2006), *A Multi Faith Resource for Healthcare Staff*

Mowat, H (2007), *The Potential for the Efficacy of Healthcare Chaplaincy – Spiritual care in the UK; A Scoping Study*

Spiritual Care and Chaplaincy in the NHS in Scotland

NHS Education for Scotland (Sponsored) (2007), *Standards for NHSScotland Chaplaincy Services*

Scottish Government; Scottish Inter Faith Council; NHSScotland; Fair for All: (2007) *Religion and Belief Matter: An Information Resource for Healthcare Staff*

NHS Education for Scotland (2008), *Spiritual and Religious Capabilities and Competences for Healthcare Chaplains*

The Journal of the Scottish Association of Chaplains in Healthcare (SACH Journal)

The Journal of Health Care Chaplaincy. *The Journal of the College of Healthcare Chaplains. (UK)*

13. The Working Group

Astrid Bendomir:	Doctor, Aberdeen Royal Infirmary
Sandra Falconer:	Scottish Government Health and Wellbeing Directorate
Geoff Lachlan:	Scottish Inter Faith Council
Chris Levison:	Healthcare Chaplaincy Training & Development Officer/Spiritual Care Advisor
Ron McLaren:	Vice chair, Humanist Society of Scotland
Lorna Murray:	Convenor of Scottish Churches Committee on Healthcare Chaplaincy
Anne Richardson:	Administrator, NHS Education for Scotland
Blair Robertson:	Head of Chaplaincy and Spiritual Care, NHS Greater Glasgow and Clyde
Jacqui du Rocher:	Director of Roman Catholic Chaplaincy, Edinburgh Royal Infirmary
Hafiz Sadiq:	Consultant, Yorkhill Hospital
Hina Sheikh:	Equalities Manager, Lanarkshire Health Board
John Thomson:	Secretary to Church of Scotland, Ministries Council, Chaplaincies Task Group
Carrie Upton:	Chaplain, Royal Hospital for Sick Children, Edinburgh

14. Recommendations

1. To commend Health Boards on Work done to implement HDL 2002 76 and affirm the understanding that spiritual care is a necessary and integral part of the whole person care offered by the NHS in Scotland.
2. To support inter professional educational initiatives to enable a wider understanding of the context and meaning of spiritual care and its relationship to health among all healthcare staff.
3. To promote research which broadens and enlightens an evidence base for the efficacy of spiritual and religious care in health
4. To encourage education on equality legislation and promote a service which delivers spiritual care equitably to people of any or no declared faith community or belief group.

Spiritual Care and Chaplaincy in the NHS in Scotland

5. To retain a senior lead manager for spiritual care in each health board.
6. To update Spiritual Care Policies in light of local need and national developments.
7. To review the role and composition of Spiritual Care Committees to ensure that the primary function, of engaging with local faith communities/belief groups and enabling dialogue between healthcare staff, spiritual care providers and community groups, continues and develops in the best way for each Board.
8. To encourage professionals within the spiritual care team to maintain their good standing with the faith community or belief group in which they have roots, to play a meaningful part in chaplaincy professional associations and to work harmoniously with those of the wide variety of faith and belief groups within Scottish society.
9. To continue the work of Healthcare Chaplaincy Training through NHS Education for Scotland and. This to include study days, conferences and the development of relevant research, courses and qualifications for spiritual care staff, volunteers and other interested staff.
10. To recommend the use of Standards for NHSScotland Chaplaincy Services as the audit tool for the review of the spiritual care service in each health Board.
11. To recommend the use of business plans, cost benefit analysis and all relevant factors i.e. not only the size of the unit or number of beds, when determining spiritual care staff provision.
12. To recommend that Boards employ Spiritual Care Staff for their qualifications and pastoral abilities who are trained to highest standard. It is envisaged that the new Certificate in Healthcare Chaplaincy, once established, and functioning, (expected from September 2009) or equivalent will become a requirement for all new appointments (of significant hours) either to have, or be committed to obtaining, as a condition of appointment. Such staff are expected to work with the whole health care community, patients, carers and staff, providing spiritual care for all and either providing or facilitating the appropriate religious care for those requiring it.
13. To make necessary arrangements with any group, not represented as NHS employees on the spiritual care team and where a needs analysis justifies provision on a denominational or single faith basis. Any working within such an arrangement would require the direct authorisation of their faith/belief community. A contract would require to be put in place and such people would be accountable within the NHS to the head of department.
14. To use a system of assessors in the employment of whole time chaplains.
15. To develop, as far as is possible and feasible in each Board, a system of honorary chaplains or local faith/belief group representatives who would be called on to respond to specific faith community/ belief group religious or spiritual need.

Spiritual Care and Chaplaincy in the NHS in Scotland

16. To encourage departmental and individual spiritual care staff formation with continuous professional development, the use of reflective practice and pastoral supervision.

17. To make use of the Capability and Competency Framework in professional and personal development in relation to the Knowledge and Skills Framework.

18. To maintain links with and continue the work of the Spiritual Care Development Committee as a national forum for discussion among faith communities, belief groups, healthcare staff, chaplaincy associations, the Scottish Government Dept of Health and Well-being, the Equalities Unit of NHS Health and the Healthcare Chaplaincy Training and Development Unit.

19. To develop new ways of providing spiritual care to health service users in community settings.

20. To seek ways of obtaining informed consent to spiritual care both at time of admission and during a patient's time of treatment.

21. To ensure adequate human, financial, accommodation and support resources terms for a spiritual care/chaplaincy service are consistent with a 24/7 basis throughout the year. Where this level of service is not currently provided an action plan showing how and when this will be achieved should be developed.

22. To continue the development of professional and research documents, journals and activities, both within Scotland and where possible in a UK context, which will enable advancement towards self or national regulated/ registered health profession status.

23. To encourage co operation with other health professionals and to work as members of the multi professional healthcare team whenever possible.



SCOTTISH EXECUTIVE

Health Department
Directorate of Nursing

St Andrew's House
Regent Road
EDINBURGH
EH1 3DG

Dear Colleague

SPIRITUAL CARE IN NHSSCOTLAND

Summary

1. This letter accompanies guidance which requires NHS organisations to develop and implement spiritual care policies that are tailored to the needs of the local population.

Background

2. The Report of a Working Group on Spiritual Care in the NHS was issued for consultation in Summer 2001 and was discussed at the NHSScotland Spirituality in Health and Community Care Conference of November 2001. This Guidance is based on that Report and was the subject of further consultation with key stakeholders during the Spring and Summer of this year.

Action

3. Chief Executives of NHS Boards are required to develop and implement a spiritual care policy for their Board area that complies with this guidance. This policy should be submitted to Miss Laura Ross (at the address below) by 30 May 2003.
4. Chief Executives of NHS Trusts are required to develop and implement a local plan for a spiritual care service that complies with the overarching Board policy. This plan should be submitted to Miss Laura Ross by 30 September 2003.
5. Local progress in adopting the final guidelines will be assessed on the Scottish Executive Health Department's behalf by the Healthcare Chaplaincy Training and Development Unit. Assessment will be carried out on the basis of relative progress made by organisations.

Yours sincerely

ANNE JARVIE
Chief Nursing Officer

28th October 2002

Addresses:

For action

Chief Executives, NHS Boards
Chief Executives, NHS Trusts
Chief Executives, Special Health
Boards

For information

Medical Directors, NHS Trust and
Boards
Directors of Nursing, NHS Trust
and Boards
Directors of Human Resources,
NHS Trusts and Boards
Commission for Racial Equality
Ethnic Minority Resource Centre
Local Health Councils and SAHC
Chaplaincy Organisations
NHS Chaplains
Faith Communities
The Interfaith Council
Church of Scotland Board of
National Mission

Enquiries to:

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St Andrew's House
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This guidance is also located on
the Scottish Health on the Web
(SHOW) Site at
www.show.scot.nhs.uk



**GUIDELINES ON CHAPLAINCY AND
SPIRITUAL CARE IN THE NHS IN SCOTLAND**

**SEHD
October
2002**

About this guidance

This guidance is drawn from a report prepared by a Working Group of representatives of NHS staff and faith communities. The Report was issued for consultation in Summer 2001 and discussed at the NHSScotland Spirituality in Health and Community Care Conference of November 2001. This guidance incorporates comments received on the report during the consultation and at the conference.

Related Guidance

This guidance should be considered in conjunction with the NHS guidance on *Fair for All: Working towards a culturally competent services* (HDL(2002)51 available at www.show.scot.nhs.uk).

Guidance Replaced

This circular supersedes NHS circulars SHM 8/1964, SHHD/DGM(1986)48 and NHS MEL(1994)50.

Note on Terminology

The Working Party, on whose report this guidance is based, was asked to consider possible alternatives to the titles 'chaplain' and 'chaplancy' which might reflect the growing interfaith and 'non religious' dimension of spiritual care in today's NHS. While the title 'chaplain' is probably preferred by Christian faith communities and is widely accepted, each faith community should be able to choose an appropriate title for its spiritual caregiver. For the purposes of this guidance, unless specifically stated, the term 'spiritual care' is used to cover chaplancy, spiritual and religious care and 'spiritual caregiver' to cover chaplains, and others who deliver spiritual or religious care.

Chaplancy departments may wish to consider whether they should be redesignated as 'Departments of Spiritual and Religious Care'.

Support for the Service

The Health Department has funded a Healthcare Chaplancy Training and Development Unit.

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Healthcare Chaplancy Training &
Development Officer/Spiritual Care
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Langside Road
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The Unit is available to provide support and assistance to all NHS Board areas in the planning, writing and implementation of their spiritual care policies. It will also support the Scottish Executive Health Department in the development of:

- national guidelines and policies for the continuing improvement of spiritual care services;
- national standards with reference to UK and European standards for the delivery of spiritual care in NHSScotland;
- a programme of education and training for spiritual caregivers prior to, and at all stages of their career and a programme of training for staff and volunteers; and initiate related research.

Among other work being developed with the Unit's support are:

- A research project led by Dr Harriet Mowat at Paisley University looking at the spiritual needs of patients in NHSScotland and the implications for the role of hospital spiritual caregivers.
- A project led by Dr Desmond Ryan at Edinburgh University aimed at extending the capacity of NHSScotland staff to work with the spiritual issues of patients and their families by providing appropriate education and experience.
- A project led by Rev Bob Devenny at Borders General Hospital aimed at assessing the spiritual needs and integrating the spiritual care of families dealing with sudden and progressive disability ie from stroke, heart attack, the result of an accident, multiple sclerosis and dementia.

Developing Spiritual Care in the NHS

The Department acknowledges the support of a number of individuals and organisations in developing this guidance. To support NHSScotland in this critical transitional period, the Department has established a Spiritual Care Development Committee. Over the initial three years of implementing this guidance, this interfaith group will allow representatives of NHSScotland, the faith communities in Scotland, chaplaincy professional organisations and others with an interest in spiritual care to support the development of spiritual care services across Scotland. It will advise the Scottish Executive Health Department on spiritual care matters in NHSScotland and support and oversee the work of the Healthcare Chaplaincy Training and Development Unit.

SEHD
October 2002

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Spiritual Care in NHSScotland

Background

1. Hospital and healthcare chaplaincy, which had their origins in the voluntary hospitals, have been a feature of the NHS since its inception. Politicians of all persuasions and the community at large recognised the importance of hospital religious ministry to the sick, injured, frail and dying, to their carers and to the staff who care for them. Fifty years on, the NHS has been transformed beyond all recognition as patterns of illness have changed and the range of therapeutic possibilities has expanded. The resources of the NHS of which chaplaincy is one, are still focussed on the treatment and care of those whose health has been compromised and survival threatened.

2. Since 1948, patterns of religious belief and practice have also undergone a major reformation. Membership of the mainstream churches has declined: Islamic, Hindu, Sikh and Buddhist faith communities are firmly established; 'New Age' religions are in evidence. We live in a pluralist society in which individual beliefs find expression in a multiplicity of forms. It has been necessary for NHS chaplaincy and spiritual care services to keep pace with these changes. Chaplains in healthcare settings who once offered a purely religious ministry to members and adherents of their own denomination now devote most of their working time to patients, carers and staff who have no link with any faith community yet may well profess a belief in God, recognise they have spiritual needs and, while they are in hospital or another healthcare setting, look to the NHS to provide spiritual care. Throughout the NHS today chaplains are still expected to offer an appropriate religious ministry to those who remain in membership of faith communities; they are also called upon to give spiritual care to the majority of patients, carers and staff who have no association whatsoever with any religious group.

Definitions

3. The Working Group on whose report this guidance is based offered the following distinction between religious and spiritual care:

Religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community

Spiritual care is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation.

Spiritual care is not necessarily religious. Religious care, at its best, should always be spiritual.

A Broader Role

4. Everyone, whether religious or not, needs support systems, especially in times of crisis. Many patients, carers and staff, especially those confronting serious or life threatening illness or injury, have spiritual needs and welcome spiritual care.

They face ultimate questions of life and death. They search for meaning in the experience of illness. They look for help to cope with their illness and with suffering, loss, fear, loneliness, anxiety, uncertainty, impairment, despair, anger and guilt. They conjure with the ethical dilemmas which advancing technology and heightened expectations generate at the beginning and end of life. They address in depth, perhaps for the first time, the realities of their human condition. Those actively associated with a faith community, now statistically in a minority, expect to derive help and comfort from their religious faith and from the faith communities to which they belong. The beliefs and rituals of their religion and the ministry of its leaders and members are often sufficient to meet their spiritual needs. On the other hand, the majority who have no such religious associations yet recognise their need for spiritual care, look for a skilled and sensitive listener who has time to be with them. A person who will acknowledge the deep desires and stirrings of their spirit, recognise the significance of their relationships, value them and take them seriously. A person who can help them to find within themselves the resources to cope with their difficulties and the capacity to make positive use of their experience of illness and injury. The NHS must offer both spiritual and religious care with equal skill and enthusiasm.

5. Spiritual caregivers and religious leaders are not alone in offering this care. It is given by many members of staff in the course of their professional work, by visiting relatives, significant others and friends (termed 'carers' in this guidance) and by patients, informally, to each other. But in today's health service we need the distinctive contribution of caregivers who are trained in spiritual and religious care and have time to give it.

6. In some healthcare settings, spiritual care may not readily be offered on a one-to one basis, for example to those with severe communication difficulties, but rather by the creation of a communal spirituality and a positive spiritual environment in which patients are well cared for and staff find fulfilment in their work. Responsibility for this rests primarily with management and staff. The role of the spiritual caregiver in such units is to offer support to staff and carers as may be needed.

7. Continuity of spiritual care is important in a patients' journey from one NHS facility to another and from the NHS to other facilities in the community such as hospices, sheltered and supported accommodation, nursing homes and their own homes. This will be achieved only through partnership between NHS spiritual caregivers and those who give spiritual care in these community-based settings.

Principles of A Spiritual Care Service

The following basic principles should underpin all spiritual care services provided or funded by the NHS. They should:

- be impartial, accessible and available to persons of all faith communities and none and facilitate spiritual and religious care of all kinds;
- function on the basis of respect for the wide range of beliefs, lifestyles and cultural backgrounds found in the NHS and in Scotland today;

- value such diversity;
- be a significant NHS resource in an increasingly multicultural society;
- be a unifying and encouraging presence in an NHS organisation;
- never be imposed or used to proselytise;
- be characterised by openness, sensitivity, integrity, compassion and the capacity to make and maintain attentive, helping, supportive and caring relationships;
- affirm and secure the right of patients to be visited (or not visited) by any chaplain, religious leader or spiritual caregiver;
- be carried out in consultation with other NHS staff; and
- acknowledge that spiritual care in the NHS is given by many members of staff and by carers and patients, as well as by staff specially appointed for that purpose.

Roles and Responsibilities

NHS Boards

9. NHS Boards are required, in consultation with their local faith communities, patient representatives and their planning partners, to develop and implement a spiritual care policy for the provision of chaplaincy, religious and spiritual care services across their Board area. This policy should implement the principles of this guidance and:

- ensure that spiritual care is provided to patients, carers and staff in ways that are responsive to their needs;
- ensure that the spiritual care services are adequately staffed, regulated and funded;
- ensure that proper arrangements are made for the spiritual care of those who belong to smaller faith communities;
- promote partnership in the matter of spiritual care between its service providers and other healthcare services, such as hospices, care homes, self help organisations and voluntary bodies, and where the NHS Board contributes funds to these services, ensure that spiritual care of comparable clinical quality is provided in them; and
- promote a close working partnership between their service providers and local faith communities on the provision of spiritual care services and the appointment and employment of spiritual care staff.

A Spiritual Care Committee

10. NHS Boards are required, in consultation with its service providers, to establish a Spiritual Care Committee to support the integrated planning and delivery of spiritual care services across the area they serve. The Committee should normally meet at least twice a year. Its membership should reflect the size and

nature of the NHS organisations and faith communities in the area served. As a minimum it should consist of:

- an NHS Board nominee to act as convenor;
- representatives of the main faith communities in the area served, nominated by the appropriate presbytery, bishop, faith community governing body or inter faith council;
- two lay persons nominated by the local Health Council, or other appropriate patient representative organisation, such as a Patients' Council;
- representatives of NHS staff with an interest in spiritual and religious care;
- representatives of the area's spiritual care staff and volunteers; and
- the Head of the Department of Religious and Spiritual Care and the Spiritual Care Manager of each local service provider.

11. The remit of a Committee should include:

- providing advice on, and a forum for developing the NHS Board's spiritual care policy and overseeing its local implementation;
- maintaining partnership between the local healthcare system, its spiritual care staff and local faith communities;
- providing an advisory function to spiritual caregivers; and
- overseeing the process of the appointment of spiritual care staff.

12. Each local service provider may wish to establish a local sub-committee to oversee the delivery of the local spiritual care service. Membership of the sub-committee should reflect the size and nature of the organisation and faith communities in the area it serves.

Local Service Providers

13. Local service providers are required to develop and implement a local plan for the provision of a spiritual care service that complies with the overarching NHS Board policy.

A Local Spiritual Care Service

14. The exact nature of the local spiritual care service will be determined by:

- the type of hospitals, units and community services served;
- the condition, spiritual need and religious affiliation, if any, of the patients and carers served and the nature of their distress;
- the expectations of patients, carers and staff for pastoral support, spiritual care, religious ministry and facilities for worship;
- the expressed views of those who use the services provided and those that live in the communities served;
- the expressed views of the faith communities in the area served;
- the education, training and support needs of staff, students and volunteers; and
- the morale and wellbeing of each individual and the hospital/healthcare community as a whole.

15. The local service provider should:
- decide if the establishment of a local sub-committee of the Board's Spiritual Care Committee is required;
 - establish a Department of Spiritual and Religious Care (see note on terminology);
 - appoint a senior manager as the spiritual care manager;
 - calculate the number of spiritual care sessions required;
 - appoint or arrange the appointment of a spiritual caregiver(s) to offer spiritual care to persons of all faiths or none in the area served;
 - in consultation with local faith communities, appoint or arrange the appointment of faith community spiritual caregivers;
 - in consultation with faith communities appoint or arrange the appointment of a Head of The Department of Spiritual and Religious Care;
 - facilitate the visits of religious leaders and spiritual caregivers to hospital and health care services;
 - establish a system for the documentation of patients' religious affiliation, if any, and their spiritual needs; and a system of notification or referral which, within the constraints of confidentiality, enable patients on admission or while in care to request a visit from their local religious leader or spiritual caregiver or from a member of the department of religious and spiritual care;
 - provide accommodation, accessories and facilities for worship of relevant faith communities;
 - provide information about the facilities for religious and spiritual care available to patients, carers and staff and ensure appropriate signage to the office of the department of spiritual and religious care, quiet room or sanctuary;
 - provide training for NHS staff in assessing spiritual need and providing spiritual care;
 - provide office accommodation for use by spiritual caregivers;
 - ensure that the training of spiritual caregivers is an integral part of its HR strategy and that funding, time off and cover are be provided to enable this training to occur;
 - ensure spiritual caregivers have access to professional supervision and support;
 - ensure appropriate arrangements are in place to monitor and review the spiritual care service;
 - ensure that individual spiritual caregivers have clear and recognisable lines of accountability for their professional conduct and are in good standing with their faith community; and
 - ensure that volunteers recruited to help with spiritual care service are selected and trained appropriately.

A Spiritual Care Manager

16. A senior manager in each service provider organisation should be appointed as the Spiritual Care Manager. The role of the Spiritual Care Manager should be to:
- have regular meetings with the Head of Department and spiritual caregivers;
 - be a member of the NHS Board Spiritual Care Committee; and
 - represent the interests of the service provider in the management of the local system of appointment and review.

The Spiritual Care Manager should also keep the workload of spiritual caregivers under regular local review, and ensure that data is kept to allow the sessional calculations to be regularly updated.

Spiritual Caregivers

17. Service providers should appoint an appropriate number of spiritual caregivers to offer religious and spiritual care to its patients, carers and staff. Each faith community in the area served should be consulted about how it wishes to deliver spiritual care, support, information and advice to their members. The employment costs or expenses of a spiritual caregiver, the title of which can be chosen by the faith community, may be reimbursed. A decision on this should be made in accordance with the criteria set out in Appendix A.

Head of Department

18. It is essential for the effectiveness of the spiritual care service that all spiritual caregivers work together as a single team and that there is a Head of Department responsible for the co-ordination of spiritual care services. The post of Head of the Department of Spiritual and Religious Care should be advertised in the normal way and the most appropriate person selected.

19. The Head of Department will report to the organisation's Spiritual Care Manager and, where appropriate, be advised by its Spiritual Care Sub-Committee. They should also ensure that appropriate arrangements are in place to provide support and supervision to members of the spiritual care team and to help them deal with the stresses inherent in their work. The Healthcare Chaplaincy Training and Development Unit has been asked to develop and enhance these processes.

Care Team Membership

20. The World Health Organisation's definition of health is holistic, including the spiritual element alongside physical, emotional, mental and social. The provision of spiritual care within the NHS is therefore an integral part of the healthcare offered. Spiritual caregivers are therefore members of the professional care team. It is essential that they are provided with the information they need to provide spiritual, religious and pastoral care.

Patient Confidentiality

21. Patients have a right to appropriate spiritual care and a right of confidentiality. It is the duty of the NHS to ensure these rights are met. As part of the healthcare team, chaplains are under the same duty of confidentiality as all other healthcare professionals. Informed consent is the ideal. In order to provide spiritual care, a certain level of information is required. Usually this will consist of basic demographic information. However, on occasion more comprehensive information will be required. All patients should be informed that they have the right to withhold personal information such as, religious affiliation and that if they do not exercise this right, this information will be passed to the spiritual care department.

22. Access to patient information, the keeping of spiritual care departmental records and the use of that information must conform to the Caldicott Committee Guidelines² and the Data Protection Act³. All spiritual caregivers and volunteers should sign an appropriate local confidentiality statement. They must also follow their own professional code of conduct⁴ regarding confidentiality.

Administrative Support

23. Secretarial and support services should be provided to staff engaged in spiritual care work. In larger units a whole-time or part-time, secretary/receptionist should be appointed to the department of spiritual and religious care.

Assessing the Need for Spiritual Care Services

24. The broad considerations, which determine spiritual care provision and the range of responsibilities of spiritual caregivers, are set out in paragraphs 14, 15 and Appendix A.

25. Traditionally, bed occupancy figures for each faith community have been the main criteria that determined the total number of sessions available and the proportion of these sessions applicable to each faith community. There are two problems in securing a realistic set of criteria: a lack of information on patients' religious affiliation; and the difficulty of quantifying the time expended in supporting people at times of deep personal distress, prolonged serious illness and sudden or long-awaited bereavement. The Healthcare Chaplaincy Training and Development Unit will undertake a study with the aim of improving the basis of calculating the spiritual care workload.

26. In the meantime, the broad guidelines set out in Appendix A should be used to calculate the number of sessions required for each part of the service's operation. It suggests an indication of the number of beds in each kind of unit that would warrant one session. It also makes an allowance for work with staff, teaching and

² www.show.scot.nhs.uk/newfolder/publications/me/caldicott.manual.doc

³ www.legislation.hmso.gov.uk/acts/acts1998/19980029.htm

⁴ Code of Professional Conduct for Healthcare Chaplains (www.chaplains.co.uk)

other 'special circumstances'. A notional session consists of a half day (3.5 hours). Ten sessions or five days point to a whole time appointment.

27. The small number of people from ethnic minorities in an area may not be sufficient to justify a sessional appointment. However, as recommended in the '*Fair for all* guidance⁵, steps must be taken to ensure that the spiritual needs of individuals and family groups from ethnic minority faith communities are met, and that any necessary language support is provided.

Appointment and Employment of Spiritual Caregivers

28. Any denomination or faith community can apply to the NHS to make a whole-time or part-time appointment. The Spiritual Care Committee will decide if a paid appointment is necessary. However, any officially recognised spiritual caregiver will have the necessary costs of his or her work reimbursed.

Qualities and qualifications

29. All spiritual caregivers must be in good standing with, and acceptable to their own faith community. They should also be persons with the right personal qualities and the required professional skills. They must:

- have undergone or be willing to undergo the necessary training;
- have a proven ability to get on with people from different backgrounds;
- have a knowledge and understanding of their faith;
- be able to work on the basis of mutual respect for patients, carers and staff; and
- be able to listen empathetically to the personal beliefs of those they serve within the context of the orthodox teachings of their faith community.

Responsibilities

30. Whole-time spiritual caregivers will normally be responsible for some or all of the following:

- planning, delivering and developing a spiritual care service to meet the assessed need, for example in acute units a 24 hour, 7 day a week service;
- visiting and supporting patients through spiritual care, pastoral conversation and religious ministry as appropriate;
- conducting services of worship in a quiet room, sanctuary or other suitable accommodation;
- offering prayers, sacraments and other religious ministries at the bedside, cot side or dayroom;
- supporting carers, especially where patients are seriously ill, chronically sick, terminally ill or have already died and then to give bereavement care;
- supporting staff through pastoral care, the ministry of presence and, where appropriate, counselling;

⁵ *Fair for all: Working towards a culturally competent services* (HDL (2002)51) available at www.show.scot.nhs.uk

- providing informal advocacy on behalf of patients and their carers;
- at the request of a patient or carer, ensuring their confidential referral to their own religious leader;
- facilitating the ministry in hospital or other NHS facility of the religious leaders of faith communities who may seek assistance and advice;
- providing an informed resource on ethical, religious and pastoral matters;
- participating in induction and in-service training of staff, for example on spiritual need and spiritual care, the role of the spiritual caregiver, etc;
- be involved along with other staff in the delivery of bereavement care and in the training of staff in the care of the dying and bereaved;
- serving on NHS committees as requested;
- establishing and maintaining contact between the NHS and local faith communities by fulfilling speaking engagements, liaising with religious leaders and, with the support of the organisation's volunteering, manager recruiting volunteers;
- in consultation with local voluntary services, selecting, training, supporting and supervising volunteers to work with the chaplain and elsewhere; and
- being involved in the planning and execution of the major incident policy.

31. Requests for spiritual care may come from staff, carers, a patient's own minister or 'religious leader', as well as from patients themselves. The most fruitful pastoral work is often generated through regular, proactive ward visiting.

32. Spiritual caregivers should be prepared to give appropriate spiritual care to people from all faith communities and to those who have no religious affiliation.

Training Posts

33. Spiritual caregivers need not always be 'ordained' ministers or clergy. NHS organisations can make arrangements with faith communities to recruit and train lay persons for this work. The Healthcare Chaplaincy and Development Unit is working with the NHS and faith communities to develop national standards for such training.

34. A number of 'chaplain's assistant' posts currently exist. The staff in these posts should be able to choose whether to continue in post, with the option of applying for full chaplain's posts if appropriate. Some may choose to embark on a formal training programme. While automatic promotion of existing assistant to the post of chaplain is not an acceptable option, the possibility of regrading, depending on qualifications, responsibilities, and competencies should be considered.

Volunteers

35. Volunteers can play a significant part in enhancing and strengthening a spiritual care service. Volunteers should be sought from the widest possible community with special consideration being given to smaller faith communities. Volunteers need to be carefully recruited and properly trained for the tasks they are expected to undertake. These tasks can include offering a lay pastoral and sacramental ministry; escorting patients to worship; providing music, flowers, reading and writing assistance, transport, befriending; and notifying religious leaders at the request of patients or carers. The spiritual care services volunteers should be recruited and managed with the support of the organisation's volunteering manager.

Recruitment

36. All posts should be publicly advertised. Applicants should be interviewed to ensure that choice and fairness are assured. The interview panel should be a joint one, including appropriate faith community and NHS representatives. This ensures that the appointee will be both pastorally and doctrinally acceptable to the faith community and carry the support and approval of the NHS.

37. For whole time appointments the panel should be supported by at least one professional assessor. The professional assessor should be a practising spiritual caregiver of not less than three years experience, nominated by the professional bodies, who works in a similar capacity in a different area.

Terms of Employment

38. It has been customary for chaplains to be employed by a faith community on a contractual basis with the NHS organisation's involvement and approval. The Board of National Mission of the Church of Scotland has traditionally appointed and employed whole time and part time chaplains, regardless of the denominational allegiance of the chaplain concerned. Other faith communities, notably the Roman Catholic and the Scottish Episcopal Churches have appointed and employed part time faith community chaplains. All these services are provided under arrangements whereby the local NHS organisation reimburses the employing faith community for the whole time or part time costs of the appointment.

39. The 1990 NHS and Community Care Act also allows the NHS to directly employ chaplains. However, whichever employment arrangement is adopted, a close working partnership between the NHS organisation and faith communities is essential.

Provision of Facilities

Quiet Room, Sanctuary or Worship Space

All NHS organisations should have at least one room set aside exclusively for worship, meditation and reflection. The room's title should make it clear it is a multi-faith facility, readily adaptable for the use of members of all faith communities or none. It might be called a 'quiet room', 'sanctuary' or 'prayer room'. Larger hospitals

might have more than one designated room. Accessories for the worship of all faith communities and space to store them when not in use should be provided as required. A system for the provision of appropriate music should also be provided.

Room for Meeting and Teaching

Spiritual caregivers should also have an office and interview accommodation where they may meet distressed patients and carers and interview staff in privacy. They should also be given access to suitable teaching accommodation. Office equipment, including PCs and Internet facilities, suitable literature, journals, textbooks, mobile phone and pagers should be routinely provided.

Information and Signage

Information about the spiritual care service should be made available to patients, carers and staff through leaflets, employee induction and training sessions and other literature. Signage to the 'quiet room', 'sanctuary' or 'prayer room' and to the Department of Spiritual and Religious Care should also be provided.

Mortuary Facilities

The beliefs and practices of all faith communities should be respected and appropriate provision for rituals and other offices should be made in consultation with them. The 'quiet room', 'sanctuary' or 'prayer room' should not be used for viewing.

Documentation, Notification and Referral

Accurate documentation by Admission Unit and other staff is of importance to those who wish their own local religious leader or spiritual caregiver notified of their admission and to those who wish to request a visit from the appropriate spiritual caregiver. All service providers should therefore operate a prompt and effective system of notification, which operates within the constraints of patient confidentiality (see paragraphs 21 and 22). Admission forms must include clear documentation of patient's religious affiliation and of any request for a visit from a religious leader or spiritual caregiver.

Local training should ensure that staff are aware of the reasons why documentation is so important. Questions about religion and spiritual need must be asked sensitively and Admission Unit and ward staff will need training and support in this. If a patient is too unwell to give information, the help of those accompanying the patient should be sought.

Since a patient's condition and consequently their spiritual need may change dramatically after admission, spiritual care records are not static and have to be updated as required. Training of ward staff should make them aware of the need to make referrals to religious leaders or spiritual caregivers when necessary. Each service provider must have a clear protocol to achieve this and mechanisms to ensure it is adhered to.

All departments of spiritual and religious care should carry a comprehensive list of up-to-date contacts for all the faith communities in the area served by their organisation so that appropriate notification may be made.

Staff Training in Assessing Spiritual Need

Patients and carers often express their own spiritual needs and their direct care staff must be able to advise them of the spiritual and religious care available to them. Staff should also be aware of their responsibility for identifying any unmet spiritual need and for ensuring that action is taken to address it. The assessment of spiritual need is a skilled task best undertaken by those who directly care for patients and their families. Staff who are aware of spiritual need will be able, if properly trained, to offer better spiritual care themselves and will be proactive in accessing spiritual care services rather than acquiescing to an arrangement which is solely reliant on 'chaplain's rounds'.

Training for staff in assessing spiritual need and providing spiritual care is already offered in some NHS organisations and greatly valued by staff. This should be a normal part of professional development for all clinical and non-clinical staff involved in patient care throughout the NHS. The Healthcare Chaplaincy Training and Development Officer has been asked to develop this with the NHS Education Board and ensure that local spiritual care departments are equipped to deliver this in-house training.

SEHD
October 2002

Areas Of Healthcare Work ⁶	Range of Beds/Persons Justifying One Session
1. Acute inpatient: ie paediatric, medical, surgical, gynaecology, mental health, oncology	30 - 40
2. Intensive care units: ie neonatal, assisted ventilation, high dependency, post operative, transplant surgery.	10 - 20
3. Palliative care: ie standards for palliative care in Scotland indicate that a specialist unit of 16+ beds should have a whole time post.	6 - 18
4. Maternity	30 - 40
5. Long stay units: ie care of the elderly, long stay mental illness, long stay learning difficulties, etc.	25 - 50
6. Day care units: ie day hospital, day centre, ambulatory care, day surgery, oncology, stroke rehabilitation, and renal dialysis.	30 - 50
7. Accident and emergency, casualty and admission unit.	20 - 40
8. Care in the community: visits to supported accommodation number of tenants seen number of carers seen chaplain at learning disabilities school Plus time spent travelling between units	1 - 3 (depending on size) 2 - 6 1 - 3 up to 4 hours per week
9. Members of staff	250 - 500 staff justify one session
10. 24 hour cover and holiday cover	A sessional allowance should be made to ensure compliance with the EC Working Time Directive and to ensure appropriate off duty and holiday cover.

⁶ To include work with both patients and carers

Estimates of time required for other weekly commitments⁷

Activity	Range
11. Teaching/speaking engagements	0.5 - 5 hours
12. Worship services	1.5 - 4 hours
13. Bedside services, sacraments, etc.	0.5 - 10 hours
14. Pastoral counselling - by prior appointment.	1 - 5 hours
15. Administration , ie paperwork, meetings, committees, supervising volunteers, research, ethics discussions, etc	1 - 10 hours
16. Head of Department duties	1.5 - 4 hours

Funerals

Patients and carers often seek help from the NHS in arranging and conducting funeral services. The Working Group's research suggested the number of deaths, including stillbirths and neonatal deaths, could range from 5 - 1500 per annum and this could generate between 8 and 50 requests to conduct funerals each year. An allowance should be made for this.

Calculating the Workload

The calculation of the total sessions should be made in consultation with spiritual care and records department staff in three stages:

- a bed/person/staff calculation based on the sessional figures in categories 1 -7, 9 and 10 above;
- that total should be divided proportionally among staff who offer spiritual care to the non-affiliated and faith communities according to the bed occupancy figures for each group served;
- additional sessions, or parts of sessions, should then be allocated for the work in categories 8 and 11 - 16 above.

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⁷ including preparation time



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