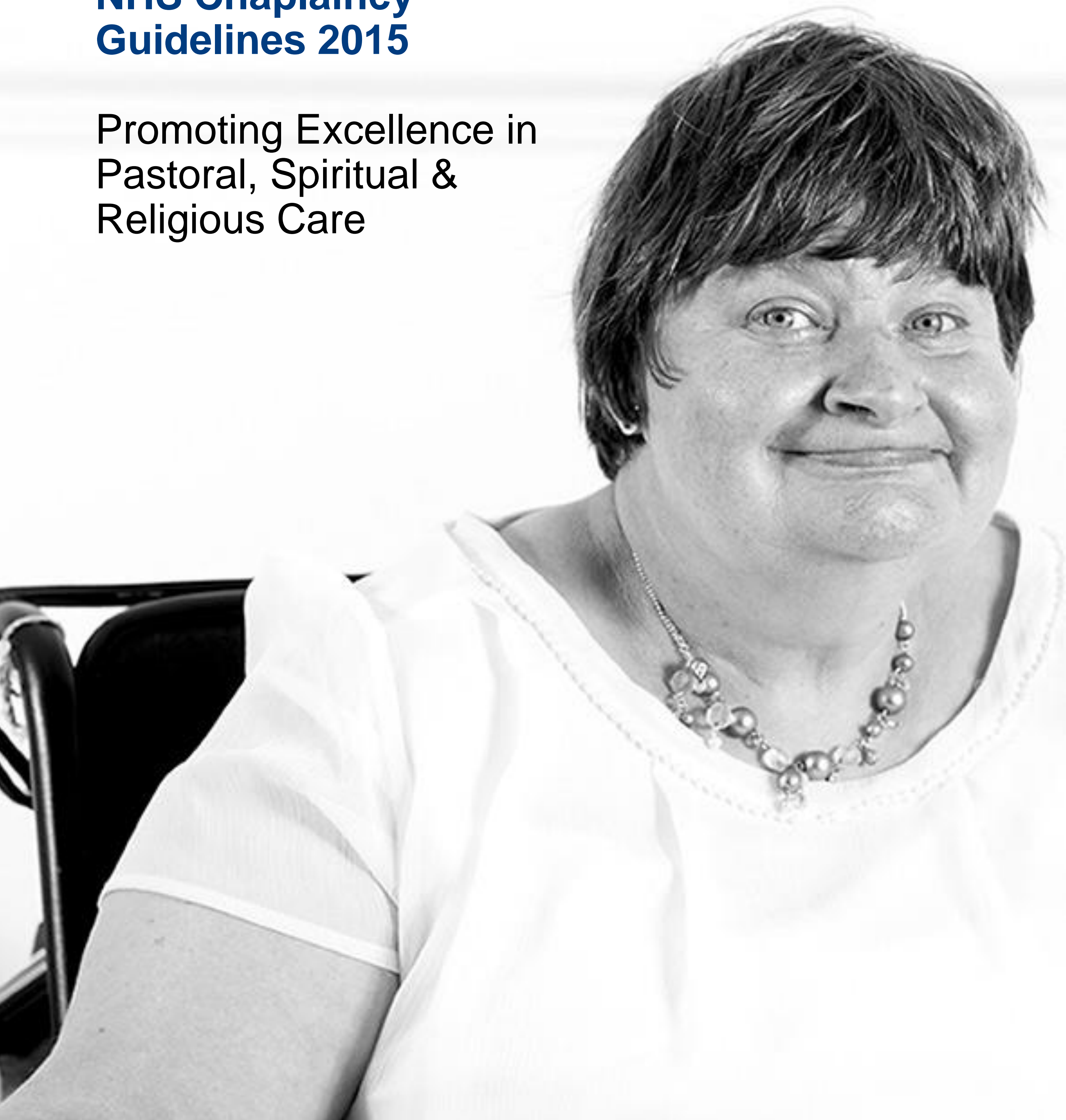
NHS England

NHS Chaplaincy Guidelines 2015

Promoting Excellence in Pastoral, Spiritual & Religious Care



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NHS England – NHS Chaplaincy Guidelines 2015

Promoting Excellence in Pastoral, Spiritual & Religious Care

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Prepared by: The Revd Dr Chris Swift in consultation with the Chaplaincy Leadership Forum (CLF)* and the National Equality and Health Inequalities Team, NHS England

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The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

* The Chaplaincy Leaders Forum (CLF) was developed in September 2013 as an effective mechanism for dialogue between NHS England, and the wider chaplaincy associations listed below:

- College of Health Care Chaplains (CHCC) - professional group within Unite Union, with a membership of almost 1000 members.
- Association of Hospice and Palliative Care Chaplains (AHPCC) - professional group supporting and working with people in end of life care.
- UK Board of Healthcare Chaplains (UKBHC) a professional group which holds a voluntary professional register for chaplains.
- Health Care Chaplaincy Appointment Advisers is a partnership with the leading chaplaincy bodies and the NHS England. The advisers themselves are experienced practitioners covering a range of health care chaplaincy contexts. They have no role in validating the faith or belief position of applicants or candidates for interview but advice employers about their professional suitability. This includes an assessment of applicants against published standards, job evaluations and other documentation relevant to the advertised post.
- Healthcare Chaplaincy Faith and Belief Group (HCFBG) which includes all 9 world Faith groups and the British Humanist Association attend as observers.

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1 Executive summary

"At its best, our National Health Service is there when we need it, at the most profound moments in our lives. At the birth of our children. At the deaths of our loved ones. And at every stage in between - as we grapple with hope, fear, loneliness, compassion - some of the most fundamental elements of the human spirit."

Simon Stevens
Chief Executive, NHS England
March 2015

"Local NHS trusts are responsible for determining, delivering and funding religious and spiritual care in a way that meets the needs of their patients, carers and staff."

Norman Lamb, MP, Minister of State for Care Services, Department of Health, Commons Written Answers 17 December 2013.

These guidelines replace those published in 2003 and provide a comprehensive description of good practice in chaplaincy care for the NHS in England.

The document responds to changes in the NHS, society and the widening understanding of spiritual, religious and pastoral care. In the light of the 2010 Equality Act new guidance is provided for the care of patients and service users whatever their religion or belief.
The guidelines recognise the development of chaplaincy in a range of specialities including General Practice and in areas such as Paediatrics and Palliative care.

Research and innovation are affirmed as important areas for chaplaincy both for improved practice and as a basis for commissioners to understand the benefits of chaplaincy-spiritual care.

The guidance draws on evidence from practice to recommend the resources needed for chaplaincy staffing across a range of contexts in the NHS. Implementation of the guidance will improve support for patients, carers, family members, volunteers, and other people accessing NHS services and staff across the health service.

It is anticipated that further documents and good practice guides will be developed in partnership with other agencies to elaborate and contextualise these guidelines.
For the purposes of this document:

Throughout this guidance we have used the term ***'chaplaincy'***, as it is widely used in the NHS. It is intended to include the pastoral and spiritual care provided to patients, family and staff, whatever it is called in practice, and to include religious care provided by and to religious people. The term 'chaplain' is intended to also refer to non-religious pastoral and spiritual care providers who provide care to patients, family and staff

Spiritual care is care provided in the context of illness which addresses the expressed spiritual, pastoral and religious needs of patients, staff and service users. These needs are likely to include one or more of the following:

- ways to support recovery
- issues concerning mortality

- religious convictions, rituals and practices
- non-religious convictions and practices
- relationships of significance
- a sense of the sacred
- exploration of beliefs

It is important to note that people who do not hold a particular religious affiliation may still require pastoral support in times of crisis.

Religion or belief is as defined in the 2006 Equality Act: (a) “religion” means any religion, (b) “belief” means any religious or philosophical belief, (c) a reference to religion includes a reference to lack of religion, and (d) a reference to belief includes a reference to lack of belief.

1.1 What do we mean by chaplaincy?

Discussions have taken place over the years about the term ‘Chaplaincy’, its history and its meaning. The term ‘chaplaincy’ in the context of this guidance is not affiliated to any one religion or belief system. There have been changes in attitudes and contemporary language driven by changes in our communities. To that end modern healthcare chaplaincy is a service and profession working within the NHS that is focused on ensuring that all people, be they religious or not have the opportunity to access pastoral, spiritual or religious support when they need it.

2 Introduction

This guidance is for NHS commissioners, NHS Trust boards, managers and health care chaplains. It replaces the guidance issued in 2003 and sets out the expectations for chaplaincy to provide 'high quality care for all, now and for future generations'[1].

For as long as there have been hospitals there have been chaplains. In 1948 the employment of chaplains became the responsibility of the NHS. Since then chaplaincy has evolved in response to changing needs with increasing professionalism. This has enabled chaplains to share good practice and begin to build a body of professional knowledge and emerging research[2]. Chaplains are professional staff qualified and contracted to supply spiritual, religious or pastoral care to patients, service users, carers and staff. They are one of the smallest professional groups working in the NHS. In many situations chaplains sustain a 24/7 service and respond to requests for care and support across the full range of clinical areas.

Chaplaincy has always been a partnership between paid staff and those engaged to offer pastoral, spiritual or religious care support on a voluntary basis. It is estimated that for every hour of funded professional chaplaincy at least one hour of voluntary care is provided. This partnership is a major asset for the NHS. It ensures that chaplaincy volunteers are trained and supervised by professional staff.

The changing nature of communities in England means that chaplains respond to calls of increasing complexity[3]. The diversity of religions, beliefs and cultures within the population has grown and the need for chaplaincy departments to advise providers about equality and access has increased. In addition to religious needs chaplaincy managers must consider how best to determine and deliver spiritual care to those whose beliefs are not religious in nature. In doing this, equality legislation, the NHS Charter and human rights obligations are of vital importance[4], but critically the experiences of patients, and carers is enhanced by ensuring either religious or non-religious pastoral support is available.

In order to put patients first the NHS in England seeks to understand the rich variety of beliefs and values of the population in its care. Chaplains are an essential resource for achieving the ambition to provide high quality care for all and promote the protected characteristics of both religion and belief. It is important to note that chaplains are not alone in providing pastoral or spiritual care and the nursing profession has a long established role in supporting the spiritual well-being of patients[5].

Chaplaincy provides highly skilled and compassionate pastoral, spiritual or religious support for patients, carers and staff facing situations which are at times harrowing and stressful. These include: sudden infant death; psychosis; diagnosis of life-threatening conditions; end of life care; and various kinds of self-harm. There is a growing body of evidence that appropriate spiritual care has an immediate and enduring benefit for those utilising chaplaincy in these situations[6].

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[1] NHS England, "*Putting Patients First: The NHS England Business Plan for 2013/14 – 2015/16*" 2013.
[2] Swift, Christopher. "*Hospital chaplaincy in the twenty-first century: The crisis of spiritual care on the NHS*".Ashgate Publishing, 2nd Edition, 2014 and Mowat, Harriet. "*The potential for efficacy of healthcare chaplaincy and spiritual care provision in the NHS (UK): A scoping review of recent research*" *Commissioned by NHS (UK) Yorkshire and the Humber* (2008).
[3] British Social Attitudes Survey, 2013
[4] HM Government, Equality Act 2010.
[5] RCN, "*Spirituality in nursing care: a pocket guide*", 2011.
[6] A comprehensive summary of published studies can be found in Koenig, Harold, Dana King, and Verna B. Carson. *Handbook of religion and health*. Oxford University Press, 2012.

These guidelines do not anticipate every detail of each context in which they should be applied. The NHS in England benefits from chaplaincies that are shaped by the requirements of the local care setting. At the same time it is important that standards common to all chaplains are observed, and that local determination of services is reviewed against the best available shared understanding of pastoral spiritual or religious care.

3 Patient and Service User Care: equality, safety and compassion

Those accessing NHS services have always had the opportunity to receive pastoral, spiritual or religious care from an NHS chaplain. Chaplains are trained and accredited by both the NHS and by their religion and belief community. Patients and service-users expect chaplains to be knowledgeable about issues of religion or belief and skilled in providing compassionate pastoral, spiritual or religious care in the health service.

In order to provide safe and effective spiritual care those commissioning and managing chaplaincy services should give due regard to the following good practice:

- Chaplains must abide by the requirements of their sponsoring religion or belief community, their contracting organisation, the Code of Conduct[7] and all relevant NHS/NICE standards
- Patients, service users and staff must be made aware of the nature, scope and means of accessing chaplaincy services within their setting. Only with adequate awareness can a provider evidence equality of access.
- Patients, service users and staff should be able to access chaplaincy at any time on any day of the week in facilities where urgent out-of-hours support is requested on average at least once a week.
- Where patients from a single religion or belief group average at least one call per week a separate on-call service should be provided. In circumstances where calls are below this level creative partnership with other providers and agencies should be explored in order to offer the best possible pastoral, spiritual, or religious care for patients.
- Where requests for support relate to a particular religion or belief the chaplaincy service should be able to access appropriate support for the patient or service user and, when this cannot be matched, other chaplaincy support should be offered.
- For patient and practitioner safety the provider's Lone Working policy must be followed.
- Patients and service users can expect to receive care from chaplains which is in accordance with nationally agreed competencies and capabilities (see http://www.ukbhc.org.uk) and in a manner authentic to the practices and beliefs of the community the chaplain represents.
- Where an instance of safeguarding arises during the course of spiritual care the chaplain must alert the patient or member of staff to the reporting obligations of the chaplain. The policies of the chaplain's NHS organisation must be followed in all circumstances.
- To ensure safety, accountability and continuity of care chaplains should maintain a record of work in a locally agreed format and in accordance with NHS policies for record keeping.
- Patients and service users have a right to expect that chaplaincy care will be experienced as neither insensitive nor proselytising.

[7] The Chaplaincy *Code of Conduct* has been endorsed by all the UK professional membership bodies for chaplains as well as by the Healthcare Chaplaincy Faith & Belief Group and is currently under review by the Roman Catholic Church in England and Wales.

- Compassion should always inform chaplaincy practice and is a key outcome of the patient's experience of the service being provided.[8]

[8] DH, "*Compassion in Practice: Nursing, Midwifery and Care Staff. Our Vision and Strategy*" 2012.

4 Staff and Organisational Support: informed, competent, critical

"Staff are dealing with their own ageing whilst also observing the ageing of their patients and the reaction to this of the relatives. None of this is particularly easy and spiritual practices seemed to help staff manage these complexities"[9]

Staff working in the NHS and their employing organisations, are entitled to access support from the chaplaincy service.

Chaplains are trained in practice-guiding disciplines such as theology, philosophy and ethics as well as in interpersonal skills and pastoral counselling. Their formation offers organisations and professions a resource to deepen understanding about the pastoral, spiritual and religious needs of the health care population.

Chaplains should be encouraged to draw on their wide contact with patients and service users to represent areas of concern to senior management. They may also have an appropriate role in supporting and encouraging members of staff to voice any concerns they may note in the course of their duties[10]

Best practice for quality pastoral, spiritual or religious care for staff and organisations is achieved by:

- The location of chaplaincy departments alongside allied health professional or similar clinical groupings.
- Ensuring staff awareness of how to access chaplaincy services which includes the availability of non-religious pastoral and spiritual support.
- Recording and reporting aggregated data about the number of times other health care staff access chaplaincy support and the time spent providing this support.
- If a chaplain has a concern about an aspect of organisational life this can be reported through line management. However, it is expected that a chaplain will have the option to communicate a significant concern directly to a member of the governing body.
- The lead / senior chaplain should produce an annual report of activities and outcomes, making this available to a wide audience, including the governing body and local communities of religion and belief.
- Organisations must have due regard to the health and well-being of chaplains. For small teams, many offering round-the-clock services, relevant legislation and NHS policies must be adhered to.
- Appointments to chaplaincy posts should be made by organisations in accordance with the latest guidance from the Panel of Professional Advisers (Appendix A).

[9] Mowat, Harriet. "*Gerontological chaplaincy: the spiritual needs of older people and staff who work with them.*" Health and Social Care Chaplaincy (2013): 27-31.
[10] Francis, R (2015) DH *Freedom to speak up review.*

5 Key Components for an Effective Chaplaincy Service

An effective chaplaincy service in any setting shares a number of key components. The following is a check-list of what should be expected from a quality chaplaincy service:

- The service has a designated lead chaplain.
- The chaplaincy has a written policy or guidance document describing the service and what care those using the service can expect to receive.
- A method of assessing belief, religion and pastoral needs should be described in the guidance document or separately.
- The chaplaincy department's staffing is calculated in accordance with the recommendations made below and the staffing is reviewed annually.
- Chaplains and chaplaincy volunteers collectively share the skills, knowledge, experience and insight to offer a comprehensive service.
- The chaplaincy department is fully included in relevant provider meetings and forums to ensure that pastoral, spiritual or religious care is integral to the holistic response to patient need.
- The chaplains have access to office space, administrative support, networked computers and data essential to the performance of their role.
- As part of annual appraisals development plans are written for each chaplain and supported (recognising that not all AHP funding sources are available for chaplains). Such plans need to take account of the hours a chaplain works, recognising that there are many part-time chaplains as well as some chaplains working under Service Level Agreements.
- Chaplains supervise all areas designated for faith-specific use, multi-faith use and use by those of non-religious beliefs. These should be well maintained, inviting and safe, and have available facilities to support worship (e.g. running water, storage for sacred items etc).
- Chaplaincies have procedures for auditing their work, both in terms of quality and quantity, so that the service is fully accountable within the organisation.
- There are regular opportunities for the chaplain(s) to engage in pastoral supervision[11] in a group or one-to-one setting as well as by involvement with their religion or belief group.

[11] Information about this can be found at: http://www.pastoralsupervision.org.uk/ (accessed 11 October 2014)

6 Volunteers in Chaplaincy

Volunteers are selected and trained members of chaplaincy teams who offer their services in support of spiritual care. There are many roles assigned to volunteers in the NHS[12], ranging from assistance in transporting patients to collective acts of worship to those visiting patients in a designated area. Many religion or belief groups, which are numerically small in the catchment area of a provider, may also have volunteers serving in chaplaincy to provide advice and support for these communities. In some cases the latter may be referred to as 'Honorary Chaplains' if their NHS training and status in their local belief or religious community matches the criteria for paid chaplaincy staff.

The relationship between chaplains and the chaplaincy volunteers is of vital importance. Volunteers require thorough selection and training as well as supervision and ongoing development. In all cases volunteers in chaplaincy must be recognised by the health provider and issued with an appropriate agreement. There needs to be close co-operation between the provider's voluntary services manager and the chaplain involved in the recruitment of volunteers.

Best practice for quality pastoral, spiritual or religious care provided by volunteers is achieved when:

- The chaplaincy and/or the organisation produce written policies for the recruitment; screening; training; deployment and expected benefits of using volunteers in chaplaincy[13].

- Quality assurance is gained through regular audit of volunteers' attendance, conversations with NHS staff responsible for the volunteer's area, and occasional follow up visits to patients who have received a visit from a volunteer. Volunteers will be aware of these steps and receive constructive and supportive feedback on their role and its outcomes.

- In addition to complying with the relevant policies of the health provider chaplaincy volunteers attend at least one annual training event focussing on the safe practice of pastoral, spiritual or religious care.

- All chaplaincy volunteers will be aware of the chaplains' *Code of Conduct* and be expected to adhere to its standards. Referring to the *Code* and explaining its features should be a regular part of induction and ongoing development.

- Systems are developed locally to maintain and monitor volunteers' contact with patient data and the means to refer patients (or staff) requiring further spiritual, religious or pastoral care.

- Chaplains recruiting volunteers should have regular contact with the organisation's lead for voluntary services and, where appropriate, the relevant religion or belief community.

- Whenever a concern is expressed about a volunteer's work the volunteer is told as soon as possible and concerns are shared clearly and supportively.

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[12] UK Department for Communities and Local Government. "*Key Communities, Key Resources Engaging the capacity and capabilities of faith communities in civil resilience*". Report, London: Communities and Local Government Pub., June 2008. Online: http://webarchive.nationalarchives.gov.uk/20120919132719/www.communities.gov.uk/documents/communities/pdf/846112.pdf (Accessed October 2014).

[13] Volunteering England produces a range of good practice tools and resources: http://www.volunteering.org.uk/

7 Chaplaincy Staffing

"Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well supported"[14]

Chaplaincy services should have adequate resources to carry out the work an employer requires. Where a 24/7 service is provided for urgent need consideration must be made of the staffing needed to ensure chaplains are not unduly burdened. Wherever possible, patients should have access to a chaplain of their religion or belief to ensure appropriate pastoral, spiritual or religious care.

Across the NHS there are many patients and service-users unable to exercise their religion or belief without support. An effective chaplaincy department is the most reliable way to ensure that the freedoms guaranteed by the European Convention on Human Rights are observed and promoted.

This section of the guidance is in six parts. It begins with a calculation regarded as most suitable for acute care settings. There follows guidance on staffing levels for mental health settings, general practice, specialist palliative care, paediatric units and community providers.

7.1 Overview

Chaplaincy in the NHS has always been related to patient or service user numbers.

For many years the primary figure for staffing calculations has been an average of 35 inpatients equating to 3.75 hours per week of chaplaincy (matched by religion/ belief). In large organisations this fostered the growth of multi-faith teams corresponding to user populations. Chaplains consulted in the formation of this guidance stated that in practice this figure continues to relate to operational demands. At the same time some international studies have identified a staff-to-patient ratio approximating current English practice in acute provision[15]. This figure is also similar to that used in Scotland and Wales.

It is widely known that data about the religion or beliefs of inpatients is both limited and frequently inaccurate. However, independently gathered information shows that a significant minority of patients who have a particular religion or belief wish to practice it during their episode of care[16] (and are often unable to do so). Given that chaplains are also requested by patients not identified with a particular religion or belief, and that patients' religion or beliefs may be incorrectly recorded on NHS systems, recognition of this has been included in the recommendations below.

In order to fulfil the Public Sector Equality Duty health care organisations should make every effort to request and record information about the religion or belief of service users and patients. Audits to verify the accuracy of this data, check users' awareness that chaplaincy is available to them, and monitor the quality of experience and any agreed religious, spiritual or pastoral outcomes. This will enhance an organisation's ability to demonstrate that it is meeting the Equality Duty.

[14] *"A promise to learn – a commitment to act: Improving the Safety of Patients in England"* National Advisory Group on the Safety of Patients in England (2013)
[15] Boddé, Ree. "*Towards Benchmarking in Health Care Chaplaincy and Pastoral Care in Australia.*" *Australian Journal of Pastoral Care and Health Vol* 2.2 (2008).
[16] Clayton, A., '*Religious Need in the NHS in England: The Contribution of Picker Inpatient Surveys'*, Journal of Health Care Chaplaincy 1:2 (2012): 77–89.

It is important to note that some people who do not belong to a religion or belief can also access and fully utilise chaplaincy services. This needs to be born in mind when making calculations and employment decisions. NHS organisations need to ensure the chaplaincy service is accessible to those without a religion and employment decisions are based on robust data and where applicable are fully compliant with the occupational requirement provisions of the Equality Act 2010.

8 Chaplaincy in Acute Care

"People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences."[17]

Best practice for good quality pastoral, spiritual or religious care is achieved by:

- Ensuring that all patients and service users are asked about their religion or belief and offered appropriate chaplaincy support. This information must be recorded accurately with referrals passed on promptly.
- Allocating 3.75 hours per week of chaplaincy care for an average inpatient population of 35 patients with posts matched by religion or belief. This calculation should be made on the basis of accurate information about the religion and beliefs of the patient or user population.
- Allocating 3.75 hours per week of chaplaincy care for every 35 patients not identified with a particular faith or belief system. Posts relevant to this population are to be open to any appropriately qualified chaplain of any recognised religion or belief community that can effectively carry out the role.
- Allocating 3.75 hours per week of chaplaincy care for every 500 WTE staff irrespective of their particular religion or belief.
- Allocating 3.75 hours per week of management/professional leadership time for the lead chaplain for each whole-time equivalent chaplain in the team, recognising that small teams may require an increased allocation in order to meet organisational expectations.
- Allocating of 3.75 hours per week for each NHS contract funeral taken by chaplains. This time includes preparation, contact with relatives/friends, travel to the funeral location and the service itself.
- Matching chaplaincy provision for end-of-life care to best practice models, such as the ratios of staffing found in most hospices. This can mean 37.5 hours per week of chaplaincy care, appropriately allocated, for every 24 patients in the last 72 hours of life[18].
- Ensuring that at least 20% of a chaplain's working time is available for some or all of the following duties:
    - Participating in staff education, development in spiritual care and pastoral supervision
    - Membership of ethical and other committees where the chaplain offers specialist knowledge and experience
    - Managing chaplaincy volunteers
    - Developing expertise for research and publication

[17] NICE Quality Standards, Holistic Support, accessed at the following address on 13/12/13: http://www.nice.org.uk/guidance/qualitystandards/endoflifecare/HolisticSupportSpiritualAndReligious.jsp
[18] This calculation is influenced by the guidance issued by the Association of Hospice and Palliative Care Chaplains.

- Making clear when a post is identified as a training position that adequate time is ring-fenced for study, development, education and training.

The guidance on staffing for acute providers cannot be exhaustive but the above offers a framework for chaplains and managers to determine the required level of local provision. In particular, additional resources are likely to be needed for areas such as intensive care facilities, regional specialisms and major trauma centres.

9 Chaplaincy in Mental Health Care

"Recognising a person's spiritual dimension is one of the most vital aspects of care and recovery in mental health. People who use services increasingly wish to have services view them as whole persons in the context of their whole lives; and spirituality and faith is a vital element in that"[19]

Those commissioning and managing mental health care services should ensure adequate provision of pastoral, spiritual or religious care is made for their service users. It is widely recognised in practice that chaplains are an integral component of contemporary recovery based models of mental health.

Service users experiencing mental health conditions may have a complex relationship with issues of doubt, religion or belief. NHS chaplains are skilled at working with people to ensure that pastoral, spiritual or religious concerns are addressed in ways that enhance resilience and support healthy living.

Pastoral, spiritual or religious needs are expressed in a wide range of ways in mental health settings. This includes both more general ways of expressing spiritual need and also need reflecting a heightened concern to receive care from a chaplain of the service user's own religion or belief.

Adequate chaplaincy staffing for mental health services requires:

- An allocation of 3.75 hours per week of chaplaincy for every 20 patients, taking into careful consideration the composition and needs of the user population by religion or belief.
- Where there is a need for chaplaincy involvement in community work there should be an additional allocation of 3.75 per week for every 15 chronically ill service users.
- Given the dispersed nature of many care settings within a single provider additional hours may need to be added to recognise the travelling time involved.
- At least 3.75 hours per week of chaplaincy for every 200 whole-time equivalent staff.
- Allocating 3.75 hours per week of management/professional leadership time for the lead chaplain for each whole-time equivalent chaplain in the team, recognising that small teams may require an increased allocation in order to meet organisational expectations.
- Ensuring that at least 20% of a chaplain's working time is available for some or all of the following duties (which may be distributed in larger teams):
    - Participating in staff education, development in spiritual care and pastoral supervision
    - Membership of ethical and other committees where the chaplain offers specialist knowledge and experience

[19] Gilbert, P. "*Guidelines on Spirituality for Staff in Acute Care Service: Recognising a person's spiritual dimension is one of the most vital aspects of care and recovery in mental health*" (2008) Staffordshire University.

- Managing chaplaincy volunteers including religion or belief-specific visitors
- Developing expertise for research and publication
- Allocating time to prepare for work with a service user. Risk assessment is especially important where lone working is required.

10 Chaplaincy in General Practice

"Every patient is different... nothing prepares you for the consultation with the patient in front of you, dealing with their psychological, their physical, their social, and increasingly their spiritual needs"[20]

The provision of chaplaincy in the NHS has historically favoured facilities offering inpatient care. As the NHS undergoes a process of transformation with renewed emphasis on primary care it is important to address pastoral, spiritual or religious needs in these settings. This should be done in partnership and co-operation with the longstanding support offered by many local organisations of religion or belief.

Some GP practices already have experience of providing a chaplaincy service. Initial assessment of this provision found that a "'Chaplains for Wellbeing' service in primary care improves mental health and well-being among those referred to it"[21].

Chaplains have the privilege of working with patients' values and the opportunity to affirm religion or belief central to a person's identity and sense of worth.
A small but growing body of evidence links the use of chaplaincy to reduced stress, anxiety, depression, isolation and spiritual disease[22]. These benefits have the potential to enhance patients' resilience in the face of illness.

Chaplains in primary care can have an important role in staff support, both individually and as a community of workers. Repeated care for distressed people, including those who have been through traumatic experiences (such as a Major Incident) has an inevitable impact on staff. A chaplain in primary care can support staff and work to enhance patients' experience of care.

In developing chaplaincy in primary care it is recommended that commissioners introduce pilot schemes in suitable practices and evaluate their outcomes. Given the small scale of this work, networking practices and researchers, and developing a validated Patient-Reported Outcome Measure are priorities. There is a significant connection between primary care and community care and close working between chaplains in these areas should be pursued actively.

Adequate chaplaincy staffing for primary care health services requires:

- 3.75 hours of chaplaincy for every 250 whole-time equivalent staff with the availability of chaplaincy advertised so that all staff are aware of the service
- Defined and documented means of access for patients and service users to receive professional chaplaincy services
- An indicative staffing of 37.5 hours of chaplaincy to a practice population of 50,000

[20] Dr Clare Gerada, Chair of the Council of the Royal College of General Practitioners speaking on Radio 4's *Woman's Hour* on 22 October 2013.
[21] Kevern, P & Hill, L. (2015). '*Chaplains for well-being in primary care: analysis of the results of a retrospective study.* Primary health care research & development, 16(01), 87-99.
[22] Holloway, M., et al. "Spiritual care at the *end of life: A systematic review of the literature.*" National End of Life Care Program, available online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215798/dh_123804.pdf *(accessed on 11 October, 2014)* (2011).

11 Chaplaincy in Specialist Palliative Care

"Commissioners ensure they commission services with adequate provision for offering, facilitating and providing (including sign-posting and referral) spiritual and religious support to people approaching the end of life that is appropriate to person's needs and preferences."[23]

Specialist palliative care facilities, including hospices, offer a unique context for the provision of pastoral, spiritual or religious care. The World Health Organisation recognises that spiritual care is a core element of palliative care[24]. It is widely accepted that people in need of palliative care may experience spiritual distress alongside their clinical symptoms.

Given the specialised work of units dedicated to the provision of palliative care it is essential that chaplains are integrated into the multi-disciplinary team. Where palliative care chaplains work within acute hospitals they should be members of their hospital Palliative Care Team.

Current guidance from the Association of Hospice and Palliative Care Chaplains[25] recommends the following staffing in dedicated palliative care units:

- Units with fewer than 16 beds – minimum of a half-time appointment.
- Units with 16 beds or more – minimum of a full-time appointment.

Within dedicated palliative units a chaplaincy department's commitment to outpatient, day therapy and community services should also be taken into consideration. Chaplains will regularly be involved in the support of patients' families pre-bereavement and in many instances will play a significant role in bereavement care, including the conduct of patients funerals and the organisation and conduct of memorial services and related events.

As members of the multi-disciplinary team chaplains will often be responsible for delivering staff education, supervision and support, and will require their own pastoral supervision to equip them for these tasks.

In designing or reviewing a chaplaincy service in a palliative care setting accurate information about patients' religion or belief, as well as their pastoral and spiritual needs, should be considered carefully[26].

[23] QS13: NICE Quality standard for end of life care for adults, 2011.
[24] www.who.int/cancer/palliative/definition/en/
[25] www.ahpcc.org.uk (accessed on 11 October 2014)
[26] The Leadership Alliance for the Care of Dying People emphasises the need for compassionate care tailored to the needs of the dying person. http://www.england.nhs.uk/ourwork/qual-clin-lead/lac/ (accessed 15/10/14)

12 Chaplaincy in Specialist Paediatric Care

The spiritual needs of younger people and children require highly skilled and imaginative care.

The ethical and safeguarding considerations for care in specialist paediatric units are of paramount importance. Chaplains working in such areas will require enhanced training tailored to their context.

The families and friends of younger people and children face particular challenges to religion or belief and spirituality. Chaplains in paediatric settings will need to be equipped to support those facing these challenges and will require support and supervision.

It is recommended that staffing levels and allocation of posts are the same as those of specialist palliative units, especially given the level of outpatient contact and the support of families.

The *Paediatric Chaplaincy Network* is producing guidance on standards of care and the competencies expected of chaplains working with children and young people[27].

[27] http://www.paediatric-chaplaincy-network.org/ (accessed 15 October 2014)

13 Chaplaincy in Community Care

"Religion/spirituality as a resilience factor may be associated with meaning in life, a broad form of social support, greater access to resources through regular attendance at church/services, but also at another level may determine diet, exercise, alcohol and tobacco use."[28]

Care for people outside NHS facilities is a growing aspect of health provision. Most people prefer to be cared for at home if possible and, with a rising population of elderly people, it is anticipated that this aspect of health care will increase. Many different agencies including religious or belief groups have a long history of providing supportive care in the community[29].

Staff working in the community should have access to chaplaincy services. This is both to support them in the day-to-day demands of caring and also to assist in their care for patients either by advice or attendance. Many service-users living with mental health illnesses are supported in the community and there is evidence that chaplaincy involvement can lead to both a reduced sense of isolation, signposting to additional services and increased resilience[30].

There is a significant connection between primary care and community care and close working between chaplains in these areas should be pursued actively.

One way forward for community chaplaincy may involve wider developments in the NHS such as telemedicine and the internet. It is expected that in the next decade work will be undertaken to trial pastoral, spiritual or religious care support via both telephone e-mail, teleconferencing etc in order to offer accessibility to services for those receiving community care.

The benefits of pooling resources within a locality and region are significant. Where smaller religion or belief communities would struggle to gain resources for chaplaincy in a given area, links with neighbouring regions – and the use of remote support – could enable isolated patients and service-users to be supported and valued.

[28] Davydov, Dmitry M., et al. "*Resilience and mental health*." Clinical Psychology Review 30.5 (2010): 479-495.
[29] November, Lucy, '*The Impact of Faith Organisations on Public Health and Social Capital*', can be found at http://www.faithaction.net/wp-content/uploads/2014/09/FaithAction-Public-Health-Report.pdf (accessed October 2014) Faith Action, 2014.
[30] Research in many areas of chaplaincy work is limited in both scope and complexity. However, case studies are emerging which illustrate the positive impact of chaplaincy e.g. Watkins, Leanne. *"Should emergency nurses attempt to meet patients' spiritual needs? Leanne Watkins offers a reflective case study in which the intervention of a chaplain helped a woman with mental health problems deal with self-harm."* Emergency Nurse 22.6 (2014): 36-38.

14 Information Governance

All NHS staff requires access to the information needed to carry out their duties. Access to appropriate information is essential for chaplains to provide excellent spiritual care. Such access is subject to strict legal rules and NHS policies which must be observed by all staff.

The Public Sector Equality Duty (PSED) enshrined in the 2010 Equality Act requires NHS services to eliminate discrimination, to advance equality of opportunity and to foster good relations. This cannot be achieved without accurate statistical information about the patient and service user population. Providers of health care should ensure they make every effort to capture and record this information.

14.1 Best practice for providing excellent spiritual care

For reasons of both pastoral, spiritual or religious care and equality, providers should make every effort to request and record data about religion or belief.

In order to have the information needed to provide excellent spiritual care it is essential that:

- All NHS patients and service users should be asked if they wish to declare their religion or belief and to have this recorded.
- When NHS patients and service users express their pastoral, spiritual or religious needs, and request to be referred to the chaplaincy service, this information should be recorded and action taken.
- All NHS patients and service users who provide such information should be fully informed as to how their information is intended to be recorded, used and shared and of their right to refuse to consent to such processing.
- Where referrals are made an assessment of pastoral, spiritual or religious need should be carried out by a chaplain using an agreed method.
- Patients and service users are given access to the most suitable chaplain to meet their pastoral, spiritual or religious needs.
- In order for an assessment to be carried out patient information (name and religion or belief) should be made available promptly to the staff sanctioned by the provider to carry out this work with the patient's explicit consent to the referral.

14.2 Information and Staff Safety

The NHS has a duty of care for both patients and its staff. In order for appropriate care to be provided and for chaplains to be aware of any risks associated with the patient or service user. When appropriate all chaplains must be informed about these risks, and, provided there is a basis for concern, have access to the relevant information relating to the safety concern only. These judgements must be made on a case-by-case basis and do not justify wholesale access to clinical information systems.

15 Training, Development & Research

"Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams"[31]

Chaplains poorly trained to provide pastoral, spiritual or religious care can cause harm. Those providing spiritual care are often called to patients and families in a state of severe distress. Poor communication skills; pastoral insensitivity; or a failure to identify essential elements of the patient's belief system may all create potentially serious risks for both the patient and the organisation.

Professional chaplaincy job profiles describe required competencies according to the chaplain's grade. In addition, there are nationally agreed capabilities and competencies for health care chaplains as well as faith and belief specific guidance[32]. Together these documents set out the progress chaplains should make to develop their role.

Caring for patients, service users and staff is the primary role of health care chaplains. Providing that care always requires time for reflection, learning and improvement. Unless chaplains work to develop their skills and knowledge, as well as their own spiritual discipline, there is likely to be a diminishing return in their pastoral effectiveness. Chaplains need to learn from one another: through research; in their own religious or belief community; by reflective practice, and from the insights of colleagues in related disciplines.

Best training and development for quality pastoral, spiritual or religious care is achieved by:

- As stated above, regular reviews, at least annually, of the chaplain's development needs
- Compliance by chaplains with their employers' mandatory training and equality policy
- Maintenance of an up-to-date Professional Development Portfolio
- Supporting chaplains' participation in suitable training provided by the NHS, chaplaincy professional bodies and the chaplain's own community of religion or belief.
- Enabling newly appointed chaplains to access chaplaincy induction training
- Regular, planned pastoral supervision to reflect on practice
- All chaplains should be familiar with the profession's research standard[33], meet the foundation level and plan to develop elements of the next level
- Encouraging chaplains and chaplaincy teams to remain engaged with the wider community including where relevant local Healthwatch, inter-faith groups and other relevant patient forums including those that are non-belief and non-religion

[31] Berwick, D. "*A promise to learn - a commitment to act. Improving the safety of patients in England*. National Advisory Group on the Safety of Patients in England." (2013).
[32] E.g. '*Caring for the Catholic Patient: A Guide to Catholic Chaplaincy for NHS Managers & Trusts'* published by the Catholic Truth Society on behalf of the Catholic Bishops' Conference of England and Wales, 2007.
[33] http://www.nhs-chaplaincy-spiritualcare.org.uk/Research_Standards_0704.pdf accessed on 11 October 2014.

Independent reports have found failings in NHS care linked to a 'tick-box' culture[34]. Chaplains have a unique potential to support approaches which view the patient or service-user holistically. It is recommended that the insights of this role should be shared within provider organisations, their boards and through chaplaincy involvement in the training and development of other NHS staff.

[34] Francis, Robert. *Report of the Mid Staffordshire NHS foundation trust public inquiry: executive summary*. Vol. 947. The Stationery Office, 2013.

16 Further Areas of Guidance for Chaplaincy Services

16.1 Appointing Chaplains

When making chaplaincy appointments it is recommended that employers contact the co-ordinator of the Professional Advisers Panel at an early stage – ideally before the advert and supporting documentation have been written (Appendix A).
Effective chaplaincy depends on the quality of appointments and it is expected that every effort is made to recruit candidates of the highest calibre.

16.2 Multi-Faith & Belief Rooms

The provision of suitable areas for worship; prayer; contemplation; reflection; meditation, stillness and peace is required in order for human rights and equality to be observed. It is also a positive incentive in recruitment to have areas available close to clinical practice which staff can attend without difficulty.

It is difficult to define the exact criteria for such spaces as local needs, organisational scale and accommodation pressures can all affect the options available.

Researchers at the University of Manchester have produced guidance concerning the consideration which should be made when planning or re-providing this kind of accommodation[35]*.*

16.3 Bereavement Services

Chaplains are frequently involved in end-of-life care and arrangements following death. There are often close links with bereavement services in the acute sector. Sometimes chaplaincy managers will line-manage the bereavement staff and in all circumstances it should be expected that chaplains are involved in both the delivery of bereavement support and also in planning the care offered to relatives. Chaplains have a key role to play in the provision of contract funerals.

16.4 Major Incident Response (MAJAX)

The role of chaplains in major incident response should be included in local MAJAX policies. This should highlight the value of deploying chaplains to support attending relatives as well as the injured. Chaplains can play an important role in subsequent staff support and de-briefing.

The Home Office and Cabinet Office have published guidance on emergency planning in relation to Faith Communities which is a helpful resource chaplains and NHS organisations[36].

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[35] This information can be accessed through the following site hosted by the University of Manchester: http://www.sed.manchester.ac.uk/architecture/research/mfs/ (accessed 11 October 2014)
[36] See UK Government (Home Office and Cabinet Office), 'The Needs of Faith Communities in Major Emergencies: Some Guidelines' (accessed 11 October 2014) 2005: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61226/faith_communities.pdf

17 Appendix A:

Letter to CEOs regarding the new arrangements for chaplaincy appointments:

12 December 2011

To: Chief Executives of Hospital Trusts Hospital
Chaplains

New arrangements for provision of Health Care Chaplaincy Appointment Advisers.

The purpose of this letter is to explain the new arrangements that will come into effect from 3 January 2012, for advising on the appointment of Health Care Chaplains in England.

Background: From the early 1970s until 2010 the Church of England's Hospital Chaplaincy Council (HCC) had led in servicing a Panel of Assessors to assist such appointments. In recent years the UKBHC has offered Professional Advisers to advise on the professional aspects of chaplaincy appointments.

The Church of England has had to withdraw from its role so it has been necessary to find a new way ahead for the recommendation of advisers. The new system is the result of discussions between the bodies concerned for chaplaincy.

Following discussions between the Churches Committee for Health Care Chaplaincy (CCHCC), the United Kingdom Board for Health Care Chaplaincy (UKBHC), the Multi-Faith Group for Health Care Chaplaincy (MFGHC), the Church of England and the Department of Health agreement has been reached to initiate a new and unified system for the recommendation to Hospitals and Trusts of Advisers to assist in the appointment of full-time chaplains.

A New Structure

A Panel of Health Care Chaplaincy Appointment Advisers drawn from the different religion and faiths in England will be established from whom Advisers can be recommended to Trusts who seek assistance in the complex process of appointing chaplains to acute and mental health hospitals.

The Panel will be set up and overseen by a Reference Group of five Senior and experienced Chaplains. It will be serviced by a Panel Co-ordinator. (The responsibilities of the Reference Group, Coordinator and Advisers are included in the attached Appendix).

Implications

The key person to contact is the Panel Co-ordinator Rev. Malcolm Master at malcolm.masterman@nhs.net*

Signed Debbie Hodge – for MFGHC, Derek Fraser – for UKBHC Paul Mason – for CCHCC, Malcolm Brown for C of E

*Subject to NHS Chaplaincy Guidelines Amendments 2015, Malcolm Masterman is no longer Panel Co-ordinator, for more information on the work of the Healthcare Chaplaincy Appointment Advisors Panel, please contact Debbie Hodge on debbie.hodge@freechurches.org.uk

18 Consultation and Involvement

See the Equality Analysis document for details of the consultation and involvement process