

## REVISED GUIDELINES ON CHAPLAINCY AND SPIRITUAL CARE IN THE NHS SYNOPSIS OF THE REPORT OF THE WORKING PARTY

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*The Working Party Report prepared for the Scottish Executive Health Department will form the basis of new guidelines for spiritual care and chaplaincy in the National Health Service (NHS) in Scotland. It is summarised by the working party convener.*

### Introduction

The Working Party, set up on the initiative of the Scottish Executive Health Department (SEHD) Division of Health Gain, met four times and worked against a tight time scale. After three meetings it produced an interim report which was circulated to interested parties and revised in the light of the responses received, most of which were favourable, some critical. This synopsis covers only the salient features of the report. Interested readers should study the report itself.

The membership of the Working Party consisted of representatives of the ACTS Scottish Churches Chaplaincies Committee, the Church of Scotland, the Roman Catholic Church, the Scottish Episcopal Church, the Scottish Inter Faith Council, the Humanist Association of Scotland, the Scottish Association of Chaplains in Healthcare, the College of Health Care Chaplains (Scotland Branch), the Association of Hospice Chaplains (Scottish Branch), the Chaplaincies Administrator, the part time Chaplaincy Training Officer and a Senior Research Fellow from the Department of Nursing Studies at Edinburgh University.

The interest of the SEHD in spiritual and religious care, demonstrated by the formation of the Spirituality in the NHS Steering Group, the decision to fund the three year appointment of the Whole-time Healthcare Chaplaincy Training and Development Officer for Scotland and the inauguration of the Chaplaincy Training and Development Group added impetus to our enterprise.

The SEHD (2000) document 'Our National Health: A plan for action, a plan for change' with its emphasis on national standards delivered locally, increased

accountability, listening and responding to individuals and communities, patient centred services, integrated planning and decision making and ensuring that the design and delivery of services is placed as close to patients and communities as possible was deemed to be as relevant to chaplaincy and spiritual care as to other NHS services.

### Why new guidelines?

It was necessary to replace the three existing chaplaincy circulars with a single set of new guidelines for three main reasons: firstly, the changes which have taken place in the NHS - expanded therapeutic possibilities, more seriously ill inpatients and the involvement of chaplains in care in the community; secondly, changes in patterns of religious belief and practice in Scotland - decline in church membership coupled with increased interest in spiritual matters, the advent of world faith communities and new age religions, the privatisation of belief in a pluralist society; and thirdly, the changes in chaplaincy itself - the growth in the number of whole-time chaplains, increasing professionalism and the growing demands for ministry to those with no religious affiliation, to carers and to staff.

### Principles

The Working Party drew up a set of principles which should underpin all chaplaincy and spiritual care in the NHS. Impartiality, availability to persons of all faith communities and none, respect for the wide range of beliefs, lifestyles and cultures found in Scotland today are fundamental in an exchequer funded service. Chaplains must be a unifying and encouraging presence, must never impose or proselytise and their services should be characterised by openness, sensitivity, integrity, compassion and a

capacity to make and maintain attentive, helping, supportive and caring relationships. Chaplaincy should be exercised in consultation with other NHS staff.

### **Spiritual and religious care**

Central to the report is the recognition of the need for Health Boards and Trusts to make provision not only for the religious but also for the spiritual needs of patients, carers and staff in the NHS. The Working Party clarified the distinction between religious and spiritual care thus: 'Religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community: spiritual care is given in a one to one relationship, is completely person centred and makes no assumptions about personal conviction and life orientation'.

While spiritual care is not necessarily religious, religious care, at its best, should always be spiritual. The report acknowledges that chaplains must offer both spiritual and religious care with equal skill and enthusiasm. It also affirms that spiritual care is delivered not only by chaplains and spiritual caregivers but also by many members of staff in the course of their professional work, by carers and by patients informally to each other.

### **The responsibilities of Health Boards and Trusts**

The Working Party looks to Health Boards and Trusts to accept spiritual care as an integral part of NHS provision and encourages them to include it in their policies, fund it adequately and ensure it meets the standards set for it. The report asks them, in consultation with faith communities, community representatives, NHS staff, chaplains and spiritual caregivers, to formulate and implement a strategy for the provision of spiritual and religious care and to commission the necessary services. In particular it suggests that they establish a Department of Spiritual and Religious Care, appoint a chaplaincy line manager, consider setting up a Chaplaincy Committee, calculate the number of chaplaincy sessions required, appoint or arrange the appointment of a chaplain or chaplains who will be expected to offer spiritual care to persons of all faiths and none and where appropriate, in consultation with local faith communities, to appoint or arrange the appointment of faith community chaplains and spiritual caregivers. A Head of Department, usually one of the chaplains, should also be appointed.

Boards and Trusts should provide: accommodation and accessories for multi-faith worship; accommodation for the use of chaplains and spiritual caregivers; information about facilities for spiritual and religious care; signage; an accurate system of documentation of patients religious affiliation, if any, and their spiritual needs; a system of notification or referral which, within the constraints of confidentiality, would facilitate the ministry of religious leaders and spiritual caregivers to patients who wished to see them and enable staff of the department of spiritual and religious care to exercise their ministry.

Provision should also be made for the training of chaplains and spiritual caregivers, members of staff of all professions who deliver spiritual care in the course of their work, and volunteers.

### **The appointment and employment of chaplains**

Neither the Working Party nor the respondents to the interim report could agree whether chaplains should be employed directly by the NHS or, as traditionally in Scotland, by faith communities. There are arguments for and against both options. The Working Party therefore resolved to leave it to Boards and Trusts to decide which course to follow. The Working Party agreed, however, that Trusts and faith communities should work together in the provision of chaplaincy and spiritual care and in the appointment and employment of chaplains so that those appointed are pastorally and doctrinally acceptable to faith communities and carry the support and approval of the NHS. Posts should be advertised and at least one assessor, a practising chaplain working in a similar Trust in a different area, nominated by the chaplaincy professional bodies, should play an advisory part in the appointment process. It is essential that all appointments are seen to be made impartially.

Each faith community should be able to have its own chaplain or spiritual caregiver if it wishes (the title to be chosen by them), to give spiritual care, support, information and advice to patients, carers and staff of that faith community in the Trust. Trusts should ensure that the care of those who belong to smaller faith communities is available. Trusts will also decide whether chaplains are paid or unpaid according to the sessional criteria outlined below. It is envisaged that a single chaplain might give spiri-

tual care to those of several different faith communities.

The Working Party report states that chaplains need not necessarily be ordained but they must be in good standing with their own faith community and have the required personal qualities and professional skills. They must have undergone or be willing to undergo the necessary training and be able to relate to people of different backgrounds, working on the basis of mutual respect. There is some evidence that chaplains gain credibility from being rooted in a faith community. The report stresses that whether employed by the NHS or a faith community, all appointed chaplains and spiritual caregivers should be designated as members of the Trust professional caring team and integrated as such.

Chaplain's Assistant posts in future might become training posts. Meantime assistants should be able to remain in post or apply for full chaplain's posts if they wish. Automatic promotion is not an acceptable option.

Chaplains should have access to secretarial services. Volunteers, provided they are carefully recruited and properly trained, make a significant contribution.

#### **Sessional and other criteria**

The criteria for the calculation of chaplaincy sessions provided in the Advisory Notes attached to NHS circular SHHD (1986) are no longer adequate for determining chaplaincy workload in today's NHS. Trusts need to take account not only of the numbers of patients and staff and their religious affiliation, if any, but also of the full range of chaplaincy work and the time chaplains spend fulfilling their various responsibilities such as work with carers especially in bereavement, teaching commitments, informal advocacy, liaison with faith communities and their leaders, committee work and providing information and advice on ethical, theological, pastoral and religious matters. Recent developments in community healthcare chaplaincy must also be taken into account.

An informal survey was conducted to ascertain the views of a sample of whole-time and part time chaplains of different denominations in different areas of healthcare across Scotland. They were asked to indicate what they thought would be a fair estimate of the bed/ person numbers and other factors which would justify one three and a half hour session of

chaplaincy time and to state the number of hours they spend in other related areas of chaplaincy work. While the Working Party recognises that each Trust will make its own assessment with the help of its chaplains, it offers a range of revised criteria which reflect the views of practising chaplains and may prove helpful to Trusts in making their calculations. The units for which figures are given include acute inpatient, intensive care, palliative care, maternity, long stay, day care, accident and emergency/ admission and care in the community. Estimates are also given of the average time spent on other commitments such as work with staff, teaching/ speaking engagements, worship services, formal counselling by prior appointment, funerals and administration. The steps to be taken in making the calculation are described. The Working Party acknowledges that a fuller survey and more rigorous assessment must be undertaken so that its revised criteria may be further refined.

#### **The assessment of spiritual need and staff training**

It is widely accepted that greater emphasis should be given to the assessment of spiritual need and staff training so that staff may be better equipped to recognise spiritual need in their patients, make referrals and offer spiritual care themselves. Staff training, already offered by some chaplains, is greatly valued. The Working Party recommends that it should become a mandatory part of professional development.

The training, support and supervision of chaplains, as of other healthcare professions, should become an accepted feature of Trust policy and funded accordingly.

The contribution of the newly appointed Chaplaincy Training and Development Officer and his assistant will be an essential part of this process.

#### **Appendices to the report**

Appendix 1 spells out the facilities which should normally be provided: a dedicated sanctuary, quiet room or worship space; a room for meeting and teaching; information and signage; facilities for rituals and religious offices in the mortuary area. Appendix 2 refers to documentation, notification and referral while Appendix 3 discusses confidentiality, data protection and access to information. Appendix 4 discusses the regulation of chaplaincy, registra-

tion, accreditation, accountability and codes of professional conduct. It comments on pay and conditions of service, pension arrangements and off duty cover and notes issues requiring further consideration. Appendix 5 asks that as Boards and Trusts develop their policies, a seamless transition from existing to future provision be assured. Appendix 6 names the members of the Working Party.

A Postscript discusses the need for a National Consultative Council for Chaplaincy and Spiritual Care in the NHS.

## Conclusion

The timely and welcome interest in the provision of spiritual and religious care shown by the SEHD and its readiness to require Health Boards and Trusts to develop a strategy and to implement it offers chaplains with both a challenge and an opportunity. The Working Party Report provides the NHS, faith communities and chaplains with a tool for consultation, change and development.

Each Board and Trust, along with representatives of local communities, faith communities and its own chaplaincy staff, will interpret and apply the report in the light of local needs and circumstances. The chaplaincy training and development officer and his assistant will be available to help, co-ordinate and advise.

Of itself the report is but one part of an exciting and necessary process. Doubtless its shortcomings will become apparent as each consultation occurs. But it is offered in good faith and in the hope that it will be used to positive effect by those whose responsibilities include the provision of chaplaincy and spiritual care. In the final analysis what matters most is that patients, carers and staff in the NHS receive the spiritual care that is best suited to their needs.

## References

SEHD 2000 *Our National Health, a plan for action, a plan for change*. The Scottish Executive Health Department, Edinburgh.

SHHD 1986 DGM 48 (Dear General Manager) *Advisory Notes on the Criteria for the Appointment of Hospital Chaplains*. Formerly the Scottish Home and Health Department, now, The Scottish Executive Health Department, Edinburgh.

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