

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

**NHS HDL (2002) 76**

*Editorial Note: The introduction, background section and the table of contents have been edited. The main body of text has been reformatted in this journal's style. The full unedited version of the guidelines and the accompanying Health Department Letter are available from the Scottish Executive Health Department, St. Andrew's House, Edinburgh, quoting the reference: NHS HDL(2002) 76.*

### **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](http://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 'chaplaincy' 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 chaplaincy, spiritual and religious care and 'spiritual caregiver' to cover

chaplains, and others who deliver spiritual or religious care.

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

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### **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.

### **Spiritual Care in NHSScotland**

#### **Background**

Since 1948, patterns of religious belief and practice have also undergone a major reformation. Membership of the mainstream churches has declined: Is-

lamic, 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

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

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.

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.

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.

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

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**

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.

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.

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**

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**

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.

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 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**

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 seasonal calculations to be regularly updated.

## **Spiritual Caregivers**

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**

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.

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 De-

velopment Unit has been asked to develop and enhance these processes.

## **Care Team Membership**

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**

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.

Access to patient information, the keeping of spiritual care departmental records and the use of that information must conform to the Caldicott Committee Guidelines<sup>1</sup> and the Data Protection Act<sup>2</sup>. All spiritual caregivers and volunteers should sign an appropriate local confidentiality statement. They must also follow their own professional code of conduct<sup>3</sup> regarding confidentiality.

## **Administrative Support**

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**

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.

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.

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 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.

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*' guidance<sup>4</sup>, 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**

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**

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**

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;
- 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.

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.

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**

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.

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**

Volunteers can play a significant part in enhancing and strengthening a spiritual care service. Volun-

teers 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**

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.

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**

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.

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 paragraph 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 pa-

tient 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.

**Appendix A**

<b>Areas Of Healthcare Work<sup>5</sup></b>	<b>Range of Beds/Persons Justifying One Session</b>
1. <b>Acute inpatient:</b> i.e. paediatric, medical, surgical, gynaecology, mental health, oncology	30 - 40
2. <b>Intensive care units:</b> i.e. neonatal, assisted ventilation, high dependency, post operative, transplant surgery.	10 - 20
3. <b>Palliative care:</b> i.e. standards for palliative care in Scotland indicate that a specialist unit of 16+ beds should have a whole time post.	6 - 18
4. <b>Maternity</b>	30 – 40
5. <b>Long stay units:</b> i.e. care of the elderly, long stay mental illness, long stay learning difficulties, etc.	25 – 50
6. <b>Day care units:</b> i.e. day hospital, day centre, ambulatory care, day surgery, oncology, stroke rehabilitation, and renal dialysis.	30 – 50
7. <b>Accident and emergency,</b> casualty and admission unit.	20 – 40
8. <b>Care in the community:</b> 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. <b>Members of staff</b>	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.

Estimates of time required for other weekly commitments<sup>6</sup>

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

1. a bed/person/staff calculation based on the sessional figures in categories 1 -7, 9 and 10 above;
2. 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;
3. additional sessions, or parts of sessions, should then be allocated for the work in categories 8 and 11 - 16 above.

SEHD

October 2002

## References

1. [www.show.scot.nhs.uk/newfolder/publications/me/caldicott.manual.doc](http://www.show.scot.nhs.uk/newfolder/publications/me/caldicott.manual.doc)
2. [www.legislation.hmso.gov.uk/acts/acts1998/19980029.htm](http://www.legislation.hmso.gov.uk/acts/acts1998/19980029.htm)
3. Code of Professional Conduct for Healthcare Chaplains ([www.chaplains.co.uk](http://www.chaplains.co.uk))
4. *Fair for all: Working towards a culturally competent services* (HDL (2002)51) available at [www.show.scot.nhs.uk](http://www.show.scot.nhs.uk)
5. To include work with both patients and carers
6. including preparation time