

REVISING THE GUIDELINES: STEPS ALONG THE WAY

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Abstract: This article describes the launch and content of Revised Guidelines on Spiritual Care and Chaplaincy in NHS Scotland 2008. A Chief Executive's Letter based on the report is under consultation before being distributed. The report consolidates and develops the guidance of HDL (2002) 76. A survey of developments was carried out. Relevant recent documents were consulted and their function explained. A series of recommendations was made concerning work in boards concerning policies, service provision and employment. Relationships with faith/belief communities, Data protection, and chaplaincy provision were examined. Feedback has been and is being welcomed prior to finalised CEL. The integration of spiritual care to health and wellbeing is an ongoing journey.

Key words: Guidelines for Spiritual care; CEL, spiritual care policies, chaplaincy, education, faith/belief communities, recommendations

The launch of Revised Guidelines for Spiritual care and Chaplaincy in NHSScotland took place on 18th June. The papers for that day included; HDL (2002) 76 - the previous guidance; a report produced by a working group covering developments since that significant document with recommendations for the future; and a draft Chief Executive's Letter (CEL) which would become the next stage instructions from the Department to all Health Boards.

NHS health policy documents are usually due for revision after three years. The longer gap in this instance was indicative of the far reaching changes which took and are still taking time to implement fully. Issues such as the development of spiritual care committees, the formation of departments, the direct employment of chaplains and the steady acceptance of responsibility for a service previously seen as mostly provided from outside, all part of a culture shift, do not happen overnight. The pace of change in the NHS was recently described to me by a manager as hyper change now almost a way of life. Chaplaincy may not be hyper but we are certainly part of a fluid environment.

HDL (2002) 76 was a milestone document, but what should come next? The main thrust of that policy instruction was an insistence that spiritual

care was the realm of everyone in NHSScotland. The term "spiritual care giver" was not restricted to chaplains. The service was described as person centred and inclusive, for those of any faith community or none, because people with beliefs and values do not necessarily belong to any of the traditional faith communities or belief groups. The difference between religious care and spiritual care was highlighted in order to emphasise this broad view. The work of chaplains was described as that of pastoral care and encounter in a non judgemental context, accepting people as they are and enabling them to make use of their own resources, spiritual or religious, to cope, to reconcile, to heal or to accept and find what peace they can during times of ill health.

The idea of a revision was challenging. The aim would be to consolidate, develop and look to the future. The national Spiritual Care Development Committee was now the vehicle which would steer and prepare the document through the auspices of the Healthcare Chaplaincy Training Development / Spiritual Care Advisory unit of NHS Education for Scotland (NES).

We began with a fairly informal survey of health boards, asking how the service had developed since the issue of the HDL of 2002. The answers showed many variations but there were common themes and

very much a shared direction of travel. As well as the establishment of spiritual care committees in virtually all board areas, the direct employment of chaplains and the new board wide departmental structures, there had been other significant developments. Relationships with local faith and belief communities had been fostered, supervision was an increasingly recognised need for chaplains, accommodation was being organised imaginatively in many instances being more inclusive of minority groups while maintaining the variety of functions required. Spiritual and religious care was now involved in the patient focus and the equality/diversity agendas of many health boards and often better understood because of this. Data protection interpretation and lack of information was an area of difficulty for many and teaching and pastoral care of staff was an area of considerable growth.

The working group also took careful note of several significant documents produced over the last few years. *A Scoping Study, a Multi Faith Resource, Standards for NHSScotland Chaplaincy Services, Capabilities and Competences for Religious and Spiritual Care for Chaplains, Religion and Belief Matter, What do Chaplains Do? a research paper*, were among those noted and referred to. The Standards and Capability Framework were explained as they presented an auditable description of the service as well as fairly detailed skills, knowledge and aptitudes required to be a safely practising chaplain.

The working group looked at the many issues in turn describing the situation, the developments and the needs. At the end of the document there were twenty three recommendations which summarised the conclusions within.

One of the most challenging discussion centred on who are the chaplains of the future and on what grounds would they be appointed? It was agreed that the emphasis should be to employ those who are skilled and experienced pastorally rather than representatives of specific faith/belief communities. It is desirable that a chaplaincy team might be taken from a variety of communities but it is more important that the best candidate be appointed from whichever background. If there was an obvious lack in the team then boards might be empowered

to make a special arrangement or contract for services.

Some standardisation of the training of chaplains is now required as well as an acknowledgement that they would come from many different cultural and faith backgrounds. A Certificate in Healthcare Chaplaincy had been commissioned by NES and the contract is with Glasgow University who are at present preparing the curriculum. In order to take their place fully as healthcare professionals chaplains will require a degree of regulation appropriate to their role. Chaplaincy associations are looking to the possibility, initially of self regulation, but eventually of becoming registered as an Allied Health Profession. Many of the building blocks necessary for this to be considered are being put in place. Boards would from now on be expected to use the Chaplaincy standards as the way of reviewing their spiritual care service. In future, newly appointed chaplains will be expected to have or to work towards a basic certificate showing competence to practise.

Spiritual care has been concentrated in the acute and in patient mental health sectors. It is seen as crucial to develop better patterns of spiritual care for those whose health needs are met in the community. Mental health chaplains are beginning to pioneer new forms of community chaplaincy and this will become an area of increasing importance with close links to GP practices and Community Healthcare Partnerships. Provision of chaplains has also to move away from a simple formula based on bed numbers. The work of chaplains is far too integrated for that to be an adequate measure and a proper business needs analysis should form the basis of necessary chaplaincy provision. Formal employment legislation, Agenda for Change, and European working time directives must now be taken into account, in particular in relation to a 24/7 service.

The recommendations were more a natural progression of the journey rather than any dramatic change of direction. They are intended both to consolidate good work done and to point to the way ahead. They include the following:

To develop education for and by chaplains, including research and multi professional engagement.
To maintain a lead (spiritual care) manager in each Health Board

To review spiritual care policies along with the form and function of Spiritual Care Committees.

To encourage chaplains to maintain and nurture their own spiritual roots, to develop the professional associations, to undertake continual professional development (CPD) including reflective practice, to have pastoral supervision, to promote professional standards and maintain links locally and nationally.

To standardise the appointment procedure e.g. with use of assessors.

To make use of the Service Standards as an audit tool, and the Capability Framework as an educational resource.

To develop care in the community

To seek ways of improving informed consent for information and to continue the discussion.

To ensure that all faith/belief communities and individuals are catered for equitably through robust referral, contact or honorary chaplain system.

To develop business plans to ensure adequate provision and resourcing.

The report of the working group was launched at the conference on 18th June. At the same time a draft CEL was issued, based on the report, which is out for consultation. The finalised CEL will most likely be sent to each Health Board for implementation and action early in the autumn. The full Revised Guidance Report on Spiritual Care and Chaplaincy in NHSScotland 2008 will be the reference document for the CEL containing explanation and background for the instructions and recommendations.

Feedback to date has suggested that there might be clearer references to the ongoing NHS Scotland agenda such as "HEAT" Targets and "Better Health, Better Care". The status of other healthcare or chaplaincy courses or qualifications is somewhat unclear. The career framework of chaplains is in formation and there appear to be some different interpretations among health boards. Data protection rulings have disadvantaged the spiritual care service in ways which some appear unable or unwilling to acknowledge. The place of denominations in chaplaincy will continue to be discussed as the phrase "in good standing" does not always seem to convey the appropriate message. A chaplain's grounding and on going nurture within a faith/belief community is seen as the most important part of the relationship. Making a needs analy-

sis the basis for chaplaincy provision is not an easy solution as demands for specialist spiritual care is difficult to define and can increase dramatically where the service is well perceived and experienced.

These are some of the initial comments along with a general welcome for the revision and a clarification of some of the issues and developments which have taken place over the last six years. The hope of the working group and the Spiritual Care Development Committee (SCDC) is that the report and the CEL will provide a solid basis for continuing a better integration of spiritual care within the health service providing care which is, holistic, whole person, and which values the humanity of patients, carers and staff and contributes positively towards the health and wellbeing of all.

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