NHS Chaplaincy

Meeting the religious and spiritual needs of patients and staff

Guidance for managers and those involved in the provision of chaplaincy-spiritual care
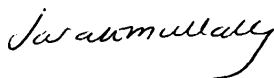
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Foreword

I hope you will find this best practice guidance both interesting and helpful. It is for use by all NHS Trusts as a strategic and best practice guide to the provision of chaplaincy-spiritual services for patients and staff. I hope it will provide a firm foundation on which NHS Trusts can build and enhance existing services.

The Department of Health is committed through *The NHS Plan*, to support delivery of NHS services that put patients at the heart of everything they do. The cornerstone of the modern NHS is the ability to respond sensitively to the diverse nature of the communities it serves; all services, including spiritual ones, should be delivered appropriately to service users and NHS staff. One of the key aims of this guidance is to enable chaplaincy services to meet the needs of today's multi-cultural and spiritually diverse society.

This guidance draws directly upon the experiences of working chaplains around the country. I hope you will find the information and examples in practice a meaningful basis from which you can make the most of your local chaplaincy services. The summary of key points provides a useful review of best practice guidance.

I am grateful to colleagues from the Multi-Faith Group for Healthcare Chaplaincy and its predecessor body, the Multi-Faith Joint National Working Party. Both groups have worked with colleagues from the NHS and Department of Health in compiling this guidance. It is clear to me that chaplains perform an extremely demanding job, often in difficult circumstances, and their skills and dedication are essential to the work of the NHS.

I acknowledge that this guidance will provide a focal point from which dialogue about local resource allocation can take place. I believe that this guidance sets out an aspirational background against which development can take place. In such a way, it might be seen as the catalyst for discussion, cross-cultural learning and local action, which together will ensure that these services develop to their full potential and maximise their utility for all.

Sarah Mullally

Sarah Mullally,
Chief Nursing Officer
Department of Health
November 2003

From the Chair of the Multi-Faith Group for Healthcare Chaplaincy

For those of us who have long been working to create a dialogue between people of different faiths, this guidance is an exciting step forward in the formal and official recognition that we live in a multi-faith society, that people of all faiths have spiritual and religious needs and that these needs must be appropriately met in healthcare settings. We acknowledge wholeheartedly the work of chaplaincy team leaders and working chaplains around the country who have long reached out to the diverse faith communities, but we believe that it is entirely appropriate that this guidance is now made accessible to patients, staff and other users of multi-faith chaplaincy, which is a right rather than a favour. The privilege given to faith and professional bodies in drafting this guidance represents a modern approach in placing spiritual/religious care firmly within the holistic care the NHS has always striven to offer.

I want to pay tribute again to all the members, past and present, of the Multi-Faith Group for Healthcare Chaplaincy and of its predecessor body, the Multi-Faith Joint National Working Party. They have given generously of their time, knowledge, wisdom and skill during the drafting of this guidance. We have, of course, had our challenging moments, but the experience of working together has predominantly been one of genuine collaboration and growing fellowship between the members of the different faiths involved in the two bodies. On such a good foundation the work of multi-faith chaplaincy can only grow.

The Hon. Barney Leith

Chair, Multi-Faith Group for Healthcare Chaplaincy

November 2003

Introduction

This best practice guide is intended for use by NHS Trust Boards and chaplaincy-spiritual care managers. The guidance sets a framework for the context and provision of chaplaincy-spiritual care services throughout the NHS. It offers guidance about providing spiritual care that is equal, just, humane and respectful, and should be discussed with the chaplaincy-spiritual care department in order to highlight areas where provision can be improved.

This guidance replaces HSG(92)2 and supports the provision of spiritual and religious care that has been part of the NHS since 1948. All NHS Trusts provide spiritual support for patients, staff and relatives through chaplains and faith community representatives. This document sets out arrangements to ensure sufficient steps are taken to meet the religious and cultural needs of the healthcare community, whilst also acknowledging that chaplains-spiritual care givers are concerned with those who do not profess any particular faith.

The NHS Plan, *Your Guide to the NHS* and National Service Frameworks (NSFs) provide national standards for respect for privacy and dignity, religious beliefs and people's spirituality. Meeting the varied spiritual needs of patients, staff and visitors is fundamental to the care the NHS provides.

The Human Rights Act, introduced in October 2000, enshrines in law the right of the individual to religious observance. This underlines the need for NHS Trusts to provide appropriate world faith representatives and worship spaces for faith communities within the healthcare population.

This document is the first collaboration between the Department of Health, the Multi-Faith Group for Healthcare Chaplaincy (and its predecessor, the Multi-Faith Joint National Working Party), representing the main world faith communities and NHS Chaplaincy organisations.

A list of those who have contributed to the writing of the document is included as Annex 3.

No theological or doctrinal definitions are made in this document. Its purpose is to enable the NHS to provide flexible and innovative responses in chaplaincy-spiritual care for all patients, their carers and staff according to the faith or spiritual tradition to which they belong, or to those who profess no particular affiliation.

In this context it is helpful to distinguish between religion and spirituality. Spiritual needs may not always be expressed within a religious framework. It is important to be aware that all human beings are spiritual beings who have spiritual needs at different times of their lives. Although spiritual care is not necessarily religious care, religious care, at its best, should always be spiritual (Association of Hospice and Palliative Care Chaplains, 2003).

For the purposes of this guidance, references to religion and/or faith are taken to include the nine major world faiths: Bahá'í, Buddhism, Christianity, Hinduism, Jainism, Judaism, Islam, Sikhism and Zoroastrianism.

New Roles and Relationships

The role of the Department of Health (DH) is changing, with the move towards more local decision making which enables local needs to be better met. Such change is underpinned by the emergence of new roles, relationships and cultural shifts, within the health and social care system. DH website www.doh.gov.uk/about/index.htm sets out the role and purpose as follows:

- *to support the government to improve the health and well being of the population*

- *drive forward change and modernisation in the NHS and social care, as well as improving standards of public health.*

As a result, the Department's role will focus on:

- *setting overall direction*

- *setting national standards to enhance quality of services*

- *securing resources/making major investment decisions to ensure services have the capacity to deliver.*

It will have a less 'hands-on' approach, with clear priorities, fewer targets and less instruction from the centre.

The NHS Modernisation Agency and the Social Care Institute for Excellence will identify and spread best practice locally.

Joint working with key partners, such as Commission for Healthcare Audit and Improvement (CHAI), and the Commission for Social Care Inspection (CSCI) is central to the Department's new role.

Locally, the Strategic Health Authority will take on the 'HQ' role for the NHS, creating a strategic framework, establishing performance agreements and building capacity to support performance improvement. Meanwhile, Primary Care Trusts (PCTs) will lead with the local public and their partners on public health issues and development of Health Improvement Programmes based on health needs.

This guidance reflects these new relationships and ways of working. It is non-prescriptive, allowing local management maximum scope to develop an appropriate multi-faith chaplaincy service for its Trust. By making locally informed judgements about facilitation of chaplaincy delivery it is envisaged that all Trusts will provide a high quality, modern service.

Additional information about new ways of working may be found at:
www.doh.gov.uk/shiftingthebalance/shifting1.htm

1 A framework for chaplaincy-spiritual care

Experience shows that chaplaincy-spiritual care is most effective if led by a Board-level Director. The standard and quality of the service provided for patients, carers and staff by the chaplaincy team should be monitored regularly by the Trust Board and subject to regular review, which should include feedback from people who use the service.

NHS Trusts appointing chaplains-spiritual care givers should work within a suggested framework. The following best practice issues should be considered.

- The chaplaincy service is headed by a designated member of the chaplaincy–spiritual care team.

- Chaplaincy provision is made available across the organisation out of normal hours and staffing levels take account of this.

- In order to respond in the most appropriate way to the distinctive religious needs of patients and staff, each member of the chaplaincy-spiritual care team retains the religious responsibility for his/her own faith community.

- Adequate arrangements are made for the spiritual, religious, sacramental, ritual, and cultural requirements appropriate to the needs, background and tradition of all patients and staff, including those of no specified faith.

- Suitable and authorised persons are appointed to chaplaincy-spiritual care posts in partnership with representatives of the appropriate faith community (for details of whom to contact regarding appointment processes, please see the next section).

- All appointments are made in partnership with the appropriate faith community/ies (some open posts involve more than one community).

- Standard human resource procedures are followed, with the involvement of the panel of assessors as necessary.

- Clear lines of management/accountability are established to enable a consistent standard and quality of service for all patients and staff.

- Sufficient staff are available for the size and scope of the Trust's overall responsibility for all patients and staff (see Annex 1 for guidance).

- Appropriate and timely access to services from smaller faith communities is provided (as well as minorities within faith groups). It is important to know the faith needs of the patient and staff population.

- Resources and opportunities for training and professional development are provided.

2 Appointments to chaplaincy posts

Chaplaincy appointments are Trust appointments. Human Resources Departments within Trusts advise on the appointment procedures for chaplains-spiritual care givers. An effective appointments panel is likely to include:

- a representative of the faith community concerned

- a member of the panel of assessors (for whole time appointments).

The panel of assessors is a resource available to assist all Trusts in making chaplaincy appointments. Good practice suggests that fair and effective appointments are most likely to be made when an assessor is deployed. An assessor should be identified as soon as a vacancy becomes apparent, to provide maximum opportunity for advice on issues such; as job descriptions, advertisements, skill mixes and job evaluation etc.

Faith community representatives for NHS appointments

Faith community representatives ensure that the candidates hold the authority of the faith community and can be empowered to act as its representative within the healthcare setting.

Faith community representatives have the following contact points:

For **Roman Catholic and Anglican** appointments contact Bishop's Advisers on Healthcare at www.nhs-chaplaincy-spiritualcare.org.uk and look under 'Bishop's Advisers'.

For **Free Church** appointments contact the Free Churches Secretary for Healthcare Chaplaincy at chaplaincy@cte.org.uk

For **Jewish** appointments contact the Jewish Visitation Committee via

rabbi@jvisit.org.uk

For other **World Faith** representatives contact the Multi-Faith Group for Healthcare Chaplaincy at Assessors@mfghc.com

The panel of assessors for NHS appointments

Members of the panel of assessors receive training to advise on the professional suitability and competence of candidates. Assessors have experience in both chaplaincy and management and will be aware of the current policies and operational issues around chaplaincy. Advice on the role of assessors may be found at: www.doh.gov.uk/assessors.htm

In order to reflect this best practice guidance and ensure the panel can best assist Trusts operating in the today's NHS, the panel's membership, ways of working and the extent of its remit in relation to *all* appointments, is currently (2003) being reviewed.

Requests for an assessor should be sent to the co-ordinator of the panel at

assessors@nhs-chaplaincy.com

Key points

- The panel of assessors and the faith community representative are contacted at the earliest opportunity in order to gain maximum advice and support.

- Through close working with the panel of assessors and with local chaplaincy managers, a Trust's Human Resources Department has access to all appropriate support and guidance.

3 Confidentiality and data protection

Background

The Data Protection Act 1998 became effective in March 2000. Its main objective is to ensure that the processing of personal data complies with certain key principles (see Annex 2), which are designed to protect individuals in relation to the disclosure of personal data. The central requirement is that personal data should be processed fairly and lawfully. For health information, this means that the patient understands what their information will be used for and that the common law duty of confidence is complied with.

Aims

The Data Protection Act's (DPA) aim is to protect individuals in many everyday situations. It is not intended to limit people's access to services such as spiritual care and support, which could help them at vulnerable or distressing times. However, an organisation acting as a data controller is required to carry out its obligations with respect to the DPA and the associated common law duty of confidence. This includes chaplaincy provision and the organisation's admissions systems.

Key principle

Information about patients is held in confidence by the NHS. In considering arrangements which afford adequate protection, Trusts will find it helpful to relate to the principle that, wherever possible, patients must be given the opportunity to give their permission as to how information about them is used. Patient-identifiable information should not normally be used for any purpose other than that for which it was provided or disclosed without the patient's explicit consent. Further information is available on the Information Commissioner's website http://www.dataprotection.gov.uk and in Annex 2.

Legal points

Religious affiliation is classed under the Data Protection Act as 'sensitive personal data' and any disclosure would therefore be required to satisfy a 'Schedule 3 condition' (i.e. the Schedule which sets out how, under certain specific conditions, disclosure may be allowed) in addition to the common law of confidentiality. The only exception to the 'duty of confidence', is where there is a legal obligation to disclose (such as a court order), or a robust public interest (such as a serious criminal activity). More detail about potential exemptions is located on the Information Commissioner's website.

Information for patients

Trusts may inform patients about the availability of chaplaincy services, for example through information leaflets and 'welcome packs'. This is an evolving area of responsibility and Trusts should ensure that their systems are kept under review.

Explicit consent

Systems should be in place to ensure that patients are asked for their permission to pass on information about their spiritual needs to the chaplaincy service.

- On (or before) admission to hospital, patients should be asked whether they would like to have their religious affiliation recorded. They should be informed that this data will be processed for one or more specified purposes (see also the second principle of data protection at Annex 2). Patients should also be asked for permission to pass this information to the chaplaincy service for the purposes of spiritual care.

- In order to ensure confidentiality, local information systems must be able to capture individual consent efficiently.

- Systems and local guidance should also be able to reflect the decisions of those patients who may change their minds about details being passed to the chaplaincy service.

- If a patient who is capable of providing meaningful consent fails to respond to consent-seeking questions, this should be interpreted as unwillingness to have their religious affiliation captured and passed on to chaplaincy services.

Patients unable to give consent

The *NHS Confidentiality Code of Practice* says the following about disclosure of information to chaplains, in circumstances when a person's condition prevents them from conveying consent:

> *'Where a patient is not competent to consent to disclosure, e.g. due to unconsciousness, the decision rests with those responsible for the provision of care, acting in the best interests of the patient. The views of family members about what the patient would have wanted should be given considerable weight in these circumstances.'*

Where information is already held on the health record, it is the decision of the clinician, to use this in the best interest of the patient.

Example in practice

Nottingham University Hospital NHS Trust is in the process of rewriting its leaflet for patients, which is used to explain what the chaplaincy service can offer. The intention is to develop such leaflets, placing them around the hospital, (as part of standard bedside packs). It will also be possible to put similar information in clinics. Such effort is already paying dividends in terms of there being a raising of this service's general profile. It has also helped to more readily identify the service as a general resource for both patients and staff.

Work is continuing in conjunction with the neighbouring Trusts, such as Nottingham City Hospital and Nottinghamshire Healthcare, to adopt a common approach and make best use of overlapping resources. Additional work is also continuing with the Patient Admission System – to ensure that its procedures and prompts can assist in recording all necessary information about religious affiliation and can pass it on when consent has been given.

General Principles of the Nottingham Approach:

- ensure that the patient is aware they can change their mind and that this information will also be recorded and passed on to the chaplaincy service

- develop a robust system of recording a patient's religion and wishes about contact by the chaplaincy service

- train staff who admit patients, how to deal with questions about spiritual care

- regularly assess the information collated, to ensure the provision of patient care is constantly suited to patient needs

- provide ward staff with a resource (e.g. a leaflet), which can guide them in ensuring patients have access to a comprehensive service.

- Improve other kinds of patient information about spiritual and religious care within hospital, e.g. posters, use of 'Patientline' and hospital radio.

Nottingham University Hospital NHS Trust

Contact: 0115 924 9924

Key points

- wherever possible, patients must be given the opportunity to give their permission as to how information about them is used.
- Accessible information such as leaflets and welcome packs are provided so all patients are aware of available religious and spiritual support.
- *Caldicott Guardians* exercise responsibility for confidentiality and rule on whether sharing information is appropriate. Chaplains and Trust managers can seek their advice if they have any concerns.
- Robust systems should be in place to ensure explicit consent is sought before passing information to the chaplaincy service.

4 Volunteers in chaplaincy-spiritual care

Volunteers and lay visitors are integral to the chaplaincy team. Trusts should make sure that their arrangements for using volunteers are applied equally to chaplaincy-spiritual care services. Experience shows that arrangements work best where there are:

- appropriate recruitment selection and training procedures

- contracts and appointment letters

- appropriate screening processes

- clear job descriptions.

Managers should ensure that chaplaincy volunteers are acceptable to the appropriate faith communities and that their work is supervised. Volunteers may also be useful in supporting patients and visitors with no specific religious faith. Training and development opportunities should be available for volunteers, to ensure they are effective members of the chaplaincy team.

Example in practice

The chaplain was initially asked by the senior nurse manager in A&E if chaplaincy visitors could be introduced on the unit. Initially, members of the existing ward teams who were interested in a slightly different form of ministry were invited to make up a team in A&E. We now have a designated A&E chaplaincy visitor team, co-ordinated by one of the original volunteers and responsible directly to the chaplain.

The work that is done has a very practical bias – members of the team provide tea and coffee for patients, staff and visitors as well as running a variety of errands for patients and their families/friends. Their input does much to ease the strain of the unavoidable waits that sometimes occur in the department. On occasions, patients or their families/friends will ask a visitor to pray with them; this would not be offered routinely but a request for prayer is always met. Sometimes patients, visitors or staff will ask a visitor to involve the chaplain, or to contact their own priest/minister/ religious leader and this will be done immediately.

As time has gone on, the role of the chaplaincy visitors has developed and time is spent chatting with patients and their friends/families. The visitors **always** explain that they are representing the chaplaincy and this is almost always received in an entirely positive way. Patients who are then admitted will find that they almost certainly meet another representative from the chaplaincy during their stay on the ward and often comment favourably about this continuity.

Confidence in the work of the visitors has steadily grown among the A&E staff and volunteers are now asked if they will sit with bereaved families when appropriate and are directed to

patients who are perceived as needing particular support. At the same time the visitors have developed an informal ministry of staff support and will often spend time chatting with staff about personal as well as work-related issues.

Accident and Emergency Department, St. Peter's Hospital, Chertsey

Contact: 01932 872000

Example in practice

The 'Befriending Scheme' was set up three years ago in the Pastoral and Spiritual Care department of Fieldhead Hospital, in response to particular needs of a number of mental health service users looking for help establishing a better quality of life in the community. Currently there are about 15 befrienders (volunteers with paid expenses) linked on a one-to-one basis. We also have a waiting list of people (users) waiting for recruitment and training of befrienders. We involve other clinical staff in the ongoing supervision and training programme.

Fieldhead Hospital, Wakefield

Contact: 01924 327 000

Key points

- Volunteers are selected just as carefully as members of staff and their documentation is kept up to date.

- Induction, training and development opportunities are provided for volunteers using published examples of schemes or those tailored to local use.

- It is clear who the volunteers are and what they are representing. They do **not** have an evangelistic role, but patients and their companions need to know to whom they are talking.

- Volunteers have the opportunity to get to know staff, especially the nurses. The volunteer team can be of great help to hospital staff – but they need to know who the volunteers are to be able to have confidence in them.

5 Worship and sacred spaces

NHS Trusts should provide accessible and suitable spaces for prayer, reflection and religious services which are open to patients and staff 24 hours a day. Appropriate locations which can accommodate at least 20 (seated) people are usually sufficient, but the needs of those in beds and wheel chairs need to be accommodated.

Spaces for prayer, reflection and religious services have great value as places of calm in times of anxiety and as a sanctuary from other pressures. An appropriate location and 24 hour access to such a space is recommended.

Different religions have specific requirements and more than one space is likely to be required, with flexibility of furnishing and use of religious symbolism to allow for use by different faiths. Members of the chaplaincy team will be able to advise on appropriate faith community requirements.

New worship spaces can be sited near the chaplaincy-spiritual care offices, together with interview accommodation, ablution facilities, staff room and meeting space. Where existing buildings are modified, they should meet the same requirements but may not always achieve coterminous spaces.

The estate management processes for new build, Private Finance Initiative developments and upgrading can vary and may require different involvement of the chaplaincy for their implementation. Chaplains should be involved in the planning process at the earliest opportunity.

Example in practice

We undertook a small upgrading scheme to make additional space within the chapel precinct. We spent some time ensuring that the argument for upgrading to the Trust Board, had the right statistics about actual and projected usage and included an up-to-date patient population profile with regard to religious affiliation, reference to any perceived or documented shortcomings in existing facilities (e.g. complaints from patients, visitors, staff or national standards documentation) and reference to any relevant legislation (e.g. Human Rights Act).

The quality of the partnership between the Chaplaincy-Spiritual Care service, the Trust Estate department and the architect commissioned to design the scheme was the most important facet of the process. We could not choose the Estate Team, but were able with guidance to choose the architect. We wanted a partnership that was a creative and positive one. Although we were able to find someone who shared our vision of our 'workspace', we also needed to listen and learn from the architect as the scheme unfolded.

Christie Hospital NHS Trust, Manchester

Contact: 0161 446 3000

Key points

- Good communication between all parties is established and maintained, particularly where spaces are to be shared.

- A code of conduct on how to use the premises is drawn up; this covers topics such as use of music, food, items on display, walking across other people praying, and use of a variety of religious leaders.

- Arrangements are made for secure storage of religious artefacts and symbols.

- There is access to equipment out of normal working hours, including Bibles, Korans, prayer mats, Hindu tapes, etc.

- The processes to improve worship and sacred spaces are clear and an appropriate team is assembled to conform to Trust guidance on accommodation changes.

6 Training and Development

Trusts are responsible for training and development. Recent advice including that in the *Improving Working Lives* standard (2000) and *Agenda for Change* (2002/3), outlined the benefit of training and development opportunities in providing support to staff. Appropriate training and development investment should be made available to all members of the chaplaincy-spiritual care team regardless of whether they are whole time, part-time or volunteer visitors.

The existing statement of Healthcare Chaplaincy Standards was updated in 2002. This updating, by a sub-group of the Chaplaincy Education and Development Group, enhanced the standards by the addition of the knowledge underpinning each standard and by the creation of standards for professional supervision and reflective practice. Since their updating, the standards have been publicised at training and development events and are accessible on the website for the Multi-Faith Group for Healthcare Chaplaincy at www.mfghc.com

The South Yorkshire Workforce Development Confederation (SYWDC), based in Sheffield, accepted national responsibility for chaplaincy-spiritual healthcare workforce issues in early 2002. SYWDC published a survey of healthcare chaplaincies in February 2003 and *Caring for the Spirit*, the strategy for the chaplaincy and spiritual healthcare workforce is published in November 2003. For further information and access to these documents, see the SYWDC website at: http://www.sywdc.nhs.uk/

Details of current healthcare chaplaincy training courses are available from:

- Healthcare Chaplaincy Training and Development Office, Church House, Great Smith Street, Westminster, London SW1P 3NZ

  Tel: 020 7898 1895/1893

  Email: training@c-of-e.org.uk

  www.nhs-chaplaincy-spiritualcare.org.uk

- The College of Health Care Chaplains, 49 Chesterton Park, Cirencester, Gloucs GL7 1XS

  Tel and Fax: 01285 643660

  Email: chris@chrweb.co.uk

  www.healthcarechaplains.org

Example in practice

We distribute a training bulletin every four months to reach chaplaincy managers so that regular reviews of the availability of training events can be made. We try to ensure that all our

courses are recognised as appropriate by the NHS and have accreditation from academic departments where they contribute to continuing professional development.

Although we have tried to simplify our systems, it is still hoped that chaplains will apply early both to avoid disappointment and also to ensure that payment is made within the timetable suggested. We also like to think that staff coming on courses are not 'on call' immediately before the start of the course and therefore too tired to benefit from the training. At the same time, we hope to pick up such comments as part of our evaluation process and can feed them back to Trusts wherever possible.

From the Healthcare Chaplaincy Training and Development Office, London

Contact: 020 7898 1895

Key points

- The annual appraisal process includes identifying training needs and ways to meet them so that these can be included in personal development plans.

- Journals and websites are searched regularly for new opportunities for development.

- Learning outcomes are achieved locally.

7 Bereavement services

The Kennedy Report (Recommendation 12) (Bristol Royal Infirmary, 2001) states that *'all NHS Trusts should provide support and advice to families at the time of bereavement'*.

Chaplaincy-spiritual care is central to providing support and assistance to the bereaved. All NHS Trusts should ensure that the dying and recently bereaved are able to access chaplaincy services at the appropriate time.

The chaplaincy team should play a valuable role in educating staff in some of the issues surrounding bereavement. Chaplains should maintain and develop close links with all those involved in bereavement care*,* for example, emergency services, critical care units, maternity services, and providers of post-mortem services. Chaplains can also offer support to staff who suffer personal bereavement.

Example in practice

As a member of the Trust Bereavement Team, the chaplain is heavily involved in their project to review communication between all users of the bereavement service. With support from the Modernisation Team on training issues, we are reviewing and revising all the service's literature in order to improve access for all community groups with appropriate translations into many languages.

Central Manchester and Manchester Children's University Hospitals NHS Trust

Contact: 0161 276 1234

Key points

- All clinical areas have access to reliable guidance on the care of patients of differing faith communities at and after death, and of the needs of the bereaved.

- The Trust-wide bereavement policy committee includes a member of the chaplaincy-spiritual care team.

- Chaplains-spiritual care givers are the Trust experts on arranging and providing liturgies and ceremonies to meet the needs of the bereaved, especially in the case of neonatal and child death and in annual services of remembrance.

8 Emergency and major incident planning

Chaplains-spiritual care givers have an important role to play in disaster and emergency planning, as their range of skills and services may be needed by a wide variety of users at short notice. Chaplaincy teams should be fully involved in preparing NHS Trusts' emergency plans, and their roles should be clearly defined with major incident plans, so that their contribution can be readily accessed.

Chaplaincy teams can also be a valuable resource for major or critical incident support and debriefing. Chaplains-spiritual care givers involved in any such incident may also be in need of support.

Example in practice

Our department offers a debriefing service to all areas of the hospital Trust. Any time a critical or traumatic incident occurs, which would warrant such support, the facilitator sets a number of dates to allow maximum access and notices are posted to advertise the session and advise of venue. The debriefing service was used for a number of staff groups following the Potters Bar train derailment incident and is increasingly being seen as a resource by a variety of groups throughout the Trust. Feedback from the debriefing sessions has been very positive and is reflected in the increased use of the service.

Barnet General Hospital, Middlesex

Contact: 020 8216 4000

Key points
- Key members of the chaplaincy-spiritual care team are known in the Trust for their skills, so they can be useful contributors to the variety of debriefs that occur both during and after a major incident.

- The spiritual care team contribute to the Trust's major incident plan and are aware of their role in the plan.

- Chaplaincy team members have the necessary skills for visiting people who are inpatients as a result of a major incident.

Summary

The following key points summarise this best practice guidance.

Appointments to chaplaincy posts

- The panel of assessors and the faith community representative are contacted at the earliest opportunity in order to gain maximum advice and support.

- The Human Resources Department has, via the panel of assessors and local managers, access to all appropriate support and guidance.

Data protection

- Wherever possible, patients have the opportunity to give their permission as to how information about them is used.

- Accessible information such as leaflets and welcome packs are provided, so that all patients are aware of available religious and spiritual support.

- *Caldicott Guardians* exercise responsibility for confidentiality and rule on whether sharing information is appropriate. Chaplains and Trust managers can seek their advice if they have any concerns.

- Robust systems should be in place to ensure **explicit consent** is sought before passing information to the chaplaincy service.

Volunteers

- Volunteers are selected as carefully as members of staff and their documentation is kept up to date.

- Induction, training and development opportunities are provided for volunteers using published examples of schemes or those tailored to local use.

- It is clear who the volunteers are and what they are representing. They do **not** have an evangelistic role but patients and their companions need to know to whom they are talking.

- Volunteers have the opportunity to get to know staff, especially the nurses. The volunteer team can be of great help to hospital staff – but they need to know who the volunteers are to be able to have confidence in them.

Worship and sacred spaces

- Good communication between all parties is established and maintained, particularly where spaces are to be shared.

- A code of conduct on how to use the premises is drawn up; this covers topics such as use of music, food, items on display, walking across other people praying, and use of a variety of religious leaders.

- Arrangements are made for secure storage of religious artefacts and symbols.

- There is access to equipment out of normal working hours, including Bibles, Korans, prayer mats, Hindu tapes, etc.

- The processes to improve worship and sacred spaces are clear and an appropriate team is assembled to conform to Trust guidance on accommodation changes.

Training and development

- The annual appraisal process includes identifying training needs and ways to meet them, so that these can be included in personal development plans.

- Journals and websites are searched regularly to identify new opportunities for development.

- Learning outcomes are achieved locally.

Bereavement services

- All clinical areas have access to reliable guidance on the care of patients of differing faith communities at and after death, and of the needs of the bereaved.

- The Trust-wide bereavement policy committee includes a member of the chaplaincy-spiritual care team.

- Chaplains-spiritual care givers are the Trust experts on arranging and providing liturgies and ceremonies to meet the needs of the bereaved, especially in the case of neonatal and child death and in annual services of remembrance.

Emergency and major incident planning

- Key members of the chaplaincy-spiritual care team are known in the Trust for their skills so they can be useful contributors to the variety of debriefs that occur both during and after a major incident.

- The spiritual care team contribute to the Trust's major incident plan and are aware of their role in the plan.

- Chaplaincy team members have the necessary skills for visiting people who are inpatients as a result of a major incident.

Sources of further information

Mental Health

The National Institute for Mental Health in England (NIMHE) is working on a project with the Mental Health Foundation. By 2004 it aims to produce a report on the 'Importance of spirituality in a whole person approach to Mental Health'.

This work should deliver a framework of good practice to encourage mental health professionals to engage with the spiritual dimension of client groups. It will be a multi-audience document aimed at service users, chaplains and other stakeholders who pursue social inclusion. The outcome aims to encourage all of above to evaluate and bring to bear the capacity of the faith community, to support mental health and community-based services.

www.nimhe.org.uk

Primary Care

The National Primary and Care Trust Development Programme (NATPACT) offers support to PCTs in developing their organisations. The website provides information about the range of information available.

www.natpact.nhs.uk

Department of Health

www.doh.gov.uk/about/index.htm

Information Commissioner's Office and Data Protection issues

http://www.dataprotection.gov.uk

South Yorkshire Workforce Development Confederation

http://www.sywdc.nhs.uk/

Healthcare Chaplaincy Training and Development Office

Church House, Great Smith Street, Westminster, London SW1P 3NZ

Tel: 020 7898 1895/1893 Email:mary.ingledew@c-of-e.org.uk

www.nhs-chaplaincy-spiritualcare.org.uk

Multi-Faith Group for Healthcare Chaplaincy

C/o Hospital Chaplaincies Council, Church House, Great Smith Street, London SW1P 3NZ

Tel: 020 7898 1892

www.mfghc.com

The College of Health Care Chaplains

49 Chesterton Park, Cirencester, Gloucs GL7 1XS

Tel and Fax: 01285 643660

Email: chris@chrweb.co.uk

www.healthcarechaplains.org

Association of Hospice and Palliative Care Chaplains

The AHPCC published their Standards for Hospice and Palliative Care Chaplaincy in May 2003. These Standards, the accompanying Self Assessment Tool and general further information are available as examples of good practice concerning the facilitation of chaplaincy service audit at www.helpthehospices.org.uk

Annex 1: Framework for calculation of total chaplaincy-spiritual care time

This framework represents a suggested formula based on current best practice. Here the Multi-Faith Group for Healthcare Chaplaincy (MFGHC) progresses the original formula (Hospital Chaplaincies Council, 1987), by proposing an approach which attempts to better reflect the demands of the modern-day NHS upon the chaplaincy service. It is acknowledged that this approach does not yet adequately reflect recent changes such as those in primary care chaplaincy, nor those in other specialised areas of chaplaincy.

It is also acknowledged that immediate local application of the framework to specific services could lead to an apparent shortfall of chaplaincy-spiritual care staff in relation to the number of beds/staff/specific responsibilities. It is important to note therefore, that the tables below represent guidance, as opposed to a definitive statement, on the actual number of units of chaplaincy-spiritual care to be provided locally. The framework sets out a flexible, best practice background, against which local dialogue can take place in order to achieve progress in provision levels over a period of time. Such progress would be reported as part of the Local Development Plan (LDP).

Using this framework, chaplaincy-spiritual care units are calculated as follows.

Stage 1

Every 35 beds　　　　　= 1 unit of chaplaincy-spiritual care [1]

Every 500 WTE Staff　　= 1 unit of chaplaincy-spiritual care

These units are intended to cover the general responsibilities of the healthcare chaplain as set out in the statement of key roles contained in the healthcare chaplaincy (occupational) standards document.

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[1] Each unit of chaplaincy-spiritual care is deemed to last for 3.5 hours.

Stage 2: Acute services

Add units for the following specific responsibilities.

Type of health care service/responsibility	Minimum additional units
Day hospital	1 unit
Day surgery unit	1 unit
Nurse education/ supervision	2 units
Specialist palliative care services	2 units
Specialist units, e.g. regional service unit (NNICU)	1 unit per unit
Teaching responsibilities/ethics committees	1 unit
Management responsibility for co-ordinating chaplaincy-spiritual care teams	3 units – to be allocated to the chaplaincy team leader
Managing (chaplaincy-spiritual care) volunteers	2 units
Bereavement services according to the involvement of the chaplaincy team	1 unit
Units in response to specific local circumstances, e.g. locum cover, travel time	As appropriate
Staff support, teaching, acting as a Trust resource for spiritual care for all the faith communities	2 units
Research units	1 unit

Stage 2: Mental health services

Add units for the following specific responsibilities.

Type of health care service/responsibility	Minimum period numbers
Responsibility for referrals, counselling, pastoral therapy per 40 patients	2 units
Day hospitals, day clinics, drop-in centres, etc. per 40 patients	2 units
Domiciliary visits and maintaining contacts and support systems	2 units
Staff support, teaching, acting as a Trust resource for spiritual care for all the faith communities	2 units

Management responsibility for co-ordinating chaplaincy-spiritual care teams	3 units - to be allocated to the chaplaincy team leader
Managing (chaplaincy-spiritual care) volunteers	1 units
Specialist regional units/forensic (according to size)	1+ unit per Unit
Other specialist services	1 unit
Visiting and travel time	1 unit
Nurse education/supervision	2 units
Teaching responsibilities/ethics committees	1 unit
Bereavement services according to the involvement of the chaplaincy team	1 unit
Units in response to specific local circumstances, e.g. locum cover	As appropriate

NB: Other service providers, such as PCTs, should use the relevant areas of responsibility for which they provide services in order to calculate chaplaincy units.

Stage 3: Making adequate provision for the needs of all faiths

Having calculated the total number of units recommended for the Trust, consideration will need to be given to the allocation of units between chaplaincy functions and the needs of patients and staff.

Three management units would usually be allocated to the chaplaincy team leader. The remaining units should then be converted into WTE based on the representations of faiths/denominations within the patient and staff population of the Trust.

In allocating units for the major world faiths, consideration should be given to making an appointment which is more than just the minimum appropriate contribution. These units would be spent in:

• visiting and individual consultation

• leading organised worship - where this takes place on site

• in dealing with educational responsibilities towards staff and liaison needs with the faith community.

Other issues, such as organising cover for absence and travelling times, should be absorbed within these units.

Annex 2: Data protection

Information Commissioner's Principles of Data Protection

Anyone processing personal data must comply with the eight enforceable principles of good practice. Data must be:

- fairly and lawfully processed

- processed for limited purposes

- adequate, relevant and not excessive

- accurate

- not kept longer than necessary

- processed in accordance with the data subject's rights

- secure

- not transferred to countries without adequate protection.

Personal data covers both facts and opinions about the individual. It also includes information regarding the intentions of the data controller towards the individual, although in some limited circumstances exemptions will apply. With processing, the definition is far wider than before. For example, it incorporates the concepts of 'obtaining', holding' and 'disclosing'.

Source: Website of the Information Commissioner:
http://www.dataprotection.gov.uk/principl.htm

Additional sources of information and guidance

1 NHS Code of Confidentiality:
http://www.doh.gov.uk/ipu/confiden/protect/index.htm

2 The Patient Confidentiality and Caldicott Guardians' website (contains broader information about the role of data controllers and has useful additional links)
http://www.doh.gov.uk/ipu/confiden/index.htm

3 Website of the Information Commissioner (provides contact information for data controllers/individuals who have queries on specific issues)
http://www.dataprotection.gov.uk/principl.htm

4 Letter from the Hospital Chaplaincies Council {to all chaplaincy networks (Dec 2001)} reproduced for information, below.

Letter to Chaplaincy networks, sent December 2001 to Chief Executives of NHS Trusts and to chaplaincy networks from Rev Edward Lewis, Chief Officer of the Hospital Chaplaincies Council

Dear Colleague

Chaplains-spiritual care givers and the Data Protection Act (DPA)

As mentioned in my previous general letter in August, I had hoped to write to you at the beginning of October regarding this issue. However, it has taken much longer than planned to get representatives from all the parties involved together. The meeting took place last week with representatives from the Information Commissioner's Office, Department of Health solicitors and officials, and HCC officers and the Church House solicitors.

The conclusion of this meeting, agreed by all parties is that, unfortunately, chaplains are not able to take advantage of the exemption in Schedule 3 of the Data Protection Act 1998, which allows sensitive personal information about patients to be processed without explicit consent, where that processing is necessary for medical purposes. This is because chaplaincy is not deemed to be included in the definition of 'medical purposes'. The Information Commissioner takes the view that this definition is not wide enough to include spiritual care.

Chaplains-spiritual care givers are still able to make themselves available to patients on wards, as well as visit wards and departments generally. They should however, respect the wishes of any patient who has previously indicated that they do not wish to be visited by a chaplain. It is acceptable and desirable for procedures to be put in place that support patients changing their minds from time to time.

The Commissioner's representative also agreed that patients who are brought into hospital unconscious, and are therefore not able to give explicit consent themselves, may be assumed to allow a relative or friend to offer that consent. The Commissioner has made it clear that her advice may be subject to testing in the Courts, and that such situations need to be monitored on a case-by-case basis.

The consequences of this decision are that patients must give explicit consent before information regarding their religion can be passed on to the chaplaincy team. Once the patient has given explicit consent to this information being disclosed, it should be passed to the chaplaincy-spiritual care team as soon as possible. The Department of Health is likely to issue further guidance about this explicit consent in the New Year and Trusts will probably review their procedures with chaplaincy team leaders.

Trusts will need to ensure that the necessary consent is obtained in an appropriate and sensitive way. Chaplaincy team leaders will want to help with the design of necessary

questionnaires and leaflets as well as input to training units for those interviewing patients for their consent.

During the admissions process, patients should be made aware that the Trust employs chaplains-spiritual care givers, who are highly trained professionals, bound by NHS rules of confidentiality, who will walk along side them during their stay in hospital, at whatever level of involvement best suits the patient.

Chaplaincy team leaders may also wish to encourage local clergy and faith leaders to make their congregations aware, on a regular basis that this procedure is followed within public services and especially in hospitals. Patients and their carers should be encouraged to ask for their details to be passed on to the Chaplaincy-spiritual care department.

If Trusts fail to set up an adequate system for allowing patients to be asked about their spiritual care whilst in hospital and to register their consent for this information to be passed on, they could themselves be liable under The Human Rights Act 1998, should a patient claim that s/he was denied the right enshrined in Article 9 of the ECHR to manifest his or her religion, in worship, teaching, practice and observance.

The way in which this new situation develops will need to be monitored carefully to ensure that the duties to provide spiritual care are not foreclosed by the need to obtain appropriate consents. I should be grateful if colleagues would advise me of any problems that occur, as well as examples of good practice, so these can be represented to colleagues at the Department.

In the meantime, please do not hesitate to contact me - edward.lewis@c-of-e.org.uk - if you wish to discuss the content of this letter.

With every kind wish

Edward J. Lewis

Annex 3: Working party members and consultees

The Rev'd Canon Neil Barnes

Manager of Chaplaincy Services, Mental Health Services of Salford NHS Trust

Spokesperson for the College of Health Care Chaplains

Mr Tim Battle

CHCC/HCC Training and Development Officer

Mr Ervad Rustam Bhedwar

World Zoroastrian Organisation

The Rev'd Robert Clarke OBE

Chief Executive, Hospital Chaplaincies Council

Co-ordinator of the Multi-Faith Joint National Consultation (to October 2000)

Ms Carol Dawson

Patient Empowerment Team, Department of Health (to November 2002)

Miss Jacquie Flindall

Vice Chairman, Hospital Chaplaincies Council

Ms Lesley Hilton

Section Head Patient Empowerment Team, Department of Health (from July 2001)

Mr Duncan Innes

Section Head Patient Empowerment Team, Department of Health (to June 2001)

The Hon Barney Leith

Secretary, National Spiritual Assembly of the Baha'is of the United Kingdom

The Rev'd Edward Lewis

Chief Executive, Hospital Chaplaincies Council

Co-ordinator of the Multi-Faith Joint National Consultation (from November 2000)

The Rev'd Malcolm Masterman

Senior Chaplain, County Durham and Darlington Acute Hospitals NHS Trust

Mr Sital Singh Maan

Sikh Spokesperson

Mr Manhar L Mehta

Chairman, The National Council of Vanik Associations (UK)

Spokesperson for the Jain Community

Mr Chowdhury Mueen-Uddin

The Muslim Council of Britain

Mr Deepak G Naik

National Council of Hindu Temples

The Rev'd Christine Pocock

Free Churches Secretary for Health Care Chaplaincy, Health Care Chaplaincy Steering

Committee, Free Churches Group within Churches Together in England

HM Shafique Rahman

Chaplain, Barts & The London NHS Trust

Spokeperson for the Muslim Faith

Miss Sarah Roache

Patient and Public Involvement Team, Department of Health (from November 2002)

Mr Iqbal Sacranie OBE

Secretary-General, The Muslim Council of Britain

Mr Paul Seto

Secretary, Network of Buddhist Organisations (UK)

Mr Indarjit Singh

General Secretary, Sikh Council for Inter-Faith Relations

The Rev'd Preb Peter Speck

Trust Chaplaincy Team Leader, Southampton University Hospitals NHS Trust

Spokesperson for the DoH National Panel of Assessors for Hospital Chaplaincy

The Rt Rev'd Howard Tripp

Auxiliary Bishop in Southwark

Spokesperson for the Roman Catholic Bishops' Conference of England & Wales

The Most Venerable Dr Pandith Vajiragnana

The London Buddhist Vihara

Rabbi Martin van den Bergh

Senior Hospital Chaplain, Visitation Committee representing the Jewish Community

Mr Roger Wallis

Patient and Public Involvement Team, Department of Health

References

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Bristol Royal Infirmary (2001) *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995*, Bristol: BRI

Department of Health (2000) *Improving Working Lives*, London: DoH

Department of Health (2003) *Agenda for Change*, London: DoH

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