NHS Chaplaincy Guidelines 2014
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“Local NHS trusts are responsible for determining, delivering and funding religious and spiritual care in a way that meets the needs of their patients, carers and staff.”

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

The NHS “touches our lives at times of basic human need, when care and compassion are what matter most.”

*The NHS Constitution: the NHS belongs to us all 2013*

For the purposes of this document:

**Spiritual care** is care provided in the context of illness which addresses the expressed spiritual needs of patients, staff and service users. These needs are likely to include one or more of the following: existential concerns; religious convictions and practices; relationships of significance; and the exploration of faith or belief.
Foreword
TBC
Executive Summary

Chaplaincy Guidelines *NHS England*

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

The document responds to changes in the NHS, society and the widening understanding of spiritual and religious care. In the light of the 2010 Equality Act new guidance is provided for the care of patients and service users who do not identify with a religious faith.

The guidelines recognise the development of chaplaincy in general practice and growing specialism in areas such as paediatrics and palliative care.

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

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

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

Chaplains are NHS staff qualified and employed to supply spiritual, religious and pastoral care to patients, service users, carers and staff. They are one of the smallest professional groups working in the NHS. In many situations chaplains sustain a 24/7 service and respond to requests for care and support across the full range of clinical areas.

For as long as there have been hospitals there have been chaplains. In 1948 the employment of chaplains became the responsibility of the NHS. Since then chaplaincy has evolved in response to changing needs with a growing professional identity. This has enabled chaplains to share good practice and begin to build a body of professional knowledge and emerging research\(^2\).

The changing nature of communities in England means that chaplains respond to calls of increasing complexity. The diversity of religions and cultures within the population has grown and the need for chaplaincy departments to advise providers about equality and access has increased. In order to put patients first the NHS in England seeks to understand the rich variety of beliefs and values of the population in its care. Chaplains are an essential resource for achieving the ambition to provide high quality care for all and promote the protected characteristics of both religion and belief\(^3\).

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

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

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

Patient and Service User Care: equality, safety, compassion

Those accessing NHS services have always had the opportunity to receive care from an NHS chaplain. Chaplains are trained both by the NHS and by their faith or belief community. Patients and service-


\(^3\) HM Government, Equality Act 2010
users expect chaplains to be knowledgeable about issues of faith and belief as well as skilled in providing compassionate spiritual care in the health service.

In order to provide safe and effective spiritual care those commissioning and managing chaplaincy services should take into consideration the following guidance:

- Chaplains must abide by the requirements of their sponsoring faith or belief community, their contracting organisation, the Code of Conduct and all relevant NHS/NICE standards.

- Patients, service users and staff must be made aware of the nature, scope and means of accessing the chaplaincy within their setting.

- Patients, service users and staff should be able to access chaplaincy at any time on any day of the week in facilities where urgent out-of-hours support is requested on average at least once a week.

- Where requests for support relate to a particular religion or belief the chaplaincy should be able to access appropriate support for the patient and, when this cannot be matched, other chaplaincy support should be offered.

- For both patient and practitioner safety the current Lone Working policy of the provider, and professional bodies (Appendix A), must be followed.

- Patients and service users can expect to receive care from chaplains which is in accordance with the current competencies and capabilities (see http://www.ukbhc.org.uk).

- Where an instance of safeguarding arises during the course of spiritual care the chaplain must alert the patient or member of staff to the reporting obligations of the chaplain. The policies of the chaplain’s NHS organisation must be followed in all circumstances.

- To ensure safety, accountability and continuity of care chaplains should maintain a record of their work in a format agreed by their employer and in accordance with NHS policies for record keeping.

- Patients and service users have a right to expect that chaplaincy care will be experienced as neither judgemental nor proselytising.

- Compassion should inform chaplaincy practice and is a key outcome of the patient’s experience of the service being provided.  

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Staff and Organisational Support: informed, competent, critical

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

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

Chaplains are trained in practice-guiding disciplines such as theology and philosophy, and their formation offers organisations a resource to deepen understanding about the spiritual needs of the health care population.

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

Best practice for quality spiritual care for staff and organisations is achieved by:

- The location of chaplaincy departments within allied health professional or similar clinical groupings.
- Ensuring staff awareness of how to access chaplaincy services.
- A record of the number of occasions staff access chaplaincy support should be collated and reported annually (see below).
- If a chaplain has a concern about an aspect of organisational life this can be reported through line management. However, it is expected that a chaplain will have the option to communicate a significant concern directly to a member of the governing body.
- The lead / senior chaplain should produce an annual report of activities and make this available to a wide audience, including the governing body and local communities of faith and belief.
- Organisations must have due regard to the health and well-being of chaplains. For small teams, many offering round-the-clock services, relevant legislation and NHS policies must be adhered to.
- Appointments to chaplaincy posts should be made by organisations in accordance with the latest guidance from the Panel of Professional Advisers (Appendix C), which includes a consideration of staff need.

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Key Components for an Effective Chaplaincy Service

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

- The service has a designated lead chaplain.
- The chaplaincy has a written policy or guidance document describing the service and what care those using the service can expect to receive.
- A method of assessing spiritual, religious and pastoral needs should be described in the above document or separately.
- The chaplaincy staffing is calculated in accordance with the recommendations made below and the staffing is reviewed annually.
- Employed chaplains and chaplaincy volunteers collectively share the skills, knowledge, experience and insight to offer a comprehensive service.
- The chaplaincy is fully included in relevant provider meetings and forums to ensure that spiritual care is integral to the holistic response to patient need.
- The chaplains have access to office space, administrative support, networked computers and data essential to the performance of their role.\(^6\)
- As part of annual appraisals development plans are written for each chaplain and supported (recognising that not all AHP funding sources are available for chaplains, e.g. research development via PhD).
- Chaplains supervise all areas designated for faith-specific use; multi-faith use and use by those following non-religious beliefs. These areas should be well maintained, inviting and safe.
- Chaplaincies have procedures for auditing their work, both in terms of quality and quantity, so that the service is fully accountable within the organisation.
- There are regular opportunities for the chaplain(s) to engage in reflective practice either in a group or one-to-one.
- Staff employed to provide a chaplaincy service should receive regular supervision from an appropriately qualified person.

\(^6\) In the *Information Governance Review* (2013) found “a strong consensus of support among professionals and the public that safe and appropriate sharing in the interests of the individual's direct care should be the rule, not the exception”\(^\text{a}\). However, this review was focussed upon the sharing and safeguarding of health and social care information. It does not provide Chaplains with a legal basis for accessing confidential patient information without the explicit consent of the individuals concerned.
Volunteers in Chaplaincy

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

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

Best practice for quality spiritual care provided by volunteers is achieved when:

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

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

- In addition to complying with the relevant policies of the health provider chaplaincy volunteers attend at least one annual training day focusing on the safe practice of spiritual care.

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

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

- The lead chaplain for volunteers should have regular contact with the organisation’s lead for voluntary services.

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

“Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well supported”

Chaplaincy services should have adequate resources to carry out the work an employer requires. If a 24/7 service is provided then due consideration must be made of the staffing needed to ensure chaplains are not unduly burdened. The College of Health Care Chaplains guidance paper on this topic is Appendix B. This provides direction on the number of staff needed to maintain on-call.

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

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

Overview

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

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

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

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Chaplaincy in Acute Care

“People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.”

Best practice for quality spiritual care is achieved by:

- Allocating 3.75 hours of chaplaincy care for an average inpatient population of 35 patients. This calculation can be made on a faith/belief specific basis.

- Allocating 3.75 hours of chaplaincy care for every 35 patients not identified with a particular faith or belief system. Posts relevant to this population are to be open to any qualified chaplain of any recognised faith or belief.

- Allocating 3.75 hours of chaplaincy care for every 500 WTE staff irrespective of their particular faith or beliefs.

- Allocation 3.75 hours of management/professional leadership time for the lead chaplain for each whole-time equivalent chaplain in the team.

- Allocating of 3.75 hours for each NHS contract funeral taken by chaplains. This time includes preparation, contact with relatives/friends, travel to the funeral location and the service itself.

- Ensuring that at least 20% of a chaplain’s working time is available for some or all of the following duties:
  
  - Participating in staff education and development in spiritual care
  
  - Membership of ethical and other committees where the chaplain offers specialist knowledge and experience
  
  - Managing chaplaincy volunteers
  
  - Developing expertise for research and publication

- Matching chaplaincy provision for end-of-life care to best practice models, such as the ratios of staffing found in most hospices. This can mean one whole-time post for every 24 patients in the last 72 hours of life.

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

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10 NICE Quality Standards, Holistic Support, accessed at the following address on 13/12/13: http://www.nice.org.uk/guidance/qualitystandards/endoflifecare/HolisticSupportSpiritualAndReligious.jsp

11 This calculation is influenced by the guidance issued by the Association of Hospice and Palliative Care Chaplains.
The guidance on staffing for acute providers cannot be exhaustive but the above offers a framework for chaplains and managers to determine the required level of local provision.
Chaplaincy in Mental Health Care

“Recognising a person’s spiritual dimension is one of the most vital aspects of care and recovery in mental health. People who use services increasingly wish to have services view them as whole persons in the context of their whole lives; and spirituality and faith is a vital element in that”\textsuperscript{12}

Those commissioning and managing mental health care services should ensure adequate provision of spiritual care is made for their service users.

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

While religious identification may be significant for some service users, spiritual needs are often expressed in more general terms in mental health care. This partly reflects the age profile of those drawing on mental health services compared with acute care populations. The use of faith or belief-specific criteria for staffing is therefore less pronounced in these contexts.

Adequate chaplaincy staffing for mental health services requires:

- An allocation of 3.75 hours of chaplaincy for every 35 acutely ill patients.

- At least 3.75 hours of chaplaincy for every 500 whole-time equivalent staff.

- Allocating 3.75 hours of management/professional leadership time for the lead chaplain for each whole-time equivalent chaplain in the team.

- Ensuring that at least 20% of a chaplain’s working time is available for some or all of the following duties (which may be distributed in larger teams):
  
  o Participating in staff education and development in spiritual care

  o Membership of ethical and other committees where the chaplain offers specialist knowledge and experience

  o Managing chaplaincy volunteers

  o Developing expertise for research and publication

- Allocating time to prepare for work with a service user. This may include a risk assessment, especially where lone working is required.

\textsuperscript{12} Gilbert, P. “Guidelines on Spirituality for Staff in Acute Care Service: Recognising a person’s spiritual dimension is one of the most vital aspects of care and recovery in mental health” (2008) Staffordshire University.
Chaplaincy in General Practice

Every patient is different... nothing prepares you for the consultation with the patient in front of you, dealing with their psychological, their physical, their social, and increasingly their spiritual needs.¹³

The provision of chaplaincy in the NHS has historically favoured facilities offering inpatient care. As the NHS undergoes a process of transformation with renewed emphasis on primary care it is important to address spiritual needs in these settings.

Some GP practices already have experience of providing a chaplaincy service. Initial assessment of this provision found that “a ‘Chaplains for Wellbeing’ service in primary care improves mental health and well-being among those referred to it”¹⁴.

Chaplains have the privilege of working with patients’ values and the opportunity to affirm beliefs central to a person’s identity and sense of worth. A growing body of evidence links the use of chaplaincy to reduced stress, anxiety, depression, isolation and spiritual distress. These benefits have an obvious value in primary care and have the potential to enhance patients’ resilience in the face of illness.

Chaplains in primary care have an important role in staff support, both individually and as a community of workers. Repeated care for distressed people, including those who have been through traumatic experiences (such as a MAJAX) makes an inevitable impact on staff. A chaplain in primary care can support staff and work with practice managers to strengthen patients’ experience of a caring environment.

In developing chaplaincy in primary care it is recommended that commissioners introduce pilot schemes in suitable practices and evaluate their outcomes. Given the small scale of this work, networking practices and researchers, and developing a validated Patient-Reported Outcome Measure are priorities.

Adequate chaplaincy staffing for primary care health services requires:

- 3.75 hours of chaplaincy for every 250 whole-time equivalent staff with the availability of chaplaincy advertised so that all staff are aware of the service

- Defined and documented means of access for patients and service users to receive professional chaplaincy services

- An indicative staffing of 1 WTE chaplain to a practice population of 250,000

Primary care has a key role to play in improving health outcomes and reducing health inequalities. ¹⁵

¹³ Dr Clare Gerada, Chair of the Council of the Royal College of General Practitioners speaking on Radio 4's Woman's Hour on 22 October 2013.
¹⁴ Kevern, P. and Hill, L., ‘Chaplains for well-being’ in primary care: analysis of the results of a retrospective study, Primary Health Care Research and Development 20014 – in press
Chaplaincy in Specialist Palliative Care

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

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

Given the small and specialised work of units dedicated to the provision of palliative care it is essential that chaplains are integrated into the multi-disciplinary team.

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

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

Chaplaincy commitment to outpatient and community services should also be taken into consideration. In many instances chaplains will play a significant role in bereavement care including the planning, preparation and conduct of memorial services or events.

Chaplaincy in Specialist Paediatric Care

The spiritual needs of younger people and children require highly skilled and imaginative care. The ethical and safeguarding considerations for care in specialist paediatric units are of paramount importance. Chaplains working in such areas will require enhanced training tailored to their context.

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

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

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

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17 www.who.int/cancer/palliative/definition/en/
18 http://www.paediatric-chaplaincy-network.org/
Chaplaincy in Community Care

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

Care for people outside NHS facilities is a growing aspect of health provision. Most people prefer to be cared for at home if possible and, with a rising population of elderly people, it is anticipated that this aspect of health care will increase.

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

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

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

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

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Information Governance

The Law

All NHS staff require access to relevant information needed to carry out their duties. Access to appropriate information is essential for Chaplains to provide excellent spiritual care.

Clinical NHS staff regularly process information about patients’ physical or mental health. Similarly, Chaplains will regularly process information about patients’ religious beliefs or other beliefs of a similar nature.

Both types of information are subject to a duty of confidence and constitute “sensitive personal data” within the meaning of the Data Protection Act 1998. As a result the use of such information is subject to strict legal rules which must be observed by all NHS staff.

It is recognised that the duty to share information within the health service can be as important as the duty to protect patient confidentiality. To facilitate the sharing of information in the best interests of patients for the purposes of direct health and social care, clinical NHS staff may be able justify sharing information about patients’ physical or mental health without their explicit consent. This is due to a specific provision in the Data Protection Act 1998 in respect of processing sensitive personal data for “medical purposes” and the doctrine of implied consent to share confidential information with other registered and regulated health and social care professionals for the purposes of direct health and social care.

However the law does not currently permit Chaplains to rely upon such justifications. Therefore, Chaplains must obtain explicit consent from the patient before obtaining any information about patients or processing such information for the purposes of providing Chaplaincy services.

The Information Governance Review confirms both what is meant by explicit consent and when it is required:

*Explicit consent is unmistakeable can be given in writing or verbally, or conveyed through another form of communication such as signing. A patient may have capacity to give consent, but may not be able to write or speak. Explicit consent is required when sharing information with staff who are not part of the team caring for the individual. It may also be required for a use other than that for which the information was originally collected, or when sharing is not related to an individual’s direct health and social care.*

Consent obtained from patients to process their information will only be valid and applicable in respect of the specific ways in which, and purposes for, the patients have been informed of and reasonably expect. It is essential that patients are made fully aware of all such purposes at the outset, that the information is not processed for any other purposes and that their wishes as to how their information is processed are respected.

Where the patient is assessed as lacking the mental capacity to provide explicit consent, any use of information about them (whether in relation to their health or religious beliefs) must be in the patient’s “best interests” within the meaning of the Mental Capacity Act 2005.

The public sector Equality Duty enshrined in the 2010 Equality Act requires NHS services to eliminate discrimination, to advance equality of opportunity and to foster good relations. This cannot be achieved without accurate information about the patient and service user population.

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21 “Processing” includes all use of a patient’s information, including obtaining, recording, holding, retrieving, sharing, altering and deleting such information.


23 See the Mental Capacity Act 2005 Code of Practice, in particular paras 16.19 to 16.25, for further guidance.
Best practice for providing excellent spiritual care

For reasons of both spiritual care and equality, providers should make every effort to assess and record data about faith and belief.

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

- All NHS patients and service users should be asked if they wish to declare their faith or belief and to have this recorded

- If NHS patients and service users express their spiritual needs, and request to be referred to the chaplaincy service, this information should then be recorded and action taken.

- All NHS patients who provide such information should be fully informed as to how their information is intended to be recorded and of their right to refuse to consent to such processing.

- Where patients agree to be referred, providing an impartial assessment of spiritual needs by a qualified and trained member of NHS staff (such as a chaplain) using an agreed method

- If required, giving patients access to the most suitable chaplain to meet their needs

In order for an assessment to be carried out patient information (name and faith or belief) should be made available promptly to the staff sanctioned by the provider to carry out this work with the patient’s agreement to the referral.

Information Further information on the legal position in respect of Chaplains access to patient data can be found in Appendix D

Information and Staff Safety

The NHS has a duty of care for both patients and its staff. In order for appropriate care to be provided, and for chaplains to be aware of any risks associated with the patient or service user, all chaplains must be informed about these risks and where appropriate have access to the relevant patient information relating to these risks and the spiritual needs of these individuals. There is no legal basis or clinical justification, however, for chaplains to have access to the confidential patient information held in their medical records without the explicit consent of the individuals concerned or their legal representatives.

Data Recording

The work of chaplains should be recorded in a manner agreed by the provider. As NHS staff chaplains have a duty to be accountable for their work; transparent in their practice; and competent in their care. Accurate records promote team working within a chaplaincy and enable care to be continued when there is unexpected interruption (such as staff illness).

While health professionals may record details of the patients’ religious or similar beliefs and the fact that a referral to a Chaplaincy service has been made in the patient’s health records, patients must not be assumed to consent to or reasonably expect Chaplains to access or record information in their medical records. Access to medical records by Chaplains must only ever be with the patient’s explicit consent and is only likely to be justified in exceptional circumstances.

As patients are likely to have different wishes and expectations in respect of health information on the one hand and spiritual information on the other, it is essential that information obtained and
generated through the patient's use of the Chaplaincy service is held separately to the medical records. Patients must be made aware that these records are being kept in case they should wish to access them in future.
Chaplains poorly trained to provide spiritual care can cause harm. Those providing spiritual care are often called to patients and families in a state of severe distress. Poor communication skills; emphasis on inappropriate religious teachings; or a failure to identify critical elements of the patient’s belief system may all create potentially serious risks for both the patient and the organisation.

Professional chaplaincy profiles (e.g. KSF) describe required competencies according to the chaplain’s grade. In addition, there are agreed capabilities and competencies for health care chaplains which the UKBHC has published. Together these documents set out the progress chaplains should make to meet the demands of their role.

Caring for patients and staff is the primary role of health care chaplains. Providing that care always requires time for reflection, learning and improvement. Unless chaplains work to develop their skills and knowledge there is likely to be a diminishing return in their pastoral effectiveness. Chaplains need to learn from one another, from research, and from the insights of colleagues in related disciplines.

Best training and development for quality spiritual care is achieved by:

- Regular reviews, at least annually, of the chaplain’s development needs
- Compliance by chaplains with their employers’ mandatory training
- Maintenance of an up-to-date Professional Development Portfolio
- Supporting chaplains’ participation in profession-specific training either within or beyond the local organisation including relevant higher degrees
- Enabling newly appointed chaplains to access chaplaincy induction training
- Local arrangements for either a chaplain-specific journal group or participation by chaplains in a suitable group hosted by another profession
- All chaplains should be familiar with the profession’s research standard, meet the foundation level and plan to develop elements of the next level

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Independent reports have found failings in NHS care linked to a 'tick-box' culture. Chaplains have a unique potential to support approaches which view the patient or service-user holistically. It is recommended that this role be developed and accessed more frequently by providers, enabling spiritual care to sense-check the way health care is applied.
Further Areas of Guidance for Chaplaincy Services

Appointing Chaplains

When making chaplaincy appointments it is recommended that employers contact the co-ordinator of the Professional Advisers Panel at an early stage – ideally before the advert and supporting documentation have been written (Appendix C).

Effective chaplaincy depends on the quality of appointments and it is expected that every effort is made to recruit candidates of the highest calibre.

Multi-Faith & Belief Rooms

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

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

Researchers at the University of Manchester have produced guidance concerning the consideration which should be made when planning or re-providing this kind of accommodation (link).

Bereavement Services

Chaplains are frequently involved in end-of-life care and arrangements following death. There are often close links with bereavement services in the acute sector. Sometimes chaplaincy managers will line-manage the bereavement staff.

It is recommended that chaplains use such links to ensure that funerals conducted by the hospital meet the standards expected.

Major Incident Response (MAJAX)

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

College of Health Care Chaplains

Policy for Community Chaplaincy Lone Working

Introduction

A Community Chaplain is defined as a member of staff whose terms and conditions of employment require him/her to work alone, at times away from their base, within the community. This may or may not mean that they visit patients in their own homes.

It is recognised that in accordance with NHS Trust's duties under the Health and Safety at Work Act 1974, establishing safe working arrangements for Community Chaplains is no different from managing the safety of other employees. Employees' duties under the Health and Safety at Work act are to take reasonable care of themselves and other people affected by their lone working practices.

It is generally accepted that working alone in community is potentially more hazardous than working with others. Clearly it would be safer to work in a community base such as a clinic or health centre. However the College recognises that there are important pastoral reasons for visiting patients in their own homes, and developing relationships with clients based on trust and respect are intrinsic to the role of chaplains.

The College recommends that the guidelines issued are followed in partnership with any local arrangements that Trusts might choose to pursue. Training in the recognition of signs of violence, breakaway techniques and action to be taken in the event of an emergency such as fire, sudden illness or accident. It is important to avoid panic reactions in these 'unusual' circumstances. Whilst MSF will provide support, practical advice and indemnity insurance, there are a number of pointers that chaplains should recognise as good practice.

1. Pursue a ‘transparent’ approach to community work.
2. Keep a rigorous diary of times, places and duration spent with clients.
3. If in any doubt, initial visits should always be on Trust premises.
4. A procedure of appointment schedules and nominated contact persons should be followed.
5. Chaplains should avoid ‘community visits’ out of hours.
Guidelines for Community Chaplaincy Lone Working

Before a chaplain visits a patient in their own home, it is advisable to review all the available information about the patient and their circumstances, and thereby assess the potential risks. They should consider in particular where the patient lives, who they live with, the potential for violence and aggression and any additional health and safety risks. Much of this information should be available from the source of the referral, e.g. Consultant Psychiatrist, CPN, GP etc.

1. If the chaplain is in any doubt at all then the initial visit should be arranged to take place on Trust premises rather than the patient’s home.

2. When lone working, the chaplain should complete a schedule of appointments, including contact numbers where possible, and leave this with a nominated contact person at their base prior to going into the community.

3. Chaplains should avoid ‘out of hours’ visits.

4. It is recommended that chaplains carry mobile phones provided by the Trust. They should contact their base/nominated colleague on completion of their visit.

5. If the chaplain fails to call in after two hours, the nominated colleague should make a call to the chaplain’s mobile phone.

6. If the chaplain fails to respond, the nominated colleague should attempt to contact the last person on the chaplain’s appointment schedule, to make contact/gather relevant information. If it is at the end of the day, the home telephone number should be tried prior to working back through the appointment schedule.

7. If the chaplain cannot be traced the nominated colleague should inform the chaplaincy manager, or out of hours, the Trust on-call manager. If there is any cause for concern the police should be contacted and request a visit to the last known contact.

In addition:

A chaplain is advised to keep clear notes in their appointment diary, about the dates, times and duration of their visits to a patient’s home, and report any untoward incidents during their visit.

See accompanying check list for further guidance.
Chaplaincy Management

Are your chaplains who work in the community

- fully trained in strategies for the prevention of violence and break-away techniques?
- fully briefed about the area in which they work?
- given all available information about their clients?
- given access to a Trust mobile phone for use during community visits?

Chaplains have you:

- previewed the case and sought relevant advice?
- left an appropriate schedule with a nominated colleague?
- made plans to contact your colleagues on completion of visit?
- got a clear idea about the area into which you are going?
- thought about the home you are to visit and its location? Is it at the top of a tower block, down a country lane, in a one-way street? Where will you park so you can leave quickly? Is it well lit?
- got the skills necessary to defuse potential problems, manage violence and aggression, and secure a 'safe' break-away
College of Health Care Chaplains: on-call staffing recommendations:

At present, the overwhelming majority of chaplaincy departments offering out of hours on-call services do not comply with the EWTD. Chaplaincies without any on-call provision may well find they meet the requirements of the Directive without much difficulty. The key problem for others is:

**Being on-call off-site is not work neither is it rest, and the Directive states that workers must have at least 90 hours of rest on average per week. (NB The EU is currently reviewing these rules).**

1. It is recommended that all chaplains work towards 90 hours rest time per week, averaged over a 17 week period (excluding annual leave), as soon as possible.

In order to implement these chaplaincy departments may need to establish a group of *bank chaplains* to cover some on-call periods each week.

**Bank Chaplains should:**

Be properly recruited, including all relevant employer checks, and put on a suitable contract accompanied by a job description appropriate to Agenda for Change. The College recommends that such chaplains abide by the CHCC Code of Conduct, and that this is stated in their contract.

**Bank Chaplains should NOT:**

Be regarded as a cheap solution to issues raised by the EWTD; be detached from the opportunities for training and CPD available to others in the team; or be regarded as ‘amateur’ helpers providing a lesser standard of service.

**Part and whole-time chaplains taking part in an on-call rota should:**

- Ensure that they receive the remuneration for being on call stipulated by Agenda for Change (a percentage salary uplift on a sliding scale)
- Ensure call-outs are both remunerated or recompensed with time off in lieu for the period from first contact to return home
- Establish that within the 17 week period an average of 90 hours uninterrupted rest time is provided (uninterrupted meaning that the 90 hours comprise clear periods of time when the chaplain will not be contacted regarding her/his work or be at risk of returning to work)
- Ensure that one day per week is a day off from work duty of any kind, including being on-call

Example A:
A chaplaincy team has 2 whole-time chaplains and 3 part-time chaplains.

The team discuss the implications of the EWTD, arrive at a working model, and the Head of Chaplaincy makes a recommendation with costings to the Trust.

Solution:

All chaplains agree to on-call cover one night a week. In addition to their night during the week one chaplain would cover the weekend as well. e.g. Chaplain on Monday also covers the following Saturday and Sunday but does no further duty till the following Thursday or Friday.

Consideration also needs to be given to additional cover of at least one bank chaplain to support the team during annual leave periods and sickness. Only then can the 90 hour averaged rest be achieved.

The solution must be signed by all participants as an agreement to work in this way. It lasts for 5 years from that date.

Example B:

A Trust has 1 whole-time Free Church Chaplain and 1 part-time Catholic Chaplain.

The team discuss the implications of the EWTD, arrive at a working model, and the head of chaplaincy makes a recommendation with costings to the Trust.

Solution:

In this example it is decided on the basis of local experience that two systems would need to be in place.

The whole time chaplain would need to seek 5 other local ministers to support an on call system providing the 90 hour average rest over a 17-week period. A Trust would have to cover on call payment and call out fees for these bank chaplains.

A similar solution would need to be sought for the Part Time Catholic chaplain.

If mutual and joint working of the on-call system could be agreed between all Christian communities then a Trust could arrive at a lower costing of provision.

The solution must be signed by all participants as an agreement to work in this way. It lasts for 5 years from that date.
2. It is recommended that Chaplaincy Departments review their on-call staffing levels through a process of local discussions taking into account all evidence of current demand as well as the views of patients and staff. Applicable health service guidance for your area should also be consulted.

3. It is recommended that Chaplaincy Departments in close proximity to each other meet and discuss the potential for greater collaboration in out of hours on-call arrangements.

   Note: This proposal presents some obstacles (e.g. ensuring chaplains are properly recognised by another employers) but these should not deter suitable areas from discussing the issue.

4. Item 3 may be of particular relevance to chaplaincies where there is evidence of need for out-of-hours support for smaller faith communities in the locality. It will need to be recognised that a chaplaincy response may not always produce a chaplain of the patient’s desired faith tradition. Such a situation is inevitable.
Letter to CEOs regarding the new arrangements for chaplaincy appointments:

12 December 2011

To: Chief Executives of Hospital Trusts Hospital Chaplains

**New arrangements for provision of Health Care Chaplaincy Appointment Advisers.**

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

**Background:** From the early 1970s until 2010 the Church of England’s Hospital Chaplaincy Council (HCC) had led in servicing a Panel of Assessors to assist such appointments. In recent years the UKBHC has offered Professional Advisers to advise on the professional aspects of chaplaincy appointments. The Church of England has had to withdraw from its role so it has been necessary to find a new way ahead for the recommendation of advisers. The new system is the result of discussions between the bodies concerned for chaplaincy.

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

**A New Structure**

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

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

**Implications**

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

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

Advice provided by the Patient Information Advisory Group in 2002 on the legal position with respect to Chaplains access to patient data

The Advisory Group recognised that in many hospitals chaplains played a key role within health teams. However, it was agreed that common law and Data Protection requirements were clear: consent should be obtained from patients before details of their religious affiliation were made available to chaplains or before chaplains contacted representatives from other faiths to advise them that a member of their laity had been admitted to hospital.

The members believed that information about a person’s religious affiliation should be regarded as a sensitive data item under the terms of the Data Protection Act 1998, and also that some patients would regard information about their admission to hospital to receive treatment as confidential in itself.

The Advisory Group drew attention to the fact that most NHS Trusts sought information about the religious affiliation of patients when they were admitted to hospital. In most cases it was therefore possible at the beginning of each care episode to seek consent for this information to be shared with the hospital chaplain or other religious representatives. However, where patients were unconscious or unable to provide consent at admission, then Trusts should seek advice from the patient’s family or make a decision in the best interests of the patient.

Members recognised that the practicalities of changing computer systems might make recording this information difficult it was recommended that this issue should be taken in to consideration when new systems were being procured. In the meantime chaplains should be able to provide information to patients about the services they provide by distributing leaflets and posters or through hospital welcome packs.

Extract from Minute 8 of the Patient Information Advisory Group’s meeting on 20 June 2002 - http://www.hra.nhs.uk/documents/2013/10/piagminutes200602.pdf

Advice provided by the Information Commissioner as reported by the Rev Edward Lewis

“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.

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.

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.

Table Template
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<th>Person responsible and their Directorate</th>
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