

**STANDARDS FOR SPIRITUAL CARE
IN THE NHS IN WALES 2009:
SUPPORTING GUIDANCE**

November 2009

FOREWORD

The NHS in Wales is working hard to deliver world-class health services for the people of Wales.

Meeting the needs of people in all their diversity is an essential part of how we do this. We are all different and one of the challenges to public services is to recognise this and to help support staff to deliver services that are sensitive to our individual needs. This is particularly important for people receiving health care, their families and friends. I want the NHS in Wales to be aware of and care for the diverse spiritual, cultural and religious needs of the people who use services. It would be easy to assume that people with religious belief leave their faith at the door when they enter hospital or go to see their doctor. The reality is that these needs often become stronger at such times and can be central to a patient's experience of health care. Similarly, for those with no particular faith, feeling vulnerable when they or a loved one are ill or faced with difficult decisions can present challenges in how to cope. They may need offers of support. All of these situations come under the banner of spiritual care and the NHS needs to recognise, as I am sure it does, that spiritual care forms an important element of the services the NHS in Wales provides to help prevent and treat illness.

Hospital chaplains have long played a key role in providing a spiritual care service to patients, their families and carers and staff. Throughout the NHS today chaplains offer religious ministry to members of faith communities but they are also called upon to give wider spiritual care to the majority of patients, carers and staff who have no association whatsoever with any religious group. These members of staff are key to helping deliver improvements in this important area. They can also help staff to cope with difficulties which can present when their own faith comes into conflict with their duties as healthcare providers.

We have listened to a variety of people across Wales who are concerned about the status of spiritual care services in the NHS. They told us that they felt that this was a service that needed to receive more recognition because of its importance to patients. They told us that there was a need to raise the profile of spiritual care and to make it part of the day-to-day work of the health service.

I agree that it is time to issue a clear statement about this valuable service and I am expecting all NHS organisations within the reformed NHS to work towards implementing these standards.

Edwina Hart MBE AM
Minister for Health and Social Services

About this guidance

This guidance is written to support the attached standards and the development of spiritual care services within NHS Wales. It draws heavily on the Guidance issued in Scotland in 2002, which was considered by our working group to be an excellent example, and of some relevance, here in Wales. We would like to thank colleagues in Scotland for their generosity. The guidance is issued for action by NHS organisations and for noting as good practice by primary care practitioners. In this context NHS organisations refers to the 7 Local Health Boards and 3 specialist NHS Trusts in Wales. NHS organisations can assess how well they are doing in meeting the spiritual care needs of their patients as part of their regular self assessments in complying with the Healthcare Standards for Wales. This process is monitored by Healthcare Inspectorate Wales as part of their regular reviews and inspections.

This guidance is also intended to preserve the right to freedom of thought, conscience and religion, as detailed in Article 9 of the Human Rights Act.

Who is this guidance for?

The strategy is aimed at LHBs and NHS Trusts managing spiritual care services in Wales. It will be of interest to faith communities and to the public in general, as well as NHS staff in their support of whole-patient care. There is a lot of good practice already in existence and we recognise that many current LHBs and NHS Trusts will already have policies and procedures in place. The new organisations are therefore requested to review those against this guidance and the standards.

Acknowledgements

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Reverend Cliff Chonka, College of Healthcare Chaplains
Reverend Wynne Roberts, Pastoral Care and Partnership Manager, North West Wales Trust
Reverend Edward Lewis, Chief Executive, The Hospital Chaplaincies Council
Reverend Robert Lloyd-Richards, Former Senior Chaplain (retired), Cardiff & Vale NHS Trust

Reverend Lance Clark, Senior Chaplain, Cardiff & Vale NHS Trust
Imam Farid Khan, Gwent Healthcare NHS Trust

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TABLE OF CONTENTS

	Executive Summary	7
I	Spiritual Care in the NHS in Wales <ul style="list-style-type: none">• The need for spiritual care	8
II	Delivering spiritual care services <ul style="list-style-type: none">• Standards for spiritual care• Capabilities and competences for healthcare chaplains• Multi-faith spiritual care• Patient confidentiality issues• Providing spiritual care facilities• Continuity of spiritual care	10
III	Developing the spiritual care workforce <ul style="list-style-type: none">• Quantifying the need for spiritual care services• Appointment of chaplains and spiritual care-givers• Recruitment• Education, training and development• The wider spiritual care team• Managing the spiritual care team	14
IV	Taking the spiritual care strategy forward <ul style="list-style-type: none">• Developing a spiritual care policy• Principle characteristics of an effective spiritual care service	18
Appendix A	Capabilities and Competences for Healthcare Chaplains/ Spiritual care givers	20
Appendix B	Useful contacts	21
Appendix C	Calculation of spiritual care hours	24
Appendix D	Table of Multi-faith practices	28

EXECUTIVE SUMMARY

- This document sets out ministerial expectations for spiritual care in the NHS in Wales. It provides a strategic framework in order that local people can influence the detail of services provided for them. Putting in place services which provide the range and style of spiritual care described in the strategy is important for the care of patients, staff and the healthcare system.
- The uniqueness of Wales and its people needs to be matched by services tailored to their needs. Chapter 1 sets out aspects of this uniqueness in relation to national identity, geography, language and spirituality. The need for spiritual care is described in relation to the census results, showing a high pre-disposition for religious care in many areas but also a need for non-religious care on the part of some of the population.
- Issues about the delivery of spiritual care are set out in chapter 2. These include the challenges of providing care for an increasing number of Welsh people from the World faiths and achieving standards of spiritual care which match the aspirations set out in the Welsh standards document. The chapter also stresses the need for attention to the facilities used by spiritual care services which are offered to all NHS users and often in constant use.
- Chapter 3 is devoted to the issues which arise for the small but unique spiritual care workforce. The links with faith community formation bring complex issues for recruitment and development balanced by the advantages of strong community engagement which these also engender. Reference is also made to the needs of the wider spiritual care team which have the potential to encompass all members of staff and a significant number of spiritual care volunteers.
- Proposals for implementing the strategy are set out in chapter 4. These assign the lead role for reviewing and re-focusing services to local NHS organisations which are responsible now and in future for delivering spiritual care services. The Health and Social Services Directorate General (HSSDG) of the Welsh Assembly Government will lead work on spiritual care standards, education and training, and the determination of a range of healthcare professional issues.

SPIRITUAL CARE IN THE NHS IN WALES

1. Hospital and healthcare chaplaincy, which had their origins in the voluntary hospitals, has been a feature of the NHS since its inception. Politicians of all persuasions and the community at large recognised the importance of hospital religious ministry to the sick, injured, frail and dying, to their carers and to the staff who care for them. Fifty years on, the NHS has been transformed beyond all recognition as patterns of illness have changed and the range of therapeutic possibilities has expanded. The resources of the NHS, of which chaplaincy is one, are still focused on the treatment and care of those whose health has been compromised and survival threatened.
2. Since 1948 patterns of religious belief and practice have grown to reflect and respect the multi-faith diversity of our society. Whilst membership of the Christian church (whose faith is lived out by various denominations) and basic beliefs are still very much the norm, Jewish, Muslim, Hindu, Sikh and Buddhist faith communities are firmly established in Wales as well as many others. At the same time, people who have moved away from being actively involved with their faith community, nevertheless while holding to their core beliefs, evolve a spirituality which is personal to them and no longer bound by that spirituality's origins. Understanding and planning to meet the cultural needs of a diverse population presents considerable challenges.
3. Throughout the NHS today healthcare chaplains/spiritual care-givers offer both an appropriate religious ministry to those who remain in membership of faith communities (or whose roots are in those communities) and they also provide care to those whose spirituality is not aligned with a particular faith community. In this way, chaplains/spiritual care-givers provide a comprehensive service across the whole of the NHS often working closely with other members of staff employed in patient support roles including for example bereavement officers, members of palliative care teams, and public and patient involvement and patient experience staff.

The need for spiritual care

4. The table below (2001 census) shows the proportion of the Welsh population and their religious identity.

	People	% in Wales	% in UK
Christian	2,087,242	71.9	71.6
Buddhist	5,407	0.2	0.3
Hindu	5,439	0.2	1.0
Jewish	2,256	0.1	0.5
Muslim	21,739	0.7	2.7
Sikh	2,015	0.1	0.6
Other religions	6,909	0.2	0.3
All Religions	2,131,007	73.4	76.8
No Religion	537,935	18.5	15.5

Not stated	234,143	8.1	7.3
All no Religion/ Not stated	772,078	26.6	23.2
Base	2,903,085	100	100

Source: Census 2001

5. As the above table indicates even though the numbers involved in world faiths are small in Wales, it is vital that spiritual care services have contacts in the wider communities as hospitals will have patients from different parts of Wales and not just from the immediate locality that the hospital serves.
6. The majority of people, whether religious or not, need support systems in their life, especially in times of crisis. Most patients, carers and staff, especially those confronting serious or life threatening illness or injury, will have spiritual needs and will welcome spiritual care. However the choice is always theirs. They may face ultimate questions of life and death and search for meaning in the experience of illness. They look for help to cope with their illness and with suffering, loss, fear, loneliness, anxiety, uncertainty, impairment, despair, anger and guilt.
7. On the other hand, the majority who have no such religious associations yet recognise their need for spiritual care look for a skilled and sensitive listener who has time to be with them, to recognise the significance of their relationships, value them and take them seriously. The NHS must offer both spiritual and religious care with equal skill and enthusiasm.
8. Chaplains/spiritual caregivers and religious leaders are not alone in offering this care. It is given by many members of staff in the course of their professional work, by visiting relatives, carers and friends and by patients, informally, to each other. But in today's health service we need the distinctive contribution of caregivers who are trained in spiritual and religious care and have time to give it.
9. Continuity of spiritual care is important in a patient's journey from one NHS facility to another and from the NHS to other facilities in the community such as hospices, sheltered and supported accommodation, nursing homes and their own homes. This will be achieved only through partnership between NHS chaplains/spiritual caregivers and those who give spiritual care in these community-based settings.

DELIVERING SPIRITUAL CARE SERVICES

Standards for spiritual care

10. The publication of Healthcare Standards for Wales has made the emphasis on quality a driving force for all parts of the NHS. These standards were not necessarily aimed at individual services and spiritual care was not given any prominence. Within individual departments of spiritual care, effort has gone in to making these NHS standards applicable to the local service. The Standards are issued under the section 47 of the Health and Social Care Community Health and Standards Act 2003. They are presented to facilitate the audit of spiritual care services, to ensure equality across services and to develop an integrated approach to the delivery of spiritual and religious care while at the same time being open to the diversity of local services and needs.

Capabilities and competencies for healthcare chaplains

11. As a reference to the Standards, **Appendix A** is guidance on a competence and capability framework for individuals working as healthcare chaplains. The framework will help to inform and develop education and training, the planning of work based learning and the personal development of healthcare chaplains.

Multi-faith spiritual care

12. Even though the 2001 census showed that there is a spread of religions, this spread is patchy with some faith communities concentrated in only two or three places, and individuals of faith dispersed in very small numbers. Being able to meet the individual's need to see a minister of their own faith community can therefore be difficult to achieve in a reasonable timescale. The spiritual care service may therefore need to be able to provide spiritual care to people of all faiths as well as those people who have no religious spiritual needs.
13. Where there are concentrations of people of faith, every effort should be made to ensure that individuals expressing religious needs have these met by an appropriate religious care-giver. To achieve this will require careful pre-planning and liaison with faith communities locally.
14. Caring for people who have religious needs one does not follow can be difficult especially when patients may not be able to request particular care because of their illness. A guide to the cultural awareness/specific needs of people of faith when receiving healthcare is at **Appendix D**.

Patient confidentiality issues

15. Patients should be able to expect appropriate spiritual care but they have a right of confidentiality. It is the duty of the NHS to ensure these rights are met. As part of the healthcare team, chaplains will be treated as an equal member of the staff employed

by the NHS and are therefore under the same duty of confidentiality as all other healthcare professionals. Informed consent is the ideal. In order to provide spiritual care a certain level of information is required. Usually this will consist of basic demographic information. However, on occasion more comprehensive information will be required. All patients should be informed that they have the right to withhold personal information such as religious affiliation and that if they do not exercise this right, this information will be passed to the spiritual care team.

16. Access to patient information, the keeping of spiritual care departmental records and the use of that information must conform to Caldicott Guidelines and the Data Protection Act. All chaplains/spiritual caregivers and volunteers should sign an appropriate confidentiality statement. They must also follow their own professional code of conduct regarding confidentiality.
17. Accurate documentation by admission unit and other staff is of vital importance to those who wish the spiritual care team or their own local religious leader notified of their admission and to those who wish to request a visit from the appropriate spiritual care-giver. All service providers therefore need to operate a prompt and effective system of referral and notification, which operates within the constraints of patient confidentiality. Admission forms need to include documentation of patient's religious affiliation and of any request for a visit from a religious leader or chaplain/spiritual care-giver. Local documentation/systems should be reviewed to ensure this is the case.
18. Local training should ensure that staff are aware of the reasons why this documentation is so important. Questions about religion and spirituality need to be asked sensitively and admission and ward staff will need training and support in this activity. If a patient is too unwell to give information, the help of those accompanying the patient may be sought in the short term.
19. Since a patient's condition and consequently their spiritual needs may change after admission, the patient's wishes and their care records will need to be reassessed and updated on a regular basis. This re-assessment of spiritual needs is likely to be undertaken by ward staff, and chaplains/ spiritual care-givers will need to have in place a referral system which aids quick and comprehensive communications between the patient's care staff and the spiritual care team.

Providing spiritual care facilities

Quiet Room, Sanctuary or Worship Space

20. Many Welsh hospitals were founded by people with a strong background in the Christian faith and thus they may bear the names of Christian saints and have centrally-placed worship spaces (chapels) that incorporate articles of faith and devotion. These facilities are greatly valued but must also be shared equitably. It is not appropriate that all the currently available facilities are devoted only to one faith community and NHS organisations will need to consider how best to meet the

emerging accommodation needs.

21. Within major patient facilities all NHS organisations will need to have at least one room set aside exclusively for worship, meditation and reflection. The room's title should make it clear it is a multi-faith facility, readily adaptable for the use of members of all faith communities or none. It might be called a 'quiet room', 'sanctuary' or 'prayer room'. Larger hospitals might have more than one designated room.
22. Accessories for the worship of all faith communities and space to store them when not in use need to be provided as required. Consideration should be given to separate spaces for men and women and for the provision of washing facilities, soap, paper towels, etc. A system for the provision of appropriate music will also need to be provided. Care should be taken to ensure that simply because a room is available for use by members of all faiths; it does not as a result become bland or uninspiring.
23. Good communication between all faith groups requiring sacred space will be essential. A code of practice on the use of the room should be agreed so that users of the facility are aware of the importance of exercising respect and dignity towards others and their beliefs.

Office accommodation and equipment

24. Chaplains/ spiritual care-givers will need office and interview accommodation where they may meet distressed patients and carers and interview users in privacy. In larger hospitals, chaplains/ spiritual care-givers may need separate offices and interview accommodation near to the primary worship/ sacred space. In small hospitals, chaplains/ spiritual care-givers should have designated office and interview rooms which they can use when they are on duty.
25. Office equipment, including computers, internet access, journals, textbooks, and library facilities should be routinely provided for chaplains/ spiritual care-givers as for other professional staff. Clear arrangements need to be agreed at a local level for the management of the budget for these resources ideally within a spiritual care department.

Information and signage

26. Information about the spiritual care services should be made available to patients, carers and staff through leaflets, employee induction and training sessions and other literature. Signage to the 'quiet room', 'sanctuary' or 'prayer room' and to the spiritual care offices should also be provided.
27. All information and signage should be provided bilingually in Welsh and English and other languages as appropriate.

Procedures following death and mortuary facilities

28. Following a death, the beliefs and practices of all faith communities should be respected and appropriate provision for rituals and other offices should be made in consultation with them. All hospitals should ensure that comprehensive guidance is issued to staff and that training is given to ensure appropriate steps are taken following death. Mortuary facilities require appropriate provision for dealing with the needs of differing faiths and should offer suitable accommodation to meet the needs of relatives and friends of the deceased.

Continuity of spiritual care

29. Continuity of spiritual care is important in a patient's journey from one NHS facility to another and from the NHS to other facilities in the community such as hospices, sheltered and supported accommodation, nursing homes and their own homes. Great care is necessary to ensure that issues which are regarded as confidential within the patient's hospital encounter are not divulged unwittingly during this transfer. Similarly, care is required to ensure that patients whose spiritual needs are not aligned with a particular faith community can be cared for in community settings.

DEVELOPING THE SPIRITUAL CARE WORKFORCE

30. The spiritual care team should sit within the management structure of the healthcare organisation with an appropriate clinical management link. The number of chaplains/spiritual care-givers working in healthcare is few and their work is specialised and important. Many will be part-time in healthcare and have responsibilities in other areas. The spiritual care team includes lay workers, some of whom discharge faith-based activities, and volunteers who provide a most important resource to the spiritual care service. This chapter highlights the important issues for this special part of the NHS workforce.

Quantifying the need for spiritual care services

31. NHS organisations are required, in consultation with their local faith communities and patient representatives to develop and implement a spiritual care policy for the provision of chaplaincy, religious and spiritual care services across their area. This policy should implement the attached standards and principles of this guidance and:
- ensure that spiritual care is provided to patients, carers and staff in ways that are responsive to their needs;
 - secure the support of NHS Boards to such a service;
 - ensure that proper arrangements are made for the spiritual care of those who belong to smaller faith communities;
 - promote partnership in the matter of spiritual care between its services and other healthcare services, such as hospices, care homes, self help and voluntary organisations, and where the NHS organisation contributes funds to these services, ensure that spiritual care of comparable quality is provided in them;
 - promote a close working partnership between their services and local faith communities on the provision of spiritual care services and
 - proactively use the networks forged by the spiritual care teams to advise and comment on other aspects of policy;
 - ensure that the cultural and spiritual needs of individuals and family groups from ethnic minority faith communities are met, and that any necessary language support is provided.
32. Local Health Boards will need to appoint an appropriate number of chaplains/spiritual caregivers to offer religious and spiritual care to patients, carers and staff. (It is recognised that the delivery functions of the 3 specialist NHS Trusts are different and will require a more tailored approach possibly in partnership with other NHS organisations). Each faith community in the area served should be consulted about how it wishes to deliver spiritual care, support, information and advice to their members.
33. There can be problems in securing a realistic set of criteria to assess the make up of a prospective spiritual care team. For example, a lack of information on patients' religious affiliation; the difficulty of quantifying the time expended in supporting people

at times of deep personal distress; prolonged serious illness, and sudden or long-awaited bereavement. It is also difficult for smaller hospitals where spiritual care services operate on a part-time basis. Discussions should therefore take place locally, using evidence from patients' forums and staff engaged in providing this sort of support (e.g. chaplains, bereavement officers) to make a judgment on the extent of service to be provided.

34. To provide a baseline for quantifying staff resources in a spiritual care department the criteria at **Appendix C** can be used. In addition the exact nature and management of the local spiritual care service will be decided locally and informed by the following:
- the type of hospitals, units and community services served;
 - the condition, spiritual need and religious affiliation, if any, of the patients and carers served and the nature of their distress;
 - the expectations of patients, carers and staff for pastoral support, spiritual care, religious ministry and facilities for worship;
 - the expressed views of those who use the services provided and those that live in the communities served;
 - the expressed views of the faith communities in the area served;
 - the education, training and support needs of staff, students and volunteers; and
 - the morale and wellbeing of each individual and the hospital/healthcare community as a whole.

Appointment of chaplains and spiritual care-givers

35. Ideally, an appropriate number of chaplains/ spiritual care-givers should be appointed by NHS organisations to offer religious and spiritual care to its patients. All chaplains/spiritual care givers must be in good standing with and acceptable to their own faith community. The process of appointment of a chaplain/ spiritual care giver should also not be discriminatory in any way.
36. They should also be persons with the right personal qualities and the required professional skills and must:
- have undergone or be willing to undergo the necessary training and checks e.g. CRB checks
 - have a proven ability to get on with people from different backgrounds;
 - have a knowledge and understanding of their faith;
 - be able to work on the basis of mutual respect for patients, carers and staff;
 - be prepared to give appropriate spiritual care to people from all faith communities and to those who have no religious affiliation; and
 - be able to listen with empathy to the personal beliefs of those they serve within the context of the orthodox teachings of their faith community.

Recruitment

37. All spiritual care posts should be publicly advertised. Applicants should be interviewed according to NHS recruitment procedures to ensure that choice, fairness and adherence to the highest standards in HR practice is assured. The interview panel may include appropriate faith community representatives in an advisory capacity.
38. For chaplaincy/spiritual care appointments the panel should be supported by at least one professional adviser. The professional adviser should be a practicing spiritual caregiver of not less than three years experience, nominated by the professional organisations, who works in a similar capacity in a different area.

Education, training and development

39. Spiritual care-givers may not always be “ordained” ministers or clergy who have attained an established educational level during their faith formation. NHS Workforce departments will need to develop local mechanisms to ensure appropriate scrutiny of the background and qualifications of people engaged in the delivery of spiritual care within the NHS.
40. NHS organisations which make arrangements with faith communities to recruit and train lay persons for spiritual care work will need to also ensure that these people are trained for this work. NHS organisations should facilitate training for healthcare chaplains as set out in the competences and capabilities framework at **Appendix A**. Chaplains/ spiritual care-givers are used to providing training for their own volunteers.
41. A training programme organised locally will usually include:
 - stress in the workplace;
 - dealing with difficult situations;
 - bereavement;
 - health and safety in the workplace;
 - Data Protection Act in relation to personal data that is held about a patient;
 - general issues that are common to all staff such as the basics of infection control.
42. Patients and carers often express their own spiritual needs and their direct care staff must be able to advise them of the spiritual and religious care available to them. Staff should also be aware of their responsibility for identifying any unmet spiritual need and for ensuring that action is taken to address it. The assessment of spiritual need is a skilled task best undertaken by those who directly care for patients and their families. Staff who are aware of spiritual need will be able, if properly trained, to offer better spiritual care themselves and will be proactive in accessing spiritual care services rather than acquiescing to an arrangement which is solely reliant on ‘chaplain’s rounds’.
43. Training for staff in assessing spiritual need and providing spiritual care, as well as cultural awareness is already offered in some NHS organisations and greatly valued by

staff. This should be a normal part of professional development for all clinical and non-clinical staff involved in patient care throughout the NHS. **Appendix B** has contact details of general training providers.

The wider spiritual care team

44. Volunteers play a significant part in enhancing and strengthening a spiritual care service. Volunteers need to be carefully recruited and properly trained for the tasks they are expected to undertake and in accordance to the organisation's volunteering framework.
45. The spiritual care services volunteers should be recruited and managed with the support of the voluntary services manager and will also be subject to required statutory checks. The WCVA is the voice of the voluntary sector in Wales. Their guidance 'Recruiting Volunteers: A Manual of Good Practice' is available from the WCVA on request.

Managing the spiritual care team

46. It is usual for the human and financial resources of the spiritual care service to be managed by a chaplain/ spiritual care-giver appointed for this task. The management content of this post will vary according to local circumstances and will usually be a full-time managerial commitment. The chaplaincy/spiritual manager will need to fit into the management structure of the healthcare organisation. The merger of existing healthcare organisations into the new organisations offers an opportunity for the consolidation of existing spiritual care teams and for more specialist resources to be shared across the whole organisation.
47. The spiritual care manager who takes forward the new and larger spiritual care service will need support in the new role which this requires. It may particularly be the case that models of leadership in faith communities differ from those in the NHS and care will be necessary to ease this learning requirement.
48. Each Trust/LHB will currently have a small team of chaplains/ spiritual care-givers balanced between the local faith traditions and with a mix of whole-time and part-time posts. There may not be a need to change the work pattern of every chaplain/ spiritual care-giver but each should have the opportunity to contribute to the outcome of the review process and to help shape the future service.
49. The role of the chaplaincy/spiritual care manager should also include regular meetings with chaplaincy/spiritual care-givers. They should also represent the interests of the service provider in the management of the local system of appointment and review. There should be clear responsibility at Board level for the spiritual care service and a clear line of accountability from the spiritual care team to a lead Director.

TAKING THE SPIRITUAL CARE STRATEGY FORWARD

Developing a spiritual care policy

50. This strategy should be pursued at a pace which reflects the importance of spiritual care to patients and staff within the NHS. The strategy is not starting from point zero and there is already a significant spiritual care service within NHS Wales which now needs review in order to facilitate appropriate development. Within the next twelve months, we hope to see significant gains for spiritual care through this process.
51. The implementation approach is based on undertaking a review of current spiritual care provision and agreeing a plan for the future within each LHB and Trust during the early part of 2010. The plan would be taken forward at a pace agreed locally but should be in place by September 2010. The resources currently devoted to spiritual care need to be safeguarded so that they are available for deployment in future. Progress of these actions needs to be monitored at all levels of the NHS structure.
52. Each LHB should lead the implementation of this strategy within its area. NHS Trusts will also need to consider the delivery of the attached standards and the spiritual care policy to their services and work in partnership with LHBs in reviewing their policies. This will involve tasking a senior manager to undertake a strategic review of spiritual care services working with local stakeholders including current spiritual care providers, faith communities and user interests. Each NHS organisation should undertake their own equality impact assessment to establish that each strand of equality and diversity is completely covered. The entire review should be completed and action agreed within twelve months.
53. An outcome of the review will be a clear statement about the degree to which the issues raised by the strategy are being resolved within existing resources. Ultimately, this is about ensuring that the spiritual needs of patients and carers are being met satisfactorily. If additional resources are required, they will need to be considered for local prioritisation by healthcare organisations.
54. In parallel with these reviews, we suggest that the WAG, HSSDG should agree to review the following topics on an all-Wales basis (with help and support from NHS organisations):
 - The attached standards for spiritual care provision arising from Healthcare Standards for Wales and performance management issues arising therefrom;
 - Education and training requirements for chaplains/ spiritual care-givers, their co-workers and the members of the wider spiritual care team.
55. LHBs/ Trusts will need to identify the human and financial resources devoted to the spiritual care service as part of their baseline review.

Principal characteristics of an effective spiritual care service

56. The following basic principles should underpin all spiritual care services provided or funded by the NHS in Wales. They should:

- be impartial, accessible and available to persons of all faith communities and none, and facilitate spiritual and religious care of all kinds;
- function on the basis of respect for the wide range of beliefs, lifestyles and cultural backgrounds found in the NHS and in Wales today;
- value such diversity;
- be a significant NHS resource in an increasingly multicultural society;
- be a unifying and encouraging presence in an NHS organisation;
- never be imposed or used to convert;
- be characterised by openness, sensitivity, integrity, compassion and the capacity to make and maintain attentive, helping, supportive and caring relationships;
- affirm and secure the right of patients to be visited (or not visited) by any chaplain, religious leader or spiritual caregiver;
- adhere to the Code of Conduct for Healthcare Chaplains;
- adhere to the Values and Standards of Behaviour framework;
- be carried out in consultation with other NHS staff; and
- acknowledge that spiritual care in the NHS is given by many members of staff and by carers and patients, as well as by staff specially appointed for that purpose.

APPENDIX A

**CAPABILITIES AND COMPETENCES FOR HEALTHCARE
CHAPLAINS / SPIRITUAL CARE GIVERS**

APPENDIX B

USEFUL CONTACTS

The United Kingdom Board of Healthcare Chaplaincy (UKBHC) UKBHC, P.O. Box 105, Addenbrooke's Hospital, Cambridge, CB2 2QQ www.ukbhc.org.uk

The UKBHC is the self regulatory body for healthcare chaplains, supported by all four UK professional membership organisations. It sets standards, produces the code of conduct, maintains a register and deals with fitness to practice. A registered practitioner is known as a 'Board Registered Chaplain'

Association of Hospice and Palliative Care Chaplains (AHPCC)

Tom Gordon, President, Marie Curie Hospice, Frogston Road West, Edinburgh, EH10 7DR
www.ahpcc.org.uk

Hospice and Palliative Care chaplains aim to: work within a multidisciplinary team committed to providing holistic care; be proactive in assessing and meeting the complex spiritual and religious needs of patients, their families and carers; discern and respect the cultural, spiritual and religious diversity of all patients, their families and carers; and ensure that all spiritual and religious care is patient led and focused on the needs of individuals, their families and carers

The College of Health Care Chaplains (CHCC),

Health Sector, Unite, 128 Theobald's Road, London, WC1V 8TN.

Tel: 020 3371 2013 (Carol English) or 020 3371 2004 (William Sharpe).

www.healthcarechaplains.org.

The CHCC is a multi-faith, inter-denominational, UK-wide membership organisation that promotes the professional standing of, and provides training to, healthcare chaplains. It is an autonomous section of the trade union UNITE.

Northern Ireland Healthcare Chaplains' Association (NIHCA)

Director of Training, Rev Derek Johnston and secretary, Rev Jennifer Bell via

nihca@chaplains.co.uk

www.nihca.co.uk

The NIHCA exists for the personal, vocational and professional well being of healthcare chaplains, thereby equipping them to exercise a more holistic ministry. Its aims are, among others, to support healthcare chaplains in carrying out their responsibilities, to facilitate and provide appropriate training for chaplains, and to establish and promote good working relationships with religious and other organisations concerned with healthcare.

Scottish Association of Chaplains in Healthcare (SACH),
Membership Secretary, Chaplains Office, Aberdeen Royal Infirmary, Fosterhill, Aberdeen,
AB25 2ZN
www.sach.org.uk

SACH is a professional body representing the interests of chaplains in healthcare throughout the UK. Its main activities include promoting and maintaining standards of chaplaincy; providing training and education; and providing support and fellowship.

St Michaels College

54 Cardiff Road, Llandaff, CF5 2YJ Tel: 02920 563 379
www.stmichaels.ac.uk

St Michael's is a constituent College of Cardiff University and a Church in Wales Theological College. It has a Centre for Chaplaincy Studies which provides educational, professional development and research support for chaplains working in various areas including healthcare. This support includes post-graduate qualifications in chaplaincy studies and induction programmes specifically designed for chaplains working in healthcare chaplaincy.

The Multi-Faith Group for Healthcare Chaplaincy (MFGHC)

Rev Edward J. Lewis, Room 366, Church House, Great Smith Street, London, SW1P 3NZ.
Tel: 020 7898 1892 or email chief.officer@mfghc.com
www.mfghc.com.

The Multi-Faith Group for Health Chaplaincy was established in December 2002 in order to advance multi-faith healthcare chaplaincy in England and Wales. The Group seeks: to facilitate a common understanding and support for healthcare chaplaincy amongst Faith Groups, chaplaincy bodies and users; provide a means of consultation between the Faiths about healthcare chaplaincy; and works in co-operation with healthcare and chaplaincy organisations, bodies and authorities.

Diversiton

8 Osborne Promenade, Warrenpoint, Co Down, BT34 3NQ, Northern Ireland
Tel: 0845 301 5482
www.diversiton.com

Diversiton provides a range of training programmes and resources in religion and belief for organisations throughout Great Britain.

Wales Council for Voluntary Action (WCVA)

Baltic House, Mount Stuart Square, Cardiff Bay, CF10 5FH,

Tel: 0800 288 8329

www.wcva.org.uk

The WCVA is the voice of the voluntary sector in Wales. WCVA represents voluntary organisations, volunteers and communities. The publication, 'Recruiting Volunteers: A Manual of Good Practice', is available from the WCVA in hardcopy on request.

Equality and Human Rights Commission (EHRC)

Equality and Human Rights Commission Helpline Wales,

Freepost RRLR-UEYB-UYZL, 3rd Floor, 3 Callaghan Square, Cardiff, CF10 5BT

Tel: 0845 604 8810

www.equalityhumanrights.com

The role of the EHRC is to promote equality and human rights, and to create a fairer Britain. It provides advice and guidance, works to implement an effective legislative framework and raises awareness of the public's rights.

British Institute for Human Rights (BIHR)

King's College London, 7th Floor, Melbourne House, 46 Aldwych, London, WC2B 4LL

Tel: 020 7848 1818

The BIHR provides a range of information and other resources (including briefings and toolkits); develops and delivers training and consultancy for the voluntary and community and public sectors on both practice and policy; leads and/or collaborates on demonstration and pilot projects across the voluntary and community and public sectors; undertakes research and policy analysis; lobbies national government and Parliament; and conducts media activity and campaigns and occasional strategic legal interventions

APPENDIX C

CALCULATION OF TOTAL SPIRITUAL CARE HOURS

Spiritual caregivers will normally be responsible for some or all of the following:

- planning, delivering and developing a spiritual care service to meet the assessed need, for example in acute units a 24 hour, 7 day a week service;
- visiting and supporting patients through spiritual care, pastoral conversation and religious ministry as appropriate;
- conducting services of worship in a quiet room, sanctuary or other suitable accommodation;
- offering prayers, sacraments and other religious ministries at the bedside, cot side or dayroom;
- supporting carers, especially where patients are seriously ill, chronically sick, terminally ill or have already died and then to give bereavement care;
- supporting staff through pastoral care, the ministry of presence and, where appropriate, counselling;
- providing informal advocacy on behalf of patients and their carers;
- at the request of a patient or carer, ensuring their confidential referral to their own religious leader;
- facilitating the ministry in hospital or other NHS facility of the religious leaders of faith communities who may seek assistance and advice;
- providing an informed resource on ethical, religious and pastoral matters;
- participating in induction and in-service training of staff, for example on spiritual need and spiritual care, the role of the spiritual caregiver, etc;
- be involved along with other staff in the delivery of bereavement care and in the training of staff in the care of the dying and bereaved;
- serving on NHS committees as requested;
- establishing and maintaining contact between the NHS and local faith communities by fulfilling speaking engagements, liaising with religious leaders and, with the support of the organisation's volunteering, manager recruiting volunteers;
- in consultation with local voluntary services, selecting, training, supporting and supervising volunteers to work with the chaplain and elsewhere; and
- being involved in the planning and execution of the major incident policy.

	AREAS OF HEALTH CARE WORK	RANGE OF BEDS/PERSONS/ACTIVITY TO NUMBER OF UNITS/HOURS
1	Acute inpatient: i.e. paediatric, medical, surgical, gynaecology, mental health, oncology.	3.75 hours/1unit : 37 beds/patients
2	Intensive care units: i.e. neonatal, assisted ventilation, high dependency, post-operative, transplant surgery.	3.75 hours/1 unit : 10 – 20 beds/patients
3	Palliative care: in order to meet standards for palliative care (NICE, Liverpool Care Pathway), it is recommended that 16 or more beds should have a whole time post.	10 sessions – i.e. 1 full-time post or 6 – 18
4	Maternity	3.75 hours/1unit : 37 beds/patients
5	Long stay units: i.e. care of the elderly, long stay mental illness, long stay learning difficulties	3.75 hours/1unit : 25 – 50 beds/patients
6	Day care units: day hospital, day centre, ambulatory care, day surgery, oncology, stroke rehabilitation, renal dialysis.	3.75 hours/1unit : 37 beds/patients
7	Accident and emergency: casualty and admission unit.	3.75 hours/1unit : 20 – 40 beds/patients
8	Care in the community: visits to supported accommodation – <ul style="list-style-type: none"> • Number of tenants seen • Number of carers seen • Chaplain at learning disabilities school • Travel time between facilities. 	3.75 hours/1unit: 1 – 3 (depending on size) 3.75 hours/1unit: 2 – 6 3.75 hours/1unit: 1 – 3 3.75 hours/1unit To be determined locally.
9	Members of staff:	3.75 hours/1unit : 250 – 500 staff
10	24 hour, on-call and holiday cover:	An allowance of hours/units should be made to ensure compliance with the EC Working Time directive and to ensure appropriate off duty and holiday cover.
11	Teaching or Speaking engagements:	3.75 hours/1 unit
12	Worship services:	3.75 hours/1 unit

13	Bedside services, sacraments etc:	3.75 hours/1 unit per 15 bedsides
14	Pastoral counselling: by arrangement/appointment.	3.75 hours/1 unit per 2-3 clients
15	Administration: paperwork, meetings, committees, supervising volunteers, research, ethics discussions etc	11.25 hours/3 units
16	Head of department duties	11.25 hours/3 units
17	Managing volunteers	3.75 hours/1 unit
18	Training/Education CPD/KSF - backfill	3.75 hours/1 unit

Funerals

Patients and carers often seek help from the NHS in arranging and conducting funeral services. An allowance should be made for the number of deaths, including stillbirths and neonatal deaths.

Calculating the Workload

The calculation of the total sessions should be made in consultation with spiritual care and records department staff in three stages

- a bed/person/staff calculation based on 3.75 hours/1 unit figures in categories 1 -7, 9,10, 14, 15, 16 & 17 above;
- that total should be divided proportionally among staff who offer spiritual care to the non-affiliated and faith communities according to the bed occupancy figures for each group served;
- additional sessions, or parts of sessions, should then be allocated for the work in categories 8 and 11 - 13 above.

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 representation 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

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

The table is for guidance only and is subject to review at a later date.

MULTI - FAITH PRACTICES

Set out below is guidance for the care required by deceased patients and their families of varying faith groups.
Not everyone in a religion or denomination will share exactly the same beliefs and all have their fundamentalists and liberals.

The main principle is, wherever possible, ASK THE FAMILY

	CHRISTIAN	JEWISH	MUSLIM	BUDDIST	SIKH	HINDU	JEHOVAH'S WITNESS	MORMON
<i>Holy Book and Holy Day</i>	The Bible SUNDAY	The Old Testament SATURDAY	The Koran FRIDAY	Many scriptures No weekly Holy Day	Guru Granth Sahib SUNDAY*	The Vedas No weekly Holy Day	New World Bible SUNDAY	The Bible, Book of Mormon SUNDAY
<i>Diet</i>	Some may fast during Lent	Kosher only, no pork, no shellfish. Meat and milk not mixed at same meal	Halal meat only, no pork, no alcohol Fast during Ramadan, but not if very ill	Vegetarian	Diet is up to the individual, though Halal and Kosher food are not permitted	No Beef, many are vegetarians	Tobacco is not allowed. Anything Containing blood cannot be eaten	No stimulant, so no tea, coffee, alcohol
<i>Approaching Death</i>	Likely to wish to see member of clergy. Variations between denominations but may take communion or give last confession	No last rites but might wish to see a Rabbi. When death occurs the Declaration of Faith (Shema) is recited	Family usually join the dying in prayer and recitation of the Qur'an. Imam might visit. Dying to face South –East to Mecca	Quiet needed for meditation. Might require a monk or religious teacher to visit. Prayers chanted.	Comfort may come from reciting from Guru Granth Sahib. Some may want holy Ganges water, which the family bring	Prefer to die at home. Might want to lie on the floor to die. Comfort from hymns, prayers, mantra, holy items	No blood transfusions. A dying witness might appreciate a visit from an Elder of their faith	No specific rituals.
<i>Organ Donation</i>	No religious objection	No religious objection	No religious objection, but many decline	No religious objection	No religious objection	No religious objection	No blood transfusions	No religious objection
<i>Last Offices</i>	There are many denominations, so consult the family. Many will appreciate a priest or minister to pray with and anoint the patient. Contact the hospital Chaplain for specific advice Some Roman Catholic families may wish to place a rosary in the deceased patient's hands and/or a crucifix at the patient's head	Remove tubes and instruments unless the family ask otherwise. Patients must not be washed, but may be dressed in a plain shroud. The body will be washed by the local Jewish funeral association. The body should not be left alone, or in the dark if possible. contact the Chaplaincy Team if there is no-one able to be with the body	Ideally the body should be untouched by non-Muslims. If no family are present, close the patient's eyes and straighten the body. The head should be turned to the right shoulder, and the body covered with a plain white sheet. The body and hair should <i>not</i> be washed, nor the nails cut	Different schools of Buddhism require different rituals – confirm correct one with the family. A Buddhist monk or nun may be asked to be present. The patient's body should be wrapped in a plain cloth in a room with no religious symbols	Usually the family takes responsibility for the last offices, but staff may be asked to close the patient's eyes, straighten the body and wrap it in a plain white sheet. Keep the turban in sight of the patient. Do not remove the miniature sword, bracelet, special shorts, or comb which fastens the patient's hair. Do not cut the hair or trim the beard	Ask the family before touching the body. The family may wish to wash the body. Do not remove sacred threads, jewellery and religious objects. Eyes are closed and limbs straightened: the family may like to do this. The patient's family may wish the body to be placed on the floor. They may wish to burn incense	There are no particular rituals	There are no particular rituals. Relatives will advise staff if the patient wears a one or two piece sacred undergarment. If this is the case, relatives will dress the patient in these items
<i>Post Mortem</i>	No objection	Unlikely unless for legal reasons, but some Jews will accept.	Unlikely, unless for legal reasons. If so organs / tissues should be replaced	No objection	No objection, but discuss any potential delay to the funeral arrangements	Unlikely, unless for legal reasons, but discuss with family	No objection; for individual opinion	No objection for cause of death and scientific purposes
<i>Funerals</i>	Burial or cremation	As soon as possible, within 24 hours; usually burial	As soon as possible, within 24 hours; always burial	Cremation	Cremation	Cremation	Burial or cremation	Usually burial
<i>Afterlife</i>	Resurrection & Judgement	Resurrection & Judgement	Resurrection & Judgement	Reincarnation	Reincarnation	Reincarnation	Resurrection & Judgement	Resurrection & Judgement
<i>Other Considerations</i>	Varying practices between many denominations	Beliefs vary according to branch and degree of Orthodoxy. Modesty is important; female should be attended by females and males by males. If possible the body should be untouched for 30 minutes and ideally should not be moved on the Sabbath / Festivals	Muslims pray five times daily at set times and need to wash before prayer. An ill patient will continue to practice for as long as possible. Modesty is very important – women may want head to foot clothing, men must be clothed from the waist down.	In Western Buddhists, where the family are not always of the same faith, may be necessary to ensure the family are aware of the wishes of the deceased. If family members are Buddhist, give them privacy for prayers and mantras	There is no priesthood but a strong community. Early prayers are often said before breakfast and patients prefer to wash beforehand. Suicide is forbidden; if one has occurred the family will need to be dealt with very sensitively	Purification of the body is important and patients will wish to bathe in running water. Fasting is common at festival times –it should be explained if this will affect medication. Modesty should be respected – same sex for bed bath	They will probably carry a card instructing medical staff that they are opposed to taking any blood / blood products. Releasing the hospital from any responsibility following limited treatment	Some who have undergone a special temple ceremony will wear a sacred undergarment that is private and must be treated with respect. Health is important and all stimulants are forbidden (including caffeine)

