Report of the Scoping Study Group on the Provision of Spiritual Care in NHSScotland

September 2005
Executive summary

Over the last few years, the Scottish Executive Health Department (SEHD) has undertaken several initiatives highlighting the need for ‘whole person’ care which is responsive to the needs of individuals and communities of varying culture, background and belief. These have included Patient Focus and Public Involvement, Fair For All, Partnership for Care, and HDL(2002)76 Spiritual Care in NHSScotland. In light of this ongoing work and a realisation of the changes in society with regard to beliefs and communities, a Scoping Study Group was convened by NHS Quality Improvement Scotland (NHS QIS).

The Group met on a quarterly basis over a period of 18 months in order to look at the current provision of spiritual care services within NHSScotland, and to identify ways in which NHS QIS could support ongoing or new initiatives to ensure that the provision of spiritual care is consistent in its availability and tailored to individual need. A seminar open to NHSScotland staff was held to discuss key issues raised by the Group in a draft version of this report. It was also an opportunity to disseminate research, share practice and network with colleagues.

NHS QIS provided information to the Group on available NHS QIS products and support in facilitating discussion. The Group ensured that patient needs were given full consideration and where possible, worked in partnership with other NHS and external organisations with similar goals.

The following key requirements for NHSScotland were discussed:

- generating better awareness of the spiritual care needs of patients, relatives and staff within NHSScotland
- generating increased awareness of the role of every staff member in the provision of spiritual care, including but not limited to the chaplain’s role
- ensuring that a consistent approach to the provision of spiritual care is adopted across NHSScotland, and
- establishing a high-quality benchmark for the provision of spiritual care across NHSScotland.

To achieve these aims, the Group recommended that the following NHS QIS products could be evaluated for inclusion in the work programme:

- guidance note on the delivery of spiritual care in NHSScotland, and
- national standards for the provision of spiritual care.

Further evaluation, in line with NHS QIS’ current workplan and constraints such as relocation, is not likely to take place before the fiscal year 2007/08.
Acknowledgements

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- The Scoping Study Group members (see Appendix 1).
- Rev Alister Bull, Chaplain, NHS Greater Glasgow
- Rev Bob Devenny, Healthcare Management Consultant
- Mr Jim Duffy, Clinical Governance Facilitator, NHS Tayside
- The Very Rev Graham Forbes CBE, NHS QIS Board member
- Ms Annette Harvie, Stroke Awareness Trainer, NHS Lanarkshire
- Dr Marilyn Kendall, Research Fellow, General Practice, University of Edinburgh
- Rev David Mitchell, Chaplain, Marie Curie Centre, Glasgow
- Mr Andrew Moore, Assistant Senior Nurse Manager, NHS Ayrshire and Arran
- Dr Harriet Mowat, Managing Director, Mowat Research
- Rev Lorna Mowat, Mental Health Chaplain, NHS Lothian
- Dr Scott Murray, Clinical Reader, General Practice, University of Edinburgh
- Mr Alastair Pringle, Patient Focus Manager, SEHD
- Ms Hina Sheikh, Black and Ethnic Minority Co-ordinator, NHS Lanarkshire
- Sister Isabel Smyth, Honorary Lecturer, Faculty of Divinity, Faculty of Education of Glasgow University
1 Introduction to NHS QIS

NHS QIS was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. The responsibilities of NHS QIS cover all aspects of the services provided by the NHS, and include providing an independent check on how these services are performing. NHS QIS also supports NHS staff by issuing clear, authoritative advice on effective clinical practice and service improvements.

NHS QIS aims to support the delivery of:

- higher standards of care
- improved outcomes for patients
- better experiences for patients and carers, and
- better value for money.

These objectives are achieved through four key functions that link together:

- providing guidance on effective practice
- setting standards
- reviewing and monitoring performance, and
- supporting staff to improve services.

There are a variety of products provided by NHS QIS to equip NHSScotland to improve the quality of care and treatment delivered at a national level.

This document is the summary of a scoping exercise conducted to determine how the provision of spiritual care could be improved in NHSScotland. The purpose of the exercise was to make recommendations to the NHS QIS Board on how NHS QIS can best support NHS services in improving the quality and consistency of spiritual care services.
2 Background

Acknowledging the accelerating changes in the spiritual and religious landscape of Scotland, the Scottish Churches Committee on Healthcare Chaplaincy and the chaplains’ associations highlighted to SEHD the need for a training officer to guide the educational requirements of chaplains and NHS staff in spiritual care. The Department responded by convening a multifaith steering group. This group determined the lack of current guidance on the provision of spiritual care and proposed the appointment of a person or creation of a unit to promote and enable both the education and the integration of spiritual care as part of health service provision by each NHS Board. The Healthcare Chaplaincy Training and Development Unit was established in 2001, in response to this consultation. In 2002, SEHD issued HDL(2002) 76 Spiritual Care in NHSScotland. This asked each Board to write and implement a policy which took into account both the requirements of the local community and national initiatives and policy drivers, such as Partnership for Care and Fair for All. As further response to this circular, a Scoping Study Group was established by NHS QIS to identify the key issues within the provision of spiritual care in NHSScotland, and recommend where NHS QIS could best support quality improvement within this service.

In this HDL, the following definitions are given:

- Religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community.
- Spiritual care is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation.
- Spiritual care is not necessarily religious. Religious care, at its best, should always be spiritual.

The term ‘spiritual care giver’ is used throughout the HDL to describe a person who provides spiritual care in the healthcare setting. ‘Specialist’ spiritual care givers comprise 500 or so chaplains, of whom around 50 are employed on a whole-time basis and 450 are part time. They come from a variety of Christian traditions, apart from two part-time Moslem chaplains. A greater variety of faith traditions and life stance groups is found among ‘honorary’ chaplains and volunteers who answer specific religious needs and give support in many ways to the spiritual care departments of the Boards. NHS QIS and the Scoping Study Group have used the terms and definitions outlined here throughout this report. In addition to the definitions above, the Group clarified that spiritual care may be given in a person-to-family or person-to-couple relationship, and that the environment around a person can contribute to his or her spiritual wellbeing. For example, a pleasant view, spending time with a pet, experiencing good weather or one’s immediate surroundings within a building can also have a positive impact on spiritual wellbeing.

The issue of terminology is a key part of the debate around the provision of spiritual care in NHSScotland. An attempt to capture and introduce terms which are acceptable to all and used as standard must be considered when producing any further guidance.

The HDL requested that each NHS Board, including Special Health Boards, develop and implement a spiritual care policy, which should comply with guidance contained
in the HDL. At the time of writing, all 15 area NHS Boards and most Special Health Boards had written policies in place and were at varying stages of implementation. Greater progress had been made in those areas where chaplains are employed on a whole-time basis as these members of staff are more embedded within their local infrastructure and therefore are more integrated and better organised. Local progress in adopting the guidelines in the HDL was supported by the Healthcare Chaplaincy Training and Development Unit.

In the healthcare context, it is increasingly recognised that caring for the spiritual requirements of patients is beneficial to their overall wellbeing and is perceived to have a positive influence on healthcare outcomes. Chaplains have been a feature of the NHS since its creation in 1948. Awareness of the multicultural nature of Scottish society (2001 census figures are included at Appendix 2) and greater recognition of the spiritual needs of those who do not subscribe to any particular religion make it timely that a new approach to the provision of spiritual care is being considered. International research has identified the benefit to patients of access to a spiritual caregiver, to quiet space, or additional support when faced with distressing or traumatic situations. This is also true for relatives and staff. There is also benefit to all three groups in situations where a relationship has been built over time, or in times of sudden loss.

There is considerable evidence to suggest that all members of healthcare staff can have an impact on the spiritual wellbeing of others. Therefore, all staff have a responsibility for spiritual care, in addition to the specialist spiritual care giver. Support for staff in their own work environment and as they seek to consider the spiritual wellbeing of the patient has also been considered in this report.

2.1 Current guidance

Guidance endorsed, suggested or recommended by the Healthcare Chaplaincy Training and Development Unit has been sourced from the UK, Europe and North America, and includes the following key documents:

- College of Healthcare Chaplains, Hospital Chaplaincies Council and Others — Healthcare Chaplaincy Standards, 1992 and 2002
- Healthcare Chaplaincy Board of Ireland – Standards for Certification of Health Care Chaplains, 1993 (revised and approved 1999)
- Multifaith Group for Healthcare Chaplaincy – Healthcare Chaplaincy Occupational Standards (Similar to above), 1993 (revised and republished 2002)
- Scottish Association of Chaplains in Health Care – Code of Conduct, 1997-8
- College of Health Care Chaplains – Code of Professional Practice for Health Care Chaplains and Spiritual Care Givers, 2003
- South Yorkshire Workforce Confederation — Caring for the Spirit, 2003
- The Canadian Association for Pastoral Practice and Education – Standards of Practice, 2004.
The importance of spiritual care in relation to palliative care has been recognised in the following guidance, including standards developed by NHS QIS (previously known as the Clinical Standards Board for Scotland, or CSBS):

- Clinical Standards for Specialist Palliative Care, CSBS, 2002
- Spiritual and Religious Care Competencies for Specialist Palliative Care, Marie Curie, 2003
- Standards for Hospice and Palliative Care Chaplaincy, The Association of Hospice & Palliative Care Chaplains, 2003

Each NHS Board in Scotland agreed to work towards the NHS QIS standards and was reviewed against them in 2002. Adherence to other guidance listed in this section is not compulsory, but they are widely respected and used as an informal benchmark in hospices in Scotland.

In producing this document, consideration was given to the range of current documentation produced by NHS QIS which contains guidance on the role and remit of the spiritual care giver as a provider of care and as a contributor to both staff and healthcare governance:

- Draft National Standards – Clinical Governance and Risk Management, NHS QIS, 2005 (with particular reference to 3e Information Governance, specifically 3e1, 3e2 and 3e3.)
- Clinical Standards for Specialist Palliative Care, CSBS, 2002
- Best Practice Statement – The Management of Pain in Patients with Cancer, NHS QIS, April 2004
- Best Practice Statement – The Management of Chronic Pain in Adults, NHS QIS, publication date to be confirmed.

2.2 Current legislation

Current legislation relevant to the provision of spiritual care includes:

- Disability Discrimination Act (DDA) (enacted in 1995), the DDA amendments (1996, 1999) and Disability Bill (currently going through parliament) require NHS service providers to consider it unlawful to treat disabled people less favourably for reasons related to their disability
- Race Relations Act 1976 and the Race Relations (Amendment) Act 2000 which enshrine a duty not only to eliminate unlawful racial discrimination but to promote equal opportunity and good race relations
- Partnership for Care (SEHD, 2003)
- Fair For All (SEHD, 2003)
- National Health Service Reform (Scotland) Act 2004 places a duty on NHS Boards to involve the public in the planning of health services and promote equal opportunities.
Partnership for Care commits NHSScotland to extending the principles set out in Fair for All across the NHS to ensure that ‘our health services recognise and respond sensitively to the individual needs, background and circumstances of people’s lives’. The National Health Service Reform (Scotland) Act 2004 enforced these specific duties to promote public involvement and equal opportunities – these duties came into effect on 30 September 2004.

The Race Relations (Amendment) Act 2000 requires NHSScotland to make arrangements for ‘assessing and consulting on the likely impact of … proposed policies on the promotion of race equality’, having first screened all policies for relevance to the Act. A similar requirement is being considered for an amendment to the DDA and is likely to form part of any future single equality act. To comply with Partnership for Care and the National Health Service Reform (Scotland) Act 2004, NHSScotland must ensure that all policy and service developments within SEHD and NHSScotland can be shown not to disadvantage the people it serves, the following groups in particular:

- black and ethnic minority communities (including gypsy/travellers, refugees and asylum seekers)
- women and men
- religious/faith groups
- disabled people
- older people, children and young people
- lesbian, gay, bisexual and transgender communities.

Other relevant legislation includes:

- Equal Pay Act 1970
- Sex Discrimination Act 1995
- Human Rights Act 1998
- The Scotland Act 1998
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Religion or Belief) Regulations 2003.

An Age Discrimination Directive was under development at the time of writing, with a proposed timescale for publication in 2006.

2.3 Ongoing initiatives in Scotland

A great deal of work has been progressed in areas relevant to spiritual care, against a background of these guidelines and legislation. The Patient Focus and Public Involvement (PFPI) (SEHD, 2001) policy document outlines the need for the NHS to become a patient-focused service. Since its implementation, the NHS has moved to ensuring consideration is given to all needs. The NHS Reform (Scotland) Act 2004 places a duty on NHS Boards to inform, engage and consult with the public at all levels of decision making. Fair for All (SEHD, 2003) identified the need for the NHS to become a culturally competent service by meeting the needs of ethnic minority
communities. This approach is now extended in terms of equality and diversity to take account of people’s faith or religion, gender, age, sexual orientation, disability and race.

There is also a growing research base around meeting people’s spiritual care needs, including work being undertaken currently in Scotland by Harriet Mowat (commissioned by SEHD), Bob Devenny (commissioned by NHS Lanarkshire), Alastair Bull (based at Yorkhill Operating Division, NHS Greater Glasgow) and Ewan Kelly (based at NHS Lothian) among others.

From 2001-2003, The Foundation for People with Learning Disabilities funded two projects which explored the spiritual and religious needs of people with learning disabilities. (Led by Professors John Swinton and Chris Hatton; more information may be found at www.learningdisabilities.org).

Within the current context of guidelines, legislation and research, report options and recommendations were presented to the NHS QIS Board on 31 March 2005. The report was distributed in draft format to attendees at the seminar held on 5 May 2005. This revised and updated version is available to the public on the NHS QIS website (www.nhshealthquality.org) and in a range of media, as required.

Further information

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Copies of all NHS QIS publications and further information on the organisation can also be downloaded from the NHS QIS website.
3 Methodology

In September 2003, a working group was founded to determine options for the development of a system to ensure equity in the provision of spiritual care in the healthcare setting in Scotland.

The Spiritual Care Scoping Study Group was established with the following aims and objectives:

- to scope the current provision of spiritual care in NHSScotland
- to provide expert advice and support to the NHS QIS Project Team
- to categorise the types of evidence that are available
- to develop a set of criteria that could be used to robustly review the evidence, and
- to inform the drafting of the final report, including options and recommendations.

The following organisations/bodies were represented on the Scoping Study Group:

- The Involving People team, SEHD
- The Healthcare Chaplaincy Training and Development Unit
- whole-time chaplaincy (acute and primary care)
- part-time chaplaincy
- academic faculties
- senior clinical NHS Management
- life stance groups.

Representation was sought from a non-Christian NHS spiritual care unit manager who was well versed in multifaith issues within NHSScotland, however participation was declined due to other commitments.

The aim of this Scoping Study Group was to identify if and where practice and quality of care could be improved.

The Group’s remit was to provide expert advice, information and guidance, and recommend possible NHS QIS products to support NHSScotland in improving the provision of spiritual care. Where appropriate, the Group endeavoured to work in partnership with related organisations, such as the Healthcare Chaplaincy Training and Development Unit and the SEHD Involving People Team, and to include other relevant NHS QIS programmes.

Support for the Group was provided by NHS QIS. Part of the remit of the Involving People Team on this Group was to reflect the views of the general public and service users. The Group highlighted the importance of putting patient needs and preferences first in all future NHS QIS work around the provision of spiritual care.

Five meetings of the Group were convened over the period September 2003 to December 2004 to identify where NHS QIS involvement could best add value to the quality improvement agenda within NHSScotland in relation to spiritual care services.
and practices. As part of the work of the Group, NHS QIS distributed a questionnaire to two NHS Board areas for completion (see Appendix 3). Current published research and other articles on the provision of spiritual care was considered by a sub-group of the Scoping Study Group in November 2004 (see Appendix 1).

A wide range of research was uncovered by a broad literature search, with the Sub-group giving most consideration to more recent UK-based articles due to constraints of time and resources. As the Group was charged with looking at the mechanisms for the provision of spiritual care to the broad population served by NHSScotland, it was agreed that discussion of specific types of provision for certain groups (ie condition, belief, community or age-specific research) would be fully considered during the development process of any NHS QIS product selected for future work in this area. It was accepted by the Group that much valuable research is taking place on an international basis with regard to the provision of spiritual care in all its forms.

The following areas were considered by the Group:

- the current provision of spiritual care in NHSScotland by number and denomination of chaplains, availability of spiritual care policy and development, and availability of spiritual care manuals for staff
- implementation of spiritual care policies
- the development and distribution of a questionnaire within sample NHS Boards in Scotland, to gauge current knowledge of the remit of the NHS Board spiritual care department
- published literature on the current provision of spiritual care on an international basis to identify where lessons may be learned, and
- current legislation, policy and advice from SEHD.

The Group also considered how to raise the profile of the spiritual care services across Scotland, and worked on developing the content of a seminar to present the work of the Group and to promote discussion on the issues raised by this report and other work ongoing in Scotland and further afield.
4 Findings

4.1 Current provision of spiritual care

The Group found that the provision and delivery of spiritual care varies among NHS Boards. This is due to the different religious and spiritual needs of the population, the varied practices and priorities of the recent past, and the varied progress towards the implementation of each Board’s spiritual care policy over the last 2 years.

Spiritual care policies have been written and are in place in all area NHS Boards. By December 2004, these were in varying stages of implementation. Special NHS Boards, which do not usually have employees in patient-facing or clinical situations, have been developing and implementing their spiritual care policies at varying rates during 2004, and this work is ongoing.

4.2 Methods of implementation of spiritual care policies

Spiritual care policies are being implemented by working groups, the newly formed spiritual care committees, and departments of spiritual and religious care. Boards are at different stages of preparation and implementation of action plans.

4.3 Current awareness of the remit and function of spiritual care departments

Two NHS Boards agreed to distribute a questionnaire (Appendix 3), designed by the Scoping Study Group, to gauge awareness of the role and remit of spiritual care departments among frontline, public-facing staff members in the hospital setting. A total of 750 questionnaires was distributed following an initial pilot in one of the two participating NHS Boards, and 248 completed copies returned.

The questionnaire was completed anonymously, with the option of declaring length of service and type of post. The occupations of respondents included domestic staff, porters, nursing staff, administrative staff and doctors of a range of grades. Length of service of respondents ranged from 2 months to greater than 30 years. Respondents were given an opportunity to express any further thoughts about spiritual care in their workplace in a free text box, and some comments have been included in this section.

The majority of staff responded that access to spiritual care in the hospital setting is important, although one respondent expressed the view that the health service, as a state institution, should be entirely secular. The majority of respondents were aware of how to contact a chaplain. From the 64 respondents that did not know how to contact a chaplain, 27 of these were not aware of who they should speak to in order to contact somebody from the spiritual care department on behalf of the patient, relative or colleague.

The circumstances in which a chaplain is contacted elicited very individual responses. Reasons of emotional support and fear of death were identified by respondents as the most common situations requiring support from a chaplain, or ‘someone to talk to’. A conflict between ethical and personal decision making was
highlighted, as well as a need for greater guidance for healthcare professionals in these matters. One respondent identified current practice as approaching the chaplaincy unit at the patient’s request only 'if the family has any religious/spiritual issues'. A lack of patient awareness of the chaplaincy role was identified by one respondent: '[The] Chaplain visits all patients regularly but many of them don’t understand why he is speaking to them'. ‘Religious uniforms’ were thought to be a barrier to understanding wider spiritual care duties of the chaplaincy team. One respondent also reported that: ‘Staff think [spiritual care] is appropriate for death and serious illness only, when it would be useful for a multitude of issues’.

The majority (70.9%) of respondents regarded spiritual care as everyone’s responsibility. This highlights the need for greater training and awareness around spiritual care as the expectation was that everyone is capable of delivering spiritual care but in different ways – the chaplain has a distinct role, while other workers have less clearly-defined responsibilities. A long-serving member of the domestic staff commented that: ‘patients will open up to domestics and ask us to do things for them rather than “waste a nurse’s time”. I am surprised that I have not heard of spiritual care or seen it advertised in the hospitals.’ This comment shows the awareness of the impact non-clinical care can have on a patient or relatives.

Sixty-four per cent of respondents reported that they were aware of the provision of spiritual care within their place of work, and the majority of these respondents had heard of facilities including a quiet room and confidential listening, the availability of leaflets for patients and staff, and the religions and cultures or spiritual care manual. When asked if staff had the opportunity to comment on draft spiritual care information, only 6.1% reported that they had been specifically involved. Respondents to this question were mainly nurse managers and members of clinical effectiveness teams, which perhaps indicates a (perceived) lack of time for frontline staff to contribute to policy development. However, one respondent indicated that their local spiritual care department ‘make every effort, both personally and via IT, to make themselves and their roles known’. Use of internal information technology (IT) systems to inform and consult staff is perhaps a means of communication that other units should consider.

One respondent who worked within a small long-stay facility for those with learning disabilities provided responses to the questionnaire by telephone. Due to the links with local social care providers and volunteers within the community, it was thought that better access to different religious services and providers of spiritual care was available in this setting. This was perhaps due not only to a better awareness through partnership working of services on offer, but also to the support of family members and volunteers who are able to offer more practical support enabling patient attendance at different religious services or to sit and discuss concerns and fears with the individual when needed.

In addition to the survey conducted by the Scoping Study Group, a staff questionnaire carried out independently in another NHS Board area was shared with the Group. Although this questionnaire asked slightly different questions, responses to the staff survey were similar to those of the Scoping Study Group questionnaire. In the staff survey, a smaller group was surveyed. Eighty-five per cent of
respondents recognised the importance of catering for the spiritual needs of patients, carers and staff, and 58% recognised the value of all staff contributing to the provision of spiritual care. Fifty-five per cent were aware of the spiritual care service offered to staff, a question which the Scoping Study Group questionnaire did not cover. When staff were asked how they thought spiritual care services can enhance professional and personal practice, the following responses were received:

‘It makes care more person centred and holistic’

‘A wider knowledge of different spiritual/cultural needs would help’

‘By providing another essential element to enable robust and empathic decision making which would apply to personal and professional life’

‘It can provide comfort to patients in a confidential way’.

4.4 Published literature on the provision of spiritual care

A sub-group of the Scoping Study Group met to categorise, review and discuss a selection of articles and reports on the provision of spiritual care and its outcomes for staff and patients. Literature was sourced from Scotland, the wider UK, Europe and North America, with publication dates within the last 12 years. A full list of the publications that were considered can be found in Appendix 4. Membership of the Sub-group is in Appendix 1.

The Sub-group commented that much of the research used the terms ‘chaplain’ and ‘chaplaincy’ more frequently than ‘spiritual care giver’ or ‘spiritual care department’, which was found to be unhelpful in the Scottish context, and a further indication that more communication and consideration of terminology is required.

Key publications which were considered by the Sub-group to be relevant to the development of any NHS QIS product dealing with the provision of spiritual care focused on the following aspects:

- surveys regarding the patient experience of spiritual care provision
- guidance on delivery of spiritual care issued for the NHS in England and Wales
- benefits of a comprehensive spiritual care service to people with specific conditions (a limited range of these particular needs was explored including dementia, other mental illness and patients in the palliative care setting)
- development of assessment tools or standards for the delivery of spiritual care
- implications of spiritual care or religious support services on clinical practice
- the nursing role comprising spiritual care.

These publications identified gaps in service delivery and patient need, and highlighted some elements of good practice already happening in isolated areas of the healthcare system. Most authors found some difficulty in identifying the precise needs of a diverse population from a provider of spiritual care, particularly those with no religious affiliation. Hunt et al. (2003) explain that ‘… active religious or spiritual beliefs … may be significant to an individual’s ability to cope with their illness, symptoms and dying’ and that ‘this may also be true for the patient’s family or close
relatives’. In terms of the needs of patients, relatives and staff from a spiritual care department, the following list was identified by Johnson (2001):

- as a focus of reconciliation
- as one who brings a resource to a care plan
- as ‘one who can be there’ and be vulnerable
- as one who functions as a facilitator or a consultant
- as a ‘spiritual’ support for all staff
- as a reminder to the institution of the importance of spirituality.

Key barriers to achieving these goals and to effective care fall under three loose headings:

- a lack of audit
- a lack of effective documentation for use in delivering spiritual care and spiritual care training
- a lack of awareness and/or education on spiritual care matters and functions.

There is a lack of audit around the delivery of spiritual care, as outlined by Hunt et al. (2003): ‘issues concerning equity, access, the needs of users and the standard of practice may go unnoticed’. A consequence of poor audit delivery and a reason for this, is that spiritual care departments are ‘poorly-integrated’ and ‘under-resourced’.

Nolan and Crawford (1997) state that ‘academic papers need to address issues which cannot be couched in scientific or management language’ but Brocollo and VandeCreek (2004) recognise that ‘chaplains, their colleagues and administrators often cannot articulate a research-grounded understanding of what [a chaplaincy service] contributes’.

Walter (2002) suggests that a practical and achievable source of local research can be achieved through a ‘semi-structured telephone questionnaire’. This provides both qualitative evidence in narratives of experience and quantitative evidence from percentage-based analysis of stock responses; this is similar to the approach used in the questionnaire carried out by the Scoping Study Group.

A similar approach was taken by Peter Speck (2001), who has been involved in much research in this area. He found that ‘many had spiritual belief even though they had felt let down by the institutional church’. His findings showed that those with moderate strength of spiritual belief have a higher incidence of depression in the second year of bereavement, pointing to a need for ongoing support for the bereaved by those who understand the healthcare context.

This conflict between science and the unquantifiable is difficult to resolve for non-chaplaincy staff trying to deliver holistic care. Oldnall (1996) asks where spiritual care belongs in nursing theory, and goes on to explain that ‘nurse education does not adequately prepare nurses to deliver spiritual care … seen as the realm of hospital chaplains/religious agents’.

Further barriers identified include a lack of suitable facilities for worship, fire regulations which prevent the use of candles and incense required for some rituals,
and an embarrassment factor which prevents non-trained staff from enquiring about spiritual wellbeing or religious needs. The latter barrier is supported by Hunt et al. (2003), who state that ‘many multidisciplinary team members find spiritual care a difficult area to broach with patients’ and suggest that standardised documentation is important. This presents its own complications, and clarity would be required around:

- confidentiality versus the need to share
- accessibility of sensitive information
- practicality of collating and sharing this information.

Ways of resolving this and other areas of good practice found within the publications listed in Appendix 4 include:

- clear definitions of the role of the chaplain which are available to all through written and verbal information/education (National Association of Health Authorities and Trusts, 1996)
- clear introductions when a chaplain is presented to a patient, relative or new colleague including name, brief summary of remit and denomination, where appropriate (Walter, 2002)
- use of spiritual care plan charts in each patient record
- recognition of the chaplain as a member of the multidisciplinary care team, as with current practice in palliative care (Hunt et al., 2003)
- more research in line with that by Mueller, Plevak, and Rummans (2001), which contains figures and correlations between religious involvement and physical health. It gives statistical evidence for mortality, cardiovascular disease and hypertension. It also presents results of longitudinal studies on religious involvement and mental health issues, particularly depression, anxiety, substance abuse and suicide. The article also suggests formats for ‘taking a spiritual care history’ during clinical encounters.

Any of these initiatives could be introduced to spiritual care departments and would work towards ensuring a consistent national approach to how we tackle the spiritual care requirements of patients, relatives and staff within NHSScotland.
5 Considerations

It was anticipated that involving NHS QIS as well as other NHS organisations in initiatives around the provision of spiritual care within NHSScotland could lead to a number of outcomes including:

- a seminar to launch this report and to raise awareness within the service of the issues around the provision of spiritual care in NHSScotland
- issuing guidance for all staff on the role of non-clinical interventions in patient care
- issuing guidance for all staff on religious and spiritual needs of the Scottish population
- development of a standardised education programme for different types of staff on what patients may require in terms of religious and spiritual care during a hospital stay, and how non-clinical and clinical staff can contribute
- recommendations to other organisations such as equality/diversity bodies to carry out more work around spiritual care; for example, monitoring the use and availability of religions and cultures manuals or delivering educational or awareness-raising events
- consideration of the terminology used within NHSScotland around the provision of spiritual care and the introduction of nationally-accepted terms for those providing spiritual care in the healthcare setting in its range of capacities and forms
- consideration within condition-specific work of the different spiritual needs of specific populations and how to meet these
- information on the availability of support for staff members and how to access this
- advice for managers on how to implement spiritual care policies in all departments and areas, including hospital environments, long-stay facilities and the community, and
- advice for managers on how to audit the delivery of initiatives outlined here.

These outcomes are not dependent on the exact type of NHS QIS product selected, and could be prompted from work carried out as part of local or national initiatives led by other organisations. Most NHS QIS products require clinical research and peer-reviewed evidence of effectiveness prior to development. The Scoping Study Group identified that only limited research on the clinical outcomes of access to spiritual care has been produced and most of this work has been carried out overseas, which limits the products available for recommendation.
6 Recommendations

The Scoping Study Group recommended that NHS QIS should consider exploring in more detail the following options for further work in NHSScotland to support providers of spiritual care:

- **Seminar**

The Group recommended that NHS QIS hold a seminar to inform the service on the findings of this report and other ongoing work around spiritual care in the healthcare setting in Scotland. The aim of this seminar would be to raise both the awareness of spiritual care in NHSScotland and the profile of the spiritual care departments in NHS Boards. It would point the way forward towards a higher standard of care and more professionally delivered, researched and regulated spiritual care services. A summary of the discussions held at the seminar can be found at Appendix 5.

The value of holding similar events was recognised by the Scoping Study Group following the seminar on 5 May. It was suggested by the Group that future events of this nature should take place on a regular, annual basis to allow the sharing of good practice and current initiatives with contribution and attendance from NHSScotland staff and partner agencies with medical, spiritual, religious, managerial and non-frontline backgrounds.

- **Audit**

On completion of the literature review, the Group suggested that audit should be widely encouraged in NHSScotland settings where spiritual care is provided. This process could be supported in a range of ways, for example by organisations working in partnership across NHSScotland or be locally-driven. Therefore audit would not necessarily be the sole responsibility of NHS QIS. Key priority areas identified by the Group include:

  - access
  - equity
  - meeting the needs of users
  - standardisation of delivery of the service.

- **Guidance note**

An individual report providing guidance on best and achievable practice on specific topics which are identified as priorities. Priorities in spiritual care include:

  - identifying terminology acceptable to spiritual care departments and the wider NHS.
  - developing a standardised referral and record-keeping process which respects both data protection legislation and the need for healthcare professionals, including spiritual care givers, to share information which may assist in better patient outcomes
  - training of different staff groups on the potential impact of the delivery of spiritual care to patients and their relatives, and the role they may play in this.
A broader evidence base is used to inform guidance notes than has been used in this report. Neither the advice given in guidance notes nor compliance is compulsory. On publication, guidance notes are disseminated widely within NHSScotland.

- National standards

Standards must be clear, measurable and achievable, and apply equally to every NHS Board area in Scotland. This may prove difficult in relation to the provision of spiritual care, which is currently arranged differently in each NHS Board and is still a developing concept with varying levels of awareness and adherence. It may be preferable that this option is revisited once local spiritual care policies and other ongoing initiatives have had an opportunity to assimilate into working practice, but the development and launch of standards could help to raise awareness of the provision of spiritual care for staff, patients and carers.

The Group preferred standard setting as an option and suggested the following areas for inclusion:

- training/education
- policy/Board/SEHD requirements, eg Fair For All/equality and diversity approach
- structural integration of a department and spiritual care committee
- resources, eg designated staff, quiet spaces, administrative support
- audit
- access and referral protocols
- record-keeping.

The Group suggested that any guidance note or standards should be scheduled for development after current initiatives concerning spiritual care departments are embedded in the service. This would avoid any potential mixed messages being issued by different organisations, and prevent duplication of effort in the service.

- Further recommendations

Following the seminar, where opinions on the requirement for further guidance on spiritual care were invited and considered, the Group met for a final time to consider work which could be taken forward by organisations other than NHS QIS.

It was agreed that the development of national standards was still the Group’s preferred option of those products available. To support any future development of standards by NHS QIS, the Group suggested that initial work should be carried out to develop supporting guidance and competencies. This would not only facilitate the potential development and then measuring of future standards, but would also greatly benefit NHSScotland in developing an integrated approach to the delivery of spiritual care.

It was agreed that this work should be continued by a new group convened by the Healthcare Chaplaincy Training and Development Unit, now part of NHS Education.
for Scotland. The new group would have similar membership to the Scoping Study Group, and would keep NHS QIS informed of its progress. The Group further defined these initiatives as follows:

- The development of competencies for specialist providers of spiritual care and auxiliary providers of spiritual care.

- Implementation guidance to be used in conjunction with the above competencies, as guidance would help NHSScotland staff (and potentially spiritual care giver volunteers) meets competencies and prepare for any future implementation of national standards.
7 References

The following references are listed in the order in which they appear throughout the text in this report.

Scottish Executive Health Department HDL(2002)76, Spiritual Care in NHSScotland

Race Relations (Amendment) Act 2000  

Partnership for Care, Scottish Executive, 2003  
http://www.scotland.gov.uk/library5/health/hwps-00.asp

Fair for All, Scottish Executive, 2002  
www.scotland.gov.uk/library3/society/ffar-00.asp

National Health Service Reform (Scotland) Act 2004  

http://www.learningdisabilities.org.uk/html/content/why_are_we_here_accessible.pdf


NAHAT. (1996) Spiritual Care in the NHS, A guide for purchasers and providers.

## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>audit</td>
<td>Systematic review of the procedures used for care, examining how associated resources are used and investigating the effect care given has on the outcome and quality of life for the patient.</td>
</tr>
<tr>
<td>chaplain</td>
<td>A person appointed to provide spiritual and religious care to all patients, visitors, staff and volunteers in the healthcare setting, regardless of faith or no faith. A chaplain can be ordained or lay with an acknowledged status within a mainstream faith community.</td>
</tr>
<tr>
<td>denomination</td>
<td>A name, designation, or title; in particular, a general name indicating a class of like individuals, for example, members of a particular branch of the Christian faith.</td>
</tr>
<tr>
<td>Health Department Letter (HDL)</td>
<td>Formal communications from the Scottish Executive Health Department to NHSScotland (formerly known as Management Executive Letter - MEL).</td>
</tr>
<tr>
<td>Life Stance Group</td>
<td>Any group with a shared set of values and attitudes towards humanity but who do not see themselves as a faith community.</td>
</tr>
<tr>
<td>multidisciplinary team</td>
<td>A group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These factors include: the specific condition; the scale of the service being provided; and geographical/socio-economic factors in the local area.</td>
</tr>
<tr>
<td>palliative care</td>
<td>The active total care of patients and their families by a multidisciplinary team when the patient’s disease is no longer responsive to curative treatment.</td>
</tr>
<tr>
<td>religious care</td>
<td>Care given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community.</td>
</tr>
<tr>
<td>Scottish Executive Health Department (SEHD)</td>
<td>The Scottish Executive Health Department is responsible for health policy and the administration of NHSScotland. Website: <a href="http://www.show.scot.nhs.uk/sehd">www.show.scot.nhs.uk/sehd</a></td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Special Health Boards</td>
<td>The name given to Health Boards with a national remit. These Boards focus on specific areas, eg NHS Education for Scotland, or NHS Quality Improvement Scotland. Special Health Boards match regional NHS Boards in terms of administrative grading.</td>
</tr>
<tr>
<td>spiritual care</td>
<td>Care or support given in a one-to-one relationship, which is completely person-centred and makes no assumptions about personal conviction or life orientation.</td>
</tr>
<tr>
<td>spiritual care giver</td>
<td>Someone who works for NHSScotland whose role includes delivering spiritual care.</td>
</tr>
</tbody>
</table>
Appendix 1  Membership of Scoping Study Group and Sub-group

Chair

Rev Chris Levison  Healthcare Chaplaincy Training and Development Officer and Spiritual Care Co-ordinator

Group members

Rev Joanne Finlay  Part-time Chaplain, NHS Forth Valley
Mr John Kelsall  Humanist Society
Rev Cameron Langlands  Co-ordinating Chaplain, NHS Greater Glasgow
Ms Mairi McMenamin  Involving People Team, Scottish Executive Health Department
Rev Gillian Munro  Head of Department of Spiritual Care, NHS Tayside
Fr Kenneth Owens  Part-time Chaplain, NHS Forth Valley
Ms Tracey Sharp  Policy Development Officer, Training and Development Unit
Professor John Swinton  Professor in Practical Theology and Pastoral Care, University of Aberdeen
Ms Angela Wallace  Nurse Director, NHS Forth Valley

Sub-group members

Rev Cameron Langlands
Rev Chris Levison
Ms Mairi McMenamin
Rev Gillian Munro
Professor John Swinton

NHS QIS support:

Ms Katy Bullock  Project Officer
Mr Archie Dalrymple  Project Administrator
Ms Hilary Davison  Team Manager
Ms Clare Echlin  Senior Project Officer
Ms Jacqueline Ellis  Project Administrator
Miss Karen Macpherson  Health Information Scientist
Appendix 2  2001 census figures

Population of Scotland – Census 2001

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>% Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Scottish</td>
<td>88.09</td>
</tr>
<tr>
<td>Other White British</td>
<td>7.38</td>
</tr>
<tr>
<td>Other White</td>
<td>1.54</td>
</tr>
<tr>
<td>White Irish</td>
<td>0.98</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.63</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.32</td>
</tr>
<tr>
<td>Indian</td>
<td>0.30</td>
</tr>
<tr>
<td>Any Mixed Background</td>
<td>0.25</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>0.19</td>
</tr>
<tr>
<td>Other South Asian</td>
<td>0.12</td>
</tr>
<tr>
<td>African</td>
<td>0.10</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0.04</td>
</tr>
<tr>
<td>Caribbean</td>
<td>0.04</td>
</tr>
<tr>
<td>Black Scottish or other Black</td>
<td>0.02</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th>% Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church of Scotland</td>
<td>42.40</td>
</tr>
<tr>
<td>None</td>
<td>27.55</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>15.88</td>
</tr>
<tr>
<td>Other Christian</td>
<td>6.81</td>
</tr>
<tr>
<td>Not answered</td>
<td>5.49</td>
</tr>
<tr>
<td>Muslim</td>
<td>0.84</td>
</tr>
<tr>
<td>Another religion</td>
<td>0.53</td>
</tr>
<tr>
<td>Buddhist</td>
<td>0.13</td>
</tr>
<tr>
<td>Jewish</td>
<td>0.13</td>
</tr>
<tr>
<td>Sikh</td>
<td>0.13</td>
</tr>
<tr>
<td>Hindu</td>
<td>0.11</td>
</tr>
</tbody>
</table>
### Appendix 3  Questionnaire and results

#### PROVISION OF SPIRITUAL CARE QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Post:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of service in current role:</td>
</tr>
</tbody>
</table>

1. Are you aware of the spiritual care provision within your place of work?  
   - Yes  
   - No

2. Do you know the remit of the spiritual care (or chaplaincy) department?  
   - Yes  
   - No

3. Are you aware of the availability of the following:
   - Quiet room/sanctuary or chapel  
     - Yes  
     - No
   - Confidential listening  
     - Yes  
     - No
   - Leaflets for *patients* regarding culture and religions  
     - Yes  
     - No
   - Leaflets for *staff* regarding culture and religions  
     - Yes  
     - No
   - Religions and cultures/spiritual care manual  
     - Yes  
     - No

4. Have you been asked to comment on draft spiritual care information?  
   - Yes  
   - No

5. Do you think it is important for patients, relatives, carers and health care staff to have access to spiritual care?  
   - Yes  
   - No

6. Who do you think has responsibility for providing spiritual care?  
   - Chaplain  
   - Everyone

7. In which of the following circumstances might you contact a chaplain?
   - Fear of death  
     - Yes  
     - No
   - Depression  
     - Yes  
     - No
   - Emotional support  
     - Yes  
     - No
   - Family matters  
     - Yes  
     - No

8. Would you know how to contact a chaplain?  
   - Yes  
   - No

9. Would you know who to ask in order to contact a chaplain?  
   - Yes  
   - No

Would you aware of the difference between spiritual and religious care?  
   - Yes  
   - No

Would you feel confident explaining the difference to a colleague or member of the public?  
   - Yes  
   - No

*Continued/*
PROVISION OF SPIRITUAL CARE QUESTIONNAIRE

If you have any thoughts that you wish to share regarding the provision of spiritual care in your workplace, please use the space below:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Many thanks for completing this questionnaire. Your time and effort are appreciated.

Please return your completed questionnaire by 30 September 2004, using the freepost address given below:

Archie Dalrymple
NHS Quality Improvement Scotland
FREEPOST NAT19799
GLASGOW
G1 2BR
The following results were obtained from the survey of frontline staff in two Health Board areas. A total of 248 questionnaires were returned out of 750 distributed. The respondents’ occupations included:

- Nurse
- Ward manager
- Sister
- Speech and language therapist
- Nurse visitors
- Porters
- Clinical effectiveness manager
- Consultants
- Senior House Officers

1. Length of service ranged from 2 months to 30+ years.

Where percentages are shown in the following breakdown of results, they refer to the total number of respondents who marked an answer. Not every respondent answered all questions given. The number of respondents is shown in brackets next to the percentage, which was out of a total of 248 questionnaires returned.

2. Are you aware of spiritual care provision within your place of work?

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>Yes</td>
<td>64% (159)</td>
</tr>
<tr>
<td>No</td>
<td>36% (89)</td>
</tr>
</tbody>
</table>

3. Do you know the remit of the spiritual care (or chaplaincy) department?

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>57% (139)</td>
</tr>
<tr>
<td>No</td>
<td>43% (106)</td>
</tr>
<tr>
<td>No response</td>
<td>(3)</td>
</tr>
</tbody>
</table>

4. Are you aware of the availability of:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quiet room/sanctuary/chapel</td>
<td>80% (196)</td>
<td>20% (50)</td>
</tr>
<tr>
<td>Confidential listening</td>
<td>57% (139)</td>
<td>43% (106)</td>
</tr>
<tr>
<td>Leaflets for patients on cultures/religions</td>
<td>62% (152)</td>
<td>38% (95)</td>
</tr>
<tr>
<td>Leaflets for staff on cultures/religions</td>
<td>46% (114)</td>
<td>54% (133)</td>
</tr>
<tr>
<td>Religions and cultures manual</td>
<td>40% (99)</td>
<td>60% (146)</td>
</tr>
</tbody>
</table>

Have you been asked to comment on draft spiritual care information?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6% (15)</td>
</tr>
<tr>
<td>No</td>
<td>94% (232)</td>
</tr>
<tr>
<td>No response</td>
<td>(1)</td>
</tr>
</tbody>
</table>
5. Do you think it is important for patients, relatives, carers and healthcare staff to have access to spiritual care?

Yes   98% (238)
No     2% (6)
No response (4)

6. Who do you think has responsibility for providing spiritual care?

Chaplain  29% (69)
Everyone  71% (168)
No response (11)

7. In which of the following circumstances might you contact a chaplain?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of death</td>
<td>90%</td>
<td>10%</td>
<td>(2)</td>
</tr>
<tr>
<td>Depression</td>
<td>53%</td>
<td>47%</td>
<td>(46)</td>
</tr>
<tr>
<td>Emotional support</td>
<td>81%</td>
<td>19%</td>
<td>(46)</td>
</tr>
<tr>
<td>Family matters</td>
<td>59%</td>
<td>41%</td>
<td>(21)</td>
</tr>
</tbody>
</table>

8. Would you know how to contact a chaplain?

Yes   74% (183)
No     26% (64)
No response (1)

If you responded ‘No’ to the above question, would you know who to ask in order to contact a chaplain?

Yes   70% (62)
No     30% (27)
No response (89)

9. Are you aware of the difference between spiritual and religious care?

Yes   68% (165)
No     32% (79)
No response (4)

If you responded ‘Yes’ to the above question, would you feel confident explaining the difference to a colleague or member of the public?

Yes   52% (95)
No     48% (89)
No response (64)
Appendix 4 Evidence base

A list considered by the Sub-group (see Appendix 1) for inclusion in Section 4.4 of this report.


Johnson, C P. (2001) ‘Assessment tools: are they an effective approach to implementing spiritual health care within the NHS?’ Accident and Emergency Nursing; vol. 9, pp177-186


Appendix 5     Seminar programme and summary of discussion

Provision of Spiritual Care Scoping Study Group Seminar

Date          Thursday 5 May 2005          Time          10.00am – 3.15pm
Venue         Airth Castle Hotel, Airth by Falkirk

A G E N D A

  9.30 am       Registration and coffee
  10.00 am      Introduction and welcome: The Very Rev Graham Forbes
  10.10 am      Policy context presentation: Alastair Pringle, SEHD
  10.30 am      Role and purpose of NHS QIS: Jan Warner
  10.50 am      Scoping Study Group report and current issues in chaplaincy/spiritual care in NHSScotland: Rev Chris Levison
  11.10 am      Spiritual Care Standards in Palliative Care: Rev David Mitchell
  11.30 – 11.50 am Questions to speakers
  12.00 pm      Workshop session 1 (choice of three)
  12.45 pm      Lunch
  1.30 pm       Workshop session 2 (choice of three)
  2.15 pm       Coffee and networking
  2.45 pm       Plenary session and open discussion: Rev Chris Levison
  3.15 pm       Closing remarks

For further information please contact:  Katy Bullock (0141 225 6898)
                                      Katy.Bullock@nhshealthquality.org

Workshop session 1:
  1. The ETHOS Project: evidence-based integration of spiritual care into a managed clinical network (Rev Bob Devenny)
  2. The role of the chaplain in meeting spiritual needs of patients (Dr Harriet Mowat)
  3. Spiritual needs in primary care (Dr Scott Murray / Dr Marilyn Kendall)

Workshop session 2:
  4. Spiritual needs of hospitalised children with complex healthcare needs (Rev Alister Bull/Rev Lorna Murray)
  5. Multifaith competence in delivering spiritual care (Sr Isabel Smyth)
  6. Auditing Spiritual Care – how can it be measured? (Rev Gillian Munro/Mr Jim Duffy)
Key content, themes and recommendations from the Seminar

Introduction

Following on from a recommendation made in the Report of the Scoping Study Group on the Provision of Spiritual Care, a seminar to discuss current issues facing NHSScotland in terms of spiritual care was held on 5 May 2005. A full agenda of the day may be found in this appendix.

A number of key themes emerged from the day, which have been summarised in this appendix. In addition to this, a summary of each workshop and group discussion has also been provided. Presentations from speakers on the day are available on request from NHS QIS.

Based on ideas generated by open discussion, sharing good practice and the research carried out by workshop presenters, three further recommendations have been identified by the Scoping Study Group and presented here for further consideration by NHSScotland and its partner organisations.

The Scoping Study Group and NHS QIS would like to take this opportunity to thank all those who participated in the seminar. Feedback has shown that the seminar was an informative and truly interactive day, allowing the sharing of ideas and suggestions of how best to contribute to the spiritual wellbeing of NHSScotland’s service users and employees.
Emergent key themes

- There is uncertainty around what constitutes spiritual care.
- Where does dignity and respect fit in?
- Where does religion fit in?
- Interpretation can vary by group/individual/organisation
- Fair for All?
- Where does spiritual care end and psychosocial care begin?
- Who is responsible for providing which elements of spiritual care? A clear guide is needed, with definitions of roles and responsibilities.
- It is unclear how we can recognise spiritual care needs, and how we know when they have been resolved.
- A general programme of awareness raising is required for staff and service users. Can spiritual care champions achieve this, or a poster campaign?
- More sharing of information is required and variations in practice need to be addressed, with success and good practice shared, as well as lessons learned.
- Should the chaplaincy or spiritual care department always be the key focal point for spiritual care? Do Human Resources/Clinical Governance/Estates departments have roles as well?
- Can spiritual care be delivered to everyone in the same way, using standardised protocols or guidelines? Is it more effective to organise spiritual care with targeted groups in mind, according to age group, medical condition or religion/faith? Or is a standardised approach more inclusive?
- How will we know when we are getting it right in the future? Is it possible to set targets and indicators for an issue like spiritual care?
Content of individual workshops and discussion points for consideration

The ETHOS project: evidence-based integration of spiritual care into a managed clinical network

Rev Bob Devenny
Ms Annette Harvie

Rev Devenny gave a presentation on the ETHOS project, which was qualitative research into current practice regarding spiritual care for patients recovering from stroke and their families within NHS Lanarkshire. Ms Harvie spoke about the NHS Education for Scotland (NES) core competency framework for stroke care and how this is being piloted alongside Rev Devenny’s project in NHS Lanarkshire.

A general discussion ensued, with the following key points made by Rev Devenny:

• by starting from an evidence base (targeted research into the spiritual needs and treatment of a specific patient group, in this case, stroke), training programmes can be developed to identify and address the core competencies involved
• at this time, there is a ‘blurring’ of roles in terms of who is responsible for input into patients’ spiritual care. Allied Health Professionals (AHPs) and medical staff can identify and contribute to addressing patients’ spiritual care needs as well as traditional spiritual care providers such as chaplains
• do we need to put ‘boundaries’ around spiritual care, by labelling it an ‘alternative therapy’, or by seeing it as a part of clinical governance? Is it possible to do this?
• further research is needed. Robust evidence would help to ensure that policy is developed appropriately, that it emphasises the right issues, and that implementation is effective.

The audience raised the following issues:

• the lack of spiritual care function raised during Rev Devenny’s presentation would be applicable to many patients, carers and relatives, not just those experiencing stroke recovery
• spiritual care should not be confined to one department as many factors contribute to spiritual wellbeing, particularly one’s surroundings. It was suggested that planning and estates should also receive training or guidance on how to address spiritual care issues in their work
• the importance of a holistic outlook from staff delivering spiritual care was recognised – everyone should receive whole-person care from whole person carers
• over the last 20 years, the emphasis has shifted from providing solely physical care to include social and lately mental health care. Where does spiritual care fit? Should we isolate this form of care from others? By addressing types of care separately, are we at risk of forgetting one type when prioritising another?
• In the context of spiritual care, it is important not to try to follow the medical model of identifying a pathology and treating it, but instead to create and use a framework for social, emotional and spiritual support.
• A strong evidence base helps convince sceptics that spiritual care is a worthwhile value for money investment, with positive outcomes for patients and staff.
The audience expressed considerable enthusiasm for the pilot work being undertaken in NHS Lanarkshire. It was hoped that the competencies would be used on an ongoing basis once the piloting phase was finished, with the appropriate training and staffing resource to ensure success. The need for the development of spiritual care policies inclusive of front line staff was expressed, with a general feeling that those with the most patient and visitor contact are not being empowered to recognise and support those with spiritual care needs.
The role of the chaplain in meeting Spiritual Needs of Patients

Dr Harriet Mowat

This session consisted of a presentation on the recent report, ‘What do Chaplains Do?’, which examines the role of the chaplain in his or her interactions with patients. The work was carried out by Dr Mowat along with Professor John Swinton, Miss Clare Guest and Dr Elizabeth Grant and involved research conducted via telephone interviews and analysis of case studies to examine, document and explain:

- patterns of spiritual care in NHS chaplaincy
- how spiritual care is received by patients and families
- the changing circumstances of NHS spiritual care.

The key roles of the chaplain were identified as:

- finding people who need them
- identifying the nature of the need
- responding to the need through theological and spiritual praxis.

During her presentation, Dr Mowat identified a number of ways in which the above tasks may be carried out, and the challenges faced by chaplains within the current NHSScotland environment in delivering this care. There was an opportunity for brief discussion at the close of the session covering the following issues:

- The role of the chaplain in providing spiritual care for staff

One participant reported experience of a difficulty in convincing hospital management of the need for chaplaincy services to be extended to staff. In this case, staff need for chaplaincy support was seen as a failure on the part of line managers or human resources departments to ensure a supportive working environment. Other chaplains reported that they work in a different culture, where staff issues may be dealt with by chaplains with the support of managers.

- The role of Christian chaplains with patients of other or no faiths

All input into Dr Mowat’s research was from Christian chaplains, the majority of whom believe that a strong basis in their own faith allowed them to deliver care to those of other faiths or those with no faith. A number of participants were keen to deal with individuals on a case-by-case basis and negotiate a tailored model of care.

- Chaplains – who looks after them?

A non-chaplain member of the group raised this question. This had been discussed during Dr Mowat’s research and answers included family, friends, their faith, long walks with the dog and other informal ‘coping mechanisms’ which often were not enough. Suggestions of peer support and NHS staff counselling services were raised by participants at the seminar.
Spiritual needs in primary care

Dr Scott Murray
Dr Marilyn Kendall

Drs Murray and Kendall gave a short presentation on the qualitative research they carried out with general practitioners (GPs), examining their role in providing aspects of spiritual care to their patients. It was reported that a majority of the GPs saw themselves as having a role in this area and found addressing the role to be challenging yet rewarding. Barriers to delivering effective spiritual care in the community were identified as:

- time constraints
- type of patient
- type of doctor/patient relationship.

Patients were also asked for circumstances in which they would be reluctant to seek this type of support. Their responses included:

- don’t know what to say
- see their spiritual needs as their own responsibility
- not sure if it is part of a GP’s role
- afraid of a negative response
- suspicion of counselling.

In situations where palliative care is required by a patient, GPs found it easier and more rewarding to deliver a more holistic approach. GPs were happy to provide practical, emotional, psychological and spiritual care, with practical care reported as the easiest to deliver. In circumstances relating to spiritual care, most GPs were more comfortable when patients initiated discussions about their needs.

A wider discussion followed the presentation and covered the following issues:

- too much of the seminar was focused on mainstream, white or Christian points of view
- ability to discuss spiritual care depends on the patients’ prior experiences of broaching the subject
- all health professionals can be delivering spiritual care without recognising it
- the presence of the spiritual care giver is crucial to meeting spiritual care needs
- shortage of time/resources – those pastorally trained in the community such as parish ministers may be able to assist
- not all staff feel comfortable engaging with people regarding their spiritual needs during a GP consultation, and a training need was identified. This should be extended to AHPs working in the community and practice nurses.
- the different needs of those facing death and those who are living with an ongoing long-term condition were discussed
- the importance of the patient in setting the agenda for his/her own care.
- time is needed to build quality patient/doctor relationships before discussing issues around spiritual care
• an assessment of spiritual care needs should be alongside those for social, counselling, psychological and healthcare needs
• sometimes patients can meet the spiritual needs of their doctors
• spiritual care is not religious care
• importance of careful listening, regardless of role or profession
• deal with ‘lack of time’ by making the spiritual care aspect an integral part of consultation – not an ‘add on’.

The group summarised the discussion into three clear strands for further consideration:

1. The holistic needs assessment
2. Spiritual care provision throughout the patient pathway and not just at the end
3. The importance of a close relationship and careful listening when any member of the primary care team, eg GP, Allied Health Professional (AHP) or nurse, provides spiritual care.
Spiritual needs of hospitalised children with complex healthcare needs

Rev Alister Bull
Rev Lorna Murray

An initial presentation discussing the qualitative study of the spiritual needs of five hospitalised children of school age with complex healthcare needs. While adults can attempt to give clear definitions of what spiritual care for children in a healthcare setting should be, the children were able to express it through story telling.

Children’s experiences of spiritual need are revealed through the importance they give to comfort and support, such as, family, friends, a pet or through play. The idea of having ‘someone to be with’ was recognised by the children involved in the research and was found to be a very important way of coping with the experience of being in hospital. However, the needs of children with respect to the delivery of spiritual care must be recognised as distinct and separate to those of adults. Any further work carried out must take this into account, particularly if standards are being developed. Guidelines for adults may not be of equal relevance to children, and children’s standards should not be an ‘add-on’ to standards for the wider population.

Discussion among the workshop attendees covered the following points:

• does current policy take children’s spiritual needs into account?
• the need for more research in this area was identified; particularly research involving siblings and parents of hospitalised children, how children interpret spiritual needs and religious needs, and where psychosocial needs overlap
• whether spiritual care in the hospital setting on a one-to-one basis is intimidating for children and perhaps better provided to a group
• spiritual care might be provided to children through play and structured activities
• any standards or guidelines developed for adult spiritual care should not be viewed as suitable for children, nor should guidance for children’s spiritual care be an ‘add-on’ to guidance regarding adults
• it is unclear what children mean when they talk about ‘spiritual care’.
Multifaith competence in delivering spiritual care

Sister Isobel Smyth

In order to generate discussion during this session, a first hand account was given by Sr Smyth’s colleague. This account detailed the experiences of a man belonging to the Hindu faith while being treated in an NHS hospital, and was delivered by his wife. Her husband’s experience had been poor as she did not have her wishes respected by the ward staff, and her husband’s religious and spiritual needs were not met during his stay.

Sister Smyth then facilitated a broader conversation, with debate centring around three key themes:

1. Spiritual care – what is it and how do we deliver it?
2. Multifaith information – how do we communicate with our colleagues?
3. Who should provide spiritual care?

The group came up with a range of interpretations of what spiritual care is, and how these needs can be met. It was suggested that spiritual care is often discussed in a secular way and that it is viewed as a separate entity to religious care. Group members discussed whether personal human needs, such as respect for an individual and treatment with dignity, are part of care for the spirit, or whether these are separate concerns. It was suggested that the NHS encourages patients to believe that religious needs will be met, but that this is not usually the case, particularly with people of perceived ‘minority’ faiths.

There was discussion around whether a chaplain of one faith can provide spiritual care to a person of another or no faith. It was also suggested that people would not feel comfortable speaking with a chaplain of a different faith, but that in many cases the chaplain could still provide care and support as a ‘fellow human being’. It was suggested that religious dress can be off-putting to those of other faiths or those of no faith and that chaplains being ‘badged’ to visually communicate their ‘multifaith friendliness’ might be a more inclusive measure to adopt.

The group discussed the different ways in which data protection legislation has been interpreted across NHSScotland, concerning how information on religion is shared. Chaplains need to be made aware of patients’ religious needs in order to meet them, but often this information is not shared or even collected. Some NHS Boards have a strict policy not to pass information about faith to the spiritual care department; others use a disclaimer at the time of collecting the information and ask the patient’s permission to share it.

The status of this information and the patient’s view on sharing it can change during their time under the care of the NHS, but currently there is no mechanism in place to update this information in a respectful and sensitive manner. It was suggested that NHS colleagues across the wider UK may be able to share good practice in this area.

It was acknowledged that staff need to know patient needs in order to meet them. Equally, staff need background knowledge on different faiths, and if there are resources available, these should be communicated and put to good use. A staff
information website operating in NHS Lanarkshire was commended, and national roll-out suggested.

Providers of spiritual care were discussed, and the value of spiritual care givers of individual faiths/religions was recognised. The ‘spiritual care champions’ role was discussed and the resource implication of the initiative acknowledged. Their value as a communications ‘go-between’ taking non-specialist tasks away from specialist spiritual care providers and leading to improved quality of spiritual care delivery to both patients and staff was recognised.
Auditing spiritual care – how can it be measured?

Rev Gillian Munro
Mr Jim Duffy

Rev Munro spoke about the challenges and benefits of auditing spiritual care in her own NHS Board area (NHS Tayside). In her presentation, she involved Jim Duffy, NHS Tayside Lead Clinical Governance Facilitator, to discuss some of the specific approaches taken. Based on enthusiasm and commitment from Rev Munro’s spiritual care team and the support/guidance from Mr Duffy and colleagues, NHS Tayside is making initial progress towards co-ordinating its diverse historical exercises (ie variations in coverage/posts, services available, spiritual care training offered, publications/leaflets, etc) into a new, cohesive, Board-wide approach to spiritual care provision.

Some questions that Rev Munro wished the audit data to help answer included:

- what needs to be done and where the priorities lie
- who knows best about spiritual care (eg where should expertise be concentrated)
- links between spiritual care provision and patient focus and public involvement (PFPI)
- how to know when the NHS Tayside Department of Spiritual Care have got it right, or nearly right?

Mr Duffy’s slides showed some dangers in measuring or auditing the wrong areas in the provision of spiritual care, and demonstrated how various processes and outcomes could be measured. The importance of relating measured outcomes to demand, by measuring the improvement against problems experienced by service users was also highlighted.

Some of the audit data and research so far indicates that a key first step would be to audit the implementation of the spiritual care policy, with the intention to use the audit data to further refine implementation activity (and/or the policy itself) as required. Rev Munro further noted that asking the right questions, and the right style of question, and asking in such a way as to respectfully seek understanding of individuals’ beliefs, all have an impact on how to gauge a patient’s spiritual care needs.

The audience’s main points were:

- determining patients’ spiritual needs can be very difficult and not straightforward – people themselves often are not aware of their needs until these are met
- it may be that spiritual care staff should begin by identifying the greatest needs and satisfying those first
- it is important to explore how volunteers could have a contributing role in spiritual care, such as how their participation could cover some aspects of care, thereby allowing spiritual care staff to prioritise and to better focus their own provision, and
- many people welcomed the concept of auditing spiritual care, but noted that, in the effort to measure care delivery, it was crucial that less measurable (but nonetheless important) aspects of spiritual care provision are not neglected or lost.
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