Association of Chaplaincy in General Practice

Improving care through listening and guidance

GP Chaplaincy Handbook

A practical guide to service provision

2019

(Revised June 2022)

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1. Introduction

This handbook is the result of many years of experience of delivering Chaplaincy in General Practice in the West Midlands, UK. It is produced by the Association of Chaplaincy in General Practice.

Britain has a long tradition of seeking to provide comprehensive primary healthcare through General Practice. In recent decades there has been an expressed desire by patients and professionals alike, in the midst of the increasing technical skills of modern medicine, to safeguard and develop the person-centred and holistic nature of patient care. One outcome of this worthy intention has been the development of Chaplaincy in General Practice.

The Association of Chaplaincy in General Practice was established in 2014 in order to enable Chaplaincy in General Practice to be delivered to agreed national standards. It does this through:

- promoting awareness of chaplaincy in General Practice
- facilitating the setting up of this service within General Practices
- providing training and professional support to those delivering chaplaincy
- providing Accreditation for those working as Chaplains in General Practice

This handbook aims to be a practical guide to facilitate the development of Chaplaincy in General Practice in other areas of the UK.

2. Vision

People seek help from General Practice with a vast array of differing ideas, expectations and concerns. Many of these can be met by existing services, but not all. Although there is a laudable intention to increase access to psychological therapies, most General Practitioners realise that not all distressed people will be helped by counselling based on a cognitive behavioural therapeutic approach.

There needs to be an additional approach which welcomes a wide range of troubled people; that listens well; that empowers through giving people value and hope; that creates space for people to find their own solutions; and can refer on to other services people who are more ready to benefit from such support.

Chaplaincy has long provided pastoral and spiritual care within the NHS. Chaplaincy in General Practice is now recognised as a subspecialty within NHS Chaplaincy in England, described in NHS Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual & Religious Care.

3. Chaplaincy in General Practice: a service overview

Chaplaincy in General Practice:

- promotes patient wellbeing by providing a highly skilled listening and guidance service
- is delivered by people who are dual-trained in spiritual care and counselling skills
- is available for all patients irrespective of their faith, beliefs or cultural background
- has minimal exclusion criteria and offers equal access to all primary care patients
- can be accessed by self-referral or referral by any member of the primary healthcare team
- provides confidential one-to-one booked appointments as often as is requested by the patient; experience has shown that this ranges from one to ten, but the average number of appointments is two/three
- uses an holistic approach: listening to each patient's unique story, offering guidance which addresses emotional, social and spiritual needs and making referrals as appropriate
- is focused on patient wellbeing and may include patient-led exploration of personal spirituality, offering reflection, meditation and prayer where appropriate and in line with the patient's belief system
- uses wellbeing assessment tools to measure progress and aid evaluation
- can also be part of staff support services; it provides one-to-one or group meetings and can help build resilience in the multi-disciplinary team

Chaplaincy in General Practice has been found to be particularly effective for those experiencing loss or change in their lives, e.g. in relationships, work, health, bereavement, confidence, purpose, beliefs, lifestyle, self-efficacy, relocation, crisis, trauma or mental health (Kevern et al, 2015; McSherry et al, 2016).

Provision of spiritual care is important not least because patients rarely present themselves to healthcare professionals as a condition or illness in isolation from their life situation; as such, the patient may view their condition or illness in the context of how they view deeper aspects of their life, which may not be explained adequately through the biopsychosocial approach alone (Kevern et al, 2015; see also Swinton & Kelly, 2015).

For an example of a patient information leaflet, which explains the service, see Appendix A.

4. Chaplaincy in General Practice: who provides it?

It is essential that Chaplains working in General Practice:

- are professional people who are competent to deliver pastoral and spiritual care with empathy and compassion
- possess excellent interpersonal skills
- demonstrate well developed listening and counselling skills
- have significant experience of pastoral care within a healthcare or faith community context
- have an approved status from their faith community
- comply with the UKBHC Code of Conduct and Continuing Professional Development requirements
- are independent practitioners working at a minimum level of NHS Band 6
- share the values of the NHS

It is also desirable that Chaplains working in General Practice

- have previous experience of working with other faith communities
- are adaptable
- have had previous experience of working in the NHS
- are able to work with volunteers and the voluntary sector

> "Chaplains are trained in practice-guiding disciplines such as theology, philosophy and ethics as well as in interpersonal skills and pastoral counselling."
>
> NHS Chaplaincy Guidelines 2015. *Promoting Excellence in Pastoral, Spiritual & Religious Care* (Swift, 2015, page 11).

5. Chaplaincy in General Practice: the patient encounter

A scheduled appointment time in a medical centre consulting room may include:

- an introduction explaining about the service offered by a Chaplain working in General Practice and confidentiality (which is absolute, except where safeguarding issues are revealed)
- a formal measurement of wellbeing in order to assist outcome evaluation (see Appendix J)
- communication with the primary healthcare team; when appropriate, an agreed comment will be made in the patient's medical records in order to contribute towards holistic patient care
- time actively listening to the patient's story
- an intention to communicate empathy, compassion and affirmation of the patient's value
- assessing the patient's emotional, social and spiritual needs (see below and Appendix B for examples of assessment tools)
- an explanation that Chaplaincy aims to bring a compassionate presence which journeys alongside people in distress, even where situations cannot be changed
- the development of a care plan and an agreed way forward (see Appendix C for examples of potential interventions)

After the patient encounter time is scheduled for analysis, reflection and note making before the next booked patient appointment.

Spiritual Assessment and Intervention

An assessment is a statement of perception and a process of information gathering and interpretation. Spiritual assessment is considered a prerequisite for effective spiritual care. The chaplain endeavours to understand the needs, strengths and particular issues relevant to the individual patient, so that care can be provided where it is most needed. This helps understand and interpret needs through a spiritual lens. In a patient-centred holistic approach numerous factors which impact well-being need to be considered, such as belief systems, attitudes, social and economic circumstances, resources and relationships.

Conversation and active listening are key tools in the assessment process. The chaplain may bring ideas and resources to the encounter, but their person-centred approach will be guided by and responsive to the direction of the patient. The chaplain will be willing to explore new and unplanned routes.

Assessment and intervention are often integrated. What begins as a listening exercise often becomes the intervention itself as the patient unfolds their issues and gains a different perspective on them during the reflective listening encounter. The chaplain is subconsciously making assessments all the time and choosing appropriate responses to them.

6. Appointing Chaplains to work in General Practice: the process

Before starting the process of appointing a Chaplain to work in General Practice, some important factors need to be considered such as:

- who will take on the employing body role and the duration of the post
- how the post will be funded, or whether it will be a non-paid agreement
- how the person will be managed and supervised
- how the post fits with comparable roles with respect to pay and responsibilities

In line with UKBHC Healthcare Chaplaincy guidance it is recommended that Chaplains working in General Practice are appointed at Agenda for Change: Band 6 as they are 'an autonomous, qualified practitioner whose role is to seek out and respond to the spiritual, religious and pastoral needs of individuals, their carers and staff'. If there is a Chaplaincy in General Practice team, it is appropriate to have a Team Leader working at Band 7.

It is recommended that substantive posts working within the NHS are advertised through the NHS Jobs website as this promotes equality and diversity in recruitment. Experience has shown using NHS Jobs to advertise for Chaplains working in General Practice is possible both for existing NHS bodies (such as General Practice Partnerships) and for Voluntary Sector organisations delivering a service to the NHS under contract. See Appendix D for an example of one such advert. Appendix E, the accompanying Job Description and Appendix F, the sample Person Specification are both sent by NHS Jobs to potential applicants. The difficulties in selecting appropriate candidates for interview and then conducting the interviews should not be underestimated. Experience has revealed that Chaplains who have worked in hospitals or other community settings are not automatically suitable for Chaplaincy in General Practice, nor are those whose pastoral care for people has been in a faith community setting or in other areas of NHS care necessarily suitable. Nobody's previous experience will exactly fit the requirements of this new role within the NHS. However, there are many people who apply for work as Chaplains in General Practice and some are highly suitable; others can become suitable with support and training.

A selection process based on scoring the essential and desirable characteristics stated in the Person Specification is an important starting point which is followed by interviews. A successful interview process may include, not only questions from a panel (see Appendix G for some guidance about question intent) but also a role play consisting of a Chaplain-patient encounter observed by those experienced in work as a Chaplain in General Practice. The role play is followed by time for the candidate to give a written reflection about the Chaplain-patient encounter.

7. Support and Supervision for Chaplains working in General Practice
(Revised Nov 2021)

1. Principle. Chaplains working in General Practice have specific needs for support and supervision in order to practise professionally and to provide an excellent standard of care.

2. Practice. Experience has shown that a 3-fold system of support is beneficial. These elements are:

i. **Line Management.** Chaplains need to be able to identify the line(s) of accountability and support available to them in their day-to-day work. Line management usually refers to issues related to their employment, voluntary work contract or volunteering agreement, including a regular appraisal process.

ii. **Pastoral Support.** It is recommended that Chaplains have regular meetings with a person with pastoral experience or a spiritual director from the same faith background. These meetings aim to provide a safe space for the Chaplain to receive spiritual support, encouragement and prayer.

iii. **Clinical Supervision for Chaplains.**

‘Supervision’ is a term that is widely used in the fields of counselling, spiritual direction, psychology, social work and other healthcare activities. It describes a formal arrangement and relationship between the practitioner and another experienced and suitably qualified person, which provides the practitioner with the opportunity to reflect carefully on their work. It focuses on various aspects of the work, including reflective practice, boundaries, safeguarding, identifying training needs, self-care and the overall quality of the work. It also attends to the safety and welfare of the patients or clients being worked with and the quality of the service they receive.

Clinical Supervision for Chaplains recognises the intentionally therapeutic listening nature of the work, and the counselling theory and skills that the Chaplain is drawing on. It also recognises the burden of Chaplaincy work and the high level of responsibility that Chaplains have towards their patients or clients. Clinical supervision sessions use anonymised case discussion to facilitate learning, reflective practice, managing of boundaries, avoidance of dependence and attention to safeguarding issues or general safe practice. The sessions also allow for reflection on the spiritual assessment and interventions carried out by the Chaplain. They can be individual or group sessions, and can be conducted in person or online.

3. Choosing a Clinical Supervisor. In order for clinical supervision to be safe and supportive for the Chaplain, it would normally be distinct from line management. Ideally the supervisor should be an experienced practitioner in a relevant field. Experience shows that the following qualities are helpful in a supervisor, although it may not be possible or necessary for the supervisor to demonstrate them all:

a. Training and experience in counselling.

b. An understanding of working in a healthcare setting, preferably within the NHS.

c. Spiritual maturity and a sensitivity to the pastoral and spiritual framework that the Chaplain works in.

d. Training and experience in providing supervision.

4. Levels of Supervision. The amount of supervision needed is dependent on the number of Chaplaincy hours worked. As a guide, a minimum average of 60 minutes' supervision per month is recommended. If supervision is provided in a group setting, allow slightly more time. A group of no more than 3 practitioners is recommended.

5. Costs and Funding. As clinical supervision is a professional activity, it would be expected that there is a cost. Costs are normally in line with other similar activities, such as counselling. Hourly rates vary according to location and of course are likely to change over time, so in order to keep this guidance generic, we recommend that you research these fees in your area.

It is expected that the cost of clinical supervision would be borne by the organisation engaging the services of the Chaplain. We advise that this is mutually agreed at the start of the contract.

6. Contracts. A suggested template for a supervision contract is included in Appendix H of this handbook. Both parties would sign the contract, and it is advisable to review it periodically.

7. Continuing Professional Development and Accreditation. All levels of supervision (line management, personal and clinical) are eligible for calculation in your CPD portfolio. For Accreditation with ACGP, you are required to show a minimum number of CPD hours, and to provide a statement from your clinical supervisor verifying your commitment to the process. You are also required to provide an example of a supervision session, with a reflection on the capabilities and competencies covered.

8. Training and Continuing Professional Development (*Revised Jun 2022*)

Training is an integral and ongoing part of professional life as a Chaplain working in General Practice.

Training is required in a wide variety of areas, which can be described as follows:

1. **Statutory requirements**
    a. Safe guarding training regarding vulnerable children and adults
    b. Risk assessment
    c. Confidentiality and liability
    d. Prevent (radicalisation recognition) training
    e. Domestic Violence awareness
    f. Health and safety
    g. UK Board of Healthcare Chaplaincy Capabilities, Competencies and Standards

2. **Practice-guiding disciplines**
    a. Ethics
    b. Theology, faith and religions
    c. Philosophy
    d. Faith-based knowledge and practice

3. **Interpersonal and pastoral counselling skills**
    a. Listening and counselling skills
    b. Mental health awareness eg anxiety management, stress and depression, ‘mental health first aid’, living with chronic pain, self-harm and suicide risk, alcohol and substance abuse
    c. Spiritual assessment and interventions
    d. Loss and bereavement
    e. Staff support

4. **Mechanisms for service delivery**
    a. Measurement
    b. Evaluation
    c. Record keeping
    d. Case studies recording
    e. Research

5. **Self-care and personal development**
    a. Reflective practice
    b. Professionalism and therapeutic boundaries
    c. Developing self-awareness
    d. Relaxation techniques eg mindfulness

These elements are included in the Foundations of Primary Care Chaplaincy course offered by ACGP. See the 'Training & Events' page on the website for dates of this training programme.

It is recommended that Chaplains have completed training in basic counselling skills, as a minimum entry requirement. (See Appendix F for an example Person Specification for recruitment.)

Continuing Professional Development is essential for all practitioners. CPD can occur in a variety of ways, such as:

- Team meetings with speakers who are specialists on certain topics
- Peer group learning
- Group supervision sessions
- Attendance at relevant seminars, courses and lectures
- Distance learning post-graduate courses
- Online learning modules
- Personal reflection and reading

See the 'Training and Events' page on the website for details of CPD events organised by ACGP.

Individual Chaplains working in General Practice are responsible for compiling their CPD portfolios. The ACGP Accreditation process requires Chaplains to submit an evidence portfolio of their CPD (see Section 9 of the Handbook).

9. Accreditation of a Professional Service *(Revised Nov 2021)*

Chaplaincy in UK is a professional service which, since 2017, is regulated by the Professional Standards Authority through the UK Board of Healthcare Chaplaincy (UKBHC). The Professional Standards Authority is the regulatory body for all registers of health and social care professionals. Chaplaincy in the NHS is described in NHS Chaplaincy Guidelines 2015 in which it clarifies that the term 'chaplaincy' is not affiliated to any one religion or belief system. Modern healthcare chaplaincy is a service and profession working within the NHS that is focused on ensuring that all people, be they religious or not have the opportunity to access pastoral, spiritual or religious support when they need it.

Individuals working in Chaplaincy are encouraged to apply for registration with the UK Board of Healthcare Chaplaincy (UKBHC). Information regarding UKBHC registration is given below.

Accreditation with the Association of Chaplaincy in General Practice

a) The concept

There are some important differences for those working in an NHS General Practice compared to other settings. Therefore, ACGP has developed an accreditation process tailored to this context. This aims to ensure, in line with the Professional Standards Authority and the UKBHC's primary aim, the safety and wellbeing of the public by setting high standards for the professional practice of Chaplains working in General Practice. Important features which distinguish Chaplaincy in General Practice include: lone working in a community setting without an institutional structure or team; lengthy individual appointments in a highly confidential setting where significant psychological distress is revealed; delivering a new talking therapy service which is poorly understood by many healthcare workers and patients themselves. ACGP understands that Chaplaincy in General Practice is a new talking therapy which is available, along with other talking therapies, to patients in primary care settings.

Therefore, there needs to be an accreditation process which, wherever possible is the same as the UKBHC registration process, but which recognises the significance of these differences.

ACGP requires the individual to demonstrate a high level of reflective practice. In line with Higher Level 7 Education standards, all CPD activities need to be self-assessed against Competences. These Competences are based on UKBHC Spiritual Care Competences for Healthcare Chaplains (2020). This document has been adapted to define the specific contribution made by Chaplaincy in General Practice: 'Spiritual Care Competences Framework for Primary Care Chaplains'.

ACGP recognises the non-institutional nature of Chaplaincy in NHS General Practice and the fact that the Chaplains' terms, conditions of work and salaries are not usually

aligned with those in secondary care settings. Consequently, the need to consider the NHS Knowledge and Skills Framework in line with Agenda for Change criteria is not applicable.

b) **The process**

Chaplains offering this talking therapy all need individually tailored training, support and supervision. ACGP not only provides advice, but its accreditation process requires evidence of these factors.

In order to achieve accreditation by ACGP the following are required:

1. Complete contemporary personal record
2. Declarations of appropriate line management, pastoral support, clinical supervision, good standing within a faith community, personal statements of fitness to practise and compliance with the UKBHC Code of Conduct.
3. A completed CPD portfolio evidencing competences achieved and evidence of reflective practice.
4. A completed Personal Development Plan for the forthcoming year.
5. The job description and monthly work pattern for the current Chaplaincy post. ACGP requires Chaplains to be working for 6 or more hours per week in order to be accredited.

The relevant information needs to be submitted by 31st January each year.

In order to remain an accredited member of ACGP an annual submission, by 31st January each year, of the following is required:

- Declarations
- A summary CPD evidencing competences achieved and evidence of reflective practice.
- A completed Personal Development Plan for the forthcoming year.
- Monthly work pattern for the current Chaplaincy post.

All the information about the how to seek ACGP Accreditation and Re-Accreditation, including the templates that need to be used, are on the ACGP Accreditation website.

Information about registration with the UK Board of Healthcare Chaplaincy

Full details can be found here. It includes submitting evidence to demonstrate:

- declaration of compliance with the UKBHC Code of Conduct and Continuing Professional Development (CPD) requirements
- evidence of relevant qualifications and training
- evidence of employment (honorary or salaried) in a healthcare chaplaincy post
- evidence of a recognised or accredited status within a mainstream faith community or belief group
- no known existing professional conduct issues

It is required that a comprehensive personal record and portfolio is compiled and kept up to date. An essential part of registration is the annual completion of a summary of CPD activity as continuing evidence of meeting the requirements for registration and therefore fitness to practice. It is expected that this professional portfolio will be discussed as part of personal line management and supervision. The registration process requires a sponsor who is able to show that the applicant has evidence of competent supervised practice. Registration is granted when all this information has been assessed by the board's Academic Advisor. Provisional registration is offered to those recently in post and/or yet to complete agreed chaplaincy training.

The UKBHC requires an annual submission of a CPD summary as continuing evidence of meeting the requirements for registration and therefore fitness to practice. ACGP and the UK Board CPD requirements are very similar.

10. Outcomes: Measurement and Evaluation

Despite the challenges, and the risk that trying to evaluate a therapeutic relationship will have an adverse effect on that therapeutic relationship, it is essential to continually bear in mind the need to assess the nature and the efficacy of the service provided by Chaplains working in General Practice. This can be done in various ways:

- the use of validated measurements of wellbeing, such as WEMWBS, a Wellbeing Star (see Appendix J)
- the use of the NHS 'Friends and Family Test' which comments on whether patients would recommend a service to others
- case studies compiled by the practitioner and/or the patient themselves; these provide important qualitative data and allow patient stories to illustrate aspects of the service and are a means of reflection and evaluation for the practitioner (see Appendix K)
- specific patient questionnaires have some value
- external evaluation, where appropriately selected patients are interviewed at length followed by detailed analysis, has proved most informative (see McSherry et al, 2016).
- completion of Patient Reported Outcome Measures (PROMs) (see Appendix J)

Some Patient Reported Outcome Measures comments:

Comments about making sense of one's problems and sometimes being empowered to solve or improve them:

- able to find better solutions
- helped me to see that I can improve my life
- I have been able to express my life and the problems in it
- helped me enormously to understand and adjust my feelings
- given me more perspective on my problems
- find ways of remedying the issues

Comments about finding new hope and strength for the future:

- given me a reason to carry on with my life
- has enabled me to cope
- see beyond it to a more positive future
- I have gained strength and courage with the help of the listeners
- burden has been lifted
- I believe in myself a lot more now, am stronger and feel I have a purpose

Comments that show appreciation for being accepted and not judged:

- understanding and compassionate, without being judgemental
- impartial but kind and understanding approach
- a positive, non-judgemental manner

- I was listened to and believed
- able to speak to someone on neutral grounds
- much easier to be open and honest with the Chaplains
- it had been a while (8 years) that I kept things to myself

11. A Commitment to Research

Chaplaincy in General Practice is an innovative and relatively new profession and therefore has, by definition, a limited history of evidence and research.

The quantitative and qualitative analysis published to date gives an early indication that this type of intervention is of benefit to those patients who have accessed the service. These studies need to be repeated in different settings before firm conclusions can be drawn. Whether the setting in which the service occurs results in a subtle preselection of patients using the service and so influencing the outcome, needs further exploration.

This and many other questions need to be asked and should be the subject of further research. This is an obligation which rests on all professional Chaplaincy provision (see NHS Chaplaincy Guidelines, 2015 and UKBHC Standards for Spiritual Care Services 2020) and is a priority which the Association of Chaplaincy in General Practice seeks to champion. Questions such as:

- Is this service best suited to a context where it is part of a comprehensive suite of services in a primary mental health and wellbeing hub, or can it stand alone in other primary care settings?
- What is the relationship between Chaplaincy in General Practice and the more widely accepted CBT based psychological therapies? Is it a poor and cheaper version of counselling? Does it support people who are not suited to CBT based psychological therapies? Does it help prepare some people to benefit more effectively from CBT based psychological therapies?
- What is the effect of Chaplaincy in General Practice on the uptake of other services? Is there a significant reduction in demand for GP appointments as early studies have suggested? Is there a reduction in psychoactive medication for those who use this service?
- Is there evidence, as experience suggests, confirming that Chaplaincy in General Practice facilitates the connection between the primary healthcare team and local community services and organisations to the benefit of patients?
- What kinds of people, and with what previous experience, are most likely to make successful Chaplains working in General Practice?
- How can Chaplains working in General Practice be most effectively trained, supervised and developed in their role? How can templates for Reflective Practice Models and Learning Portfolios (see Appendices L and J) most effectively play a part in this process?

Research is costly, both in terms of time and money, but the cost of not doing such research is much higher. Without the required evidence, Chaplaincy in General Practice may not become available to those who would benefit from it the most, because the limited funding for patient care has been diverted elsewhere.

12. Provision and Funding of Chaplaincy in General Practice *(Revised May 2022)*

The history

Chaplaincy in General Practice or Primary Care Chaplaincy has been offered as a professional service to patients since the late 1990s and has had a variety of funding sources. General Practices have often been innovative in using funding streams to develop patient services. This is no less true of Chaplaincy in General Practice where fundholding savings and various incentive scheme payments have been used to fund this service. In some situations, partners in General Practice settings have agreed to pay for and provide this service without reimbursement.

Chaplaincy in General Practice has been for many years, and continues to be, provided and funded within the NHS in Scotland under the term 'Community Chaplaincy Listening'. Here there are clear links with hospital-based chaplaincy services.

With the advent of the General Practitioner role being influential in commissioning healthcare (initially in Practice Based Commissioning and then in Clinical Commissioning Groups) Chaplaincy in General Practice was commissioned and provided in a few areas in England. This was sometimes within the context of a primary mental health and wellbeing hub. The service was called 'Listening and Guidance provided by Chaplains for Wellbeing'. Descriptions in commissioning documents about this service and why it was commissioned by the NHS are given in Appendix L. However, provision of this service by CCGs did not become widespread. With the development of NHS policy in England of Primary Care Networks from 2019 and the creation of Integrated Care Systems instead of Clinical Commissioning Groups in 2022, new approaches have been necessary.

Current models of provision of Chaplaincy in General Practice

When considering different models of provision of Chaplaincy in General Practice it is useful to categorise them according to two criteria: Is there an external agency involved? Is the role salaried or not? It is then important to clarify which is the responsible body taking the clinical and managerial obligations for service provision.

A. No external agency involved with salaried staff

Individual General Practices, or groups of practices are legal entities that have the capacity to employ staff to care for patients. This is an option whether or not funding is provided from the NHS for this role. In the current climate, very few General Practices chose to fund this service themselves and to take on the responsible body clinical and managerial obligations for service provision

B. No external agency involved with non-salaried staff

This is essentially the same as (A) above, but the General Practitioners have appointed someone who does not receive a salary. Where this model of service

provision exists, the person is usually known and trusted by the General Practitioners involved.

C. External agency involved with salaried staff

There are an increasing number of organisations which are providing services to patients within the primary care setting. Community Chaplaincy Listening in Scotland is one such example. In this case the responsible body is the hospital Chaplaincy department. In England, there are situations where hospital Foundation Trusts are taking over the running of General Practices. This would allow hospital Chaplaincy departments to offer their service to patients in General Practice if they wished.

More frequently in English General Practice, new services are being provided through the Additional Roles Reimbursement Scheme which is part of the Primary Care Network structure which covers all General Practices (see section 13). This allows local variation in how organisations contract with the NHS to deliver services specified in the developing Primary Care Network services.

Individual General Practices are also able to negotiate directly with any organisation which might provide a service to their patients. This could be a dedicated provider of chaplaincy services. Organisations which provide Chaplaincy services may have charitable status and be able to receive grant funding to support the work. However, experience has shown that grant awarding bodies rarely consider that the provision of Chaplaincy to patients in General Practice fits within their criteria. A case has yet to be made that aligns Chaplaincy in General Practice with the care to NHS patients provided by the Hospice movement, which is funded largely by charitable sources.

D. External agency involved with non-salaried staff

In this arrangement, General Practices or a Primary Care Network negotiate directly with an organisation which provides chaplaincy services, such as Voluntary and Community Sector Organisation (VSCE). The VSCE acts as the responsible body, selects, trains and supports Chaplains as they provide a professional service. This requires a non-salaried voluntary worker contract or a volunteer agreement to be in place. These non-salaried Chaplains may be regarded as ‘Honorary Chaplains’ in much the same way as Honorary Chaplains function in a hospital setting.

Whatever the model of provision and funding, it is essential that the quality of the Chaplaincy service is at the same professional standard. The training and Accreditation/Reaccreditation process established by the Association of Chaplaincy in General Practice plays a key role in setting and maintaining these standards.

13. Primary Care Networks in England, Listening and Guidance and GP Chaplaincy *(Revised May 2022)*

All individual General Practice units have been required by NHS England, since 2019, to be part of the Primary Care Network (PCN) structure. These are geographical groups of General Practices that have obligations to work together to deliver and monitor the healthcare of their populations. NHS England has devised a number of additional roles which are intended to be in place in all PCNs. The purpose of these additional roles is to supplement the primary care workforce and to complement the services offered, in part, to make the care more holistic and person centred. The job descriptions for these roles are defined by NHS England and funding is provided to the PCNs to enable people to be appointed to these roles. The implementation of the roles, how they are employed and how they work across all the practices is negotiated locally.

Chaplaincy in General Practice can be regarded as a talking therapy which incorporates Holistic Cognitive Behavioural Therapy and can take its place alongside other therapeutic interventions which promote person centred holistic patient care. In this context it has usefully been described as 'Listening and Guidance provided by Chaplains for Wellbeing'. It has been possible to use the additional role of Social Prescribing Link Workers in such a way that some Social Prescribing Link Workers have the additional expertise in the provision of Listening and Guidance.

Other Additional Roles that have the potential to embrace GP Chaplaincy / Listening and Guidance are those of Mental Health Practitioners or Health and Wellbeing Coaches. The NHS is striving to be more holistic in the way it cares for patients and is seeking to connect more effectively with the statutory social care services and the voluntary sector. This evolving picture will be further influenced by the Integrated Care Systems which will oversee the future structures that deliver NHS and Social care.

14. References

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Reflective Practice references (see Appendix K)

GIBBS Reflective Cycle 1988, cited in Johns, C. (2004) Becoming a reflective practitioner, 2nd edition. Oxford: Blackwell

Hillier, Y.(2002) Reflective Teaching in Further and Adult Education. London: Continuum

Nash, S. and Nash, P. (2012) Tools for Reflective Practice. London: SPCK

Smyth, J.(1996) 'Developing socially critical educators.' In Working with Experience, D. Boud and N. Miller, eds. London: Routeledge

Further Reading: ACGP Evidence base and Policy

Appendix A: Patient Information Leaflet: an example

LISTENING AND GUIDANCE
WholeCare KNS

NHS

Chaplains for Wellbeing

providing

Listening and Guidance

Is life stressful?

Are you struggling with illness?

Have you suffered the loss of a loved one?

Do you need to talk to someone?

Then Chaplains for Wellbeing are here for you.

Who is able to see the Chaplains for Wellbeing?

The Chaplain is for everyone, of all faiths and beliefs. Each of us is more than physical. The health of our inner self affects our wellbeing in every respect:

- Physical
- Emotional
- In relationships
- Work
- Decision making

It may be

- You are coping with the loss of a loved one
- You are trying to cope with illness and need strength to face the day to day
- You are finding relationships difficult
- You find the pressures of life leave you empty and drained, asking, “Is there more to life?”
- You have a difficult decision to make
- You would like space to find inner strength, hope and meaning

What does the Chaplain for Wellbeing provide?

The Chaplain offers confidential pastoral and spiritual care for you the patient and your carer. This may include:

- Listening to your story
- Discussing your concerns and offering reflection and support
- Putting you in touch with other helpful agencies
- Providing useful resource material
- Helping you develop your own spiritual journey which may include the offer to pray

What will happen?

The Chaplain for Wellbeing is available to see you by appointment.

The Chaplain aims to listen to you without judgement and with respect to your beliefs and experiences.

To see the Chaplain

When you see a Doctor ask for a referral to the Listening and Guidance Service provided by Chaplains for Wellbeing, Talking Therapies which are available via the Edgbaston Wellbeing HUB or the Sandwell Mental Health and Wellbeing HUB.

Appointment

An appointment will be made by the Chaplain who will contact you and then agree over the phone or send an appointment to you. They will also indicate where the appointment will be held.

First Appointment:

- enables the Chaplain to understand your situation
- allows you to agree the way forward
- lasts about an hour

Contact details:

Appendix B: Assessment Tools: some examples

HOPE

The **HOPE** Questions as a Practical Tool for Spiritual Assessment
H: Sources of hope, meaning, comfort, strength, peace, love and connection
O: Organized religion
P: Personal spirituality and practices
E: Effects on medical care and end-of-life issues

Examples of Questions for the HOPE Approach to Spiritual Assessment

H **Sources of hope,** meaning, comfort, strength, peace, love and connection
What is there in your life that gives you internal support?
What are your sources of hope, strength, comfort and peace?
What do you hold on to during difficult times?
What sustains you and keeps you going?
For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?
If the answer is "Yes," go on to O and P questions.
If the answer is "No," consider asking: Was it ever?
If the answer is "Yes," ask: What changed?

O **Organized religion**
Do you consider yourself part of an organized religion?
How important is this to you?
What aspects of your religion are helpful and not so helpful to you?
Are you part of a religious or spiritual community? Does it help you? How?

P **Personal spirituality/ practices**
Do you have personal spiritual beliefs that are independent of organized religion? What are they?
Do you believe in God? What kind of relationship do you have with God?
What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (eg prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)

E **Effects on medical care and end-of-life issues**
Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?)
Is there anything that I can do to help you access the resources that usually help you?
Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?
Would it be helpful for you to speak to a community spiritual leader?
If the patient is dying: How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months?

Anandarajah, G. and Hight, L. (2001). Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment.

FICA

F **Faith and Belief**
Do you consider yourself spiritual or religious?
Do you have spiritual beliefs that help you cope with stress?
What gives your life meaning? Sometimes patients respond with answers such as family, career or nature.

I **Importance**
What importance does your faith or belief have in your life?
Have your beliefs influenced how you take care of yourself in this illness?
What role do your beliefs play in regaining your well-being?

C **Community**
Are you part of a spiritual or religious community?
Is this of support to you and how?
Is there a group of people you really love or who are important to you?
Communities such as churches, temples, and mosques, or a group of likeminded friends, can serve as strong support systems for some patients.

A **Address in Care**
How would you like me to address these issues?

Puchalski, C.M. 2010 Spiritual Assessment Tool FICA

FACT

F **Faith (and/or Belief)**
What is your faith or belief?
Do you consider yourself to be a person of faith or a spiritual person?
What things do you believe that give your life meaning and purpose?

A **Active (and/or Available, Accessible, Applicable)**
Are you currently active in your faith community?
Are you part of a religious or spiritual community?
Is support for faith available to you?
Do you have access to what you need to apply your beliefs?
Is there a person or group whose presence or support you would value at a time like this?

C **Coping (and/or Comfort)/Conflict (and/or Concern)**
How are you coping with your situation?
Is your faith (or belief) helping you cope?
How does faith provide comfort?
Do any of your beliefs or practices conflict with your medical treatment?
Do you have any particular concerns?

T **Treatment.**
Treatment Plan:
What interventions might be appropriate, for example on-going listening, spiritual support, use of sacred scripture, referral to counselling or other services.

LaRocca-Pitts, M. (2012) FACT a Chaplain's tool for assessing spiritual needs in an acute setting

The Four Domains

The four domains cover a holistic framework of enquiry for an encounter with a client

1) Personal domain—where one intra-relates with oneself with regard to meaning, purpose and values in life. Self-awareness is the driving force or transcendent aspect of the human spirit in its search for identity and self-worth.

Examples of questions:

Why have you come to this appointment today?
What are you good at?
What do you enjoy?
What do you find hard?
What frustrates you?
What would you like to work towards?
What helps you?
What gives you strength?
What, who do you turn to when distressed?
What gives you hope?
Is there one thing about yourself you would like to change?
If you could walk away from something, (can be from any time in your life), what would it be?
What are your concerns?
What strategies do you have to deal with those concerns?
What does spirituality mean to you?
Have you ever had a faith?
Do you have a faith?
Would you like to explore any aspects of faith or spirituality?
Does your faith help in difficult situations? If so how?
Are you part of a faith community?
What is your identity?
How do you nurture your spirit?

2) Communal domain — shown in the quality and depth of interpersonal relationships, between self and others, relating to morality, culture and religion. These are expressed in love, forgiveness, trust, hope and faith in humanity.

Examples of questions:

Who are the people that are important to you?
Who is working to look after you?
Do you look after anyone?
Who do you trust?
Is there anyone you need to forgive?
Is there anyone you need to say thank you to?
What is the kindest thing anyone has done for you recently?
What can the people around you do to make things better?
What would you like to be able to do for one special person in your life?
What does love look like in your context?
How do you receive love – from people, from God?

3) Environmental domain—beyond care and nurture for the physical and biological, to a sense of awe and wonder; for some, the notion of unity with the environment.

Examples of questions:

What is your favourite place?
What would be the most nurturing environment for you?
What one change could be one step towards the goal of finding a nurturing environment?
Where would your dream place be, what does it look like?
If you could create a perfect world what three things would you do first?

4) Transcendental domain—relationship of self with something or Someone beyond the human level (i.e. ultimate concern, cosmic force, transcendent reality or God). This involves faith towards, adoration and worship of, the source of Mystery of the universe.

Examples of questions:

If you could fly like a bird, where would you go, what would you see?
If you could tie your worries to a balloon and release them what would you send?
What things bring you peace?
What brings you joy?
What makes you feel grateful?
What lifts your spirit?
What makes you go WOW?
What does it mean to trust in God?
How can you access God's wisdom?
What is the greatest mystery of the universe to you?
What do you think is the purpose of your life?
If you were writing a prayer what would you like to say?

Adapted from: Fisher, J. (2011).The Four Domains Model, Connecting Spirituality, Health and Well-Being

Appendix C: Interventions: some examples

Interventions which can be offered by Chaplains working in General Practice

- written reminders of key concepts, positive realities and ideas which arose during the session
- giving encouraging statements and thought for personal reflection
- choose from the 'Five Ways to Wellbeing' which course of action would be most appropriate at that stage (see below)
- offer time for meditation, reflection, prayer, silence, listening to music and reading of sacred writings
- suggest the benefit of writing down personal feelings and thoughts in a journal
- arrange visits to a patient's home or other significant places having made an appropriate risk assessment
- offer to arrange religious care, such as a service of remembrance or the reciting of specific prayers
- offer to facilitate the connection with local community activities and faith communities
- facilitate a referral to psychological therapies and other services

Five ways to mental wellbeing The following steps have been researched and developed by the New Economics Foundation

Connect

There is strong evidence that indicates that feeling close to, and valued by, other people is a fundamental human need and one that contributes to functioning well in the world. It's clear that social relationships are critical for promoting wellbeing and for acting as a buffer against mental ill health for people of all ages.
With this in mind, try to do something different today and make a connection.

- talk to someone instead of sending an email
- speak to someone new
- ask how someone's weekend was and really listen when they tell you
- put five minutes aside to find out how someone really is
- give a colleague a lift to work or share the journey home with them

Be active

Regular physical activity is associated with lower rates of depression and anxiety across all age groups. Exercise is essential for slowing age-related cognitive decline and for promoting well-being. But it does not need to be particularly intense for you to feel good - slower-paced activities, such as walking, can have the benefit of encouraging social interactions as well as providing some level of exercise.
Today, why not get physical? Here are a few ideas:

- take the stairs not the lift
- go for a walk at lunchtime
- walk into work - perhaps with a colleague – so you can 'connect' as well
- get off the bus one stop earlier than usual and walk the final part of your journey to work
- organise a work sporting activity
- have a kick-about in a local park

- do some ‘easy exercise’, like stretching, before you leave for work in the morning
- walk to someone’s desk instead of calling or emailing

Take notice

Reminding yourself to ‘take notice’ can strengthen and broaden awareness. Studies have shown that being aware of what is taking place in the present directly enhances your well-being and savouring ‘the moment’ can help to reaffirm your life priorities. Heightened awareness also enhances your self-understanding and allows you to make positive choices based on your own values and motivations. Take some time to enjoy the moment and the environment around you. Here are a few ideas:

- get a plant for your workspace
- have a ‘clear the clutter’ day
- take notice of how your colleagues are feeling or acting
- take a different route on your journey to or from work
- visit a new place for lunch

Learn

Continued learning through life enhances self-esteem and encourages social interaction and a more active life. Anecdotal evidence suggests that the opportunity to engage in work or educational activities particularly helps to lift older people out of depression. The practice of setting goals, which is related to adult learning in particular, has been strongly associated with higher levels of wellbeing.
Why not learn something new today? Here are a few more ideas:

- find out something about your colleagues
- sign up for a class
- read the news or a book
- set up a book club
- do a crossword or Sudoku
- research something you’ve always wondered about
- learn a new word

Give

Participation in social and community life has attracted a lot of attention in the field of wellbeing research. Individuals who report a greater interest in helping others are more likely to rate themselves as happy. Research into actions for promoting happiness has shown that committing an act of kindness once a week over a six week period is associated with an increase in wellbeing.

Appendix D: Sample Job Advertisement

Job Advert

Chaplain for Wellbeing P/T

£XX,XXX pro rata, depending on experience

An exciting opportunity is available within the expansion of our Listening and Guidance Service. We are looking for an experienced pastoral person of faith to become part of our growing team.

The position is a part-time Chaplain for Wellbeing, working between 12-16 hours per week. The role involves providing pastoral and spiritual care for patients on a sessional basis in a one-to-one setting. Training and supervision will be provided. The Chaplain will be based in different settings.

Applicants should be of pastoral standing in their own faith community and have proven counselling skills. To find out more information about this type of chaplaincy see The Association of Chaplaincy in General Practice

Please apply via the NHS Jobs website www.jobs.nhs.uk

Vacancy reference: xxxxx

Closing Date: xxxxx

Appendix E: Sample Job Description

Chaplain for Wellbeing

GRADE:	Band 6
HOURS:	12-16 hours to be agreed
RESPONSIBLE TO:	Lead Chaplain or Lead Doctor
ACCOUNTABLE TO:	Employer
SALARY:	£xx,xxx (WTE)

Job Summary

This post forms part of the Listening and Guidance Service, commissioned by Clinical Commissioning Groups (CCGs) in the West Midlands and delivered through the employing organisation. Working as part of a community based Chaplaincy Service, the Chaplain for Wellbeing will provide pastoral and spiritual care to patients and staff, according to the employer's vision and ethos of 'whole person care'.

Key Duties and Responsibilities

1. To provide pastoral and spiritual care for patients referred through the Medical Centre and to also be prepared to offer a listening service to centre or team staff if requested.

2. To seek out and use appropriate resources and signposting to support the wellbeing and holistic care of patients and staff.

3. To ensure that record keeping is up to date and that the assessment and data entry requirements of the service are met.

4. To receive referrals to the service.

5. To work in partnership with other organisations, supporting a joined-up approach to holistic care and facilitating inter-agency referrals.

6. To be willing to support the Management Team with any new developments of the service, including a possible 'Extended Chaplaincy' role which may feature a hand-holding or navigating service as well as any new developments around the use of community volunteers.

7. To work with other Chaplains where appropriate.

8. To undertake training in order to meet standards set by the UK Board of Healthcare Chaplains (UKBHC) and to meet the requirements of the Clinical Commissioning Groups (CCGs).

9. To follow good practice, adhering to the Code of Conduct developed by the UKBHC and to practice in accordance with the Capabilities and Competencies described by this Board.

10. To be willing to promote the service among local stakeholder groups to raise the profile and uptake of Listening and Guidance across the CCG areas.

11. To comply with the employer's policies and procedures.

NOTES:

a) This is not intended to be an exhaustive list of responsibilities but more an outline framework. The post holder will be given flexibility to define the detail. Any changes will be the subject of consultation with the post holder.
b) The source of funding for the post is non-recurrent and therefore the post is for a fixed term of 12 months in the first instance. It is hoped that the post will continue after this date; existing employment rights will be rolled over into a new contract of employment.
c) All employees must adhere to Health Authority policies and procedures relating to Health and Safety, No Smoking at Work, Equal Opportunities in Employment and Harassment.
d) Chaplains in General Practice will be required to have an induction into the policies and procedures of each site at which they hold a clinic.
e) Your attention is drawn to the confidential nature of information collected within the NHS. The unauthorised use or disclosure of patient or other personal information could result in a prosecution for an offence or action for civil damages under the Data Protection Act 1984.

Appendix F: Sample Person Specification

PERSON SPECIFICATION

JOB TITLE: Chaplain for Wellbeing

ATTRIBUTES	ESSENTIAL	DESIRABLE
1. TRAINING AND QUALIFICATIONS	Accredited by church body / faith / religious community	Related professional qualification such as Counselling or other Healthcare related qualification
	To be in good standing within own faith community	
2. KNOWLEDGE AND EXPERIENCE	5 years relevant experience Pastoral knowledge and experience relevant to health care and spirituality / faith/ religious practice Experience of working with volunteers Experience of working in a team	Previous NHS experience Experience of working ecumenically and with other faith communities Experience of supervising volunteers
3. SKILLS	Excellent interpersonal skills for working with a wide range of professionals and service users Well developed listening skills and experience of using counselling skills To be highly self-aware and to demonstrate an ability to reflect upon spiritual, pastoral experience and applied theology To have the ability to follow process when assessing people's needs, to liaise with other agencies and to record outcomes Excellent communication skills including good computer skills and written and presentation skills	Experience in delivering training in spirituality or healthcare related subjects

	Attention to detailed record keeping Ability to work sensitively with confidential information and to comply with data protection	
4. PERSONAL QUALITIES	Empathetic, compassionate, committed, professional and visionary A commitment to work to the Code of Conduct and to maintain the Standards of Capabilities and Competencies set by the UK Board of Healthcare Chaplaincy A commitment to ongoing professional and personal spiritual development	Share the values of the NHS and have awareness or experience of working in the health sector Ability to adapt to change
5. OTHER	Able to offer some flexibility to cover colleagues and to work some clinics in the early evening Able to work at different Health Centres	Applicant should be able to evidence how they intend to travel to different sites and across CCG areas

PLEASE NOTE - This Person Specification will be used to score and to shortlist all applications. We strongly recommend therefore that you address the criteria as fully as possible in your application.

Appendix G: Interview process: some guidance.

There can be no perfect interview process, and there are limitations to what can be discovered about a candidate purely from a formal interview. We have found that a greater understanding of the candidate's suitability can be reached by a supplementary session where the candidate is required to lead a session with a client in an observed role play. Both participants and observers in this role play are then required to submit their reflections regarding the role play experience.

With regard to the formal interview, good questions do have an important function and we would suggest that questions should be designed to elucidate several key aspects, such as:

- their understanding of the nature of Chaplaincy in General Practice
- their understanding of the difference between Chaplaincy in General Practice and psychological therapies, such as counselling or Cognitive Behavioural Therapy, which may be available as part of patient care in General Practice
- their experience of pastoral and spiritual care
- how they care for themselves so that they remain well and able to take care of others
- their experience of and approach to working with others of different faiths and beliefs
- their understanding about confidentiality and safeguarding
- their ability to work in a multidisciplinary manner
- their approach to managing errors
- their understanding of NHS values
- their ability to work to codes of conduct
- their approach to continuing education and professional development

Appendix H: Clinical Supervision Agreement *(Revised Nov 2021)*

ACGP recommended Clinical Supervision Agreement

This is a supervision agreement between _____

and _____ .

from _____ until its review (or ending) on _____

What is supervision?

Supervision creates a context in which the Chaplain can step back and reflect, with greater clarity from an enhanced perspective, on all aspects of their clinical work. It enables formal and informal feedback on that work. It focuses on the safety and welfare of patients and the quality of the service they receive[1].

Frequency:

We will meet for Clinical Supervision every _____ weeks at a time arranged at the end of each supervisory session.

Roles and Responsibilities:

We have agreed that the Supervisor will take responsibility for:

- creating a safe place
- being supportive, encouraging and open
- facilitating exploration and clarification of thoughts and feelings
- challenging personal or professional blind spots
- monitoring the competency and ethical issues of practice
- prioritising safety issues such as child protection, domestic abuse and mental health issues
- time keeping and management of the overall agenda for sessions
- giving feedback

[1] Refer to 'Support and Supervision for Chaplains Working in General Practice' Guidance in ACGP Handbook.

- drawing up any supervisory reports which will be discussed with the Chaplain before submission.

We have agreed that the Chaplain will be responsible for:

- preparing for supervision
- presenting transparently in supervision: the content, themes, skills, theory and interventions of work with patients
- integrating learning from supervision into Continual Professional Development
- keeping notes from supervision sessions which are to be agreed and signed off.

Guidelines:

The following ground rules will guide our time together:

- confidentiality: if issues are raised which concern the Supervisor regarding unsafe or unethical practice by the Chaplain, or issues of harm to self or others brought by the patient, then discussion about disclosure will begin
- openness and honesty about the work and the supervisory relationship
- agree no leakage of information from the supervision sessions
- if either the Chaplain or the Supervisor cannot attend a session they will let the other know as soon as possible

Evaluation and Review:

Formal evaluations will take place annually as part of the annual appraisal process or as requested by either Supervisor or Chaplain.

Signed _____ (Supervisor)

Date:

Signed _____ (Chaplain)

Date:

Appendix I: Chaplain Annual Appraisal *(Revised Nov 2021)*

Your annual appraisal is a formal discussion where you and your Line Manager will look back over the year and review your CPD.

The purpose of the Annual Appraisal is:

1. To review learning, growth and professional development of Chaplain in a positive and supportive manner.
2. To discuss any concerns or needs of the Chaplain and or the Employer.

Annual appraisals are related to the Job Description and for Chaplains could include these types of questions:

1. Over the past year, what do you feel have been your main achievements?
2. Over the past year, think about any issues you may have faced which have been difficult and how you have worked to overcome these?
3. Thinking about linking with local faith groups, volunteer organisations and other external agencies, how much has this been a part of your role over the past year?
4. During the past year, how much of your time has involved linking with Practice staff in order to provide support – have there been any challenges which have made this difficult?
5. How have you managed your work-life balance and ensured that you have time for reflection and your spiritual wellbeing?
6. Do you feel that there is adequate support provided for both your professional development and wellbeing? What other methods of support would be helpful?
7. What are your aims and objectives over the coming 12 months?
8. Do you feel there are any training needs unmet which would support your development? If so, what do you think would be helpful?
9. Any other comments?

Appendix J: Measurement and Evaluation Tools

1. Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

2. Outcomes Wellbeing Star

3. Patient Reported Outcome Measures (PROMs)

4. Template for Spiritual Care Recording: Qualitative Analysis completed by practitioner (adapted from BWCH Trust Chaplaincy Department)

Case Study

Demographic data

Practitioner's Name:	
Date:	
Patient Name:	
Age:	
Gender	
Location of appointment:	
Duration of contact:	

Context

How was the client referred to you?	
Why was the client referred?	
How many times have you seen the client before this encounter?	
Are there factors affecting the intervention eg learning or physical difficulties, mental health issues?	

Encounter

Summarise the story of the encounter; include observations, body language, level of energy and interest, good and or safe practice, At what points and in what ways were your interventions intentional?

How did it begin?	
How did it develop?	
What interventions did you use?	
How did the encounter close?	

Assessment

How did you assess or identify spiritual, religious, pastoral or other need?	
What evidence enabled this to be known? Evidence of faith may include artefacts, dress or conversation).	
Was an assessment tool used, if so which one?	

Spirituality may include:

- attachment, belonging, connection, family, relationships, community, friends; purpose, beliefs and rituals
- sense of security and identity
- sense of hope or hopelessness
- what is important to the patient's sense of self
- feelings of guilt, anger, fear, love, vulnerability, shame, anxieties, hopes
- sense of the sacred

What spiritual needs were identified?	

What pastoral needs were identified?	
What religious needs were identified?	
What other needs were identified?	
How did they become apparent?	
What resources does the patient bring to address these needs?	
Were there moments of transcendence or extra-ordinary grace?	

Assessment of Intervention:

Spiritual care principles applied in this intervention:

Building relationship of trust between patient and chaplain	
Building relationship with God	
Feeling connected and valued	
Feeling listened to and affirmed	
Knowing what or who is important to the patient	
Feeling cared for	
Taken seriously; empowered	
Offered a non-medical experience of life	
Building self-esteem; helping patient feel good about themself	
Exploring the patient's feelings (worries, hopes, fears, anger, guilt,	

joys)	
Sharing humour, relaxing	
Adding to the patient's richness of experience	
Sense of meaning and purpose	
Exploring the sacred	
Nurturing rituals and beliefs	

Learning Outcomes

What went well?	
How do you measure the effectiveness of the encounter?	
What future interventions may be appropriate?	
What other information would have been helpful?	
What could have been improved?	
What specific insights are there for that particular patient?	
What general insights are there for your practice more widely?	
Are there any actions that should be implemented as a result of this intervention?	
Are there any issues to be discussed at a staff meeting or in supervision?	
What counselling skills were used in this encounter?	
What theological concepts or spirituality theories were illustrated in this encounter?	

Appendix K: Developing Reflective Practice

Reflection: a question is a tool for reflection at its simplest level; it encourages us to think and the intention is to elicit a response; it is a form of mental processing to fulfil a purpose or achieve an outcome. Reflection is giving something appropriate attention and consideration, looking at it from a variety of perspectives, being aware of the lenses we use and making a response (Nash & Nash, 2012).

The purpose of practicing reflection is to:

- develop self-awareness
- help us understand how we learn
- enable us to see how we are integrating values into practice
- help us explain what we do to our stakeholders
- empower us as practitioners as we grow in confidence and have a better understanding of what we do
- liberate us from some of our preconceptions or assumptions about ourselves and others
- help us solve problems in a creative rather than formulaic way
- encourage us to work with metaphors and images that bring fresh insights
- lead to action or decision
- develop our capacity to deal with new situations as they arise (Nash & Nash, 2012)

Reflective practice is very important in listening and guidance. The benefits of this are that it:

- provides a simple structure to process everyday experiences
- helps access prior learning
- encourages application of transferable skills
- helps and facilitates us in dealing with things that trouble us
- takes learning out of academic structures into the everyday lives of those we serve (Nash & Nash, 2012)

It is important to use reflective practice to process the encounters you have been involved with. Cultivate a pattern of reflection which you can readily use. Below are seven options, some of which you might find helpful.

Some suggested frameworks for reflection

1. DIER (Smyth, 1996)

- Describe……What do I do?
- Inform…….What does this mean?
- Confront……How did I come to be like this?
- Reconstruct….How might I do things differently?

2. DATA (Peters, 2002 cited in Hillier)

- Describe the problem
- Analyse the nature of it
- Theorise alternative ways to solve it
- Act on the basis of theory

3. Basic Reflective Model (Nash & Nash, 2012)

- Name: What is the situation/issue/dilemma/problem/question you want to reflect on?
- Explore: What are you hoping will emerge from this reflective process/ What is the end result/product/consequence that you are looking for?
- Analyse: What is/could be going on? How do you/others think/feel? Have you made assumptions about the situation? How do my values/motives/goals/traditions/discipline influence my analysis? Do I have previous experience that helps here?
- Evaluate: What options or possibilities do I have? What are the benefits or drawbacks of these? What would I change/do differently? What influenced me in this situation?
- Outcome: What is the outcome of this process? Have I learned something? Changed my practice? Taken action?

4. Gibbs Reflective Cycle (1988)

- Description – What happened?
- Feelings – What were you thinking and feeling?
- Evaluation – What was good and bad about the experience?
- Analysis – What sense can you make of the situation?
- Conclusion – What else could you have done?
- Action Plan – If it arose again what would you do?

5. Reflection: Self-awareness and Practice (adapted from Nash & Nash, 2012)

Self-Awareness

- Why have you chosen this experience?
- What feelings are associated with this experience? Do you need to process any of those feelings on your own, in supervision or with someone else?
- What was positive in this experience?
- What was negative in this experience?
- Have you learned anything about yourself through reflecting on this?
- Is there anything you need to reflect on further?

Practice

- What is the context of this practice experience?
- What was your role?
- What did you do?
- What did others do?
- Were your actions appropriate, ethical and effective?
- What could have been done differently or better?
- What were the consequences?
- Is there any follow up that needs to be done?
- Is there any theory or prior learning you can bring to this experience?
- What insights can you bring to this situation?
- What have you learned from this?

6. Reflection and evaluation of the helping relationship (adapted from Clegg, 2015 unpublished):

- helps learning from experience
- helps when `stuck` with an issue or problem with helping relationship
- provides sense of direction (to know where you are going, must know where you`ve been)

Consider feelings, thoughts, strategy, challenges and endings.

Feelings:

- How did you feel the appointment went?
- Did you wish to punish, rescue or avoid?
- What was the major emotion prevailing?
- What were the reasons for this?

Thoughts:

- What went well?
- What did not go well?
- Any disappointments?

- What could have been done differently?

Strategy:

- How clear is the patient on what they seek from these appointments?
- How well are their goals being reached?
- How much is the patient collaborating in their own success?
- What tasks remain for the patient to work on?

Challenges:

- Were any boundaries being pushed?

Endings:

- Who ended the session?
- Was it premature, abrupt, prolonged, any pattern?
- Reflect upon your own ways of coping with change, loss or endings (in a helping relationship, endings can re-awaken previous loss)

7. Theological Reflection template from UKBHC

The Story – what happened?	…according to you?	
	…from another perspective?	
	…what might have been left out / left unsaid?	
	…what didn't happen?	
The Impact – what has been the impact?	…on you?	
	…on others?	
The Vision – in the light of our experience and our values, what matters most here?	…according to what criteria?	
	…from a different perspective?	
The Experiment – what shall we try next as a way forward? – or what would we do next time in a similar situation?	…why this action?	
	…how will we do this?	
	…how will we evaluate?	
The Story – tell the story of the Experiment and continue the Reflection Cycle after a suitable time lapse…		

Appendix L: Quotations from Commissioning Documents

CCG (A)

We recognise the need for the hub to offer services which currently have no commissioning arrangements – Primary care chaplaincy (Listening and Guidance) which offers patients an opportunity for someone to listen and help them work through their problems.

This is a non-denominational, universal service which provides spiritual care. As described by NHS Education for Scotland (where primary care chaplaincy is nearly a universal service), “Spiritual Care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness, and can include the need for meaning, for self-worth, to express oneself... simply for a sensitive listener”.

Local and national evidence shows that this service is well received and makes significant improvements to wellbeing.

What is a Listening and Guidance Service?

1. It is a service for troubled and distressed people, provided through General Practice, which is accessible within 2 weeks, with or without a referral from the primary healthcare team.

2. It provides prompt access to ‘non-judgemental listening’, ‘holding’,’ support’, ‘signposting’ and a ‘safe place’ for patients to explore the issues which are important to them.

3. If it is relevant, requested and patient-led, this service provides the opportunity for patients to explore the 'existential/spiritual' issues which impact their health and wellbeing. Existential/spiritual issues, which relate to what ultimately gives an individual their personal sense of meaning and belonging, are often related to an individual's concept of faith or spirituality. Therefore, the providers of this service must be aware of the wide variety of different perceptions of faith and spirituality and they must be able to facilitate discussion on these issues without imposing their own perspective. (This service therefore fits within the European Academy of Teachers of General Practice definition of General Practice as being 'a discipline of medicine that deals with health problems in their physical, psychological, social, cultural, and existential dimensions').

Mental Health has been identified as a clinical priority for *CCG (A)*

The Lancet has recently reported a large scale study of co-morbidity (the existence of physical long term conditions with mental health issues) and multi - morbidity across 1.751 million patients registered within Glasgow GP Practices. The headline findings were that:

- 42·2% of all patients had one or more morbidities, and 23·2% were multimorbid
- onset of multimorbidity occurred 10 –15 years earlier in people living in the most deprived areas compared with the most affluent, with socioeconomic deprivation particularly associated with multimorbidity that included mental health disorders
- the prevalence of both physical and mental health disorder was 11·0%
- the presence of a mental health disorder increased as the number of physical morbidities increased and was much greater in more deprived than in less deprived people

What this highlighted was the need for a more holistic management of illness rather than compartmentalising treatment, and enabling clinicians to provide better continuity of care. People with mental health and physical health issues are likely to have poorer clinical outcomes, reduced quality of life and lesser ability to manage their condition(s) effectively.

CCG (B)

Purpose of the specification:

To set out the requirements of *CCG (B)* for the provision of a listening and guidance service that provides low level immediate psychological relief and spiritual care for people in distress. Spiritual needs can be understood as the universal but uniquely expressed human dimension encompassing the deepest human needs: intangibles such as hope, meaning, security and transcendence.

Local and national evidence shows that this service is well received and recipients report that it makes significant improvements to their wellbeing.

CCG (C)

The aim of this project is to introduce a Chaplaincy Listening and Guidance Service. This service will help distressed and troubled adults at an early stage, preventing further deterioration and need for secondary care. It is important to note that this is a multi-faith listening and guidance service which is in keeping with holistic patient care.

Mental health problems are the largest single source of disability in the United Kingdom, accounting for 23 per cent of the total ‘burden of disease’ (a composite measure of premature mortality and reduced quality of life).

Chaplaincy has existed in a few areas of General Practice for several years. It provides a prompt and easily accessible listening and guidance service for troubled people in primary care, as well as providing staff support. Patients are given a safe place to explore the issues which are important to them, through non-judgemental listening and personal support. The service is a ***non denominational, universal***

service which provides spiritual care. As described by NHS Education for Scotland (where primary care chaplaincy is nearly a universal service), “Spiritual Care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness, and can include the need for meaning, for self-worth, to express oneself... simply for a sensitive listener”.
If it is relevant, requested and patient-led, this service also provides the opportunity for patients to explore the existential/spiritual issues which impact their health and wellbeing. Existential/spiritual issues, which relate to what ultimately gives an individual their personal sense of meaning and belonging, are often related to an individual's concept of faith or spirituality. Therefore, this service may facilitate discussion about these issues without imposing any particular perspective.

Access to this service is through self-referral or through any member of the team in General Practice. Many patients do not need onward referral from this listening and guidance service, but it also enables appropriate signposting to voluntary sector community organisations or referral to statutory services where appropriate.

General Benefits of Listening and Guidance through Chaplaincy in General Practice

Patient Benefits

1. Patients can access help much earlier in their distress
2. Improved well-being
3. Increased confidence
4. Improved sense of personal value
5. Increased ability to make changes

Service Benefits

1. Early access to help can reduce complexity and severity of problems
2. Potential for more efficient use of doctor time with reduction in GP appointments
3. Potential for reduction in antidepressants and sedative prescribing
4. Potential for reduction in mental health referrals
5. Reduction in referrals to secondary care for medically unexplained symptoms
6. Specific expertise supporting policy directives which require spiritual care to be offered to patients with mental health problems, long term conditions and terminal illness
7. Provision of spiritual care to any patient in a non-stigmatising, professional and confidential healthcare context
8. Strengthening of whole person care with the patient story remaining at the centre of the healthcare process
9. Provision of staff support and an increase in General Practitioner resilience
10. Strengthened connections between General Practice and non NHS services in the locality, particularly voluntary organisations

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