**NHS Employers is undertaking a review to understand the impact and implementation experiences of the NHS Chaplaincy Guidelines which were introduced in 2015. We are gathering feedback from NHS staff and patient representatives to determine the level of understanding, application and impact. In addition we are asking staff if the best practice examples contained in the existing guidelines reflect the most up-to-date good practice examples.**

**The findings from the survey will be shared with NHS England and also at two events to be held later this year in November and December 2018. Recommendations will then be made to NHS England with the aim of refreshing (if needed) the guidelines in 2019.**

**To help assist you with your responses we have included passages from the guidance within the survey. You can also refer to the complete NHS Chaplaincy Guidelines (2015) and the accompanying Equality Analysis guidelines.**

**Who should complete this survey?**

**- Healthcare chaplains (both salaried and volunteers)**
**- Equality specialists**
**- Managers (including HR)**
**- Commissioners**
**- Directors**
**- Patient representative groups**

**The survey should take no longer than 20 minutes to complete and will close on 28 September 2018.**

**Data protection**

**All information supplied will be held by NHS Employers and may be stored on our internal contact management system. This information will remain secure and confidential and is held in accordance with the Data Protection Act and GDPR guidelines.**

**Personal information will not be shared with other third parties. Any reporting will be on an anonymous basis and will be shared outside of NHS Employers.**

**Please see our privacy policy for further information on how we will handle your data.**

* Contact information

**Your name**

**Organisation name**

**Email address**

* Job title

- Director
- Commissioner
- Manager
- Equality specialist
- Other (please specify)
- Healthcare honorary salaried chaplain
- Chaplain
- Healthcare volunteer chaplain
- HR manager

* Organisation type

- Clinical commissioning group
- Acute non-specialist trust
- Acute specialist trust
- Other (please specify)
- Mental health trust
- Community provider (Including social enterprises)
- Ambulance trust

* NHS England region you represent

- North East
- North West
- Midlands
- East
- Other (please specify)
- London
- South East
- South West

## 1. Equality analysis

* How confident are you that your organisation has integrated the key findings of the equality analysis linked to the NHS Chaplaincy Guidelines?

- ◯ Very confident
- ◯ Fairly confident
- ◯ Confident
- ◯ Not at all confident

Comments

## 2. Mainstreaming and action planning

* Does your organisation have an action plan/strategy to support the continued mainstreaming of the NHS Chaplaincy Guidelines?

- ◯ Yes
- ◯ No
- ◯ Don't know

Comments

## 3. Equality delivery system

* Does your organisation integrate work on the NHS Chaplaincy Guidelines as evidence for the Equality Delivery System (EDS2)?

- ◯ Yes
- ◯ No
- ◯ Don't know

Other (please specify)

## 4. Identifying barriers to support better practice issues

* Please rank the top barriers that prevent your organisation from meeting its NHS Chaplaincy Guidelines responsibilities (with one being the top).

- [ ] Lack of financial resources
- [ ] Lack of awareness and understanding in organisation
- [ ] Other priorities deemed more important
- [ ] Lack of leadership and senior commitment
- [ ] Lack of staffing resources
- [ ] Lack of data/information on what to do
- [ ] Organisational change
- [ ] Organisational restructuring
- [ ] Resources
- [ ] Training and skills
- [ ] Engaging the community

## 5. NHS voluntary professional advisor’s chaplaincy panel

* Are you aware of the voluntary professional advisor's panel?

- ◯ Yes
- ◯ No

## 6. Understanding and professional development

To what extent do you agree with the following statements?

**The NHS Chaplaincy Guidelines (2015) have:**

* Helped me/my organisation better understand the role of healthcare chaplaincy and the implications for me/my organisation.

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree ◯ Strongly disagree

* Helped me/my organisation shape developments relating to healthcare chaplaincy.

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree

☐ Strongly disagree

* Helped me/my organisation stay up-to-date with expert opinion and act as a key reference point for all matters relating to healthcare chaplaincy.

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree

☐ Strongly disagree

* Supported my own professional development.

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree

☐ Strongly disagree

Comments

## 7. Supporting organisational culture change

To what extent do you agree with the following statements.

**The NHS Chaplaincy Guidelines (2015) have:**

* Helped me/my organisation make changes which improve organisational effectiveness.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

* Helped me/my organisation make changes which improve the lives of our staff.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

* Helped me/my organisation make changes which improve patient care.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

* Enabled us to make necessary changes in a more cost/resource effective way.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

Comments

## 8. Promoting about service improvement, staff and patient voice

To what extent do you agree with the following statements?

**The NHS Chaplaincy Guidelines (2015) have:**

* Helped me/my organisation make the link between the NHS Chaplaincy Guidelines good HR practice and service improvement.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

* Helped me/my organisation share knowledge/good practice with others

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

* Helped me/my organisation identify and learn about good practice.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

* Helped me/my organisation contribute or channel views on staff health and wellbeing to the national debate.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

* Helped me/my organisation build stronger working relationships with others/other organisations.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

* Helped me/my organisation negotiate and agree a common approach to a challenge or issue with others.

- [ ] Strongly agree
- [ ] Agree
- [ ] Neither agree nor disagree
- [ ] Disagree
- [ ] Strongly disagree

Comments

## 9. Patient and service user care: equality, safety and compassion

* Is the best practice taken from pages 9-10 of the NHS Chaplaincy Guidelines, stated below, up-to-date with the most recent best practice?

In order to provide safe and effective spiritual care those commissioning and managing chaplaincy services should give due regard to the following best practice:

- Chaplains must abide by the requirements of their sponsoring religion or belief community, their contracting organisation, the Code of Conduct and all relevant NHS/NICE standards.
- Patients, service users and staff must be made aware of the nature, scope and means of accessing chaplaincy services within their setting. Only with adequate awareness can a provider evidence equality of access.
- Patients, service users and staff should be able to access chaplaincy at any time, on any day of the week in facilities where urgent out-of-hours support is requested on average at least once a week.
- Where patients from a single religion or belief group average at least one call per week, a separate on-call service should be provided. In circumstances where calls are below this level creative partnership with other providers and agencies should be explored in order to offer the best possible pastoral, spiritual, or religious care for patients.
- Where requests for support relate to a particular religion or belief the chaplaincy service should be able to access appropriate support for the patient or service user and, when this cannot be matched, other chaplaincy support should be offered.
- For patient and practitioner safety the provider's Lone Working policy must be followed.
- Patients and service users can expect to receive care from chaplains which is in accordance with nationally agreed competencies and capabilities (see http://www.ukbhc.org.uk) and in a manner authentic to the practices and beliefs of the community the chaplain represents.
- Where an instance of safeguarding arises during the course of spiritual care the chaplain must alert the patient or member of staff to the reporting obligations of the chaplain. The policies of the chaplain's NHS organisation must be followed in all circumstances.
- To ensure safety, accountability and continuity of care chaplains should maintain a record of work in a locally agreed format and in accordance with NHS policies for record keeping.
- Patients and service users have a right to expect that chaplaincy care will be experienced as neither insensitive nor proselytising.
- Compassion should always inform chaplaincy practice and is a key outcome of the patient's experience of the service being provided.

◯ Yes

◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 10. Staff organisational support: informed, competent, critical

* Is the best practice stated below and taken directly from page 11 within the NHS Chaplaincy Guidelines up-to-date with most recent best practice?

Best practice for quality pastoral, spiritual or religious care for staff and organisations is achieved by:

- The location of chaplaincy departments alongside allied health professional or similar clinical groupings.
- Ensuring staff awareness of how to access chaplaincy services which includes the availability of non-religious pastoral and spiritual support.
- Recording and reporting aggregated data about the number of times other health care staff access chaplaincy support and the time spent providing this support.
- If a chaplain has a concern about an aspect of organisational life this can be reported through line management. However, it is expected that a chaplain will have the option to communicate a significant concern directly to a member of the governing body.
- The lead/senior chaplain should produce an annual report of activities and outcomes, making this available to a wide audience, including the governing body and local communities of religion and belief.
- Organisations must have due regard to the health and well-being of chaplains. For small teams, many offering round-the-clock services, relevant legislation and NHS policies must be adhered to.
- Appointments to chaplaincy posts should be made by organisations in accordance with the latest guidance from the Panel of Professional Advisers.

◯ Yes

◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 11. Key components for an effective chaplaincy service

* Is the best practice stated below and taken directly from page 12 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

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

- The service has a designated lead chaplain.
- The chaplaincy has a written policy or guidance document describing the service and what care those using the service can expect to receive.
- A method of assessing belief, religion and pastoral needs should be described in the guidance document or separately.
- The chaplaincy department's staffing is calculated in accordance with the recommendations made below and the staffing is reviewed annually.
- Chaplains and chaplaincy volunteers collectively share the skills, knowledge, experience and insight to offer a comprehensive service.
- The chaplaincy department is fully included in relevant provider meetings and forums to ensure that pastoral, spiritual or religious care is integral to the holistic response to patient need.
- The chaplains have access to office space, administrative support, networked computers and data essential to the performance of their role.
- As part of annual appraisals development plans are written for each chaplain and supported (recognising that not all AHP funding sources are available for chaplains). Such plans need to take account of the hours a chaplain works, recognising that there are many part-time chaplains as well as some chaplains working under Service Level Agreements.
- Chaplains supervise all areas designated for faith-specific use, multi-faith use and use by those of non-religious beliefs. These should be well maintained, inviting and safe, and have available facilities to support worship (e.g. running water, storage for sacred items etc).
- Chaplaincies have procedures for auditing their work, both in terms of quality and quantity, so that the service is fully accountable within the organisation.
- There are regular opportunities for the chaplain(s) to engage in pastoral supervision in a group or one-to-one setting as well as by involvement with their religion or belief group.

◯ Yes

◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 12. Volunteers in chaplaincy

* Is the best practice stated below and taken directly from page 13 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

Best practice for quality pastoral, spiritual or religious care provided by volunteers is achieved when:

- The chaplaincy and/or the organisation produce written policies for the recruitment; screening; training; deployment and expected benefits of using volunteers in chaplaincy.
- Quality assurance is gained through regular audit of volunteers' attendance, conversations with NHS staff responsible for the volunteer's area, and occasional follow up visits to patients who have received a visit from a volunteer. Volunteers will be aware of these steps and receive constructive and supportive feedback on their role and its outcomes.
- In addition to complying with the relevant policies of the health provider chaplaincy volunteers attend at least one annual training event focusing on the safe practice of pastoral, spiritual or religious care.
- All chaplaincy volunteers will be aware of the chaplains' Code of Conduct and be expected to adhere to its standards. Referring to the Code and explaining its features should be a regular part of induction and ongoing development.
- Systems are developed locally to maintain and monitor volunteers' contact with patient data and the means to refer patients (or staff) requiring further spiritual, religious or pastoral care.
- Chaplains recruiting volunteers should have regular contact with the organisation's lead for voluntary services and, where appropriate, the relevant religion or belief community.
- Whenever a concern is expressed about a volunteer's work the volunteer is told as soon as possible and concerns are shared clearly and supportively.
- Making clear when a post is identified as a training position that adequate time is ring-fenced for study, development, education and training.

◯ Yes

◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 13. Chaplaincy staffing

* Is the best practice stated below and taken directly from pages 14-15 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

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

- For many years the primary figure for staffing calculations has been an average of 35 inpatients equating to 3.75 hours per week of chaplaincy (matched by religion/ belief).
- In large organisations this fostered the growth of multi-faith teams corresponding to user populations. Chaplains consulted in the formation of this guidance stated that in practice this figure continues to relate to operational demands. At the same time some international studies have identified a staff-to patient ratio approximating current English practice in acute provision. This figure is also similar to that used in Scotland and Wales.
- It is widely known that data about the religion or beliefs of inpatients is both limited and frequently inaccurate. However, independently gathered information shows that a significant minority of patients who have a particular religion or belief wish to practice it during their episode of care16 (and are often unable to do so). Given that chaplains are also requested by patients not identified with a particular religion or belief, and that patients' religion or beliefs may be incorrectly recorded on NHS systems, recognition of this has been included in the recommendations below.
- In order to fulfil the Public Sector Equality Duty health care organisations should make every effort to request and record information about the religion or belief of service users and patients.
- Audits to verify the accuracy of this data, check users' awareness that chaplaincy is available to them, and monitor the quality of experience and any agreed religious, spiritual or pastoral outcomes. This will enhance an organisation's ability to demonstrate that it is meeting the Equality Duty.
- It is important to note that some people who do not belong to a religion or belief can also access and fully utilise chaplaincy services. This needs to be born in mind when making calculations and employment decisions. NHS organisations need to ensure the chaplaincy service is accessible to those without a religion and employment decisions are based on robust data and where applicable are fully compliant with the occupational requirement provisions of the Equality Act 2010.

◯ Yes

◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 14. Chaplaincy in acute care

* Is the best practice stated below and taken directly from pages 16-17 within the NHS Chaplaincy guidelines up-to-date with the most recent best practice?

Best practice for good quality pastoral, spiritual or religious care is achieved by:

- Ensuring that all patients and service users are asked about their religion or belief and offered appropriate chaplaincy support. This information must be recorded accurately with referrals passed on promptly.
- Allocating 3.75 hours per week of chaplaincy care for an average inpatient population of 35 patients with posts matched by religion or belief. This calculation should be made on the basis of accurate information about the religion and beliefs of the patient or user population.
- Allocating 3.75 hours per week of chaplaincy care for every 35 patients not identified with a particular faith or belief system. Posts relevant to this population are to be open to any appropriately qualified chaplain of any recognised religion or belief community that can effectively carry out the role.
- Allocating 3.75 hours per week of chaplaincy care for every 500 WTE staff irrespective of their particular religion or belief.
- Allocating 3.75 hours per week of management/professional leadership time for the lead chaplain for each whole-time equivalent chaplain in the team, recognising that small teams may require an increased allocation in order to meet organisational expectations.
- Allocating of 3.75 hours per week for each NHS contract funeral taken by chaplains. This time includes preparation, contact with relatives/friends, travel to the funeral location and the service itself.
- Matching chaplaincy provision for end-of-life care to best practice models, such as the ratios of staffing found in most hospices. This can mean 37.5 hours per week of chaplaincy care, appropriately allocated, for every 24 patients in the last 72 hours of life.
- Ensuring that at least 20% of a chaplain's working time is available for some or all of the following duties: participating in staff education, development in spiritual care and pastoral supervision.
- Membership of ethical and other committees where the chaplain offers specialist knowledge and experience.
- Managing chaplaincy volunteers.
- Developing expertise for research and publication.

( ) Yes

( ) No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 15. Chaplaincy in mental health care

* Is the best practice stated below and taken directly from pages 18-19 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

Adequate chaplaincy staffing for mental health services requires:

- An allocation of 3.75 hours per week of chaplaincy for every 20 patients, taking into careful consideration the composition and needs of the user population by religion or belief.
- Where there is a need for chaplaincy involvement in community work there should be an additional allocation of 3.75 per week for every 15 chronically ill service users. · Given the dispersed nature of many care settings within a single provider additional hours may need to be added to recognise the travelling time involved.
- At least 3.75 hours per week of chaplaincy for every 200 whole-time equivalent staff. · Allocating 3.75 hours per week of management/professional leadership time for the lead chaplain for each whole-time equivalent chaplain in the team, recognising that small teams may require an increased allocation in order to meet organisational expectations.
- Ensuring that at least 20% of a chaplain's working time is available for some or all of the following duties (which may be distributed in larger teams): · Participating in staff education, development in spiritual care and pastoral supervision.
- Membership of ethical and other committees where the chaplain offers specialist knowledge and experience.
- Managing chaplaincy volunteers including religion or belief-specific visitors.
- Developing expertise for research and publication.
- Allocating time to prepare for work with a service user. Risk assessment is especially important where lone working is required.

- ◯ Yes
- ◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 16. Chaplaincy in General Practice

* Is the best practice stated below and taken directly from page 20 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

Adequate chaplaincy staffing for primary care health services requires:

- 3.75 hours of chaplaincy for every 250 whole-time equivalent staff with the availability of chaplaincy advertised so that all staff are aware of the service.
- Defined and documented means of access for patients and service users to receive professional chaplaincy services.
- An indicative staffing of 37.5 hours of chaplaincy to a practice population of 50,000.

- ◯ Yes
- ◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 17. Chaplaincy in specialist palliative care

* Is the best practice stated below and taken directly from page 21 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

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

- Units with fewer than 16 beds – minimum of a half-time appointment.
- Units with 16 beds or more – minimum of a full-time appointment.
- Within dedicated palliative units a chaplaincy department's commitment to outpatient, day therapy and community services should also be taken into consideration. Chaplains will regularly be involved in the support of patients' families pre-bereavement and in many instances will play a significant role in bereavement care, including the conduct of patients funerals and the organisation and conduct of memorial services and related events.
- As members of the multi-disciplinary team chaplains will often be responsible for delivering staff education, supervision and support, and will require their own pastoral supervision to equip them for these tasks.
- In designing or reviewing a chaplaincy service in a palliative care setting accurate information about patients' religion or belief, as well as their pastoral and spiritual needs, should be considered carefully.

◯ Yes

◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 18. Chaplaincy in specialist paediatric care

* Is the best practice stated below and taken directly from page 23 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

- The spiritual needs of younger people and children require highly skilled and imaginative care.
- The ethical and safeguarding considerations for care in specialist paediatric units are of paramount importance. Chaplains working in such areas will require enhanced training tailored to their context.
- The families and friends of younger people and children face particular challenges to religion or belief and spirituality. Chaplains in paediatric settings will need to be equipped to support those facing these challenges and will require support and supervision.
- It is recommended that staffing levels and allocation of posts are the same as those of specialist palliative units, especially given the level of outpatient contact and the support of families.
- The Paediatric Chaplaincy Network is producing guidance on standards of care and the competencies expected of chaplains working with children and young people.

◯ Yes

◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 19. Chaplaincy in community care

* Is the best practice stated below and taken directly from pages 9-10 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

Care for people outside NHS facilities is a growing aspect of health provision.

- Most people prefer to be cared for at home if possible and, with a rising population of elderly people, it is anticipated that this aspect of health care will increase. Many different agencies including religious or belief groups have a long history of providing supportive care in the community.
- Staff working in the community should have access to chaplaincy services. This is both to support them in the day-to-day demands of caring and also to assist in their care for patients either by advice or attendance. Many service-users living with mental health illnesses are supported in the community and there is evidence that chaplaincy involvement can lead to both a reduced sense of isolation, signposting to additional services and increased resilience.
- There is a significant connection between primary care and community care and close working between chaplains in these areas should be pursued actively.
- One way forward for community chaplaincy may involve wider developments in the NHS such as telemedicine and the internet. It is expected that in the next decade work will be undertaken to trial pastoral, spiritual or religious care support via both telephone e-mail, teleconferencing etc in order to offer accessibility to services for those receiving community care.
- The benefits of pooling resources within a locality and region are significant. Where smaller religion or belief communities would struggle to gain resources for chaplaincy in a given area, links with neighbouring regions – and the use of remote support – could enable isolated patients and service-users to be supported and valued.

( ) Yes

( ) No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 20. Information governance

* Is the best practice stated below and taken directly from page 24 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

For reasons of both pastoral, spiritual or religious care and equality, providers should make every effort to request and record data about religion or belief. In order to have the information needed to provide excellent spiritual care it is essential that:

- All NHS patients and service users should be asked if they wish to declare their religion or belief and to have this recorded.
- When NHS patients and service users express their pastoral, spiritual or religious needs, and request to be referred to the chaplaincy service, this information should be recorded and action taken.
- All NHS patients and service users who provide such information should be fully informed as to how their information is intended to be recorded, used and shared and of their right to refuse to consent to such processing.
- Where referrals are made an assessment of pastoral, spiritual or religious need should be carried out by a chaplain using an agreed method.
- Patients and service users are given access to the most suitable chaplain to meet their pastoral, spiritual or religious needs.
- In order for an assessment to be carried out patient information (name and religion or belief) should be made available promptly to the staff sanctioned by the provider to carry out this work with the patient's explicit consent to the referral.

◯ Yes

◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

## 21. Training, development and research

* Is the best practice stated below and taken directly from pages 25-26 within the NHS Chaplaincy Guidelines up-to-date with the most recent best practice?

Best training and development for quality pastoral, spiritual or religious care is achieved by:

- As stated above, regular reviews, at least annually, of the chaplain's development needs.
- Compliance by chaplains with their employers' mandatory training and equality policy Maintenance of an up-to-date Professional Development Portfolio.
- Supporting chaplains' participation in suitable training provided by the NHS, chaplaincy professional bodies and the chaplain's own community of religion or belief.
- Enabling newly appointed chaplains to access chaplaincy induction training.
- Regular, planned pastoral supervision to reflect on practice.
- All chaplains should be familiar with the profession's research standard33, meet the foundation level and plan to develop elements of the next level.
- Encouraging chaplains and chaplaincy teams to remain engaged with the wider community including where relevant local Healthwatch, inter-faith groups and other relevant patient forums including those that are non-belief and non-religion.

- ◯ Yes
- ◯ No

If not, please share suggestions and evidence which could be included in a refreshed version of the NHS Chaplaincy Guidelines. Please limit your contribution to 200 words.

If you have any further comments or suggestions on this survey and review of the guidelines please use this space to share.

Thank you for taking the time to complete this survey.