Royal Cornwall Hospitals
NHS Trust

Spiritual and Pastoral Care Policy

V3.0

October 2025

Summary

The aim of this policy is to recognise the importance of spiritual and pastoral care for all and to set out how the Trust will deliver this care for all patients with particular emphasis on those receiving end of life care.

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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. The aim of this policy is to recognise the importance of spiritual and pastoral care for all.

1.2. Respecting a person's spiritual needs (including their religion or belief) reflects the Trust's commitment to delivering patient-centered care and how well it responds to our local communities. It also reflects the Trust's commitment to equality and inclusion and aims to support meeting the human rights of individuals.

1.3. Spiritual healthcare is an important aspect of holistic healthcare. Total care includes care for the physical, social, psychological, and spiritual dimensions of the person. If we do not acknowledge a patient's religion or beliefs (which includes non-religious beliefs), we cannot communicate with the 'whole' person, and they cannot participate in their recovery and make informed decisions about their treatment.

1.4. Different cultures, faiths and beliefs have a variety of views on health, ill health, birth, dying and death and we need to be aware of the diversity which will affect their path and outcome of treatment.

1.5. Allowing patients to express or practice their beliefs helps them to overcome the sometimes multiple losses (health, mobility, role, status, self-image, confidence, personal life control) which ill-health brings. In palliative care faith and belief can provide hope and a sense of meaning and strength to cope with the situation. Faith and belief can provide comfort to a patient whose life is ending. The sense of belonging that a faith or belief gives can enable a dying patient to be peaceful and overcome anxiety and terminal restlessness and can be a support to bereaved relatives.

1.6. Records show that over 110 different religion/belief systems are declared by people who use our services each year. Many belief systems (both religious and non-religious) have in common the teaching of a particular way of life and therefore need to be considered as an integral part of their care.

1.7. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. The purpose of this policy is to set out how the Trust will deliver spiritual care for all patients with particular emphasis on those receiving end-of-life care.

2.2. It also sets out how the Trust will meet NHS Chaplaincy Guidelines 2023.

2.3. In addressing religious, cultural, and spiritual needs, it is also supporting our delivery of the Equality Act 2010 and the Public Sector Duty 2011 (Equality and Human Rights Commission, 2015).

3. Scope

This policy applies to all who work within the Trust whatever their personal beliefs, views or life stance.

4. Definitions / Glossary

4.1. Challenges defining ‘spiritual care’

There is no agreed definition of ‘spiritual care’ other than it normally encompasses a broad field of practice including spiritual/existential, religious and pastoral care. The Trust has chosen to use the following definitions, acknowledging that this is not everyone’s way of speaking, but to provide simple terms enabling consistent patient care along with any corresponding data collection and/or analysis.

4.2. Further challenges with the terms ‘spiritual’ and ‘religious’

‘Spiritual care’ and ‘religious care’ are very differently understood by many. However, it is helpful to also reflect on words such as values, meaning, purpose, how we look at life and for some beyond life They should neither be artificially separated nor assumed to be interchangeable. These terms are sometimes presumed to have the same meaning, but this can lead to confusion and the needs of individuals being overlooked. Some will understand spirituality to be an aspect of religious life; others will understand religion as one expression of the spiritual life, and others would like to see them as entirely distinct. Indeed, some people do not consider themselves to be religious or spiritual while others may identify as ‘spiritual’ but not ‘religious’ or even ‘religious but not spiritual’.

4.3. Spiritual

Spiritual (for the purpose of this policy) describes the way in which people make sense of their human experience. It includes all those aspects of life that enable us to be human, e.g., uniqueness; dignity; worth; conscience; values; attitudes; beliefs and relationships. Spirituality is a universal human experience that centres on the capacity to find purpose and meaning in life.

4.4. Religious

Religious (for the purpose of this policy) describes a range of beliefs and practices, often incorporating specific rituals and traditions, and for many individuals, it is the way in which they express their faith/belief. It might be described as the outward working of an inner belief.

4.5. Belief

Belief (for the purpose of this policy) describes an inclusive concept of belief, to include a strong and genuine philosophical worldview that informs human life and behaviour. Examples of such worldviews may include atheism, agnosticism, humanism, pacifism, veganism and ecological beliefs.

4.6. Spiritual Care

Spiritual care (for the purpose of this policy) describes a response provided to support a patient, member of staff or visitor in making sense of their human experience. It may include responses to those who show signs of spiritual pain or distress such as:

- Anger: directed at their God, other people or self.

- Bitterness: what have I done to deserve this?
- Regret: I should have been a better person!
- Guilt/punishments: I must have done something wrong.
- Doubt: is there a purpose/meaning for existence?
- Fear: I am not sure there is anything after death. I no longer have the capacity for resilience and acceptance in the face of suffering and/or death.
- Isolation: my family/neighbours, friends/God, etc have abandoned me.
- Loss of hope: I see no future/a negative future stretching endlessly ahead. I have lost the capacity to determine my life and my future.

Spiritual care, therefore, is important to all people, regardless of religion or belief. Patients often have a strong need to make sense of their circumstances, to find meaning in events, their relationships, and their life during periods of illness and hospitalisation. Spiritual aspects of care, therefore, recognise the humanity, uniqueness and personhood of all patients, relatives, and staff.

4.7. Pastoral Care

Pastoral care is a term often used to describe the response provided when a patient, member of staff or visitor needs support and care to meet personal and emotional challenges. This care includes the giving of time, attention, and respect to whatever the patient or user presents as well as dealing with practical problems and their resolution. Advocacy of all types could fall within this category as might supporting a patient who has just received bad news.

4.8. Religious/Non-Religious Care

Religious care broadly describes support or advice given to a patient, member of staff or carer specifically related to their religious belief or custom – for example the carrying out of specific religious rites or rituals. This can be of particular significance at key moments such as birth or death. Those who hold non-religious beliefs may also wish to use rites and rituals to express their beliefs or to create a sacred moment such as through meditation or mindfulness practice, baby naming's, non-religious funerals, and weddings etc.

4.9. Cultural Care

Cultural care is not always distinguishable from religious care in some traditions but includes the wider cultural needs and expectations of individuals such as dietary traditions, rituals relating to rites of passage, issues of modesty and so on. As a Trust we aspire to deliver holistic and sensitive care which is responsive to cultural needs whenever possible.

4.10. **End of life**

Spiritual, religious, pastoral, and cultural care is particularly significant at the end of life. Rather than the more general term ‘palliative care’, the phrase ‘end of life’ refers specifically to the last few days of life when an individualised plan of care is normally in place.

5. Ownership and Responsibilities

5.1. Role of the Director of Nursing, Midwifery and Allied Care Professionals

The Director of Nursing, Midwifery and Allied Care Professionals has director-level responsibility for Chaplaincy Services and overall responsibility for spiritual care within the Trust, ensuring compliance with duties and guidance.

5.2. Role of the Lead Chaplain

The Lead Chaplain is responsible for advising the Trust and supporting spiritual care across all services and ensuring delivery of spiritual, pastoral and religious care is adequate and appropriate (subject to the resources available), including liaison with external faith and belief communities.

5.3. Role of Individual Staff

All staff members are responsible for ensuring all patients, carers and visitors always receive appropriate spiritual care. Certain professions such as nursing and medicine have a particular responsibility for ensuring competent spiritual care is delivered and appropriate referral for cultural and religious care.

6. Standards and Practice

Delivering Spiritual, Religious, Pastoral and Cultural Care.

6.1. Recording

6.1.1. We seek to accurately record the faith/ belief affiliation of all patients (inpatient and outpatient) to support effective pastoral, spiritual and religious and cultural care when required.

6.1.2. We routinely monitor the faith/ belief affiliation of our patient group to ensure that the services we provide broadly meet the patient profile.

6.1.3. On admission, we seek to record any identified spiritual/existential needs and to support, whenever able, any request for spiritual care.

6.1.4. In maternity services, families are always asked whether they would value pastoral, spiritual or religious care at any time of fetal/baby loss and their response is recorded.

6.1.5. When a patient has been identified as receiving ‘end of life’ care, an individualised plan of care is drawn up with a specific assessment of the psychological, spiritual and emotional needs carried out. There is also a specific record of any faith/belief needs around the time of death recorded in the nursing notes and chaplaincy support is universally offered.

6.2. **Assessing and delivering**

6.2.1 The Trust understands spiritual, religious, pastoral and cultural support to be a core component of all our care delivery and, as such, is delivered in part by all staff. Whilst Chaplaincy has a key specialist role to play, the majority of spiritual care is delivered by nurses and other professions as part of the overall quality of care delivered.

6.2.2 To support this wider understanding of spiritual care, the Trust both enables and strongly encourages relevant clinical staff to develop their competency in delivering spiritual care within the holistic care model NHS England acknowledges.

6.2.3 The Trust is clear that spiritual care is a dimension of all care and, therefore, all patients have a reasonable expectation to receive it. This includes patients who are affiliated with a faith which may or may not refer to a higher power or God(s) and those who hold non-religious beliefs (taking an inclusive approach to the concept of ‘belief’ as set out above). Each individual patient will hold their own individual set of beliefs which may come from more than one tradition or worldview, and it is our aim to work in full recognition of that to offer person-centred care appropriate to each individual. The Trust is developing appropriate assessments and provision for patients under the age of 18 who have a reasonable expectation of spiritual care that is age-appropriate and right for them as an individual as well as for their families.

6.2.4 Whilst a significant number of patients have an expressed faith of ‘Christian’, this relates to a very broad range of beliefs and practices. Further, there are a wide number of individuals who identify with other religious or non-religious beliefs such as Buddhist, Hindu, Humanist, etc. Still other patients will have non-religious or spiritual beliefs of other kinds. To support the cultural, religious and spiritual needs of all, the Chaplaincy service is required to have effective relationships with a wide number of faith and belief community leaders. These individuals are endorsed by their own faith/belief group.

6.2.5 The Trust operates a cross-belief approach to Chaplaincy in which each chaplain in the team ministers to all patients, visitors, and staff, irrespective of religion or belief. For example, a Christian chaplain may minister to a non-religious patient, or a Humanist chaplain to a Christian patient. The rationale for this is that a cross-belief approach involves working to understand and integrate different beliefs and their traditions within the team and the service, playing to strengths, and matching knowledge and skills to needs. It recognises social diversity as a positive, and that individuals have a range of beliefs and practises, including those rooted in religion, culture and family traditions, in the context of a secular

society. Each individual will have a unique set of beliefs and Chaplaincy aims to work within those with respect and empathy.

6.2.6 Alongside the spiritual needs' assessment carried out for patients receiving end of life care, a clear record of the spiritual care delivered needs to be made of all significant interventions in patient care.

6.2.7 The Trust is committed to providing high quality Chaplaincy support following the guidelines set out in the 2023 NHS Chaplaincy - guidelines for NHS managers on pastoral, spiritual and religious care. This includes 24/7 emergency cover, in particular responding to end-of-life situations as expected within 'One Chance to Get It Right (2014)' as well as those arising from providing maternity and emergency services from suitably qualified or skilled individuals able to respond to the spiritual, pastoral or religious needs identified.

6.2.8 The Trust provides a 24/7 on-call system to support all patients and families with spiritual, pastoral and religious care, no matter how they might describe any faith or belief. The on-call chaplain on a particular day, regardless of their own faith or belief, will minister to the spiritual, religious and pastoral needs of any patient to whom they are called for, insofar as spiritually appropriate in that particular case. Additionally, we will retain a 24/7 system via switchboard for contacting local Roman Catholic priests to meet the needs of this significant minority.

6.2.9 Alongside care for patients and their families, the Trust takes seriously the spiritual / existential needs of its staff and chaplaincy support is available to staff on a confidential basis on request. They also work with individual staff and their managers to support staff with particular faith/belief or cultural needs in the workplace.

7. Dissemination and Implementation

7.1. This policy will be available to all Trust employees through the Trust's document library (Human Resources folder).

7.2. The main uses of this policy are the Spiritual and Pastoral Care Team who have been instrumental in updating the policy and commenting on the final document.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Performance indicators for the Spiritual and Pastoral Care Team. The service will be provided on a 24-hour, 365 days a year basis, responding to emergency situations within 60 minutes of receiving a call in 98% of incidents. Non-urgent contacts' response will be made usually within 24 hours of a request or by negotiation with those involved.

Information Category	Detail of process and methodology for monitoring compliance
	Compliance with 'One Chance to Get It Right'. Compliance with NHS Guidance on Chaplaincy 2023.
Lead	Lead Chaplain
Tool	10% sample check of referral forms and Chaplaincy database. Ongoing monitoring of spiritual care delivered at the end of life by the End-of-Life group.
Frequency	A report will be completed annually. The results of the report will be shared with the Director of Nursing, Midwifery and Allied Care Professionals annually.
Reporting arrangements	The report will be forwarded to the Director of Nursing, Midwifery and Allied Care Professionals.
Acting on recommendations and Lead(s)	Lead Chaplain to decide on any further actions as required and report outcome to the Director of Nursing, Midwifery and Allied Care Professionals.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within six months. The Lead Chaplain to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

9. Updating and Review

This policy must be reviewed within three years or sooner should local or national policy imply or demand revision at any earlier date. The policy shall be reviewed by the Lead Chaplain.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Spiritual and Pastoral Care Policy V3.0
This document replaces (exact title of previous version):	Spiritual and Pastoral Care Policy V2.0
Date Issued/Approved:	October 2025
Date Valid From:	October 2025
Date Valid To:	October 2028
Directorate / Department responsible (author/owner):	Patient Experience. Clinical Governance. The Reverend Dom Whitting, Chaplaincy.
Contact details:	01872 252899
Brief summary of contents:	The aim of this policy is to recognise the importance of spiritual and pastoral care for all: patients, families, carers and staff.
Suggested Keywords:	Spiritual, pastoral, chaplains, chaplaincy.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Director of Nursing, Midwifery and Allied Care Professionals
Approval route for consultation and ratification:	Patient Experience Group
General Manager confirming approval processes:	Purva Shrivastava, Patient Experience Manager
Name of Governance Lead confirming approval by specialty and care group management meetings:	Bernadette George, Director of Nursing, Midwifery and Allied Care Professionals
Links to key external standards:	None

Information Category	Detailed Information
Related Documents:	• Equality, Inclusion and Human Rights Policy. • E-Roster Policy. • Flexible Working Policy. • Special Leave Policy. • Supporting Staff involved in an Incident, Claim or Complaint.
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Patient Experience

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
July 2016	V1.0	Initial version	Mark Richards Lead for Chaplaincy and Voluntary Services
July 2019	V2.0	Full review of policy: • Section 2, Purpose – revised. • Section 4, Definitions/Glossary – revised. • Section 5, Ownership and Responsibilities – revised. • Section 6, Standards and Practice – revised. • Reformatted in line with current Trust template.	Mark Richards, Lead for Chaplaincy and Voluntary Services
September 2025	V3.0	• Transferred to Accessible Information Standards template. • Full review of policy.	Dom Whitting, Lead for Chaplaincy and Voluntary Services

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Spiritual and Pastoral Care Policy V3.0
Directorate and service area:	Integrated Governance
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	The Reverend Dom Whitting
Contact details:	01872 252883

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	It applies to all who work within the Trust whatever their particular personal beliefs and worldviews.
2. Policy Objectives	The aim of this policy is to recognise the importance of spiritual and pastoral care for all by all.
3. Policy Intended Outcomes	The service will be provided on a 24-hour, 365 days a year basis, responding to emergency situations within 60 minutes of receiving a call in 98% of incidents. Non-urgent contacts will be made usually within 24 hours of a request or by negotiation with those involved.
4. How will you measure each outcome?	10% sample check of referral forms and Chaplaincy database.
5. Who is intended to benefit from the policy?	Users of Trust services and staff.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** RCHT Chaplaincy Team. Patient Experience Group (PEG).
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	

Protected Characteristic	(Yes or No)	Rationale
Religion or belief	No	The Trust recognises that different cultures faiths/beliefs have a variety of views on health, ill health, birth, dying and death and liaises with external faith and belief communities.
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g., gay, straight, bisexual, lesbian etc.)	No	The Trust respects and supports the rights of those in the LGBTQ community (lesbian, gay, bisexual, transgender and questioning).

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Reverend Mark Richards.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis