

# **THE CHAPLAINCY COLLABORATIVE LAUNCH EVENT IN MANCHESTER CITY STADIUM**

A REPORT from Mark Folland  
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&

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To Healthcare Chaplains, Chaplaincy Line Managers & Bishops  
Advisers in the Greater Manchester Chaplaincy Collaborative

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## Background

This report details the discussions which took place at the Chaplaincy Collaborative Launch Event in The Manchester City Stadium on May 5<sup>th</sup> 2006.<sup>1</sup> On that day a chaplaincy collaborative for chaplains in Greater Manchester came into existence.<sup>2</sup> The report has been prepared from the notes taken by the group facilitators from the then Greater Manchester SHA.

The day was jointly planned and organised by Mark Folland, Lead Chaplain NHS North West for the '*Caring for the Spirit NHS Strategy*,' the Lead Representative for the Project in the SHA Kay Worsley-Cox, Organisational Development Manager, and Robert Merchant, Lecturer in Spirituality and Health from Staffordshire University.

Lead chaplains including their whole and part time colleagues, and chaplaincy line managers were invited by Neil Goodwin formerly CEO and Transitional Lead for the North West Cluster of SHAs to attend the day.

The launch event comprised two presentations followed by group discussion. The first presentation about the '*Caring for the Spirit Strategy*' was given by Mark Folland, and the second about the Use of Evidence in Healthcare Chaplaincy by Rob Merchant. The Agenda for the day is at the end of this document.

The discussions which followed the presentations were clustered around three questions which were discussed in facilitated groups. The key messages from the discussions have been summarised at the end of each section under the heading 'Emerging Issues' and 'Emerging Work streams.' There will be opportunities to discuss this report in future collaborative meetings and to use it to develop a programme of work for the collaborative in line with the NHS Strategy. Comments on this report are also welcomed and should be sent to [mark.folland@sasha.nhs.uk](mailto:mark.folland@sasha.nhs.uk)

Information about the *Caring for the Spirit NHS Project* including all published papers and documents can be accessed at [www.yorksandhumber.nhs.uk](http://www.yorksandhumber.nhs.uk) then click onto South Yorkshire SHA and then the chaplaincy icon.

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<sup>1</sup> *Caring for the Spirit: Implementation Plan, Guidance Note 9 – Chaplaincy Collaboratives.*

<sup>2</sup> The following Chaplaincy departments and all their chaplains in Acute, Mental Health and Primary Care Trusts are included in this collaborative:

Bolton Hospitals NHS Trust  
Central Manchester & Manchester Children's Hospitals NHS Trust  
Christie Hospital NHS Trust  
Pennine Acute Hospitals NHS Trust  
Salford Royal Hospitals NHS Trust  
South Manchester University Hospitals NHS Trust  
Stockport NHS Foundation Trust  
Tameside & Glossop Acute services NHS Trust  
Trafford Healthcare NHS Trust  
Wrightington, Wigan & Leigh NHS Trust  
Bolton, Salford & Trafford Mental Health NHS Trust  
Manchester Mental Health & Social care Trust  
Pennine Care NHS Trust

## QUESTION 1

### What are the strengths, weaknesses, opportunities and threats in participating in a 'Caring for the Spirit' chaplaincy collaborative?

1. The responses generated in the space for personal thoughts and reflection on the **strengths** demonstrated a clear interest in and commitment to the value of a collaborative being a “clearly defined structure for education,” “offering an increased knowledge base,” “better standards,” “improved networking,” “enhanced credibility in the NHS” and a “resource for sharing information about what we do.” A number of you commented to the effect that you experienced some sense of isolation in your daily work and that the collaborative structure could assist you in “not working in a vacuum.” In these ways we discussed how a chaplaincy collaborative might act as a platform for professional development. Among the strengths of collaborative working you also discussed the distinct contribution of “part-time chaplains” in relation to the emerging mixed economy in healthcare, and how their liminal position between community and NHS Trust might be developed in the current political climate.
2. At a departmental level you spoke about the way in which 'Caring for the Spirit' provided **strength** through the opportunity to work more closely together with other professionals including managers who could assist you in service development. People spoke about their hope that they would be able to “develop their practitioner work” while leaving room for the opportunity to build a more specialised portfolio through such things as multi-professional working. We discussed the important opportunity offered by 'Caring for the Spirit' (CfS) and collaboratives in their move towards an evidence-based approach to spiritual care. There was some discussion about how the multi-faith agenda in CfS might be developed and carried forward in the collaborative as many of you indicated its importance. In particular the issue of appointing suitably trained and qualified chaplains from different faith communities was discussed. A number of you raised the issue of how volunteers can be integrated into the collaborative structure.
3. At a patient level you identified the following **strengths**. One of the main themes to occur in most groups was that patients (and staff) would be able to gain a better view and understanding of what chaplains do and why they do it. There was also much discussion about chaplains being involved in the wider remit of the hospital and the opportunity to compliment patient-focussed work with patient-orientated work (e.g.; project groups, ethics committees and teaching). Under girding these discussions seems to have been a tone of regret that chaplaincy experiences some marginalisation within the NHS. Some of you saw that the collaborative structure might be an opportunity to become more “accepted” and “integrated” into the structure of the NHS. Some of you saw CfS as a way of “improving the quality of the care chaplains provide” and therefore being accountable to the NHS and faith communities.
4. There was much discussion around the **opportunities** afforded by 'Caring for the Spirit' and collaboratives. In particular your individual reflections showed that you thought the collaborative could be a place where “stronger support and advice” about service development, research and best practice

would be found. Many of you also emphasised the hope that it would be a place where you could “look through new eyes” at existing issues. You saw it as place for “networking” and some saw it as a mechanism “for getting away from the hospital.” There was discussion about its CPD structure and proposals.

5. Regarding your departments you discussed the **opportunity** for part-timers and volunteers and raised some concerns about the feasibility of this regarding time allocation. A number of you saw that the collaborative might be a place in which to network about research activities and awareness with other chaplains and other professionals. We discussed how the collaborative approach has been used effectively in the NHS for professional development and service improvement programmes with other occupations, as for example in cancer services. Many of you thought that the collaborative model will be helpful in “formalising what is already happening in chaplaincy” and providing a “resource” through to 2010.
6. In relation to patient care the main **opportunity** you discussed was the dynamic of “more spirituality and less religion.” While this was not agreed by everyone - in fact some dissented from this view quite strongly, it seems to have provoked a lively discussion about the content, nature and responsibility for providing spiritual and religious care. The other two opportunities you discussed in relation to patient care are perhaps two sides of the same coin – evidence-based practice and accountability. There was discussion about ‘how’ to access the evidence to promote and develop our work and also about ‘how’ best practice is integrated into everyday pastoral practice.
7. A number of themes emerged in the discussion about what you thought were some of the **weaknesses** in the ‘Caring for the Spirit Strategy’ and the collaborative approach. A number of you felt that the Strategy had adopted a “top-heavy management approach and structure” to the development of the service at a national level. Some of you commented that locally you did not experience enough pro-active support from your line managers and that you felt this negatively impacted on the chaplaincy service and spiritual provision to patients and staff. There were a number of comments to the effect that the strategy tells us “nothing new” or “nothing we did not already know,” and that “there is not enough time in the day for this as well.” In addition to these felt weaknesses a number of structural comments were made about the strategy as a whole. There were a number of comments along the lines that the caring for the Spirit Strategy “has not managed to win hearts and minds,” or questions like “what happens if we do not participate?” There was some question, comments and discussion about the tensions between CfS and CHCC and how this split was a clear weakness nationally. A number of you questioned the process of consultation which led to the production of the final CfS document in 2003. A few of you commented that to your knowledge you were aware that feedback which had been given at a national level as part of the listening exercise had not been included in the final document. This appears to have caused some lingering discontentment and ongoing issues regarding engagement with CfS and its implementation. There was also some question and comment as to whether there was any plan to revise the strategy in the light of these problems and issues.

8. At a departmental level you spoke about the potential difficulty and weakness of “getting everyone involved across the department including part-time staff and volunteers.” There was comment to the effect that CfS would generate more work, more meetings and that there was “no time to do basic activities, let alone research.” There was a perception that the Strategy was going to take chaplains away from “people” and the “bedside.”
9. Regarding your perceived **weaknesses** of CfS and the collaborative structure in respect of its impact on patient care, there was almost complete agreement among you that it would result in “time taken away from patient care.”
10. Among the **threats** you mentioned to yourselves and your departments you discussed that to implement CfS through a collaborative approach would involve “more work,” when some of you feel you already have “no time,” and “not enough staff.” As some of these are about resources and approaches to work, comment was made that some attention might be given to looking at the models of chaplaincy service and practice in your trusts which may not be facilitating you adequately in your work. A number of organisational threats and conflicts were commented upon sometimes framed as “CHCC vs. Collaborative” and “NHS vs. “religious organisations.” Some of you mentioned that “over 50% of chaplains do not have a first degree” and that this issue needs to be heeded as the educational section in the CfS strategy make reference to a proposed degree level of entry into the ‘profession.’
11. At a departmental level the main **threats** you spoke about mirrored some of those in 10, namely “time” to engage with the project, and sense of being “overloaded.”
12. When it came to considering any **threats** to patients in the ‘Caring for the Spirit Strategy’ you again discussed the ‘time’ that would be taken away from front line pastoral care. There was some discussion and apprehension expressed around the research work stream in relation to patients. Some of you commented that patients were being made into “research guinea pigs,” while others said that they “do not see the need to do research as it detracts from what chaplains really do”

## Emerging issues

- Examining different models of service and practice which shape the chaplaincy department and provide a framework for pastoral interventions.
- A critical examination of how the increasingly rapid move towards a mixed economy in the NHS might be harnessed by chaplaincy departments in the development of new service models in spiritual and religious care.
- Organising the collaborative to address the strengths and opportunities you identified as it develops a programme of work.
- Providing opportunities in the collaborative structure to address the felt weaknesses and threats in CfS verbalised in our discussion.

## QUESTION 2

**The Situation: “If chaplains are to progress and be able to argue for more resources and a changing role, there must be accompanying data that makes the case for change and development.” Mowat & Swinton (2005) “What do chaplains do? The role of the Chaplain in meeting the spiritual needs of patients.”**

**The Question: Chaplain or Researcher? How can chaplains balance their identity of being a spiritual care provider and working in a way which shows clear demonstrable evidence of the value of their role to the institution?**

In these conversations the following themes emerged.

1. Participants discussed the question of their “identity” as chaplains and whether or not this included the role of chaplain as researcher. There was clear agreement that we are chaplains first and foremost and only then potential researchers. Some people wondered if there was a general pool of ‘evidence’ already out there to draw on, while others questioned how adequate time might be put aside to participate in research, or to read pastoral care research papers individually or in Journal Clubs. There was also much discussion about obtaining the skills necessary for chaplains to be research aware and research active. A number of you were adamant that you did not want to be researchers or learn these skills. The question was asked as to whether a dedicated research post could be created to support chaplains funded by the SHA. Chaplaincy as “presence” has to be critically informed by an accountability of the added value of our pastoral “actions.” A number of people asked “who am I supposed to be?”
2. Some of you were very clear that the future of healthcare chaplaincy in the NHS moving rapidly as it is into a mixed market economy, patient-led and evidence-based service needs to be able to demonstrate for the benefit of patients and management the efficacy of what we do. This requires of us serious attention to reflecting on and researching the role of spirituality and religion in healthcare. A number of you noted that this will also benefit the development of chaplaincy as a profession. In general terms there was agreement that through engaging in research ‘awareness’ and ‘activity’ we “are the same person working differently.”
3. There was discussion about staff perceptions of the chaplaincy department in particular that chaplains are not always seen as part of the healthcare team. On this basis some of you said that it was difficult to access information in order to conduct any research, or to be proactive in partnering other research programmes. Others of you thought that this was also a matter of chaplains taking the initiative to engage with staff who are conducting research and see if a ‘spiritual/religious voice/angle’ needed to be considered in a given research protocol. Here some of you mentioned the role and considerable responsibilities in being members of a research ethics committee.
4. There was discussion of the need for education and training in research methodology including such things as doing a literature search, reading

qualitative and quantitative research papers and for some becoming research active. Rob Merchant from Stafford University offered to host such a day later in the year. A number of you noted the need to engage and work with University Departments, Medical and Nursing Schools in order to move the education and training agenda ahead.

5. Finally there was discussion and many questions about how to record data about the work done in the chaplaincy on a day to day basis. Some of you mentioned that you already collected departmental data of this sort and others asked if this could be made available for others learning.

## **Emerging work streams**

- Gaining a clearer knowledge of the research that has already taken place regarding spiritual issues in healthcare through Journal Clubs.
- Learning more about and developing a chaplaincy departmental capacity for evidence-based practice.
- Learning more about evidence-based pastoral care and it can influence pastoral care of patients and staff.
- Learning about what data to record and the reasons for doing so.
- Exploring the tension in the chaplains' role between 'vocation' and 'profession.'
- Learning more about what spiritual and religious care might look like in a rapidly changing NHS which is positively seeking to embrace more community provision within a mixed – public/private healthcare economy.

### QUESTION 3

#### **How can Chaplains use evidence-based practice to inform NHS development of spiritual care and increase the recognition of the profession of Chaplaincy in a multi-professional organisation spanning the public and private sectors?**

The subject was discussed at length, and the following themes emerged.

- 1 Many of you spoke about the need for Chaplains to embrace the research agenda in order to provide a firmer basis for developing specific areas of service, and perhaps even to support the *raison d'être* of chaplaincy-spiritual care in a mixed healthcare economy. If so, then individual chaplains need to be comfortable with the idea of conducting and reporting back on research projects in the same way that clinical and managerial colleagues do. There was a brief discussion about the graded nature of evidence including that outlined by the National Institute for Health and Clinical Excellence. Some of you were concerned that we were getting too engaged with measuring the 'success' of what we do that we were losing sight of the purpose of chaplaincy in secular healthcare.
- 2 It was generally agreed that there was some need for chaplains to learn more about research methodology. In support of this aspiration Rob Merchant offered to provide an introductory day to explore some nuts and bolts in research. You discussed the desirability for newly appointed chaplains to gain expertise in this area. The desirability of a research module being developed and included for ministers during their ministerial formation briefly discussed.
- 3 There was an in depth debate about what was meant by the word "data" – and whether this was understood to include such "soft data" as opinions, feelings and perceptions. If so, it was argued that this would require some extensive work to ensure it was capable of being properly assessed and critiqued. However, there was an understanding that chaplaincy needs to develop a body of evidence to support and inform its work and that this requires a move from 'anecdote' to 'evidence.' Here many of you mentioned the need to be able to collect adequate data on the patient's religious affiliation and problems here in relation to the Data Protection Act. There was a good discussion about integrated care pathways and how chaplaincy needs to be included in this important development.
- 4 There was also an acknowledgement that the majority of chaplains have very little experience of conducting research projects, reading research papers, except perhaps as part of previous study, where the emphasis is very much on academic research methodologies. There was some agreement that training in this area would be beneficial. However, there was also some discussion about how part-time chaplains might develop this work given that their main role is pastoral care. The possibility of teams containing at least one person with skills and an interest in research was considered.
- 5 It was pointed out by several present that research skills are both highly visible – and prized - in the wider NHS, and that colleagues working in multi-professional teams, research and ethics groups might be a valuable source of advice, learning and co-working. Comment was also made that the NHS has recently produced a document about research called *Best Research for Best*

*Health* (2006) which places a new emphasis on the need to develop evidence-based practice. There was discussion about the way evidence can be used to raise the profile of the chaplaincy department and move it towards a more multi-disciplinary approach to practice without losing the distinctiveness of our valued and unique contribution.

- 6 Following much discussion there was some agreement that it was as well for chaplaincy to recognise the need to be able to point to hard evidence in terms of outcomes and achievements. A number of you questioned what was really meant by “outcomes” and how these can be collected and analysed. The connection between research and ‘best practice’ was made, as was the relationship between, developing an accountable, pastorally orientated and evidenced service. A number of you mentioned the new occupational standard in research written by Peter Speck and Mark Cobb and seemed to value the distinction between being ‘research-aware’ and ‘research-active.’ There was some discussion about how we can be research aware in the absence of a literature database containing all the relevant graded papers.

In an evidence based culture where managers are looking for financial savings, all services needed to be able to demonstrate that they provide ‘value for money,’ even in those areas considered, until relatively recently as sacrosanct like chaplaincy! Managers are now talking about “evidence based management” so it could be argued that all areas of practice needed to align themselves accordingly. Again, the point about developing pockets of expertise within teams was discussed.

- 7 Overall, there was an acceptance that “evidence-based practice” is a modern cultural phenomenon which is now embedded in the NHS and here to stay, so it would be futile to ignore the implications of this in healthcare chaplaincy. It was recognised that not every chaplain would wholly embrace this or wish to have anything other than the most basic involvement of being ‘research-aware.’

It was stressed that chaplaincy needs to adopt a “toolkit” for use in a series of situations, and that this needed to be robust enough to pass scrutiny by managers and clinicians.

#### 4 **Emerging work streams**

- Learning more about evidence-based practice, workshop, e-learning, Journal club.
- Learning about how to utilise the evidence we have to support and develop the profile of chaplaincy in Trust.
- Development/modification of an appropriate toolkit – liaison with clinical colleagues?
- Learning how to construct and present a business plan and business case?
- A focus on current resources like the Occupational Research Standard.
- Accept Rob Merchant’s offer to host a day on research methodology.
- Do part-time chaplains face particular training needs that require to be specifically addressed?

Caring for the Spirit NHS Strategy  
Chaplaincy Collaborative Launch Event  
Manchester City Stadium

Wednesday 5<sup>th</sup> May 2006  
10.00 -15.30

Agenda

- 10.00 Registration and Refreshments  
10.30 Welcome and Introduction  
*Kay Worsley-Cox, Organisational Development Manager*  
10.40 Implementing Caring for the Spirit through  
Chaplaincy Collaboratives  
*Mark Folland, Lead Chaplain, 'Caring for the Spirit' NHS Strategy*  
11.15 Group Work  
12.00 Plenary Discussion  
  
12.30 Lunch  
  
13.15 Developing Evidence-based practice in Spiritual  
Care  
*Robert Merchant, Principal Lecturer in Spirituality  
and Health, Staffordshire University*  
14.00 Group Work  
14.45 Plenary Discussion  
15.00 Action Planning for Three Chaplaincy Collaboratives  
  
15.30 Finish