

The 'Caring for the Spirit' NHS Strategy (2003)
**Report on the Launch of Healthcare Chaplaincy
Collaboratives in Cumbria, Lancashire, Cheshire &
Merseyside**

For the attention of:

The Chief Executive, NHS North West SHA
The Chief Executives, NHS North West Primary Care Trusts
Trust Chaplaincy Line Managers
Trust Chaplaincy Team Leaders & their Colleagues
Faith Community Advisers

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NHS North West
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Introduction

This report details the discussions which took place at the Healthcare Chaplaincy Collaborative Launch Event in Garstang Country Hotel and Golf Club on Wednesday 29th November 2006.¹ On that day a Healthcare Chaplaincy Collaborative under the aegis of the 'Caring for the Spirit' NHS Strategy came into being for each of the following areas: Cumbria, Lancashire, Cheshire & Merseyside.² The report has been prepared from notes taken by the group facilitators NHS North West 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, Deborah Arnot, Assistant Director – Organisational Development Support, NHS North West; William Greenwood, Head of Primary Care for Greater Manchester, NHS North West, and Robert Merchant, Lecturer in Spirituality and Health in the University of Staffordshire.

Lead chaplains including their whole and part time colleagues, and chaplaincy line managers were invited by Mike Farrar CEO NHS North West SHA to attend the day.

The launch event comprised three presentations (attached) followed by group discussion. The first presentation focused on some key infrastructure changes in the NHS and was given by William Greenwood. The second examined the six key themes in the 'Caring for the Spirit NHS Strategy' and the purpose of NHS Chaplaincy Collaboratives was given by Mark Folland. The third looked at issues in developing evidence-based spiritual healthcare was 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 meeting 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

Information about the *Caring for the Spirit NHS Project* including all published papers and documents can be accessed at www.yorksandthehumber.nhs.uk then click onto South Yorkshire SHA and then the chaplaincy icon.

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

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

QUESTION 1

What are the benefits and drawbacks for you, your department and patients in participating in a 'Caring for the Spirit' chaplaincy collaborative?

1. At a professional level you spoke about the way in which 'Caring for the Spirit' can **benefit** you and your department:
 - Through creating naturally occurring opportunities to '*network*' and share ideas and practice together. This included the opportunity to give and receive 'peer support' and to be 'in the loop' regarding professional development arrangements and opportunities. A number of you also said that it will be essential to work more closely together with other healthcare professionals who could assist chaplains in service development.
 - We discussed the important opportunity offered by '*Caring for the Spirit*' (CfS) and collaboratives in their move towards an *evidence-based approach* to pastoral and spiritual care for patients. Many of you saw the Collaborative structure as providing a real opportunity to share 'good practice' together and to develop a range of approaches to promoting this approach to care.
 - There was a lot of discussion about the need to be and to *develop 'professionally'* alongside other healthcare professionals. Some of you questioned what it meant in real terms to be a professional, while others emphasised the importance of being professional in an increasingly professionalised NHS. Generally the Collaborative approach was thought to offer a range of opportunities for chaplains to 'fashion' themselves as professionals in healthcare.
 - There was much discussion about the '*need to gain a strategic view*' about current changes and reorganisations in the NHS, thus enabling healthcare chaplains to have a 'strategic voice' within Trusts. This area of discussion was linked to the need to build an evidence-based approach in healthcare chaplaincy so we can 'gain another language' in which to express what chaplains do and why we do it. This was thought to be potentially one of the most important benefits to be found in working together as a Collaborative, because the evidence-based approach would in the long term benefit patient care and show managers more clearly the human significance of our work. We discussed the need to link EBP approach with a variety of care pathways which include spiritual and religious care.
 - Some groups voiced the hope that the Collaborative might offer the opportunity to focus on issues about *time management* in the workplace, particularly in some of the more rural regions represented where hospitals and community centres can be fifty miles apart. It was questioned how the Collaborative might really work in these settings. A number of people voiced the importance here of e-working and e-learning. In these situations extra meetings, visits and the ministry of 'presence' was voiced

as a constant challenge. However, a number of you saw that this geographical challenge could also be used to your advantage as issues often become more focused where time is known to be limited.

- We discussed the ‘*use of different languages*’ through which to articulate the work of chaplains to different publics – including managers, patients and faith communities. We thought these groups would sometimes require different professional languages of engagement dependent on the nature of the contact – strategic development and pastoral contact were offered as examples. A number of groups focused on the need for chaplains to become more familiar and conversant with the language of clinicians and managers in order for meaningful dialogue to occur. This was seen as a two way street, and a number of you pointed towards a need for healthcare chaplaincy to be more confident in ‘owning’ and ‘verbalising’ language around ‘spiritual assessment and need’ and tying this into different theological traditions. We discussed the issue of different denominations and the ‘need to develop an inter-faith language.’ We discussed becoming more conversant with the different languages in the workplace and this was seen as beneficial to the development of healthcare chaplaincy and patient care.
 - Our discussion about language touched on another theme raised in this section, namely, ‘how chaplains interact with Trust colleagues.’ A number of groups saw the need to develop a more multi-professional approach to our work and emphasised the need to ‘listen to and understand each other’s perspectives.’ The emphasis in the CfS Strategy on working more closely with other healthcare professionals was thought to be advantageous and in need of quite a lot of development in some Trusts.
 - Finally, the ‘Caring for the Spirit’ NHS Strategy and Collaboratives were seen as beneficial in helping chaplains to look at *how care is now being commissioned and provided in the NHS*. We discussed how the commissioning of services, local service agreements and the growth of the private sector in the NHS was changing healthcare chaplaincy service models and practice models. We discussed how chaplaincy is well placed – the metaphor of a ‘bridge’ was used in one group – between ‘the organisational system and the public’ to address the human issues of patient need. There were requests that the collaborative look at how local service arrangements are made including service commissioning.
2. A number of themes emerged in the discussion about what you thought were some of the **drawbacks** in the ‘Caring for the Spirit Strategy’ and the collaborative approach:
- At a departmental level you spoke about the potential difficulty of ‘getting everyone involved across the department, in particular part-time chaplains and volunteers.’ This was seen as a drawback in the more rural areas and among some faith communities. While this was seen as a drawback for some, others viewed it as an opportunity to gather together for a specific purpose and to focus on developing the role and work of healthcare chaplaincy together.

- There was comment to the effect that CfS would generate more work and more meetings, both of which were seen as drawbacks, although some viewed them as challenges. There was a perception that the Strategy was going to take chaplains away from 'people' at the 'bedside.' This concern emerged in every group and was frequently linked into the view that there was not enough time to do everything and that patients came first. Some groups discussed the need to improve referral systems in healthcare chaplaincy and how they are linked to assessment and 'being seen to be a part of the healthcare team' and not simply 'an added extra.' A minority of you thought that pastoral care was being eroded by the CfS Strategy and the Collaborative approach commenting that it was too 'bureaucratic.' Some of you expressed feeling a conflict between attending the Collaborative and engaging with implementing its findings, and patient visiting.
- There were a number of comments around the funding of the Collaborative both in respect of the time it will take and also regarding access to finance to develop some of the work. Questions were asked about where the funding would come from and how much it would be per annum. Here time and financial constraints were viewed as potential drawbacks to implementing the strategy.
- The reorganisation of the NHS along more clearly business lines was seen by some as a drawback. This was often expressed in the form of questions like 'how does chaplaincy operate in the world of healthcare commissioning and payment by results?' and 'how will chaplaincy be affected by the streamlining of various services?' or 'how will NHS patients access spiritual and religious care in the independent treatment centres?' What was a drawback for some was seen as a challenge by others who expressed interest in knowing more about how chaplaincy might organise itself in the new NHS climate.
- Some expressed the view that it might be more difficult for chaplains from mental health and specialist trusts to really benefit from the Collaborative process as they were few in number and that it would therefore be difficult to compare like for like.

Emerging issues

- Developing a more professional approach to healthcare chaplaincy.
- Developing a strategic approach to working in the NHS.
- Models of service and practice in healthcare chaplaincy.
- Opportunities to learn more about the current NHS reorganisation and how it affects healthcare chaplaincy and the religious and spiritual needs of patients and staff.
- The involvement of all chaplains and other professionals in the Collaborative.
- Developing an evidence-based approach to practice.
- Learning and using different professional languages.
- Creating and seizing opportunities for multi-professional working.
- Articulating what healthcare chaplaincy is about to different publics.
- Identifying training needs and opportunities.

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 general agreement that we are chaplains first and foremost but that the role of research was clearly important. There was discussion around the need to achieve a ‘balance’ in our work between the ‘chaplain’ as someone who meets immediate day to day user needs, and the ‘researcher’ who is looking into specific current issues in order to shape future approaches to care. Many of you recognised the need for chaplains to be knowledgeable of the research literature in spirituality and religion in healthcare in order for you to be able to work effectively. There was some discussion about the need to develop both a qualitative and quantitative approach to research.
2. We discussed the need to obtain the necessary skills, resources and literature to be ‘research aware’ and in time for more chaplains to be research-active. The work of the CfS Project Team in securing the Literature Review was welcomed. Some of you expressed interest in developing skills around data collection and analysis, stating that this would be a productive use of Collaborative time and resources. A number of you said that your Trust has not supplied you with the most basic of resources for your work as a chaplain including: office space; telephones; personal computers and pagers. Without these basic essentials any thinking about being ‘research-aware’ or ‘active’ seemed a little out of place.
3. There was discussion about the need to influence and ‘get close to policy makers.’ You focused on the need to influence Trust Boards and identify ‘spiritual care champions’ in the Trust who with you might carry forward the implementation of the CfS Strategy. You discussed how Non Executive Directors may be able to assist you here in developing both a pastoral and research based profile. You mentioned that issues like performance targets, patient safety, patient care and trust based audit questionnaires might be focused on more closely as a way of profiling healthcare chaplaincy.
4. Some of you discussed the need to work with other healthcare professionals in developing a research portfolio. Here some of you mentioned the role and considerable responsibilities in being members of

research ethics committees and how this might be used to advantage in the pursuit of an evidence-based approach.

5. There was discussion about 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. 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.
6. Finally there was discussion about how developing the research arm of healthcare chaplaincy would necessarily influence and change the type of service model offered by healthcare chaplains compared to that offered by religious leaders in the community. This tension was expressed in one group as 'chaplain v parish priest.' You also discussed some of the financial implications in healthcare chaplaincy where Trusts were not willing to fund spiritual and religious care.

Emerging issues

- Developing approaches to evidence-based practice and practice-based evidence in healthcare chaplaincy.
- Learning more about evidence-based pastoral care and how it can contribute to the pastoral care of patients and staff.
- Working more strategically in trust and community regarding spiritual and religious care for patients.
- Identifying spiritual care champions in Trusts.
- Learning about what data to record and the reasons for doing so.
- Exploring the tension in the chaplains' role between 'vocation' and 'profession.'

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 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. 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. We discussed the importance of gaining user-views about the level and appropriateness of the service they received from healthcare chaplains in acute, mental health and PCT settings. There was also discussion about how healthcare chaplaincy services were publicised, accessed and whether patients really felt they were provided with the necessary information from which to make an informed choice. It was suggested that the Collaborative access information 'from people who were upset not to receive spiritual care or from people who did receive it and were happy.'
3. We discussed 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 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.
4. It was suggested that the each Collaborative look closely at the work being done in mental health and Palliative Care as they are developing EBP and are beginning to demonstrate the benefits of spiritual care on physical and mental health. Another suggestion was that in each trust chaplains need to ensure that 'patient surveys and questionnaires include questions about spiritual care.' It was also suggested that each Collaborative makes links with the 'public health and social inclusion agendas.'
5. It was pointed out 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 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. 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.’
7. 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.

Emerging issues

- Getting started on developing evidence-based practice at Trust level.
- Gaining user-views through questionnaires and surveys.
- Link into Clinical Audit Departments and put spiritual care in the relevant Trust surveys.
- Develop partnership working with those who we know are doing research into areas that do or might include a spiritual component.
- Learning more about evidence-based practice, workshop, e-learning, Journal clubs
- Focus on recent DH Research policy.
- A focus on current resources like the Occupational Research Standard.
- Need to demonstrate the value for money argument in spiritual healthcare.

Further action

The contents of this report records the work done by healthcare chaplains from Cheshire, Merseyside, Lancashire and Cumbria at the 'Caring for the Spirit' (CfS) Collaborative Launch Event in November 2006. Further, it highlights the emerging issues from the day.

Integral to the development of working together collaboratively is the practice of each Collaborative developing locally the key drivers in the CfS Strategy, at the same time as 'keeping an eye' on NHS and CfS developments at a national level. In the 'emerging issues' section we have tried to express the main points raised in the group discussions which express many of the key themes in the CfS Strategy. These issues should be viewed as areas which require further attention, development and implementation within the four Collaboratives.

How the 'emerging themes' and the CfS work is taken forward from now through to 2010 - the end point of the Strategy - will depend on how each Collaborative decides to structure itself and its work programme. Crucially, the implementation of the Strategy within each Collaborative will be heavily shaped and influenced by the set of professional relations each Collaborative establishes with a range of organisations and groups including: NHS Trusts; SHAs and PCTs; Faith communities; education providers; users, patients and PPI Forums and chaplaincy organisations.³ It will also depend on the smart thinking and action of each chaplain, as she and he imaginatively seeks to make the essentials of the Strategy their own and those of their team.

There will be an early opportunity to discuss the contents of this report in each Collaborative. Indeed, this will be necessary in order to carry forward, develop and implement the Strategy in an imaginative way. However, we are also very interested to hear your reactions and responses to this report, not least because the SHA hosted the day and recognise the importance of spiritual and religious care in the NHS for patients and staff. If you would like to contact us with your comments individually or as a team we would be pleased to hear from you.

Please send your comments on this report to: Deborah.arnot@northwest.nhs.uk

³ *Caring for the Spirit*: Implementation plan, Guidance Note 9 – Chaplaincy Collaboratives

Caring for the Spirit NHS Strategy Healthcare Chaplaincy Collaborative Launch Event

Wednesday 29th November 2006
Garstang Golf and Country Club
10.00 -15.30

Agenda

- 09.30 **Arrival and registration**
- 10.00 **Welcome and introduction**
Chair – William Greenwood, Head of Primary Care for Greater Manchester, NHS North West – Greater Manchester
- 10.15 **Implementing ‘Caring for the Spirit’ through a Chaplaincy Collaborative**
Mark Folland, Lead Chaplain, ‘Caring for the Spirit’ NHS Strategy
- 11.00 **Coffee**
- 11.15 **Group work – 1**
- 12.00 **Plenary discussion – key points**
- 12.15 **Lunch**
- 13.00 **Developing Evidence-based practice in Spiritual Care**
Robert Merchant, Principal Lecturer in Spirituality and Health, Staffordshire University
- 13.45 **Group Work – 2**
- 14.35 **Plenary Discussion – key points**
- 15.00 **Way forward – action planning**
- 15.15 **Close**

