

THE CHAPLAINCY COLLABORATIVE LAUNCH EVENT IN THE BROMSGROVE HILTON

A REPORT from Mark Folland
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Midlands

To Healthcare Chaplains, Chaplaincy Line Managers & Bishops
Advisers in Shropshire and Staffordshire, Birmingham and the
Black Country and West Midlands South

1st July 2006

Background

This report details the discussions which took place at the Chaplaincy Collaborative Launch Event in The Hilton Hotel, Bromsgrove on April 30th 2006.¹ On that day a chaplaincy collaborative for Shropshire and Staffordshire, Birmingham and the Black Country, and West Midlands South came into existence.²

The day was jointly planned and organised by Mark Folland, Lead Chaplain NHS West Midlands for the '*Caring for the Spirit NHS Strategy*,' the Lead Representative for the strategy in each SHA lead by Tamar Thompson, Director of Nursing and Workforce in the then WMS SHA, Mark Bryant, Archdeacon of Coventry and Non-Executive Director in the then WMS SHA, 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 David Nicholson, formerly CEO and Transitional Lead for the West Midlands cluster of SHAs to attend the day.

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

² All Chaplaincy departments and their chaplains in all types of NHS Trusts are included in these collaboratives. The following three lists show which acute and mental health trusts are in which chaplaincy collaborative.

Shropshire and Staffordshire Chaplaincy Collaborative

Burton Hospitals NHS Trust
Mid Staffordshire General Hospitals NHS Trust
Robert Jones & Agnes Hunt Orthopaedic & District Hospitals NHS Trust
Shrewsbury & Telford Hospitals NHS Trust
University Hospital of North Staffordshire NHS Trust
North Staffordshire Combined Healthcare NHS Trust
South Staffordshire Healthcare NHS Trust

Birmingham and the Black Country Chaplaincy Collaborative

Birmingham Children's Hospital NHS trust
Birmingham Women's Health Care NHS Trust
Dudley group of Hospitals NHS Trust
Good Hope Hospitals NHS Trust
Heart of England NHS Foundation Trust
Royal Orthopaedic Hospital NHS Trust
Sandwell & West Birmingham Hospitals NHS Trust
The Royal Wolverhampton Hospitals NHS Trust
University Hospitals Birmingham NHS Foundation Trust
Walsall Hospitals NHS Trust
Birmingham & Solihull Mental Health NHS Trust
Sandwell Mental health NHS and Social Care Trust

West Midlands South Chaplaincy Collaborative

George Eliot Hospital NHS Trust
Hereford Hospitals NHS Trust
South Warwickshire General Hospitals NHS Trust
University Hospitals Coventry & Warwickshire NHS Trust
Worcestershire Acute Hospitals NHS Trust
Worcestershire Mental Health Partnership NHS trust

The launch event comprised two presentations followed by group discussion. The first presentation about the '*Caring for the Spirit NHS 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 based on 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 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 *Caring for the Spirit 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 Strategy* including all published papers and documents can be accessed at www.yorksandhumber.nhs.uk

QUESTION 1

What benefits do you, your department and patients gain through your participation in this chaplaincy collaborative? Are there any drawbacks: If so what are they?

The responses to this question were grouped under three headings determined through personal reflection, discussion from the perspective of your department and that of patients. A number of themes emerged and are reflected in the following points.

1. The responses generated in the space for personal thought and reflection demonstrated a clear interest in and commitment to the value of a collaborative being a place of “learning” through “connecting with others.” A chaplaincy collaborative can act as a platform for the development of professional development and credibility. We thought the collaborative could be a platform for the development of ‘good practice’ through functioning as a community of chaplains who together are committed to patient care and enhanced professional practice. Among the benefits of collaborative working we noted 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 could be developed in the current political climate. We also discussed how “chaplains from different faith communities” could benefit from networking and becoming more aware of national issues in chaplaincy which are offered through the chaplaincy collaborative structure.
2. Delegates spoke about the potential they saw for a chaplaincy collaborative to develop and professionalize their every day practice with patients and staff, including the “opportunity to specialise” where the service demands. 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 to promote and develop a more professional chaplaincy which still has patient contact at its roots. Here we discussed how a chaplaincy service to patients and staff could be “strengthened.” In general we felt the collaborative could bring “fresh ideas and broaden our horizon in a secular institution.”
3. As an extension of the individual input the value of CfS and collaborative working was commented on at a departmental level. 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. Others commented that because CfS promotes a multi-professional approach to practice it offers the opportunity to “develop a professional status for spiritual care.” When this is placed alongside the Knowledge and Skills Framework (KSF), Continuing Professional Development (CPD), research and audit; the potential for “Trusts to take spiritual care more seriously” is likely, because chaplaincy will be able to emerge as a “credible profession.”

4. There was much discussion around the importance of locating a chaplaincy collaborative within the strategic structure of a rapidly changing NHS. The benefits of this were seen as including, “a higher profile for chaplaincy in the organisation of healthcare,” and “clearer lines of communication up and down” through having a “voice at a strategic level.”
5. We discussed whether the collaborative approach advocated by CfS was in fact the best and most appropriate mechanism for chaplains to adopt and whether it has a track record in the NHS or not. We noted that the collaborative approach has been used effectively in the NHS for professional development and service improvement programmes as for example in cancer services. Many of us thought that the collaborative model will be helpful in “formalising what is already happening in chaplaincy” and providing a “resource for development” through to 2010.
6. Some of you commented that the collaborative model “looks and sounds ambitious.” This spawned discussion about how a collaborative might work, what they might look like, how they are to be resourced, their focus, priorities and how they could influence the commissioning process when it comes to expanding spiritual and religious care within a mixed economy. In the developing mixed market economy of the NHS it will be the role of the Primary Care Trusts to commission services on behalf of local communities. Here some felt that a well organised and politically astute chaplaincy collaborative could take advantage of the emerging mixed economy in healthcare making a real difference to patient’s spiritual and religious care.
7. The organisation of multi-faith chaplaincy was discussed with reference to the work needing to be done in developing among others, the Muslim, Hindu and Sikh representatives.
8. Some expressed very clearly the view that “the Roman Catholic community are not really engaged with the CfS work.” This primarily related to the issue that “catholic priests do not see chaplaincy as a career or profession.” However, when it comes to working together in a collaborative to develop better patient care, evidence based practice and multi-professional working there was common agreement that this was not only important, but the way forward across faith and denominational boundaries.
9. We talked about models of service and practice. The tension between traditional forms of pastoral care, and approaches to practice drawn from the social sciences and counselling were seen as needing to be kept together in chaplaincy work. The forthcoming paper on ‘Models of Chaplaincy Service and Practice’ was mentioned.
www.sysha.nhs.uk/chaplaincy
10. As one would expect when negotiating and implementing a strategy which aspires to professionalize chaplaincy there was also apprehension, curiosity

and some fundamental disagreement about CfS. Some of you questioned how to “overcome resistance in your teams” while others questioned the “evidence” of the whole collaborative approach.

11. A number of you commented that CfS “was not organic,” and that “chaplains are not merely mangers.” The relationship between CfS and chaplaincy organisations like AHPCC, CAAB, CHCC, HCC and the MFGHC was mentioned from the perspective of questioning whether CfS and chaplaincy collaboratives were really required as there are already some mechanisms in place for chaplains to meet. Others commented on the importance of CfS, chaplaincy collaboratives and the strategic link with the SHA, the Department of Health and access to senior NHS executives which comes with this NHS Project. Some of you thought that there was a new opportunity for CfS and CHCC at a local branch level to work together within the collaborative structure.
12. The linguistic foundations of chaplaincy were explored along the lines of “the mother tongue and the father tongue.” One person expressed concern that chaplaincy is becoming too caught up in management terminology and expectations (father tongue). Some concern was expressed that the development of “evidence in chaplaincy” may be detrimental to spiritual and religious care, leading towards a conflict with healthcare managers. However, there was a general consensus that chaplains need to use management language and techniques to their advantage in the service of spiritually orientated and patient focused care.
13. We discussed how the *raison d’être* of chaplaincy is located in our “presence” and work with patients and staff. Many of you were adamant that the move towards professionalization in chaplaincy must necessarily include an improvement in the spiritual and religious care provided for patients and staff. There were many comments to the effect that you “would like to see spiritual needs of all patients formally assessed regardless of adherence to a formal faith community.” The potential here for “multi-professional working” was emphasised by a number of you alongside the importance of chaplaincy in the 21st century “developing an evidence-base approach to working with patients.”

Emerging work streams

- Learning more about multi-professional working and developing the same.
- Examining different models of service and practice which shape the chaplaincy department and provide a framework for pastoral interventions.
- Learning more about and becoming ‘research-aware’ and in time possibly ‘research-active.’
- Developing and using spiritual needs assessment models.
- Developing chaplaincy services that can harmonise the best theology and poetry with the best organisational and managerial methods for an evidenced and accountable service.
- 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.

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 two main themes emerged.

1. Participants discussed the question of their “identity” as chaplains and whether or not this included the role of chaplain as researcher. The interplay between the “whom” of our identity and the “what” of our practice requires us to integrate the being and doing of chaplaincy. 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?” Some of us 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 us 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.”
2. The second theme to emerge in our discussions reflected our 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 us noted the need to engage and work with University Departments, Medical and Nursing Schools in order to move the education and training agenda ahead.

Emerging work streams

- Learning more about the research that has already taken place regarding spiritual issues in healthcare.
- Learning more about evidence-based practice and how it can be used to develop chaplaincy departments and interventions with patients.
- Learning about research methodology, reading research papers and doing literature searches.
- Working with the sense of role dissonance between chaplain and researcher, 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?

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

- 1 The first was that Chaplains need to embrace the need to use research in order to provide a rationale for developing specific areas of service, and perhaps even to support their *raison d'être*. If so, then individual chaplains have 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 as outlined by the National Institute for Health and Clinical Excellence amongst others.

It was agreed that there was some need for chaplains to learn more about robust research methods, and how these could support and lend themselves to a more business focussed application. As part of this, the desirability for newly appointed chaplains to gain expertise in this area was discussed, as was the possibility of this area being included within ministerial education at an earlier stage, although it was felt that many ordinands would have little need of this in the early stages of their ministry.

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.’

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 the time implications, particularly for teams consisting of many part-time chaplains. The possibility of teams containing at least one person with skills and an interest in research was considered.

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. A number commented that “we should grasp all and any teaching opportunities.” 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.

- 2 The second theme concerns whether it was appropriate to expect chaplains to take on a research role – indeed, there were several vociferous objections. “I do not want to be a Researcher,” as one person said, “that isn’t why I became a Chaplain!”

However, following much discussion there was general 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. The connection between research and ‘best practice was made, as was the relationship between, developing an accountable, pastorally orientated, user-led and evidenced service. Mention was made of the new occupational standard in research written by Peter Speck and Mark Cobb.

Also in a time when managers are looking for financial savings, all services needed to be able to demonstrate that they provide value for money, even those areas considered, until relatively recently as sacrosanct! If managers are talking about “evidence based management” then 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.

- 3 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.’

However, 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. One suggestion was made to check with colleagues within a palliative care setting to learn from their experience in attempting to “map the un-mappable”. It was felt that this was a group with whom chaplaincy has much in common might be a useful partner in developing the research activity and awareness.

Emerging work streams

- Learning more about evidence-based practice, workshop, e-learning, Journal club.
- 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 and the recently produced SYSHA paper on Models of Service and Practice.

Caring for the Spirit NHS Strategy
Chaplaincy Collaborative Event
Bromsgrove Hilton

Thursday 30th March 2006
10.00 -15.30

Agenda

- 10.00 Registration and Refreshments
10.30 Welcome and Introduction
Tamar Thompson, Director of Nursing and Workforce, West Midlands South SHA
10.40 Implementing Caring for the Spirit through Chaplaincy Collaboratives
Mark Folland, Lead Chaplain, NW Region
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