NHS Education for Scotland

Board Paper Summary

1. **Title of Paper**

Healthcare Chaplaincy and Spiritual Care Update and Planned Review of Education and Training

2. **Author(s) of Paper**

Ewan Kelly

3. **Purpose of Paper**

The purpose of this paper is twofold:
- to outline the need for a significant review of Healthcare Chaplaincy Education and Training
- to update the NES Board of the recent activities initiated by the Chaplaincy Training and Development Unit of NES in relation to key policy drivers within health and social care

4. **Key Issues**

A. Healthcare chaplaincy activity relating to:

   1) Person-centred Agenda:
   - Rolling out an innovative model of values based reflective practice (developed by healthcare chaplains) in health boards in collaboration with AHP and nursing educators (written into SG Person-Centred Health and Care Delivery Programme – Staff Experience and Engagement workstream - to be showcased at the first learning event for the National Person-Centred Health and Care Programme on 20 and 21 Nov at the SECC)
   - Community Chaplaincy Listening
   - Specialist Spiritual Care Patient Related Outcome Measure (PROM)

   2) Integrating Health and Social Care

B. Review of Healthcare Chaplaincy Education and Training

Urgently required due to:
- The education and training of healthcare chaplains in Scotland has never been systematically reviewed.
- Mandatory formational education, for a profession whose main therapeutic resource is intentional use of self, is not in place.
- In order to maximize the impact of healthcare chaplaincy on health and social care and to adapt to changing systems and approaches of promoting wellbeing and responding to illhealth new models of chaplaincy practice are being developed.
- Increasing healthcare chaplains are no longer mainly from the traditional route of recruitment of experienced parish clergy but from other healthcare professions.
- Nearly one third of healthcare chaplains will retire in the next 3 to 4 years.
5. **Educational Implications**

Development of plans to create new undergraduate, postgraduate and CPD programmes to enable healthcare chaplains to be able to work creatively, collaboratively and confidently in a variety of contexts to maximise their impact on the provision of holistic health and social care.

6. **Financial Implications**

£19,950 from NMAHP budget 2012-13

7. **Which NES Strategic Objective(s) does this align to?**

Developing an innovative educational structure

8. **Impact on the Quality Ambitions**

Enhancing person-centred care

9. **Key Risks and Proposals to Mitigate the Risks**

A small team (of 2 or 3) educators rather than a single person will be commissioned to carry out the review in order to mitigate against illness or accident as the review will be carried out during January – March 2013.

10. **Equality and Diversity Impact Assessment**

   a) Briefly describe your arrangements for assessing the equality impact of any proposals outlined in this paper.

   Chaplaincy Training and Education Review:
   Assessment of equality impact will be part of the steering groups remit. Members of the steering group will be approached partly on the basis of the expertise and experience they will bring to the review process in this area. Some chaplains’ remits include equality and diversity as part of their portfolio.

   b) What potential or actual impact on people from different equality groups or other equality considerations have been identified?

   Inclusion of people from different equality groups in the planning and carrying out of the review. Ensuring equality and diversity as well as patients’ rights are key considerations during the review.

   c) What actions have been taken or proposed to address the issues you identified?

   Chaplaincy Training and Education Review:
   - Patient representation as well input from Scottish Inter-Faith Council on the steering group
   - Engagement with patient groups, third sector bodies (including Alzheimer’s Scotland and Age Scotland), Stonewall, NHS Health Scotland and ethnic minorities during the consultancy phase of the review

11. **Communications Plan**

A Communications Plan has been produced and a copy sent to the Head of Communications for information and retention:

In process of development – communications team have been contacted for advice.

Yes [ ] No [ ]
12. **Recommendation(s) for Decision**

The Board is invited to receive and endorse this update paper and support the plans for a review of the education and training of healthcare chaplains.

NES
October 2012
EK
Spiritual Care and Healthcare Chaplaincy in NHS Education for Scotland – an Update and Proposal for a Review of Healthcare Chaplaincy Education and Training

1. Introduction

The purpose of this paper is twofold:
• to outline the need for a significant review of Healthcare Chaplaincy Education and Training
• to update the NES Board of the recent activities initiated by the Chaplaincy Training and Development Unit of NES in relation to key policy drivers within health and social care

2. Background

This paper has been written by the Programme Director for Spiritual Care and Healthcare Chaplaincy who is part of the NMAHP directorate. This role is not only educational but one of national leadership and strategic development working with the Scottish Government and territorial health boards.

The integration of healthcare chaplaincy and spiritual care into health and social care is a relatively new initiative. It was only 10 years ago that the first national guidelines in Scotland regarding Spiritual Care and Healthcare Chaplaincy were developed.1

At present there are 65 full-time and 360 part-time (approximately) chaplains employed within NHSScotland. Significantly within the past six years all full-time chaplains and the majority of part-time healthcare chaplains have moved from being church employees contracted into the health service to becoming NHSScotland employees. In recent years healthcare chaplains have sought to put in place the necessary requirements for regulation of their profession. The Chaplaincy Training and Development Unit in NES has acted as a catalyst for the following developments and publications in recent years:

• **Spiritual and Religious Care Capabilities and Competencies for Healthcare Chaplains** (NES 2008)
• **Standards for NHSScotland Chaplaincy Services** (NES 2007)
• An entrance qualification into healthcare chaplaincy created in 2009– Post-graduate Certificate in Healthcare Chaplaincy (at the Univ. of Glasgow – pump-primed by NES who also funded the first 2 cohorts of students)
• A single method of regular intentional group reflective practice for full-time chaplains (to aid quality assurance) – NES training chaplains in all health boards to facilitate such activity (2011-13)

In addition, a Health Care Chaplains’ Code of Conduct (3rd edition 2011) has been developed by professional bodies in consultation with NES.

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1 HDL (2002) 76 Spiritual Care in NHSScotland. Scottish Executive Health Department. These were updated in 2009 with the publication of Spiritual Care and Chaplaincy by the Scottish Government, following CEL (2008) 49 – Spiritual Care.
Within the current financial context healthcare chaplaincy is particularly vulnerable to a reduction in its numbers and to the down grading of posts when they are assessed during vacancy. This is due to:

- a lack of a rigorous evidence base underpinning healthcare chaplaincy’s added value and value for money
- lack of understanding of the role of chaplains by health board management,
- chaplaincy’s historical lack of strategic leadership and engagement at high level nationally and locally.

Although the fiscal environment is challenging, current prioritisation of the person-centred care agenda affords a wonderful opportunity for healthcare chaplains. Significant engagement with this workstream is enabling chaplains to raise their profile and reveal to health board and SG strategic leads their added value and value for money. Recent evidence (from the USA and now Scotland) also shows healthcare chaplains help to enhance patient outcome and enable patients to be more confident in self-management and motivated to change positively change their behaviours and lifestyle. Moreover, healthcare chaplains are not only supporting staff in times of anxiety and stress but are helping them to reconnect with and, reflect on, their values in relation to their individual and shared practice (see appendix 3 and 4.6 below)

The Integration of Health and Social Care agenda has also enabled healthcare chaplains in Scotland to develop new models of chaplaincy. Traditionally, healthcare chaplains have delivered one to one acute crisis intervention in institutional settings. New models of chaplaincy working in community settings focussed on assets based approaches in co-production with individual patients and in collaboration with primary health and social care practitioners, voluntary sector workers and local community members.

3. Proposed Review of Healthcare Chaplaincy Training and Education

An extensive review of healthcare chaplaincy education and training with reference to how chaplains are vocationally educated and trained in North America, Europe and Australasia will be carried out within the next six months. NES has put in place some of the building blocks for the education and training and career progression of healthcare chaplains – the establishment of a Post-Graduate Certificate in Healthcare Chaplaincy and bursaries for study and research at doctoral level. In the past two years chaplaincy CPD sponsored by NES has moved from a more traditional conference based approach to supporting local practice based learning. However, there remain significant gaps in how we train and educate chaplains fit for purpose in modern health and social care. This is an urgent requirement due to a variety of issues, highlighted below.

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2 See appendices 1 and 2: Community Chaplaincy Listening Phase 2 (Executive Summary) and Healthcare Chaplaincy: the Lothian Chaplaincy Patient Reported Outcome Measure (PROM) – the construction of the impact of specialist spiritual care (Executive Summary).
3 As recommended in the Scottish Government guidelines Spiritual Care and Chaplaincy (2009)
3.1 Recruitment challenges

In the next three to four years between a quarter and a third of our current chaplaincy workforce will retire.\(^4\)

Recruitment to chaplaincy posts is currently no longer mainly from the traditional entry point of parish ministry (during which applicants had developed an appropriate level of pastoral competency) due to:

- Reduced numbers of parish ministers
- Hospital chaplaincy now being a less financially career option than parish ministry
- The increase in interest in a career in specialist spiritual care from those without a degree in theology or religious studies.

3.2 Development of new models of chaplaincy which do not necessarily involve acute one-to-one crisis intervention (as outlined below)

Many chaplains currently feel ill-equipped to develop and deliver more innovative forms of specialist spiritual care which involve the following areas:

- Educating, resourcing and supporting other health and social care staff
- Facilitating reflective practice
- Promoting organisational change and engagement with shared values
- Meaning making and working out with acute institutional healthcare
- Working collaboratively not as semi-autonomous individuals
- Taking responsibility for leadership and innovation as appropriate

3.3 Lack of a formational education at undergraduate level in Scotland for chaplains leading to disparity in quality of pastoral practice amongst the chaplaincy community

On a recent knowledge exchange trip to the United States it was obvious to the programme director for Spiritual Care and Healthcare Chaplaincy that such a piecemeal quality of service delivery is less in North America and that in his opinion this relates to a long-established rigorous undergraduate education, and CPD, which involves students deepening their self-awareness and engaging rigorously with the behavioural sciences, group dynamics and theological reflective practice.

4. Activity focussed on Person-Centred Workstream of Quality Strategy

4.1 Hosting an International Conference- Spiritual Care and Health: Enhancing Wellbeing and Improving Outcomes, 13 and 14 March 2012, Beardmore.

The aims of the conference were to:
- Share up to date, ground breaking research to inform spiritual care education and practice
- Promote relationships between researchers, educators and practitioners in the field of spiritual care from all over the world,
- Promote spiritual care as being an integral part of quality, holistic healthcare which is person-centred, safe and effective.

The conference was opened by Michael Matheson MSP; Scottish Government Minister for Public Health and other speakers included Sir Harry Burns; Chief Medical Officer, service users, academics and practitioners from North America, Australia, Europe and across the UK. Chaired by Murray Duncanson; Vice-chair, NES and Prof John Swinton; Centre for Spirituality and Health, University of Aberdeen, there were 155 participants in attendance and the event feedback has been very positive.


An international research network on healthcare chaplaincy has been established as a result of the conference and collaborative opportunities for future knowledge exchange and research are already being explored.

4.2 National Conference - Spiritual Care: Improving Quality and Reducing Costs, 12 March 2012, Beardmore.

This event was organised to deepen participants’ understanding of how:
- Healthcare chaplains promote quality and reduce costs in NHSScotland
- Spiritual care delivery enhances the wellbeing of patients, carers, staff and organisations.

Specialist spiritual care initiatives and examples of the impact of chaplaincy practice on patient, carer, staff and organisational wellbeing were shared in plenary sessions and enacted in workshops. Chaired by Karen Wilson; Deputy Chief Nursing Officer, other speakers included Jason Leitch; National Lead for Quality, Scottish Government, Anne Hendry; Clinical Lead for Quality, Scottish Government, and John Forsythe; Clinical Lead for Organ Donation and Transplantation, NHSScotland.

90 delegates participated including strategic leads from a variety of Health Boards as well as healthcare chaplains. There was also a celebration of 10 years of spiritual care developments since the first national guidelines for spiritual care were produced.
4.3 Community Chaplaincy Listening Services (CCL)

The Community Chaplaincy Listening Service (CCL) is a national action research programme funded by the Scottish Government (SG) and NES, and has just completed its second phase (see attachment 1 for an executive summary of findings). Patients showing signs of existential distress in the face of loss or transition are referred by their GP to chaplains working in GP practices. Phase 3 is being planned in partnership with the Centre for Spirituality and Health at the University of Aberdeen. As well as recruiting additional GP practices to the study, a wider range of contexts in health and social care where such services may be developed is being explored. Several GP practices in England are keen to join the programme. A presentation on the programme’s activity and findings was made at the recent Scottish Clinical Skills conference. Such an intentional, national programme is unique to Scotland and the programme director has recently received two invitations to speak in America at international conferences (one chaplaincy based and the other inter-disciplinary) about the Community Chaplaincy service.

4.4 Specialist Spiritual Care Patient Related Outcome Measure (PROM)

In collaboration with NHS Lothian and SG, NES is supporting the development of a specialist spiritual care PROM. The initial pilot study, funded by SG, has been completed (a summary of the findings are contained in appendix 2). Plans are being made to utilise this measurement tool in all health boards.

4.5 Spiritual Care Education for Pre and Post-registration Healthcare Staff, Utilising Spiritual Care Matters (NES 2009)

NES and SG funding allowed health boards and HEIs to bid for small grants to creatively embed and ensure sustained use of Spiritual Care Matters. Spiritual Care Matters was published in 2009 (8,000 copies) and distributed throughout the health and social care sector in Scotland – the online version is utilised throughout the world, receiving very positive feedback.

Evaluation of spiritual care education through workshops and on-line tools revealed:

Changes in **professional practice** and relationships due to:
- Heightened self awareness during practice
- Closer attention to listening skills
- Increased sense of common values with other staff
- Seeking to refer to more specialist support e.g. bereavement or chaplaincy
- Increased understanding of importance of attending to why questions and issues of identity, hopelessness and helplessness

Changes in **personal understanding** and behaviour:
- Heightened awareness of need to care for self
- Increased sensitivity to own emotional and spiritual needs
- New/clearer awareness of different ‘selves’ expressed in different roles

An article based on the findings from this project is currently being submitted to the journal *Medical Education*. An eLearning Resource entitled *Spiritual Care Matters* has been developed by the University of the West of Scotland (UWS) with the support of
NES, and this has been integrated into the pre-registration nursing curriculum at UWS. It is currently being explored whether it can be linked to ‘Flying Start’ and/or the ‘Effective Practitioner’ on-line educational tools.

4.6 Chaplains facilitating Values Based Reflective Practice

NES is currently supporting the training chaplains to facilitate interdisciplinary group values based reflective practice, translating previous experience of helping chaplains to reflect on practice to include practitioners from a range of disciplines. The aim of involving health and social care staff in such an approach to reflective practice is to:

- Help staff reflect on the values that inform their attitudes and behaviours.
- Help staff (re)connect with what motivates them to work in healthcare
- Enhance staff motivation and wellbeing
- Enhance person-centred care
- Reduce absenteeism and aid staff retention

Till October 2012, the priority has been to role out values based reflective practice in 3 boards who are the test sites for the SG’s Staff Experience project and evaluate the impact that participation makes on staff wellbeing. The programme director has recently been invited to present the methodology and findings from the pilots at the launch of the National Person Centred Health and Care Programme on 20th November at the SECC. The SG have asked healthcare chaplains to reflect on how this programme of work could be upscaled and then delivered across the whole of NHSScotland as a ‘change package’ to support the staff experience aim. Collaborative engagement with NMAHP educators in NES are already taking place to see how we can add capacity to this programme of work.

5. Activity related to the Integration of Heath and Social Care Agenda

5.1 Learning Needs Analysis of Practitioners in Primary Health and Social Care Settings in relation to Spiritual Care

Traditionally chaplaincy and spiritual care services have been institutionally based and focussed on acute one-to-one crisis intervention. Strategically, a new direction of travel in spiritual care delivery is required to help promote community resilience and cohesion by supporting individuals and communities to identify and utilise their assets to find meaning and purpose, and enhance personal and collective resilience. This should be done in collaboration with primary health and social care and third sector colleagues. NES commissioned this scoping exercise in order to:

- Assess health and social care and voluntary sectors practitioners’ educational needs around spiritual care
- Assess healthcare chaplains educational needs around existing workstreams, programmes, services and challenges in primary health and social care.
- Help develop an assets-based model of spiritual care delivery informed by a community development approach

^ See appendix 3 for methodology
The report from this scoping exercise will inform the planning and development of future educational initiatives by the Chaplaincy Training and Development Unit of NES with respect to healthcare chaplains and primary health and social care practitioners as well as those working for voluntary sector.

5.2 Co-production and Assets Based Approach to Enhancing Wellbeing

5.2.1 Testing a New Model of Specialist Spiritual Care Provision (informed by a Scoping of Narrative Based Approaches to Meaning Making)

Inspired by a conversation with Sir Harry Burns, relationships have been developed with the Kingsway Health and Wellbeing Centre in Scotstounhill in Glasgow. The Wellbeing Centre is on the ground floor of a block of flats occupied by a high percentage of community members who live with drug and alcohol addiction, chronic mental health problems and are recent immigrants. An action research project has been developed involving a local mental health chaplain who is seeking to support, educate, empower, collaborate with and learn from staff and community members in relation to communal meaning making and purpose finding.

5.2.2 Easter Ross ‘Blether’ Group

Blether is a local community initiative developed from grassroots which meets every 6 weeks to discuss issues significant to, and specifically chosen by, those who wish to participate. The group has grown over the year through word of mouth and a website advertising and explaining ‘Blether’ has been developed (http://blether.info/page2.htm). Topics in the last year have included ‘What raises your spirits’; ‘Does love last forever?’ ; ‘What is the impact on the community when a young person dies suddenly?’. The impact on personal resilience and wellbeing of participation in Blether will be evaluated. It is hoped this model of collective assets based meaning making will enable other such groups to be developed in varied contexts, for example, in care homes.

6. Conclusion and Proposal

Healthcare chaplaincy is facing great challenges to maintain a reasonable presence within NHSScotland in the next 5 years. However, at the same time there are real opportunities at strategic and operational levels for healthcare chaplaincy to maximize its impact on the person-centred agenda. To do so chaplains have to be prepared to work innovatively, collaboratively, competently and with more confidence. However, chaplains cannot be expected to do so without being adequately educated and trained. In order to facilitate this a radical overhaul of chaplaincy education and CPD is required to allow chaplaincy services to be fit for purpose. Therefore, NES will commission a person(s) to engage in Scotland, and where relevant overseas, with chaplains, health board managers and strategic leads, educators, academics, health and social care practitioners and service users to create a report recommending significant developments in education and training for Scottish healthcare chaplains.
Executive Summary

Community Chaplaincy Listening

Phase 2

Suzanne Bunniss, Harriet Mowat, Ewan Kelly

The Community Chaplaincy Listening (CCL) project enters its third phase in September 2012. This executive summary documents the second phase of the project between March 2011 and September 2012. Phase one has been written up both as a report (ref) and a journal article (SACH ref) The full Phase 2 report will be available from NHS Education Scotland in October 2012. CCL provides space and listening for patients who have troubles and concerns they want to talk about that are negatively impacting on their health wellbeing.

The patient journey through CCL

Patients are referred to the Community Chaplaincy Listening service most commonly by their GP; alternatively they can refer themselves.

- The Chaplain offers the service in a room within the General Practice Surgery
- The patient meets with the Chaplain listener who introduces them to the service.
- The patients then have as many sessions with the listener as are needed for them to tell their story, consider any existential issues they are facing and feel some sense of resolution or peace with what is currently happening in their life.
- Sessions last 50 minutes and patients are free to discharge themselves from the listening service at any time, without explanation, they are also free to return at any time in the future.

Phase one involved the set up of the action research process and early qualitative data collection from a small number of chaplains, patients, doctors and health care managers. The indications from this first year were that

- Patients overwhelmingly reported having a positive experience with the CCL service.
- GPs found the CCL service helpful.
- Building good relationships, providing clear information/ materials was important.
- Clearly articulating the concept of spiritual listening was essential.
- Listeners reported largely positive experiences of providing the CCL.
• NHS Managers would like to see the CCL as part of a suite of talking therapies.
• The use of chaplaincy volunteers as listeners in the CCL requires careful consideration.
• Having a settled space to provide the CCL service helped patients and listeners.

CCL Phase 2

Armed with this initial understanding of process, purpose and outcomes the project widened its scope. Findings were reported at a national workshop in March 2011 and lead chaplains across Scotland invited to become part of Phase 2. This resulted in 8 Health Boards delivering CCL across Scotland, using 15 listening Chaplains and covering 18 GP surgeries.

The research methodology/framework : Participatory action research:

“...a process in which researchers and stakeholders collaborate to design and conduct all phases of research (e.g., formulating research questions, research design, data collection, data analysis, dissemination, and utilization). The ultimate goal is increasing the likelihood that the products resulting from research will solve the real, “on-the-street” problems that stakeholders experience.”

The aim is to build up evidence for measuring a complex intervention as described by the Medical Research Council. This involves exploration of the theory and practice of CCL as it actually occurs using qualitative exploratory methods. The action research framework ensures that findings are fed back into the practice and used to inform the next steps; thus research influences subsequent practice.

The MRC stages of complex intervention shown in the diagram below

Complex interventions
Framework from MRC (2000)

The next research stage is to use a developed Patient Reported Outcome measure (PROM) based on a now clearly understood intervention.

The data collection techniques: Within this broad framework, phase 2 has collected data from

• Chaplain: qualitative themed interviews and development visits x 2 over 11 months
• Chaplains reflective intervention forms (24)
• Consented Patient interviews (n= 18 / 26)

• GPs and Practice Managers: feedback from email questionnaires and GP interviews/visits from all sites

• Descriptive statistics collected by the Chaplains via the practice managers.

The data analysis

- Descriptive statistics
- Use of some parts of return on investment framework; satisfaction: reaction: use: motivation: future intention
- Use of known literature and theological/philosophical insights: For instance Wounded listener, narrative gerontology, concepts of presence, transformation and use of time

Findings

250 patients used the service. The intervention averages at 3 sessions of 50 minutes per session although the actual average is nearer 1. The age range of patients using the service extends from 18 – 89 the majority of patients are over 40. 76% of the patients are female. The dominant presenting problems and reasons for using the service are reported by the patients as bereavement and relationship difficulties.

Chaplains provide a patient centred listening intervention which results in reported change in behaviour in patients which contributes to their increased sense of wellbeing and has the potential to reduce the need for GP consultations, to positively affect the subsequent consultations between the patient and GP and may contribute to appropriate use of medication for depression and subsequent reduction in medication. Chaplains help patients find coping mechanisms for life’s difficult issues within themselves that may not change the situation but help change the response to it.

Patients response to service:

- Recommend it without exception: No negative comments
- Capacity to change behaviour and feel better is demonstrated: makes a tangible positive difference. ("Went in suicidal, came out with hope").
- The process within the session is truly person centred. The patients report determining the agenda, the pace and the outcomes.

Patients reported outcomes

<table>
<thead>
<tr>
<th>Shifted my perspective</th>
<th>Found ability to get on with things</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made me hear and see my own story differently</td>
<td>Found purpose to go on</td>
</tr>
<tr>
<td>I’m a stronger person now</td>
<td>Felt pointed in the right direction</td>
</tr>
<tr>
<td>Went in suicidal came out with hope</td>
<td>Courage to talk to others</td>
</tr>
<tr>
<td>Taking less tablets</td>
<td>Gave me confidence in my GP</td>
</tr>
</tbody>
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Bunniss, Mowat, Kelly: Community chaplaincy Listening: Executive Summary

Phase 2: Autumn 2012: NHS Education Scotland
Chaplains responses: The chaplains identified three categories of presenting problem.

1. SEARCH for meaning understanding and reconciliation
2. LOSS – loneliness, anguish, confusion, “lostness” sense of abandonment
3. SHOCK – with consequent symptoms of anxiety, trauma and depression

Chaplains provide patient centred care

Chaplains and patients were both asked what happened in the encounter between them. There is a remarkable degree of coherence between the chaplains accounts of what they do and the patients accounts of what happens in the session. This is repeated in the PROMS study.

The GPs responses

The overwhelming agreement about the value of the service was that it was available and local. This was seen as different to other mental health services which had long waiting lists, often involved travel and were more proscribed. The chaplaincy service seems to positively influence subsequent consultations and the chaplaincy affiliation does not seem to be a problem. It provides much need extra time to give to patients where the life issues they are dealing with have the capacity to compromise their wellbeing and health.

Conclusions

This is a valuable person- centred service, based on the principles of therapeutic story telling and listening, that provides patients in General Practice with immediate access to help in the circumstances of life crises and dramas as well as longer term difficulties. It acts as a rest stop and gives the opportunity and time for patients to reflect on their situation and make necessary changes to the way they are seeing and acting. The results from the study show that patients, doctors and chaplains all value the service and hope for its continuation and growth. Issues of capacity and training are being addressed in Phase 3, now underway.

\[\text{Found a job/back at work} \quad \text{Drinking less} \\
\text{Helped me cope/developed coping strategies} \quad \text{Feel more in control of my choices}\]

\[\text{Chaplains responses: The chaplains identified three categories of presenting problem.} \]

1. SEARCH for meaning understanding and reconciliation
2. LOSS – loneliness, anguish, confusion, “lostness” sense of abandonment
3. SHOCK – with consequent symptoms of anxiety, trauma and depression

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\[\text{Full report on the national Scottish action research project, First cycle: March 2010 – March 2011} \]
\[\text{Prepared by Dr Harriet Mowat of Mowat Research Ltd and Dr Suzanne Bunniss of Firecloud} \]
\[\text{With Gillian Munro, Keith Saunders, TK Shadakshari, Gordon Warwick} \]
\[\text{For NHS Education Scotland. Available from NHS Education Scotland or www.mowatresearch.co.uk} \]

\[\text{Mowat H Bunniss S and Kelly E (2012) Community chaplaincy listening: working with General Practitioners to support patient wellbeing} \]
\[\text{The Scottish Journal of Healthcare Chaplaincy Vol 15 (1) 2012 pp 21-26} \]

\[\text{Beach Centre on Disability, University of Kansas} \]


\[\text{Ibid} \]

Bunniss, Mowat, Kelly : Community chaplaincy Listening: Executive Summary

Phase 2 : Autumn 2012: NHS Education Scotland
Healthcare Chaplaincy: the Lothian Patient Related Outcome Measure (PROM)

The construction of a measure of the impact of specialist spiritual care

NHS
Lothian

snowden & research
EXECUTIVE SUMMARY

Background

All NHS employees are required to provide economically sound, evidence-based care. In Scotland this is articulated in *The Healthcare Quality Strategy for Scotland* (The Scottish Government, 2010). In line with this agenda this report describes a project designed to generate evidence for the efficacy of specialist spiritual care in NHS Lothian.

A patient reported outcome measure (PROM) is a self reported questionnaire that assesses quality of life or perceived health status. The aim of this project was to develop a valid patient reported outcome measure following specialist spiritual care (chaplaincy) intervention.

The conceptual model underpinning the construction of the Lothian PROM was developed from the literature, and refined over a series of workshops and expert panels including local chaplains and world leaders in chaplaincy research. The Lothian PROM entailed five short sections:

1. Demographic details
2. Patient reported experience of the spiritual care support offered (5 Likert\(^1\) questions)
3. Patient reported outcome of that encounter (5 Likert questions)
4. Statements pertaining to spirituality (8 Likert questions)
5. Free text section for additional comments

Data

The Lothian PROM was completed by 39 of 70 people invited to participate. Chaplains recorded their impressions of these encounters independently. Telephone feedback on the experience of completing the PROM was obtained from 13 patients. Data from the first four sections was converted into summary descriptive and inferential statistics. Free text data was thematically analysed, and comparisons were generated between chaplain interpretations of encounters and patient accounts. This analysis was then synthesised into findings from ongoing national\(^2\) and local projects, and the wider literature.

\(^1\) A Likert-type scale assumes that the strength or intensity of an experience can be measured, usually on a five point range, allowing the individual to express how much they agree or disagree with a particular statement.

\(^2\) Community Chaplaincy Listening report by Mowat and Bunniss is due later 2012. It is strongly recommended these reports be read together as they entail strikingly similar conclusions by independent means. This increases the likelihood that the findings of both projects are generalisable and consistent across the Scottish population.
Results

Most participants (32/39) came from the acute services. More women than men responded, although the 3:1 ratio found here was virtually identical to current national work undertaken in community chaplaincy listening, suggesting transferability of the findings on this basis.

The responses pertaining to patient experience of the spiritual care intervention (section 2) were overwhelmingly positive. If listening, enabling people to speak what is on their mind, being understood and having faith and beliefs valued are important, then chaplains may be the best people to facilitate such outcomes. From a psychometric perspective these questions would benefit from piloting in different staff groups in order to provide comparative data and hence empirical evidence of the chaplain as specialist in spiritual care. The responses pertaining to spiritual care outcomes (section 3) were also unanimously positive.

The responses relating to spirituality trait descriptions in section 4 were heterogeneous, suggesting the sample was diverse, and that spirituality was not necessarily an important factor to the recipients of chaplaincy interventions. For example some people described themselves as spiritual but not religious. Many believed in God but not all the time. Others indicated they were not spiritual at all. Because the scores in sections 2 & 3 were so high this infers that a spiritual care encounter was useful for everyone with a need for hope and control, regardless of their beliefs. The more existential traits (spirituality, meaning) were not correlated with any outcomes. This can be explained by the secular nature of this population. A major finding from this study was that spiritual care was important to all the participants wherever they sat on the spirituality spectrum.

Positive outcomes of spiritual care intervention were strongly associated with the chaplain enabling people to talk about what was on their mind. A sense of peace was the clearest correlation between chaplaincy involvement and patient outcome. This strongly suggests that being enabled to speak about whatever was on their minds led people to achieve a sense of peace. This was highly valued by people, as corroborated in the free text data.

Analysis of the free text comments did not suggest that any aspects of spiritual care involvement or outcome had been missed within the body of the PROM (the Likert questions). Rather, the free text added explanatory depth to the responses already captured within the quantitative elements. We therefore concluded that free text data had an importance and function in allowing for expansion of quantitative responses, and should be retained for future iterations of the PROM. The telephone feedback on the wording of the questions strongly supported this conclusion by clarifying that participants understood the items within the Lothian PROM. Participants considered them personally relevant. In psychometric terms, the Lothian PROM has face and content validity.

Free text data was interpreted by the following four interrelated themes, explained in detail with exemplars in the body of the report:

- The significance of religion,
- Unmet needs in routine hospital care,
- Grateful recognition of the unique skills of chaplains (the 'guide through the gruesome'),
The need for a sense of peace in the midst of a stressful time

The quote overleaf illustrates aspects of all these themes and is repeated in full with permission of the author:

The final days of my partner’s life were the most distressing situation of my life. I had no idea how to deal with it or my feelings. The counseling that I received during those final days and in the months thereafter has been immensely helpful. I had also built up a lot of anxiety in anticipation of how her life might end. [Chaplain] was incredibly helpful in ensuring that I was able to have those final moments with her and that I could say all the things that I needed to say, without later regret of missing the moment. It was also vital that I was given the reassurance from a non-clinical body about how the end would be for [her] and that she would not suffer, which was so important. I have also seen [chaplain] several times in the months since [my partner] has died, with him even visiting me at the Sick Kids hospital where my daughter was staying at the time. I have been through a roller coaster journey of emotions and I am incredibly grateful for his continued support. I have received counseling before under much lesser situations and felt that on reflection this was by far the most effective I have received. I do not follow any faith and although at first I thought the help from a chaplain might be inappropriate for me, it immediately transpired to be irrelevant and [chaplain] seemed to tailor his counseling to suit my life. I am indebted to his help in those final days for [my partner] and wonder how I might ever have survived myself without it. It’s a vital service which is a must in that most gruesome environment of the intensive care ward 118. (A10)

One of the most significant findings was that these free text responses demonstrated a strong coherence with chaplain interpretation of interventions as evidenced by their independent descriptions. There was no case where the chaplain’s view of the encounter was different from the patient’s. This finding closely mirrors Mowat and Bunniss’ finding in a parallel NES Scotland research project, Community Chaplaincy Listening (CCL2). They cite this phenomenon as Pastoral Integrity3. Pastoral Integrity is person centred care. Evidence such as this therefore goes some way towards articulating not only the existence but the measurement of person centred care. The difficulty of articulating and measuring person centred care is discussed in the body of the report4. This finding in particular puts NHS Lothian chaplains not only at the forefront of research in their field, but of health service research and practice more generally.

Recommendations

We recommend that the overall structure of the Lothian PROM be amended to mitigate the psychometric issues discussed in detail within this report. In brief, these issues entail clarifying demographics in section 1, reversing some of the questions in sections 2 & 3, adding a specific timeframe to the outcome questions, and omitting section 4. The revised version incorporating these changes is in appendix 5.

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4 Much of this discussion is grounded in Cribb’s (2011) deconstruction of shared decision making in NHS. This is recommended reading.
In order to make best use of the outcomes of this project the validation process should continue. To this end the following projects should be considered:

**Would the findings from the Lothian PROM hold in a larger sample?**
We strongly recommend that the new version should be tested in a national population. This larger study should also include cross referencing the PROM with an agreed measure of quality of life so as to assess its construct and criterion validity. Although the Lothian PROM showed great promise, and is already clinically useful as it is, its utility will be much stronger if it proved demonstrably valid and reliable in a national sample.

**Could 3 questions discriminate referral?**
A short form of referral could be developed and tested based on the principal component analysis of Galek’s trait factors, discussed in the body of this report. That is, a positive answer to any of the three questions would warrant referral. The New Lothian PROM could then be used to measure whether these interventions were effective. This could be used alongside a treatment as usual group to ascertain the utility of the referral method.

**Would chaplains score higher than other disciplines in interventions as measured by this scale?**
We don’t know if the overwhelmingly positive responses of the people in this study were a function of poor psychometrics of the measure (ceiling effect) or a true reflection on the skills of the chaplains. In order to test this, the Lothian PROM could be adapted to also assess interventions from different disciplines. This would probably work best in comparable ‘talking’ roles such as psychology, psychiatry or mental health nursing, although given the claims made for palliative care nurses it may be interesting to include them. If it emerged that chaplains consistently scored higher than their counterparts then this would be a useful finding in relation to a discussion on chaplaincy, complexity and speciality.

**Does chaplains’ understanding of patients improve over time as measured by language convergence?**
This interesting linguistic hypothesis was raised in the chaplain feedback session discussed at the end of chapter 4. In order to test it we could use specialist techniques (Richard & Lussier, 2006) to analyse language and conversation during interventions, or use concurrent analysis (Snowden & Atkinson, 2012) to identify analogy and symmetry in encounter descriptions. This would provide deep evidence of person centred care and add to the theoretical understanding of this important aspect of communication.

**Does using Lothian PROM feedback in clinical supervision improve confidence, competence, and the value of the supervision?**
Again, in the chaplaincy feedback focus group in chapter 4, there was a deep sense of personal and professional pride in the finding that chaplain and patient descriptions of interventions were congruent. This was both very welcome and previously unknown. The most obvious issue was how to translate this information into service improvement. The general consensus was that this data would be useful in supervision sessions. There would be a number of ways to test this. For example in order to ascertain measurable improvement in relation to usual practice we would need some objective measures and a comparator group. Valid measures of self reported competence and confidence could follow supervision in groups that used this data, and be
statistically compared with those that did not. Interviews on the impact of supervision could add depth to these quantitative measures. There would be many ways of constructing such a study.

**Should chaplains continue engaging with research?**

One of the strongest elements of this project has been the involvement of chaplains throughout. They were involved in the construction, development and ongoing critical appraisal of the Lothian PROM. They provided and gathered data, and in Iain's case managed this process. They provided feedback on the results and this feedback went much of the way to suggest that these chaplains in particular saw the personal and professional value of this research. Hopefully this will translate into further consistent engagement. One of the main benefits of this process has been the growing feeling that research is not something done by other people but something done by us. We cannot recommend strongly enough that chaplains continue to engage with research as practice.

To cite this report:

Values Based Reflective Practice - I notice, wonder, realize....

**Guidelines for values based reflective practice group facilitators**
The practitioner should have prepared an outline of a case study and have sufficient copies for all the group e.g. a patient encounter, meeting with relatives, interaction with a colleague

1. Invite the presenter to give a copy of their case study out to the group. Ask the group to read through the case study and ask questions of fact to the presenter.

2. Invite the presenter to read the case study out loud, giving a sense of their own feelings/internal commentary where appropriate.

3. Invite the presenter to share anything that struck them through reading/hearing the conversation again. Is there anything that others noticed?

4. Invite the group to read the presenter’s response to the 4 insight questions (NAMV).

5. Invite the presenter to share why they have brought this encounter and to say what they hope to learn from the discussion. This is very important in order to give shape and focus to the reflection.

6. Invite the group to interact with the case study. Ask them to frame their comments in close connection with the text: e.g. I notice....; and to ask non-threatening questions, e.g. I wonder...; remind the group that although they may have opinions and ideas about the ‘meaning’ of the encounter - only the presenter was actually there and can realize things about their own work. Noticing and wondering can include the feelings and reactions the case study evokes in the reflective space.

7. Allow time and space for the presenter to respond remembering that insight belongs to them.

8. At a natural end, or when the time is coming to a close, ask the presenter what they will take away from the process - either realized during preparation of the case study or during discussion.

9. Invite each member in the group to note anything they have realized about themselves and their own practice.

10. To protect confidentiality, invite each member of the group to hand their verbatim back to the presenter.
Guidelines for Writing Case Studies for Reflective Practice

As you write about, for example, an encounter with a patient, family, colleague(s) or a meeting use the following to inform your writing

About yourself (How were you feeling before this encounter/meeting? What had happened immediately beforehand? What was your aim for this encounter? What did you anticipate your role would be?)

Your knowledge of the situation (What do you know about the situation before you enter it – this may vary from nothing at all to a great deal. Write what will be helpful to the reflection group when reading this.)

Your initial impressions (What do you notice e.g. body language; tone of voice; set up of the room; atmospheres already established? Does anything surprise you or make an impact on you?)

Describe the encounter itself and your observations about your feelings, the unspoken, the feelings of others, body language and your overall impressions.

Review (As you write down the conversation, record your current observations, feelings and questions. How do you interpret what was happening? How do you evaluate your interventions?)

Insights: NAMV
a) Whose Need(s) were met during the encounter?
b) What does this experience tell me about my caring Ability?
c) What does it tell me about Me?
d) What questions does it raise about my Values (that inform my attitudes and behaviours)?
   • With whom did the power lie in the case study?
   • Whose voice(s) dominated or had most value?
   • Whose voice(s) were not heard or undervalued?

Future action
What future action will you take in relation to this encounter:
• For the wellbeing of the patient/carer/member of staff or others involved?
• For your own future practice?
• For your own wellbeing?