Healthcare Chaplaincy Guidelines Review Workshop

15\textsuperscript{th} November 2018

Summary Notes
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1. Background

This report covers the following key areas:

a) Reaffirm the purpose of the pilot workshop held on the 15th of Nov 2018.
b) Share the key highlights of discussions held at the 15th of Nov 2018 event.
c) Outlines themes that emerged from the meeting (highlighted below in bold italics)
d) Next steps

2. Context

The NHS Chaplaincy guidelines published in 2015 provided a comprehensive description of good practice in chaplaincy care for the NHS in England. The document responded to changes in the NHS, society and the widening understanding of spiritual, religious and pastoral care. In addition, in the light of the 2010 Equality Act the guidance provided for the care of patients and service users whatever their religion or belief.

It is now three years since the guidelines were published in 2015 this review is in response to the commitment made in 2015 to review the guidelines. Therefore, NHS Employers between July and September 2018 circulated a national survey that asked respondents on the impact of the guidelines, how up to date the best practice was included and opportunities to put forward comments on how the guidelines can be (a) updated to reflect good practice (b) be more inclusive (c) more patient and staff centred and (d) part of organisational strategic and operational thinking such as the health and wellbeing agenda/EDS2

The purpose of the workshop was to ask a series of speakers to critique a section of the guidelines with reference to the following key questions:

a. what best practice should we consider for inclusion within the proposed revised guidelines
b. how can we make the guidelines more inclusive in line with the equality analysis underpinning the 2015 guidelines and the current equality analysis undertaken this year?
c. What is the distinctive experience of the type of NHS trusts and the chaplaincy experience?
d. How can we make the guidelines more patient/service user and staff focused?
e. How can we make the future guidelines a strategic tool that helps support the 10-year NHS plan?

f. Who needs to know & who do we need to influence about the guidelines across the system?

g. What support do chaplains and others in the NHS need to ensure chaplaincy is imbedded within NHS Trusts

3. **Key Highlights**

The following represents a summary of the key discussions at the workshop which in turn will support the feedback from the national survey and further workshops and a series of recommendations in March 2019:

**a) Patient and service user care: equality, safety and compassion & chaplaincy guidelines (Facilitator – Tim Couchman)**

Key points highlighted during this interactive active session included:

- The importance of promoting ‘holistic nursing care’ with reference to involving healing the mind, body, and soul of our patients. In addition, thinking about and assisting patients with the effects of illness on the body, mind, emotions, spirituality, religion, and personal relationships. Furthermore, holistic care also involves taking into consideration social and cultural differences and preferences. *(holistic nursing care)*

- The importance of accessing patient records to help chaplains with their roles was also emphasized yet this also raised the issue of credentialing of clinical and non-clinical pastoral education & requirements for chaplains to have access to key medical information. Members drew links to the chaplaincy work on education, endorsement and wider CPD wider talent management of chaplains in the system *(Information governance /chaplaincy access to data/education/endorsement & CPD)*

- The recent discussions on the ten-year plan and in particular the move towards delivering more healthcare out of acute care hospitals and closer to home and community, with the aim of providing better healthcare for patients, cutting the number of unplanned bed days in hospitals and reducing net costs. This raised important issues for the future model of chaplaincy provision away from large hospitals and more community based. *(NHS 10-year plan & chaplaincy model)*

- The Equality Analysis of the NHS Chaplaincy Guidelines undertaken in 2015 was highlighted. Key questions were posed including to what extent have NHS organisations integrated practices that demonstrate that chaplaincy services within NHS organisations follow the Equality Act 2010 and the Public-Sector Equality Duty; including ensuring due regard to advancing equality for people based on certain protected characteristics, including religion or belief. In addition, how NHS trusts have responded to changes in the NHS, society and the widening understanding of pastoral, spiritual, and
religious and care (*Update/awareness confidence EIA & Chaplaincy guidelines*)

- Participants stressed that chaplains can only do their jobs if they remain individually, collectively and organisationally rooted in the core purpose of what they do – improving care for patients, through more engaged staff, through better leadership. (*Chaplaincy & quality agenda*)
- The group also spoke about the importance of advancing ‘inclusion’ and that chaplaincy services are there for all people in society. Minority faiths and no faith as well as LGBT community were highlighted as groups who in the past have been placed at the margins of chaplaincy provision but were now able to put forward their views and experience to help shape future chaplaincy provision and guidelines. (*Inclusion LGBT & minority faiths & belief or no belief*)
- In addition, encouraging and supporting chaplains to use their knowledge, expertise and insights & contributing to the wider context of an organisation's work on service redesign and staff health and wellbeing agenda. (*Chaplains & contribution to service redesign*)
- Promote, develop and use scales measuring patient satisfaction with chaplaincy services & evidence/data needed to support patient care and development of chaplaincy (*Chaplaincy impact & evaluation & benchmarking*)

b) Staff and organisational healthcare support: informed, competent & critical & training, development & research NHS healthcare chaplaincy

- It was highlighted that the role of the NHS chaplain is not confined to the provision of religious services. The role of the chaplain has changed, and continues to change in response to the socio-cultural, political and economic climate it operates within the NHS. The paragraph on page 11 of the guidelines was highlighted ‘chaplains are encouraged to draw on their contacts with patients and service users to represent areas of concern to senior management’. (*Chaplains & wider organisational influence*)
- The key act of the chaplain gathering and evaluating relevant data pertinent to the patient’s situation and/or bio-psycho-social-spiritual/religious health was emphasised. Again, access to Information and documentation of Care was highlighted and variations in practice (*Chaplaincy access to medical data*)
- It was stressed that the chaplain must be a member of the multi-disciplinary team, with access and to information pertinent to the patient’s medical record that is relevant to the patient’s medical, psycho-social and spiritual/religious goals of care. (*Chaplains & involvement with multi-disciplinary team*)
- The issue of ethical practice and how this guides decision making, and professional behaviour was discussed within the context of reflective practice and research. (*Chaplaincy & research and practice/evaluation*)
- Continuous quality Improvement as a methodology that seeks and creates opportunities to enhance the quality of chaplaincy practice was highlighted. One such example was the adaptation of ‘Schwartz rounds’ introduced into the UK in 2009, are now run in over 150 health-care organisations. These organisation-wide forums, which are open to all staff (clinical and non-clinical) to discuss emotional, social or ethical challenges through sharing, in a safe environment, their experiences of caring for patients and families, are
intended to help improve staff well-being, effectiveness of communication and engagement, and, ultimately, patient care. Evaluations of Rounds are sparse, although evidence from the USA and the UK suggests that attending Rounds is associated with improved well-being and relationships with colleagues, and with more empathic and compassionate patient care. (quality agenda & quality improvement & chaplaincy)

- Continuous investment in research was advanced looking at chaplain practices & evidence-based care, including ongoing evaluation of new practices, and was also emphasised of the importance of chaplaincy contributing to other existing research being undertaken within an organisation. (quality improvement & research and practice)

- Discussions revealed an environment where chaplains operating within the NHS are answerable to three different and at times seemingly incompatible groups. Chaplains seek to offer care, compassion and understanding to individuals – patients, staff and others. Secondly chaplains of all faiths are employed by an institution – the National Health Service. And most chaplains belong to a faith and belief community to which they have strong personal allegiances, and which may feel that the faith and belief organisation and not the NHS has first claim on overseeing their work. Additionally, healthcare chaplaincy work is stressful and frequently involves assisting people who are confronting traumatic situations that can be difficult to accommodate within a traditional theological framework. (the role of chaplains, culture & position in organisations)

- Time and space for reflective practice was emphasised. Reflection was argued is a key element of a chaplain’s professional development and ability to e.g. understand how belief systems and practice interrelate; how to reconcile personal beliefs with those of others, particularly how one’s own belief system may affect the attitudes and behaviour of people using the chaplaincy service; and how to build professional relationships with vulnerable people in traumatic circumstances. (protected time & reflection & practice)

- The role of the chaplain it was argued was one of helper, to the organisation using themselves as instruments, and building effective relationships to deliver ‘help’. Chaplains using diverse diagnostic and intelligence could intervene within the system, using structured interventions to achieve the development of the organisation. Chaplains were encouraged to adopt and influence the work on organisational development and workforce whose practitioners use a framework of diagnostics to link the environmental factors that affect the organisation, its strategic imperative, the organisation’s ‘throughput’ (that is, linked to both the patient experience and employee satisfaction and behaviour), working back from implementation (chaplains, organisational development & system reform).

(C) Key components for an effective chaplaincy service & volunteers in chaplaincy & chaplaincy staffing (Meg Burton)

- Increasingly, the NHS employ full-time Chaplains, many of whom are lay people and are volunteers. (diverse chaplains)

- Healthcare chaplaincy in the UK changed markedly in the first decade of the millennium. Although there are, and likely always will be, differences in the ways in which healthcare chaplaincy is delivered across the different regions
of the United Kingdom, there is recognition from all that spiritual and religious care are integral to healthcare and that healthcare chaplaincy is the profession with the expertise in this area of care (chaplaincy, variation & practice).

- Discussions centred on how to define a qualified chaplain and the lack of structural outline for chaplaincy training (chaplaincy & personal development).
- In addition, the difference in general chaplaincy v chaplaincy speciality was also highlighted and career progression (role of chaplaincy).
- Furthermore, the role of chaplains & acting as a Caldicott Guardian person within a health or social care organisation was also highlighted. The accessing of personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. It was emphasised that such roles that Chaplains undertake provides opportunities for leadership and informed guidance on complex matters involving confidentiality and information sharing. (Caldicott & governance).
- The collaborative relationship between nurses and chaplains in the health care setting was highlighted and its benefits on patient café. The authors review research findings including survey results demonstrating the importance of religion and Three factors that might account for nurses' further recognition of spiritual needs are: 1) the inclusion of spiritual care in the nursing curriculum, 2) personal involvement in faith communities and, 3) the historical influences of the nursing profession. (chaplains & relationship wider NHS workforce).
- Discussion mentioned the report titled ‘A Very Modern Ministry: Chaplaincy in the UK’ written by Ben Ryan. The report suggests two primary contentions: that today in the UK chaplains are everywhere (but what that means varies enormously between fields and roles), and that their impact, while often extremely significant (and there are some phenomenal stories to this end), needs to be considered in a broader sense than it often has been (the role, positioning & branding of NHS Chaplaincy).
- Not sure staff ratio is relevant in guidance – case for change that incorporate benefits highlighted.
- Standardisation and chaplaincy & demonstrating value and working with the Care quality commission (CQC) to hold organisations to account in terms of measuring the impact of chaplaincy services were also key issues highlighted. (CQC & inspectorate regime/well led).
- In addition, benchmarking on what constitutes a good chaplaincy model and appropriate guidance on the equality act were also mentioned (what does good chaplaincy look like).

(D) Chaplaincy in Acute Care & Chaplaincy in Mental Health Care, Lead: Tim Couchman

- Chaplaincy within both the acute and mental health must address implications for chaplaincy in line with the significant shift towards place-based health across the health service. The NHS Five Year Forward View set the tone with an explicit focus on new models for population health management. In addition last November last year the Kings Fund published its call for ‘place-based systems of care’ as a basis for long term policy. And recently-
issued NHS planning guidance for local health and care systems, who will now be required to develop place-based–Sustainability and Transformation Plans (STPs), translates this concept for future services into a requirement in practice (NHS chaplaincy model of practice & NHS strategic framework)

- A key proposition at the heart of place-based care was stressed included the push towards the blurring of institutional boundaries across a location to provide integrated care for individuals, families and communities (NHS chaplaincy & place based/community services)
- Integrate guidelines with 3 high secure chaplaincy policies
- It was highlighted that it was crucial that future guidelines stressed strongly of the importance of NHS trusts commitment towards ensuring the presence of a place of worship / multi-faith room / sanctuary as an organisational imperative and demonstration of commitment to the agenda.

(E) Chaplaincy in General Practice & Chaplaincy in Community Care, Lead: Rev Meg Burton

- Discussion centred on the move towards place-based systems of care. The concept of ‘the team around the person’ leading to a more integrated service, a reduction in duplication and greater efficiency. (NHS chaplaincy & place based/community services)
- Example of GP and community pilots were shared from Coventry and Doncaster as well as the Scottish experience. This integrated approach with chaplaincy offered a vision of the future. This is a valuable person-centred service, based on the principles of therapeutic storytelling 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. (NHS chaplaincy & place based/ GP community services)
- The concept of social prescribing which enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services including chaplaincy was also discussed. This raised issued of capacity and further discussion in terms of the future chaplaincy model (NHS chaplaincy model of practice & NHS strategic framework)
- Finally, the challenge of going beyond just faith groups to build the volunteer workforce was highlighted (diverse NHS chaplaincy workforce)

(F) Chaplaincy in Specialist Palliative Care, Lead: Revd Dr Steve Nolan,

- Discussions included references to the changing times. In contemporary society, death is largely medicalised. While in former generations many people died at home, relatively young, and therefore an exposure to death was often an all-too-normal part of family life, today the norm is to die in hospital, in old age. A 2010 report by Demos found that of the half a million deaths recorded annually in Britain, around 60% took place in hospital, 17% in care homes, 5% in hospices and 18% at home, a figure predicted to fall to 10% by 2030; yet
surveys consistently show that 60-80% of people express a wish to die at home. *(place of death from hospitals to home)*

- Palliative care has been recognised as a specialism in the UK only since 1998. NICE (see below) defines palliative care as “the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier during the illness in conjunction with other treatments” (2004) *(early intervention & palliative care)*

- Discussions highlighted that the aims of palliative medicine extend well beyond pain relief, and that it should not be seen as something that begins only in the last days or weeks of life. Early reference to palliative specialists can be hugely beneficial to patients and their families. Palliative care is by no means the preserve only of *hospices* *(early intervention & palliative care)*

- The introduction of the Liverpool Care Pathway developed in 2012 was highlighted as an example that strives to ensure that we recognise the imminent approach of natural death, and it is fully explained to the patient and/or the patient’s family. The patient’s holistic needs - physical, emotional, psychological and spiritual - should be assessed and addressed as far as is possible. *(holistic care)*

- Examples were shared, which seems to indicate that some clinical staff often feel uneasy about or unable to address spiritual need at any time in a patient’s journey, including as death approaches *(wider staff education faith & belief & chaplaincy)*

- It was important chaplains support the palliative care Multi-disciplinary team (MDT), especially the consultants. As with so much in the NHS, the consultant is key and can help make things happen. *(staff integral part of multi-disciplinary teams)*

- Support of the trust board. Again, the influence of the consultant is key here e.g. to have chaplains accepted as part of the MDT *(staff integral part of multi-disciplinary teams)*

- Support of the staff on the wards. Staff took a little time to be convinced, but evidence exists to indicate the model was accepted. The fact that it continues to work effectively, and benefits patients and families, ensures continuing support from staff *(staff integral part of multi-disciplinary teams)*

- Again, it was emphasized that for chaplains to work as effective and recognised members of the multidisciplinary team chaplains need to have the same access to patient notes as other team members and to record their response to referrals, interventions and outcomes *(staff integral part of multi-disciplinary teams)*

- In addition, discussions also centred on the importance of generating evidence for the efficacy of specialist spiritual care within NHS trusts. The Scottish example of a patient reported outcome measure (PROM) a self-reported questionnaire that assesses quality of life or perceived health status was shared as an example of good practice. *(chaplaincy and impact)*

- Also, the key skills used in chaplaincy were highlighted—listening, building relationships of trust, and using intuition, compassion, imagination, and creativity—are irreducible to numerical terms and not easily measured.
• Although numbers are necessary to manage large organisations, they must never become the final word. This is beginning to be understood in the NHS, especially within the context of the quality agenda and the need alongside effective treatment, patients “want care that is personal to them, and to be shown compassion, dignity and respect by those caring for them.” These values, and a patient centred approach, are embodied in the work of chaplains. 

(Chaplains beyond numbers & wider influence and impact)
• Furthermore, discussions also entered on the word ‘chaplaincy’, & the extent it retains sufficient religious connotations to be inappropriate as a meaningful description. It was suggested that discussion should be held, and consideration be given to the name - NHS Pastoral, Spiritual & Religious Care Guidelines to reflect the diversity of people working in and accessing the NHS. 

(Chaplaincy what's in a name?)
• The blob tree methodology was highlighted to help interaction with patients.
• The challenge of providing support of a non-religious pastoral care nature. It was emphasised that chaplains and institutional managers responsible for chaplaincy or spiritual care departments need to be aware of insights into the positive contribution non-religious pastoral carers can make in building stronger, more inclusive pastoral, spiritual, and religious care services. 

(Non-religious pastoral care)
The work of David Savage was highlighted in particular how chaplaincy departments have progressed from a Christian to a multi-faith and on to a fully inclusive care service. Compelling evidence is presented showing strong and broad support for non-religious pastoral care provision. A practical guide, it outlines the beliefs and values on which this care is founded and its person-centred approach. The role, skills, competencies, and training requirements for non-religious pastoral carers are described. Institutions need to consider their policy responses to the rapid development of non-religious pastoral care provision. Several policy aspects are explored, including understanding service users' needs, recruitment, and communications. 

(Non-religious pastoral care)

Chaplaincy in Specialist Paediatric Care, Lead: Rev Paul Nash,
• Discussion focused on the distinctiveness of paediatric chaplaincy. Four distinct areas were highlighted including (a) supporting families including those receiving palliative, end of life and bereavement care (b) supporting children including spiritual and religious care (c) working as part of multi-disciplinary teams (d) staff support and self-care (Distinctive chaplaincy provision & hospital directorate)
• In addition, taxonomy of chaplaincy and what they do including build relationships, offer emotional support, demonstrate concern amongst other things. (Role of chaplains)
• The importance of chaplaincy practice linking with Nice guidelines and standards. The guidance on end of life care for infants, children and young people with life-limiting conditions: planning and management. This Recommends chaplaincy involvement and spiritual care being offered at many stages of care.
• Spiritual assessment and intervention tools designed for adults not appropriate for children (Tools and spiritual assessments). It was highlighted that it has been observed and experienced that the adult cognitive models of spiritual
assessment and interventions tools are not appropriate for most children. Therefore, tools need to account, children’s developmental levels, interests, abilities and good practice of relation and communicating with children and young people. A particular tool titled “Spiritual Play” was highlighted. It involved using bespoke and normative play activities to help the children and young people articulate their spiritual needs.

- Spiritual care with children and young people is ever complex (spirituality and complexity)
- Chaplaincy should reflect diverse population and ratios close to mental health
- Key observations highlighted with respect to the present guidelines included (a) they are guided by specialist palliative care, which were originally written with a hospice and perhaps general hospital in mind and not a specialist children’s hospital. There was no ratio for larger institutions. (b) this ratio would be deemed to be correct of these institution (c) management: Time allocated for FTE was helpful, as it was felt it almost took the same amount of time for management, supervision etc for part time staff.
- other observations included (a) many long term very poorly patients in intensive paediatric, neonatal, cardiac and HD units (b) we are doing regular contract communal funerals and memorial services as well individual ones. (c) we are doing many multi faith and beliefs beginning of life and well as end of life rituals, blessing, baptisms, prayers, naming etc. (d) family support is our normal focus. this multiplies our workload as we support patient, parents, siblings, wider family etc (e) spiritual care with children and young people is a complex, time consuming and developing discipline. (f) we have only trialled assessment and intervention tools such as spiritual play. (g) many of our institutions have a growing patient population of children and young people with mental health, intersex and gender dysphoria issues. (h) we are involved in the children’s normal life in the hospital; school, play, parties (i) staff wellbeing is exacerbated because of the difficult, stressful circumstances of our patients and their families. (j) maternity may need its own or named alongside paediatric guidelines. (k) chaplaincy support is a growing need within hospital at home and the follow up care of outpatients.
- Key recommendations included (a) ratios closer to mental health would reflect the distinctiveness and intensity of paediatrics (3.75 hours a week for every 20 patients, for every 15 chronically ill patients and every 200 staff). (b) chaplaincy staffing should reflect the beliefs, ethnic spectrum of the institution population. (c) specialist training is needed for paediatrics and maternity contexts.

4. Key Themes highlighted during the workshop included:

1. Holistic nursing care across the whole hospital irrespective of speciality
2. Chaplaincy access to patient data
3. Chaplaincy education/endorsement & CPD
4. Volunteer recruitment policies reflecting local population,
5. Need to rethink/emerge of chaplaincy into community and primary care sectors
6. NHS 10-Year plan & chaplaincy model
7. Staffing ratios/relevance and case for change
8. Update/awareness confidence EIA & chaplaincy guidelines
9. Chaplaincy & quality agenda
10. Inclusion LGBT & minority faiths & belief or no belief  
11. Chaplains & contribution to service redesign  
12. Chaplaincy impact & evaluation & benchmarking  
13. Chaplains & wider organisational influence  
14. Chaplains & involvement with multi-disciplinary team  
15. Chaplaincy & research and practice/evaluation  
16. Quality agenda & quality improvement & chaplaincy  
17. Quality improvement & research and practice  
18. The role of chaplains, culture & position in organisations  
19. Protected time & reflection & practice  
21. NHS chaplaincy model of practice & NHS strategic framework  
22. NHS chaplaincy & place based/community services  
23. Diverse NHS chaplaincy workforce  
24. Place of death from hospitals to home  
25. Early intervention & palliative care identifying patients earlier in their journey,  
   e.g. palliative care as more people wish to die at home,  
26. Hospices early intervention & palliative care  
27. Wider staff education faith & belief & chaplaincy  
28. Chaplains beyond numbers & wider influence and impact  
29. Chaplaincy what’s in a name?  
30. Non-Religious Pastoral Care  
31. Distinctive chaplaincy provision & hospital directorate  
32. Role of chaplains  
33. Tools and spiritual assessments  
34. Spirituality and complexity  
35. Integrate guidelines with 3 high secure chaplaincy policies

5. **Next Steps**

The feedback and emerging themes will help shape the proposed recommendations in line with the individual section of the existing guidelines.