

MANAGING CHAPLAINCY SERVICE DELIVERY

Chris Johnson

Abstract: *Audit, accountability and clinical performance all form what is now understood in the National Health Service (NHS) as Clinical Governance (CG) and it has profound implications for all who work in the NHS including Chaplains. CG is something they will need to comprehend and implement. This paper seeks to describe the service the Chaplaincy provides, our customers are identified, as are the difficulties of assessing whether or not we can/are delivering a quality service. I consider what criteria/performance indicators I would be looking for from an economical, efficient and effective Chaplaincy department. Then as a "customer facing organisation", I explain some of the difficulties of finding out what our customers think of our service/role and cite examples of surveys from other Trusts.*

Key words: Chaplaincy, Clinical Governance, customers, effectiveness, quality, value for money

Introduction

On September 1st. 2001 I joined the ranks of NHS middle management. The move from Chaplaincy Co-ordinator to Chaplaincy Manager was part of an overall restructuring of management in the Bradford NHS Trust but it was dependent on my participation on the course 'Managing in Health and Social Care' sponsored/prepared jointly by the Department of Health (DoH), Open University and the Institute of Healthcare Management. This paper arose out of the third module entitled 'Managing Service Delivery' and seeks to address various questions which form its main headings:

- The Service provided by the Chaplaincy Department
- Who are our customers?
- Our customer's assessment of a quality Chaplaincy Department
- A criteria for assessing if Chaplaincy is economical, efficient and effective
- Consulting the customer: a methodology for discovering what our customers think

The Service provided by the Chaplaincy Department

Chaplaincy services have been an integral part of the NHS since its inception in 1948. A series of circu-

lars issued by the then Ministry of Health specified hospital authorities 'should give special attention to provide for the spiritual needs of both patients and staff' and that management committees 'should appoint a chaplain – or chaplains from more than one denomination – for every hospital for which they are responsible' (Ministry of Health, 1948, HMC(48)62). The significance of this circular was that it clearly identified spiritual care as a component part of the health service, with hospital Chaplaincy established for the first time, as a publicly funded profession.

However, in the early 1990s there was much uncertainty regarding the future of Chaplaincy in the NHS but the publication of the Department of Health Guidelines (1992) 'Meeting the Spiritual Needs of Patients and Staff' re-affirmed the position of Chaplaincy, advising that employing authorities should 'make every effort to provide for the spiritual needs of patients and staff'. The Patient's Charter (Department of Health, 1991/1995:6) (and more recently the document 'Your Guide to the NHS', (Department of Health, 2001(a)) publicly added weight by stating that 'you can expect the NHS to respect your privacy, dignity, religious and cultural beliefs at all times and in all places'. The employ-

ment by NHS Trust of more whole-time chaplains seems to have been the desired solution.

Given the seeming necessity of this service what is it the Chaplaincy Department in the Bradford Hospital provides? We recently devised the following Mission Statement: The Chaplaincy Team exists:

- To ensure the provision of spiritual and religious healthcare for patients, carers and staff
- To facilitate spiritual healthcare within the Trust
- To remind the Trust of the importance of the whole person by teaching and example

This was an attempt to clarify our role in the light of the fact that over the last twenty years, much chaplaincy activity has been re-defined by a new understanding of spirituality and a greater emphasis on pastoral care. It was this understanding that shaped our understanding of our service. Spiritual care is variously defined but for our purposes we understood it as 'the essence of human beings as unique individuals "what makes me, me and you, you", so it is the power, energy and hopefulness in a person. It is life at its best, growth and creativity, freedom and love... it is what enables a person to survive bad times... to overcome difficulties... to become themselves' (Bradford Social Services, 1999).

Who are our Customers?

The description 'customers' does not sit comfortably with Chaplains who prefer the more 'human' words 'people' or 'patients'. Nevertheless for the purposes of this paper the term 'customer' will be used. It is important for managers to identify who their customers are, to identify what they require, and to know effectively if their needs are being met. Chaplains see their potential customers as all patients, carers and members of staff regardless of their religious belief or none. David Stoter (1995:2) writes 'every person is a spiritual being, having a spiritual dimension and thus spiritual need is universal'. Understood as such, spiritual care is not an optional extra, for those who are actively religious; it becomes an integral part of the holistic approach which is held up as an ideal in modern health care and therefore has relevance to all.

Our prime responsibility is to the patients and inevitably we come into contact with a patient's family and friends. Immediately it is identified that we have different kinds of customers yet we note that health-

care staff also form a major part of our customer base. As Douglass et al (2000:7) point out 'service users are the ultimate customers. They are at the centre of defining and delivering health... the reason the services exist'. Chaplains can (and do) make an effective contribution to the Trust's total pastoral care by working alongside various members of departmental teams. We make and receive direct referrals, consult in confidence with staff members concerning patients and hopefully provide meaningful patient-staff care. Some examples are enumerated:

Patient focus

- to develop integrated pastoral care of support, guidance, nurture and encouragement
- to provide information on faith traditions and access to resources and rituals
- offer counselling (or 'listening ear') services
- serve as a religious resource person for the patient

Staff focus

- provide pastoral care and counselling/listening services
- establish a training/development function e.g. cultural awareness,
- bereavement education
- facilitate groups for team building and critical incident stress
- debriefing

Other customer focuses are identified as:

- Strategic Focus
- Involvement in Trust groups such as the Organ Retention Group
- Regular place on 'Corporate Induction' programme for staff

External focus

- Networking/dialogue with clergy, Churches and other religious bodies
- Meeting with members of/involvement with Education/Cultural groups
- Occasional funeral and other bereavement work
- Training of volunteers who act as our regular ward visitors and provide assistance with religious 'services'

Our Customer's assessment of a quality Chaplaincy Department

The DoH (1997:3.2) document 'The New NHS' defines quality as 'doing the right things, for the right people, at the right time and doing them right first time'. However, there is no single comprehensive indicator of service quality (see e.g. Juran 1986; Crosby 1984; ISO 1986; Grocock 1986; Lilley 1999), and in health people see quality both in the way in which they are treated while they are using a service and in outcomes they derive from it.

Quality assurance originated in industry where the idea was to ensure that the product consistently achieved customer satisfaction. But there are dangers in thinking of health services as if they were products. There is little doubt as to what a car or computer is intended to achieve, at least in comparison with the outcomes of nursing care or a Chaplain's visit. For these services it is vital they are linked with objectives that specify the customer's needs which the service is intended to meet. Quality then is therefore about meeting the requirements of the customer.

If we are to evaluate our service for our customers we recognise that we must try and put ourselves in their shoes and ascertain their requirements. This is not an easy exercise for Chaplaincy because of the various understandings of the purpose and role of Chaplaincy. At one extreme Christian Chaplains have been seen by Christian customers as traditionally maintaining a religious role e.g. to pray with the sick and dying and to dispense the sacraments, whereas the role of Muslim Chaplains (for example) is not really understood by both Chaplain and Muslim customer alike. This is because Islam has very little theological, historical and cultural understanding of Chaplaincy and pastoral care. To ask customers to evaluate quality when there is so much misunderstanding of purpose is to invite confusion. This difficulty is compounded by the differing views amongst Chaplains themselves (throughout the NHS), although in Bradford we have taken a positive step towards clarification, with the recent publication of a Mission Statement noted earlier.

I collated some statements of a 'quality Chaplaincy service' and asked a number of staff and patients for their comments. Both groups gave weight to such aspects as time, attention, openness to all, ap-

proachability, listening skills, and affirmation of worth, as well as more traditional aspects of chaplaincy, such as the provision of regular services. Staff also valued chaplaincy involvement in various aspects of the wider life of the hospital, such as teaching and involvement in ethical groups.

However, it should be noted how these surveys represent small samples and as such do not give a robust base of customer opinion. It should also be observed how religious beliefs may influence quality outcomes and it was assumed that the customers questioned had some basic knowledge of Chaplaincy activity.

Criteria for assessing if Chaplaincy is economical, efficient and effective.

Ann Dix (1996) writing in the Health Service Journal in under the title 'Is God good value?' cites Rabbi Julia Neuberger who states 'it doesn't make sense to ask for proof of the effectiveness of Chaplaincy. What do you ask? How many souls have you sent to heaven? But you can assess if it is being done badly by asking if it is supporting patients and staff'.

Different approaches to audit have taken the form of an Inspection or Visitation carried out by representatives of the NHS Northern Advisory Committee. An example of this took place at Leeds General Infirmary when staff provision, educational activities, pastoral care of staff and information for patients and staff were considered (Kennedy and Webster, 1996). The aims were to support Chaplaincy services, to raise the profile, to discuss issues raised during the visit and consider ways of maintaining the service as an integral part of healthcare. As commendable as this exercise appears, the audit value is limited because it is unclear how Chaplaincy can be evaluated on the basis of a three hour visit. Also there are indications that Chaplaincy departments only agreed to a visit, if the outcome was expected to be favourable.

The introduction of the concept of Clinical Governance (CG) with its emphasis firmly on quality, has brought into focus many of the issues raised over the past ten years by three published documents: Chaplaincy 'Standards Document' (Chaplaincy Education and Development Group, 1993), 'Framework for Spiritual, Faith and Related Pastoral Care' (NHS

Executive Northern and Yorkshire Chaplains and Pastoral Care Committee 1995), 'Spiritual Care in the NHS – a Guide for Purchasers and Providers' (National Association of Health Authorities and Trusts 1996).

How then could the new systems, brought about through CG, impinge on the role of the Chaplaincy Department? Assessing this the Professional Development and Education Group of the College of Health Care Chaplains proposed five elements (Professional Development and Education Group, 2000). Chaplains, it states, should:

- Actively create an environment in which clinical excellence will flourish
- Provide a basis for evidence based practice in relation to spiritual/religious care
- Promote and support reflective practice by staff in relation to patient care
- Provide a mechanism for reviewing the quality of the Chaplaincy service
- Produce clear policies aimed at managing risks, including incident reporting, learning from mistakes and dealing with poor performance

To illustrate how this could affect our practice here in Bradford I offer the following example:

A woman who has a late miscarriage and with her partner, asks what happens next. A nurse talks about the possibility of a funeral service through the hospital and the help Chaplaincy might provide. The couple explain that they are not religious but reassured by the nurse, are happy to see one of the Chaplains. A non-religious funeral is arranged, devised by the couple and the Chaplain is asked to take part. Following the funeral the Chaplain reviews all that has happened with ward staff and it is concluded that:

- The Chaplaincy procedures in place are understood and followed by members of staff
- There is good team working with nursing staff, promoting excellence of care
- There was an appropriate response to the spiritual needs and personal care for the parents
- Equity of access was demonstrated i.e. Chaplaincy is not only for those who are religious
- There were positive outcomes: funeral went well and a letter of appreciation from the patient was received

- Good practice demonstrated the benefits of continuing professional education
- There were good reflective processes in place i.e. Chaplaincy team and ward staff, to review/reaffirm best practice
- Good risk management systems in place i.e. appropriate care of miscarried foetus and the importance of offering a funeral as part of the grieving process

If I was the Chief Executive observing the wider Trust panorama, I would probably conclude that at the present moment it is difficult to assess whether or not the Chaplaincy Department is delivering an economical, efficient and effective service. However, I would suggest the following:

- Chaplains should be professional, well trained and preferably have NHS experience
- Chaplains should be well managed and challenged with the implications of such documents as 'The NHS Plan' (DoH 2000)
- Chaplains should expect to be regularly audited. Standards and expected outcomes should be in place and periodically revised. The implications of Clinical Governance for Chaplains should be seriously addressed
- Good practice (and reflective practice) should be demanded from Chaplains noting examples from other Trusts
- CHI 'Reviewers' should have an understanding of Chaplaincy and the same expectations as other departments

Consulting the Customer: a methodology for discovering what our customers think of our department.

Chaplains have never been very good at asking what customers think of (or want from) its service. It has often been assumed that it is providing what the customer *needs*, which is not necessarily the same as *wants*. Helpfully Baker (1991) describes a *need* as 'something fundamental to the maintenance of life and maybe satisfied by any one of a number of alternatives' and a *want* is understood 'against the variations in economical, sociological and psychological factors pre-disposing individuals to prefer a specific alternative'.

One tool of accountability has been the use of Patient surveys and these have been variously at-

tempted in NHS Trusts. For example Worcester Royal Infirmary (2000) received 92 responses to a survey and its main conclusions were as follows:

- While there is significant information (about Chaplaincy) in admissions literature, it is not proving effective therefore perhaps it should be ward based
- The majority of patients using the Chaplaincy service do so for general encouragement and conversation. Only a small number use the Chapel
- Patients who had not used Chaplaincy, perceived it as useful only in negative situations
- The vast majority of patients who use the Chaplaincy service deemed it acceptable

Very few examples exist of Chaplains discovering what their staff customers think of their service and using the results to make changes and improvements. However, six years ago at Leeds General Infirmary the Chaplains and an officer from the Trust Clinical Audit Department, designed a questionnaire to ask staff about their perceptions of the Chaplain's role, their part in staff support and spiritual healthcare. The results were published in the Health Service Journal in July. I cite some of their conclusions:

- Staff were worried that Chaplains might 'do or say something religious to them
- Staff seemed willing to involve Chaplaincy with patients but reluctant to do so for their own support although (in contradiction perhaps?) they stated that Chaplaincy support was important to them
- Staff recognised 'spiritual unwellness' and would call for a Chaplain ahead of social workers and psychologists
- Staff had become willing to receive teaching from Chaplains on specific subjects e.g. Bereavement
- Staff saw Chaplains as more than 'religious functionaries'

It is difficult to ascertain if the Chaplains used the patient and staff data to improve services to their customers. The outcome appears to have been in Leeds that it 'affirmed Chaplains in their role and illustrate the diverse part they have to play'. However, given the difficulties already highlighted, more work needs to be done by Chaplains to find out our customer's opinions of our services.

Acknowledgement

This article is an abridged version of a longer assignment (Johnson 2001).

References

- BAKER, M. 1991 *Marketing: An Introductory Text*, (5th ed.) Macmillan.
- BRADFORD SOCIAL SERVICES 1999 *Spiritual Well-Being Policy and Practice*, Bradford Community Health NHS Trust, Bradford Interfaith Education Centre.
- CHAPLAINCY EDUCATION AND DEVELOPMENT GROUP 1993 *Health Care Chaplaincy Standards*, NHS Training Directorate, Bristol.
- CROSBY, P. 1984 *Quality without Tears*, McGraw-Hill
- DEPARTMENT OF HEALTH 1991, 1995 *The Patient's Charter and You – Raising The Standard*, London, HMSO.
- DEPARTMENT OF HEALTH 1992 *Meeting the spiritual needs of patients and staff*. Health Service Guidelines (92)2, NHS Management Executive, London
- DEPARTMENT OF HEALTH 1997 *The New NHS – Modern and Dependable*. The Stationary Office, London.
- DEPARTMENT OF HEALTH 2000 *The NHS Plan – A Plan for Investment*, Crown, London,
- DEPARTMENT OF HEALTH 2001(a) *Your Guide to the NHS*, Crown, London.
- DEPARTMENT OF HEALTH 2001(b) *NHS Plan Implementation Programme*, Crown, London.
- DIX, A. (1996) *Is God good value?* Health Service Journal, July 11, pp. 24-27.
- DOUGLASS, C. SANDFORD, J. HENDERSON, E. 2000 *Managing in Health and Social Care.*, Open University, Module 3, Book 1, pp.5-64, Milton Keynes.
- GROOCCOCK, J. 1986 *The Chain of Quality*, John Wiley and Sons, UK.
- JOHNSON, C. 2001 *Clinical Governance: The Implications of Quality and Competence for Health Care Chaplains in the NHS*. Unpublished M.A. Dissertation University of Leeds.
- JURAN J. 1986 *The Quality Trilogy*, Quality Progress. Vol. 19, No. 8, pp. 19-24
- KENNEDY, V. AND WEBSTER, G. 1996 *Visit to the United Teaching Hospital Chaplaincy*. Unpublished Internal Document Leeds General Infirmary Chaplaincy Department

LILLEY, R. 1999 *Making Sense of Clinical Governance*, Radcliffe Medical Press.
MINISTRY OF HEALTH 1948 *Guidance on Spiritual needs of Patients Staff*. Health Management Committee (48) 65
NATIONAL ASSOCIATION OF HEALTH AUTHORITIES/TRUSTS (NAHAT) 1996 *Spiritual Care in the NHS – A Guide for Purchasers and Providers*, Department Health, London.
NHS EXECUTIVE NORTHERN AND YORKSHIRE CHAPLAINS AND PASTORAL CARE COMMITTEE 1995 *Framework for Spiritual, Faith and Related Pastoral Care*. The Institute of Nursing at the University of Leeds, NHS Executive

PROFESSIONAL DEVELOPMENT AND EDUCATION GROUP 2000 *Clinical Governance-Five Elements*, Unpublished Paper, Health Care Chaplains, London.
STOTER, D. 1995 *Spiritual Aspects of Healthcare*, Mosby, London.
WORCESTER ROYAL INFIRMARY 2000 *Chaplaincy Patient Surveys*. Chaplaincy-Spirituality-Health Database. support@jiscmail.ac.uk

Chris Johnson is Chaplaincy Manager, Bradford NHS Trust.