View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by LSBU Research Open

[*HSCC* 6.1 (2018) 82-95]
https://doi.org/10.1558/hscc.31826
HSCC (print) ISSN 2051-5553
HSCC (online) ISSN 2051-5561

Do Oncology Outpatients Need Chaplaincy Services?

S. H. Cedar[1]
London South Bank University, London, UK
cedars@lsbu.ac.uk

J. Mitchell[2]
London South Bank University, London, UK
cedars@lsbu.ac.uk <??>

J. Watts[3]
Guys and St Thomas NHS Trust, London, UK
cedars@lsbu.ac.uk <??>

M. Hilborn[4]
Guys and St Thomas NHS Trust, London, UK
cedars@lsbu.ac.uk <??>

Abstract: Holistic patient-centred care is the aim of health services in the United Kingdom delivered through the 6Cs. Chaplains can offer aspects of this through compassionate care of the patient, particularly when a person is facing a life-limiting prognosis. This study firstly evaluated patient awareness and use of chaplaincy services in two oncology settings; Inpatient and Outpatient. Outpatients had not previously been offered chaplaincy services. Secondly, the demand and needs for a chaplaincy intervention was investigated with patients who expressed a spiritual or religious belief and had received a chaplaincy visit. Results indicated that half of the patients seen in the first evaluation identified with a spiritual/religious belief and both Outpatients and Inpatients had a similar demand for chaplaincy visits. Those receiving a chaplaincy visit before being

1. C. H. Cedar is Associate Professor of Human Biology and Reader in Biomedical Sciences, School of Health & Social Care at the London South Bank University.
2. J. Mitchell is Associate Professor of Practice Learning, School of Health & Social Care at the London South Bank University.
3. J. Watts is Chaplain at Guys and St Thomas' NHS Trust, London.
4. M. Hilborn is Hospitaller and Head of Spiritual Care at Guys and St Thomas' NHS Trust, London.

© Equinox Publishing Ltd 2018, Office 415, The Workstation, 15 Paternoster Row, Sheffield, South Yorkshire S1 2BX.

evaluated generally requested further visits. Based on these results we have now established a chaplaincy visiting service in the Outpatient chemotherapy suites to try to match demands.

Keywords: 6C's; inpatients; oncology; outpatients; pastoral; spiritual.

Introduction

There are many stages of an oncology patient's journey starting from the discovery of their symptoms, through to tests confirming a diagnosis and prognosis, to treatments including chemotherapy, surgery and radiotherapy (Leydon *et al.* 2003). The patient can go into remission or relapse and face much of the journey again. Many health care professionals may be involved during this journey with the General practitioner (GP) often providing a first contact (Bulsara *et al.* 2005).

Compassion and care for the entire person, patient-centred care, has become a highly debated aim within the National Health Service (NHS) in the United Kingdom (UK) (Darzi 2008; Adlington & White, NHS 2015). With some long-term diseases such as cancer, it can be found that rather than being patient-focused care, managing the disease becomes the main focus. The disease can, therefore, become paramount in the care and the patient becomes subsidiary to the cancer even though there is some evidence to suggest that health outcomes improve with patient-centred care (Oates *et al.* 2000).

Chaplains offer expert care that is centred on the whole person, offering many of the 6Cs that form the basis of nursing care: Compassion, Care, Communication, Courage, Competence and Commitment. Chaplains are highly trained to offer compassion and empathy by therapeutic communication (pastoral) or through ritual and observance (spiritual/religious) to those in need (Swift 2015). With long-term conditions this may provide a vital and cost-effective service, as shown in other areas of care (Hausmann 2004). The efficacy and effectiveness of health care chaplaincy is part of evidence based medicine (Jankowski *et al.* 2011; Lehair 2005; Fraser 2004). Various measures can be used to assess chaplaincy (Bodde 2008). According to the NHS Chaplaincy Guidelines 2015 (Swift 2015) the 2010 Equality Act (UK Government 2010) should be taken into consideration for all chaplaincy services regarding "patients, service users and staff must be made aware of the nature, scope and means of accessing chaplaincy services within their setting. Only with adequate awareness can a provider evidence equality of access" (Swift 2015).

A key component of this is that "Chaplaincies have procedures for evaluating their work, both in terms of quality and quantity, so that it is fully

© Equinox Publishing Ltd 2018

accountable within the organisation" (Swift 2015). Section 14.1 of the guidelines deals with how patients are informed about chaplaincy. However, when a patient comes to a tertiary hospital, such as one that is part of this study, or enters through Accident and Emergency (A&E) or by referral, such patients are not always in a state to access all the information they are given or remember all the data requested from them. Patient compliance and patient "informed" consent may be counter to the staff intention due to overload of information and poor communication (Sundar 2015; Leydon 2000).

Background

The emotional and spiritual state of patients plays a role in recovery and addressing these needs is partly the role of the chaplain. Chaplains and chaplaincy can accompany people on their journey, address spiritual and pastoral needs and offer a space for people to explore their emotions and feelings regarding their prognosis. The effectiveness of chaplaincy, however, is difficult to evidence. An evaluation of chaplaincy services helps to address this and to set a benchmark for future evaluations (Bodde 2008).

Clinical intervention seeks to restore a patient's health and improve outcomes. In evidence based medicine, clinical interventions need to be evaluated to establish efficacy. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.

An evaluation should be generalizable, so that the extent to which the findings of a clinical study can be reliably extrapolated from the subjects who participated in the study to a broader patient population and a broader range of clinical settings (Health Research Authority 2013). The UK Board of Healthcare Chaplaincy has set out standards for chaplaincy to ensure that clinical governance aims are met (UKBHC 2009). UKBHC states that using this tool an evaluation of chaplaincy service itself should be undertaken every three years.

Oncology patients have a varied journey from their first visit, usually to a GP, through various clinics for tests to gain a diagnosis or confirmation of what they already may fear, and then onto a specialist consultation and prognosis for treatment. During this journey their bodies are examined, but they are also on an emotional journey. In the study hospital, Outpatients oncology had not been served by chaplaincy before, so there was no standard to measure against.

This study therefore assessed the current service to find out what is offered and what is wanted. It compares oncology Outpatients to oncology Inpatients, an area that has well established chaplaincy visits. It conformed

© Equinox Publishing Ltd 2018

to the aims of the delivery of best practice (Health Research Authority 2013). It sought to find whether the service matched needs and was available for all. It also sought to find out if there is a difference in demand between those who have a spiritual or religious belief and those who do not. A second evaluation was carried out a month later with patients who had received some spiritual care from a chaplain to see the effect of chaplaincy services on demand for chaplaincy services.

Aims of the Study

- To undertake an evaluation to assess whether patient needs for chaplaincy visits in an oncology Outpatient department were met.
- To evaluate the need for chaplaincy services for all patients, whether they had a spiritual or religious belief or none.
- To compare the service (intervention) offered in Outpatients to the service offered to oncology Inpatients chaplaincy service.
- To see the effect of chaplaincy service (intervention) on demand for further chaplaincy services.

Method

Patients evaluated were in a hospital which is a centre of excellence in cancer treatment in the UK and attracts patients from a wide geographical region with a diverse range of diagnoses, usually including complex cases and those with specialist needs. Some of them have been treated elsewhere before arriving at this centre. Some of them have been receiving treatment for months and some had been staying in hospital for days or weeks. We did not separate these out in our inclusion criteria in this evaluation.

The evaluation was carried out in two settings, Outpatient and Inpatient, using the same evaluation tool in each setting. While all patients were receiving treatment for cancer, the patients in each setting were divided into two groups: those who said that they held religious or spiritual beliefs, who are referred to as “Spiritual” in the evaluation, and those who said they did not hold religious or a spiritual belief, who are referred to as “Pastoral” in the evaluation. The evaluation was then conducted a second time one month later in both settings with patients who had expressed a religious or spiritual belief and had experienced some spiritual care from a chaplain.

Our inclusion criteria required the recruitment of patients who were awake (we did not interrupt sleep) and not having any other clinical visit in progress. We did not distinguish between age, gender or ethnicity as we sought to offer the service to all. In Inpatients, the patient was usually alone

© Equinox Publishing Ltd 2018

when we visited, but not always. In Outpatients, the patient often had family or friends with them, but again, not always. We approached those alone and those with visitors. There were patients who decided they did not want a visit from the chaplain, or initially did not want a visit. If they stated that they did not want a visit they were, of course, not asked to partake in an evaluation. We introduced ourselves and said that we were doing a brief, anonymized evaluation which had yes/no answers for ease and speed of completion. We showed the patients the form. If they agreed to take part, they were then asked a series of questions about chaplaincy provision and their needs. The numbers evaluated are detailed in Table 1.

Table 1. Participants for Each Evaluation

Evaluation	Patients (N)	Participants (n)	Percent %
Evaluation 1	68	57	83
Evaluation 2	55	38	69
Total	123	95	77

The UK Board of Healthcare Chaplaincy (UKBHC) Standards for Healthcare Chaplaincy Services Self-Assessment/Evaluation Tool was adapted for the purpose of this research. This tool was developed to assess and evaluate chaplaincy services. It has seven domains or standards (refer to Table 2).

Table 2. Standards for Healthcare Chaplaincy Services Self-Assessment Evaluation Tool

Standard	Standard Description
Standard 1	Spiritual and religious care
Standard 2	Access to chaplaincy services
Standard 3	Partnership with faith communities and belief groups
Standard 4	Staff support
Standard 5	Education, training and research
Standard 6	Resource
Standard 7	Chaplaincy to the hospital or unit

Note: Adapted from the UK Board of Healthcare Chaplaincy (UKBHC) Standards for Healthcare Chaplaincy Services Self-Assessment Evaluation Tool_

Each standard then includes various sub-criteria. The questions were selected from this tool to be able to assess when spiritual care was needed and where to fulfil the evaluation criteria at the cancer care units at a large tertiary

© Equinox Publishing Ltd 2018

hospital. This tool is available to all UK registered chaplains and is used for assessments. We made minor alterations to assess the competencies of the chaplaincy standards of the UKBHC in line with the NHS in these settings.

As noted earlier, this evaluation involved two settings; Outpatient (OP) and Inpatient (IP). We wished to compare needs between the two settings as Outpatients had not been visited or evaluated previously. In the evaluation, patients' responses were separated in each of the two settings (OP and IP) into two groups of patients, those not holding a religious or spiritual belief.[**AQ: do you need to add: and those that held spiritual or religious beliefs?**] We established patients' belief by asking if they had a religious or spiritual belief or not. We explained that we were interested in patients' opinions as to whether they had a belief or not. Those who declared that they had a spiritual or religious belief, belonged to a religious group or held ideas that there was a greater power than nature, were termed Spiritual; those without these beliefs, who called themselves atheist or who thought this life was all there was, were termed Pastoral.

While evaluations fall outside ethical requirements, approval was sought and gained from all the departments and wards involved prior to undertaking any evaluation.

We chose to compare Inpatients and Outpatients on the same day and visited patients in the same clinical speciality, oncology, to assess needs. The wards included were male and female wards with capacity for 30 patients in each. We included three oncology wards. Outpatient/Day-care has capacity for 30 patients at one time. Most are there for 4 hours, but some for 8 hours. The same questions were asked in each evaluation as detailed in Table 3.

Each patient was first asked if they had religious or spiritual beliefs, or whether they did not. If they did they were then asked whether these needs were being met (Question 1 of the evaluation). If they did not have spiritual or religious beliefs they were asked if their pastoral needs, their needs as a person, were being met. The patients were then asked each of the other questions in the evaluation.

For the first evaluation, each setting, the Outpatient clinic or Inpatient ward, was visited for one hour each per day, once per week, for six weeks by one chaplain. The patient was approached and asked if they would take part in a very brief, anonymous evaluation about chaplaincy services, whether they held a spiritual belief or not.

For the first evaluation, the patients were asked if they would be willing to answer brief questions for an evaluation and each assessment was divided into Pastoral or Spiritual, by the patient's response. The evaluation was filled in by the chaplain while with the patient and the same questions were asked for each group. Each evaluation took less them five minutes to complete.

© Equinox Publishing Ltd 2018

1 **Table 3.** Evaluation Questions for Both Inpatients and Outpatients 1

Question	Detail
Question 1	Are your spiritual/pastoral needs being addressed?
Question 2	Are your family needs being supported?
Question 3	Were you aware of chaplaincy when you entered the hospital?
Question 4	Did you know how to contact chaplaincy during your time in hospital?
Question 5	Did you want to know more about chaplaincy?

2 2

3 Note: Questions based on the UK Board of Healthcare Chaplaincy (UKBHC) Standards for 3
4 Healthcare Chaplaincy Services Self-Assessment Evaluation Tool. 4

5 The second evaluation was carried out one month after the first evalu- 5
6 ation. The patients were not the same as had been in the first evaluation. 6
7 For the second evaluation in each setting, Outpatients and Inpatients, we 7
8 evaluated patients immediately after they had received spiritual care (inter- 8
9 vention) from the chaplain. The patients were approached in the usual 9
10 manner and asked if they wanted some time with the chaplain. This time 10
11 varied between 10 and 20 minutes. If they spoke about their spiritual beliefs 11
12 they were ranked as being in the Spiritual and Religious belief group and 12
13 asked at the end of the visit if they would be willing to have the visit evalu- 13
14 ated. The patient was then asked if they would answer a brief questionnaire, 14
15 which was the same questionnaire as the evaluation used in Evaluation 1. 15
16 The forms were evident to the patients during the visit and each patient was 16
17 informed that an evaluation of the chaplaincy service was being undertaken. 17

18 Results from the First Evaluation 18

19 **Table 4.** Results of the First evaluation Comparing Two Settings, Outpatient and Inpatient, 19
20 and Two Groups of Patients Spiritual/Religious and Pastoral 20

Participants n=57 total	*Outpatient n=33*		*Inpatient n=24*	
	Pastoral %	Spiritual %	Pastoral %	Spiritual %
	39	60	37	62
Questions:				
1: Needs met	84	50	88	77
2: Family's needs met	76	80	66	69

21 21

© Equinox Publishing Ltd 2018

Participants n=57 total	*Outpatient n=33*		*Inpatient n=24*	
3: Aware of chaplaincy	23	25	55	69
4: Contact able = **Contactable?**	23	33	55	46
5: Require more	7	50	11	15

Note: The table shows a comparison between pastoral and spiritual chaplaincy needs in Outpatients and Inpatients.

When asked about any religious affiliation, patients described themselves as either non-religious or spiritual, here called 'Pastoral', and those who expressed a religious affiliation, here called "Spiritual". The results in each setting were similar with over 60% of patients saying they had a spiritual affiliation.

Question 1: Are your spiritual/pastoral needs being addressed?

Of those in Outpatients, 84% of Pastoral patients felt their needs were addressed while only 50% of those who expressed being Religious/Spiritual felt their needs were addressed. With the inpatients, the numbers were closer, with 88% of Pastoral and 77% of Spiritual feeling supported.

Question 2: Are your family needs being supported?

In Outpatients, many people felt that their families' needs were supported, both from Pastoral (76%) and Religious/Spiritual (80%) patients. However, with the Inpatient setting for both Pastoral and Religious/Spiritual patients in this first survey, the numbers were lower than with the other groups, with patients that were Pastoral at 66% and patients that were Religious/Spiritual at 69%.

Question 3: Were you aware of chaplaincy when you entered the hospital?

The awareness of chaplaincy in Outpatients was low for both groups (23% and 25%. Inpatient awareness was higher with Pastoral (55%) being lower than Religious/Spiritual (69%).

Question 4: Did you know how to contact chaplaincy during your time in hospital?

This was low in both Pastoral (23%) and Religious/Spiritual (33%) in Outpatients while with Inpatients the numbers were Pastoral (55%) and Religious/Spiritual (46%).

© Equinox Publishing Ltd 2018

Question 5: Did you want to know more about chaplaincy?

For those in Outpatients, very few Pastoral (7%) patients wanted more information while 50% of Religious/Spiritual patients did. With inpatients, both Pastoral (11%) and Religious/Spiritual (15%) wanted more information.

Results of the Second Evaluation

Table 5 below shows the answers to the same evaluation questions, given after patients had received a spiritual visit. By this we mean that the patient had declared that they were a member of a religious or faith group and the visit they received included exploring their feelings. Some requested prayers be said.

Table 5. Patients Evaluated After a Spiritual Care Chaplaincy Visit

Participants n=38	*Outpatients n=23*	*Inpatients n=15*
Questions:	%	%
1: Needs met	73	83
2: Family's needs met	81	90
3: Aware of chaplaincy	52	66
4: Contactable	26	66
5: Require more	55	64

After receiving spiritual care from a chaplain, more of the patients in Outpatients (73%) and Inpatients (83%) felt their spiritual needs were cared for, as were their families' needs. This contrasted with the Outpatients in the first evaluation, where only 50% felt their needs were being addressed, and the Inpatients in the first survey, where higher numbers (77%) felt their families' needs were being met.

Again, awareness of chaplaincy services, and thus the ability or knowledge of how to contact them, was lower (52% in Outpatients and 66% in Inpatients) than expected as the leaflets about chaplaincy are given to each patient. Outpatients had a very low knowledge (26%) of how to contact a chaplain.

About half of the patients (55% in Outpatients and 64% in Inpatients) wanted more chaplaincy visits. This was similar to Outpatients in the first evaluation (50%) but contrasted with Inpatients where only 15% had wanted more chaplaincy visits.

© Equinox Publishing Ltd 2018

Discussion

This evaluation involved 95 people in two separate evaluations conducted over 10 weeks in two settings, Inpatient and Outpatient, to give an initial estimate and comparison of spiritual needs. The selection criteria and approach after our introduction, showing the brief evaluation form from the start and asking whether they would be willing to participate in a very brief evaluation of these questions, resulted in a high response rate.

The majority of those with no spiritual affiliation reported their needs were met in a pastoral capacity. A majority of inpatients (77%) with spiritual needs reported their spiritual needs were being taken care of. However, only 50% of those with spiritual needs in Outpatients felt their needs were met. This was the first time that they had chaplaincy visits. When this group had been offered a chaplaincy visit and then asked about their needs, this came at a similar level as the inpatients (73% Outpatient and 83% for Inpatients). Receiving chaplaincy services, even just this one time, seems to have served a need. All clinical interventions in hospitals are aimed at being brief and resulting in treating acute needs while making a patient feel cared for. This implies that even one visit is enough to make a patient feel valued, listened to or cared for.

Having spiritual needs met may affect recovery and well-being. Prompt discharge of patients is a high priority in the NHS. Koenig *et al.* (2001) found evidence for a positive link between a patient having spiritual or religious beliefs and improved health. Marin *et al.* (2015) showed that patients who are visited by chaplains are generally more satisfied with their hospital stay. This indicates that chaplaincy provides a service for the patient and the hospital that improves patient outcomes.

This is a very busy tertiary hospital and the oncology areas are centres of excellence for the entire country. Chaplaincy staffing levels may not be adequate to meet the needs of patients, the transient nature of the outpatients and the turnover of the inpatients. While many were satisfied with the numbers of chaplaincy visits, 50% of patients expressing spiritual affiliations in Outpatients said that they would like more Chaplaincy care. This may reflect the seriousness of their diagnosis, its effect on their lives and their need to come to terms with the consequences of this change. When the evaluation was completed, a number of them needed spiritual care to talk about their journeys and how they seemed to have lost themselves in being ill.

One finding that differed between groups was whether patients wanted more spiritual care. In Outpatients about 50% did in both evaluations. That patients in Outpatients wanted more spiritual than pastoral care could be due to a number of factors. These include factors such as having been

© Equinox Publishing Ltd 2018

diagnosed more recently or having less contact with clinical staff outside of the initial treatment moment and hence less interactions with carers.

With Inpatients, however, only 15% said they wanted more chaplaincy services in the first evaluation while that number increased to 64% in the second visit, after a chaplain had offered spiritual care. Perhaps inpatients are used to having their own faith leaders visit and think this sufficient. Being offered more may increase demand for more. If so this suggests that there is a perceived value benefit of chaplaincy visits which is an area for future studies. It may also be that the people in Outpatients who are religious, or observant, have their own ties to a community of worshippers or faith groups and feel that this provides support, while the hospital chaplain is less needed due to their hospital stay being of a short duration.

The timing of the evaluation may also affect the findings. For an inpatient this evaluation may coincide with the only visit by a chaplain they receive while in hospital, or it may be one of many if they are in hospital for many weeks. For outpatients this was the first visit by a chaplain, but some of the patients may have been attending chemotherapy over a number of weeks. Chaplains are generally trained that clinical treatments may override all other factors as the hospital has become focused on clinical care. Emotional and spiritual needs may be thought of as secondary in all hospital settings (Lake *et al.* 2016).

This timing may also be evident in the patient's response to their family's needs being met. **While it we high for [AQ: please check meaning and amend sentence**] the second evaluation, those having had a spiritual visit, with the visit alone perhaps increasing feelings of well-being, the response to the question on whether the family's needs were being met was quite low for inpatients in the first evaluation of both Pastoral and Spiritual patients. The patients in both groups may have been in for a while and they may not have been sure how their families were coping or whether the families were putting on a brave face in front of the patient. The patients might have been anxious about their families on two counts: how the family was coping without the patient, especially if the patient was previously working or caring for the family, and worrying that the family was anxious about the patient. This is an area that could be further addressed in chaplaincy visits, especially as those who had chaplaincy visits had fewer concerns regarding their families.

The awareness of Chaplaincy services was very low in Outpatients for both Spiritual and Pastoral in the first survey. This may be due to the patients being overwhelmed with their diagnosis and not being able to process so much information. Again, this increased in the second survey even though it was the first time the patient had a chaplaincy visit in Outpatients. Having the chaplaincy visit and then being asked about the awareness of chaplaincy

© Equinox Publishing Ltd 2018

services, in this order, may remind people of what they had seen in the initial induction to treatments in the hospital pack, giving them time to reflect on it.

Awareness of the availability of chaplaincy was over 50% with the inpatients. Patients' religious/spiritual beliefs is an optional question on the hospital forms and where they know they are going home and can access any other needs in their home environment.

This lack of awareness of chaplaincy services was echoed, as expected, in whether patients knew how to contact a chaplain. This may be low for the outpatients as they are not expecting to be in hospital long and do not make the same provisions as those expecting to stay as inpatients. They are only expecting to be in for the day and come with what they need for the day, such as food, drink and entertainment. When approached, most of them said they had some awareness of chaplaincy services in hospitals, but had not thought about it in their circumstances.

In this initial evaluation, no distinction was made in the time between diagnosis and treatment and whether this was the first round of treatment or much later rounds. Further work to distinguish this and relate it to spiritual needs would be of interest.

Being able to repeat the evaluation with larger numbers of patients may give greater reliability. For consistency, these results are all from one researcher but for reliability it would need to be repeated by other researchers.

A further study to gain more qualitative feedback is now underway as a patient evaluation of service.

Conclusion

This was the first time outpatients at this hospital had chaplaincy visits and this evaluation allowed the service to estimate the needs in this new clinical area. The measure was used to compare needs using the same evaluation tool on the same day with inpatients suffering from the same conditions. These findings suggest a need for chaplaincy to serve those with or without religious or spiritual beliefs in a health care environment, caring for the whole person.

These preliminary results point to a need in Outpatient areas for chaplaincy visits which have, up until now, been restricted to Inpatients wards. Of the 1.5 million workforce of the NHS, chaplains account for 500 full time equivalents and make one million visits (NHS Statistics 2011). Given the aim for patient-centred care and the chaplain's expertise in this area, increasing chaplaincy services may indicate a cost effective way to enhance patient outcomes, which this evaluation helps to establish.

© Equinox Publishing Ltd 2018

Chaplains are professionals, trained to be alongside the patient in times of crisis. While outpatients are only in the hospital for a few hours per week and can return to their own support network, these networks are not always available and may be burdened with other needs. Outpatients in oncology are facing difficult life journeys, sometimes facing palliative treatments, and a trained professional offering holistic care may help to improve the quality of life of those in crisis.

References

Adlington, K., and J. White (2015) *NHS: Our Declaration: Person-centred Care for Long-term Conditions*. Publications Gateway Reference 03960 https://www.england.nhs.uk/category/publications/ and https://tinyurl.com/y7glqx6f (last accessed 7 December 2016).

Bodde, R. (2008) "Towards Benchmarking in Health Care Chaplaincy and Pastoral Care in Australia". *Australian Journal of Pastoral Care and Health* 2 (2): 1–13.

Bulsara, C., A. M. Ward and D. Joske (2005) "Patient Perceptions of the GP Role in Cancer Management". *Australian Family Physician* 34(4): 299–302.

Darzi, A. (2008) *High Quality Care for All: NHS Next Stage Review Final Report*. Vol. 7432. London: Her Majesty's Stationery Office,

Fraser, D. J. (2004) "Clarity and Cost Effectiveness in Chaplaincy". *Scottish Journal of Healthcare Chaplaincy* 7(1).

Hausmann, E. (2004) "Chaplain Contacts Improve Treatment Outcomes in Residential Treatment Programs for Delinquent Adolescents". *Journal of Pastoral Care and Counseling* 58(3): 215–24. https://doi.org/10.1177/154230500405800306

Health Research Authority (HRA) UK (2013) *Defining Research*. NHS Publications. UK. www.hra.nhs.uk. Last accessed 6 December 2016.

NHS Statistics (2011) https://tinyurl.com/ycct8w9d

Jankowski K. R. B., G. F. Handzo and K. J. Flannelly (2011) "Testing the Efficacy of Chaplaincy Care". *Journal of Health Care Chaplaincy* 17: 3–4, 100–25. https://doi.org/10.1080/08854726.2011.616166

Koenig H. G., D. King and V. B. Carson (2001) *Handbook of Religion and Health*. Oxford: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195118667.001.0001

Lake E. T., H. D. Germack and M. K. Viscardi (2016) "Missed Nursing Care is Linked to Patient Satisfaction: a Cross-sectional Study of US Hospitals". *BMJ Quality and Safety* 25: 535–43. https://doi.org/10.1136/bmjqs-2015-003961

Lehair, X. (2005) "Reflection on An Evaluation: Healthcare Professionals' Views of Spiritual Care". *Scottish Journal of Healthcare Chaplaincy* 8 (1): 23–26.

Leydon, G. M., M. Boulton, C. Moynihan., A. Jones., J. Mossman., M. Boudini and K. McPherson (2000) "Cancer Patients' Information Needs and Information Seeking Behaviour: Indepth Interview Study". *BMJ* 320: 909–13. https://doi.org/10.1136/bmj.320.7239.909

Leydon, G. M., J. Bynoe-Sutherland and M. P. Coleman (2003) "The Journey Towards a Cancer Diagnosis: the Experiences of People with Cancer, Their Family and Carers". *European Journal of Cancer Care* 12(4) 317–26. https://doi.org/10.1046/j.1365-2354.2003.00418.x

Marin D. B., V. Sharma, E. Sosunov, N. Egorova, R. Goldstein and G. F. Handzo (2015) "Relationship Between Chaplain Visits and Patient Satisfaction". *Journal of Health Care Chaplaincy* 21(1): 14–24. https://doi.org/10.1080/08854726.2014.981417

© Equinox Publishing Ltd 2018

Oates, J., W. W. Weston and J. Jordan (2000) "The Impact of Patient-centred Care on Outcomes". *Family Practice* 49(9): 796–804.
Sundar, S. (2015) "New Law on Consent Will Overload Seriously Ill Patients". *BMJ* 350: 1787. https://doi.org/10.1136/bmj.h1787
Swift, C. (2015) NHS Chaplaincy Guidelines: Promoting Excellence in Pastoral, Spiritual and Religious Care. London: NHS England.
UK Board of Healthcare Chaplaincy (2009) *Self-Assessment/Evaluation Tool.* Cambridge: UK Board of Healthcare Chaplaincy.
UK Government (2010) *Equality Act*. London: Her Majesty's Stationary Office.

© Equinox Publishing Ltd 2018