DEVELOPMENT OF A SPIRITUAL CARE PATHWAY IN A NHS TRUST

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SUMMARY

There is evidence that health service users want their spiritual needs to be taken into account during treatment, and that this has positive benefits, but that it often does not happen in practice. The barriers seem to include embarrassment, lack of awareness and training, fear, and lack of time. We describe a process of development of a spirituality care pathway, within the context of a wider organisational response to awareness of the need to respond to spiritual care needs presented during the course of delivery of mental health care services. The process highlighted the importance of developing awareness and ownership of the importance of spiritual care in all parts of the service and amongst all professional groups as well as among service users. A range of spiritual interventions were identified as deliverable within the care pathway and a process of monitoring and review was put in place. An organisational response to spiritual needs presented during mental health care was found to be widely appreciated by service users and staff and was effectively developed within existing professional and management processes.

There are numerous and important reasons for taking religion and spirituality seriously as a part of clinical healthcare (Koenig 2007). Amongst other things, these include: evidence that patients want such matters to be addressed as a part of the care that they receive, evidence that spirituality and faith provide important coping resources in times of stress, the isolation that people experience from their faith communities as a result of illness (especially, but not only, when admitted to hospital), the impact of religious belief on treatment decisions and compliance, and the evidence that spirituality and faith impact on health outcomes. It is also clear that matters pertaining to spirituality and faith cannot be the sole prerogative of the chaplain. Quite apart from the sheer numbers (there simply aren't enough chaplains to address all of these matters individually), they impact on almost all aspects of care and therefore all health professionals need to be sensitive and aware about the ways in which they will emerge and how they should best be handled during the course of routine clinical practice.

At the outset, it is important to note that spirituality and religion aren't necessarily the same thing, although for some people they are (Cook 2004; Sims and Cook 2009). For others, they are unimaginably different. Both spirituality and religion are important in healthcare delivery and the issues that they raise often overlap in practice. It will therefore not be necessary to make much of the differences here, except to state that many people consider themselves "spiritual but not religious" and so it is important to be aware of the appropriateness of language which will be inclusive of different perspectives and not to reduce the whole affair to matters of religious faith. Many atheists and agnostics, and those who would eschew all labels of a religious kind, today consider themselves to be spiritual people and to have spiritual needs relevant to healthcare.

Guidance for health professionals, concerning the appropriate ways of handling these issues, has been issued in various forms (Mental Health Foundation 2007; Department of Health 2009; The Scottish Government 2009; Welsh Assembly Government 2010; Cook 2011). However, much of this guidance focuses on the role and responsibilities of the individual health practitioner. This is important, given the boundaries and barriers that might act to prevent staff from intervening in matters of spirituality and faith. These include lack of training, perceived role legitimacy, lack of time, and fear of misunderstanding or litigation. However, relatively little has been published about the ways in which NHS trusts, or other organisations, may implement good practice and less appears to be written about potential boundaries and barriers that might impede development of spiritual care at this level.

We describe here our experiences of developing and implementing an organisation wide approach to identifying spiritual needs and delivering spiritual care within one particular NHS trust.

TEES, ESK & WEAR VALLEYS NHS FOUNDATION TRUST

Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV) is a large NHS trust serving the population of north-east England in a geographical area between North Yorkshire and County Durham. It provides a full range of mental health, substance misuse and learning disability services for a population of about £1.6 million people.

In 2007 TEWV adopted a quality improvement system based upon the Toyota Production System (Spear and Bowen), adapted for healthcare by the Virginia Mason Hospital in Seattle (Kenney 2010). Importantly, the approach emphasises teamwork and respect for people. Other principles of this approach include continuous improvement, an emphasis on finding the right process for the intended outcomes, and continuous vigilance in problem solving. As a part of this approach, processes were adopted within the trust for rapid performance improvement including, notably, the Rapid Process Improvement Workshop (RPIW). The RPIW addresses issues of consistency, efficiency and good practice in the processes supporting and implementing the trust's operations, including delivery of pharmacological or psychological treatments, and other aspects of clinical

care and service delivery. It provides a facility for shared, creative, thinking and collective problem solving. It is an intensive process which ensures that all relevant people are brought together over the course of a short space of time (usually a week) in order to understand current practice and to develop new and improved practices which are based on the best available evidence, taking into account statutory and policy obligations and the realities of service delivery "on the ground".

In support of the process of developing and enhancing clinical care pathways, the trust has evolved its own unique variant of the RPIW: the Rapid Pathway Development Workshop (RPDW). The RPDW is, essentially, an RPIW devoted specifically to the task of developing and improving clinical care pathways. The RPDW is now routinely implemented within the trust as the primary means of developing new clinical care pathways.

TEWV has a chaplaincy service comprising four full time and three part time chaplains. This team includes representatives of mainstream Christian denominations (Anglican, Methodist and Roman Catholic) and a Muslim Chaplain – representing the make-up of the population of North East England. Members of the chaplaincy team also regularly work with service users who do not identify with any particular faith tradition, and see this as an important part of their work. For a number of years the chaplaincy team has offered non-religious retreats for staff and also staff training in identifying and addressing spiritual needs, which have emerged positively from a rigorous process of evaluation. Notwithstanding this provision, it is recognised that there is a limit to how much spiritual care can be provided within the trust if it is only to be provided in these particular, direct and indirect, ways.

DEVELOPING AND IMPROVING SPIRITUAL CARE

A Spirituality Working Group (SWG) was established in TEWV in 2008 with a view to finding a way forward within the trust which would provide clarity of expectations for staff and service users in relation to spiritual care, and which would promote good practice both locally and further afield. This group was from the start multi-professional, including chaplains, nurses, doctors, a clinical psychologist and members of other disciplines, and sought to engage with and receive representation from the trust's service users. In 2009 a non-executive director of the Trust was appointed as Chair.

The aims of the group were to "work to ensure that the spiritual needs of service users, carers and staff are understood and met". It sought to achieve these aims by:

- Being a focal point for gathering information about various disparate activities and projects around spiritual care within the trust, and facilitating communication between them.
- Promoting awareness of the importance of spirituality for mental health.
- Offering guidance to services about the assessment and addressing of spiritual needs.
- Promoting training for staff to develop confidence and skill in appropriate ways to address spirituality.
- Promoting research into the benefits of addressing spirituality within trust services.

The group also sought from the outset to ensure its accountability within the Trust as a whole, and to ensure that it engaged with issues arising at all levels of management and in all areas of clinical activity and service delivery. It established a pathway of reporting to the Trust's Equality and Diversity Steering Group.

The group identified a series of immediate working priorities, which included:
- Supporting the effective inclusion of attention to spiritual needs within the Care Programme Approach.
- Establishing and learning from a service user reference group.
- Establishing a multi-disciplinary clinicians' group to address matters of spirituality.
- Drawing up a code of practice for members of staff working with issues of spirituality.

- Collecting and disseminating examples of good practice in spiritual care around the trust.
- Investigating and affirming the place of spirituality within LD services.

In the process of considering how best to address the first of these priorities, and in engaging with the wider structures of management, it was realised that the RPDW could be an effective way of developing, piloting and implementing spiritual care pathways. With this in mind, a Spirituality RPDW was planned and eventually implemented in early 2011.

DEVELOPING A SPIRITUAL CARE PATHWAY

The Spirituality RPDW was attended by representatives of all relevant clinical disciplines, a variety of different services from within the trust, chaplaincy, and the service user reference group.

The Spirituality RPDW gathered information on both the research evidence base concerned with spirituality in mental health care (eg Mental Health Foundation 2007; Cook, Powell et al. 2009) and the experiences of staff and service users. Based upon this research and experience a TEWV definition of spirituality was developed which was thought to be relevant and helpful for both staff and service users:

Spirituality is:
- Meaning and purpose in the things we value
- The search for inner freedom, wellbeing and peace of mind
- An experience of living, flourishing and finding hope amidst pain or difficulties
- Loving relationships with self, others and something beyond, giving a sense of belonging
- Being in the present moment

This definition shows close resemblance to definitions of spirituality published previously in the healthcare context (Cook 2004; Jackson and Cook 2005; Royal College of Nursing 2011). For example, it has been suggested (Mental Health Foundation 2007) that key characteristics of spirituality include meaning, value, transcendence, connecting and becoming. All of these characteristics are evident in our definition, albeit transcendence is represented more by finding ways of transcending suffering than in traditional religious terms, and "being" was preferred by our staff and service users over "becoming".

It was important that this definition emerged in the particular form that it eventually assumed (depicted as a flower with the above bullet points each occupying a separate petal) and with the particular wording that was adopted, as this provided ownership to the group, and especially to the particular local service user concerns to which it relates.

Existing spiritual care pathways were examined, based upon the collective experiences of the group, and a clinical algorithm was developed which described the ways in which assessment and care planning might more effectively and reliably address the spiritual needs of service users during the course of their care within the trust. Work was undertaken on developing literature suitable for use with both staff and service users, and consideration was given to necessary staff training needs.

The new clinical algorithm which emerged from the RPDW included a brief initial assessment designed to identify spiritual needs and then provided for various ways in which these needs might be met, either independently (where the service user feels able to draw on their own resource, or resources external to the trust), or routinely by clinical staff, or else by specialist referral to chaplains and other "specialists" within the trust. In principle, this pathway would appear likely to be of equal value within other areas of healthcare than the mental health context within which it arose. However, inevitably, the particular spiritual needs that it

seeks to identify, and the interventions that it leads to, are focused on the concerns of mental health service users. We imagine that a different profile of needs and interventions would find emphasis in (for example) pathways developed specifically for use in palliative care or oncology, but that the same basic pathway would still be applicable.

An aspiration which had been in consideration prior to the RPDW was for a specialist spirituality liaison service which might bring together staff with particular expertise in spirituality and religion in relation to mental health, in support of addressing complex or specialist needs arising in selected cases. This idea received enthusiastic affirmation from the group, although it was realised that the proposal carried significant resource implications which would have to be addressed. As an interim measure it was felt to be important to identify local "leads" from whom staff and service users could seek further advice where necessary.

The Spirituality RPDW also drew attention to the range of spiritual interventions which were already available within the trust. These included mindfulness and related cognitive therapies, reflective reading, art, music, gardening and pottery, yoga, opportunities for prayer and religious worship, and referral for specialist help from chaplaincy services.

Following the RPDW, a series of pilot sites within the trust were selected as parts of the service within which the newly developed clinical care pathways and associated literature could be implemented on a trial basis, with appropriate audit, review and feedback. Progress on implementation following an RPDW is routinely reviewed at 30, 60 and 90 days by members of the RPDW group. Progress is formally reviewed in the presence of the sponsoring Director at 3 months and 6 months. At the time of writing these processes are still in progress and interviews are currently being conducted in order to gain fuller feedback about staff and service user experience of implementing the pathway in the pilot sites. In the light of this, it is likely that the initial brief assessment questions will be reviewed and modified.

The SWG has also continued to meet and pursue its wider agenda. Amongst the issues that have come to our attention during these review and monitoring processes have been the need to adapt the materials that we have developed for use in Learning Disability services and for work with other client groups (for example, services for people with dementia). Service users and carers continue to be involved in the review processes, both on the follow-up to the RPDW and in the SWG, but we are aware that there is a need to be vigilant to ensure that we are able to engage as wide a participation in these processes as possible.

Key Components of Spiritual Care Delivery

Approaching spiritual care from an organisation perspective, within a NHS trust, drew our attention to the importance of four important components of spiritual care delivery:

1. **Awareness** of the importance of spirituality in clinical care seemed to us to be foundational. Working with the service user reference group suggested that service users were already aware of the importance of spirituality, in various and different ways, based upon their own experience, although it was not possible for us to quantify this in any way. We got the impression, from anecdotal accounts provided by service users and staff, that not all staff within the trust were aware of the importance of identifying and sensitively responding to spiritual needs arising during the course of providing mental health care. The RPDW identified an extensive evidence base, and a range of existing legislative and policy guidance which supported and informed the need to provide spiritual care within mental health services. The discussions that took place between staff and service users, before during and after the RPDW, also revealed that there were a variety of barriers to delivery of spiritual care, about which we all needed to be aware and vigilant. These included lack of training and perceived competence, fear of misunderstanding or complaint, ignorance and (at least sometimes) prejudice.

2. We became aware that it was important not only to have support from the trust Board, although this was clearly invaluable, but also that we needed to find **support and ownership** for the process of introducing clinical care pathways from all stakeholders, including not only clinical staff but also management and, most importantly, service users. This broad involvement in ownership and development of the process needed to be engaged in all levels of planning and implementation.

3. Having identified needs, it is important to have available appropriate, relevant and effective **interventions** which may be expected to address these needs. We were pleased to find that a range of available options already existed within our trust and so, for us, the important task became the process of making these more widely known and available. However, we are aware that not all organisations might find themselves in this position, and that not all services within our own trust had historically benefitted from effective availability of these therapeutic resources.

4. In an age of evidence based medicine, and perhaps particularly in a management environment such as the one within our trust, ongoing **review, monitoring and audit** are vital to demonstrate efficiency and effectiveness of any care pathway. This can be seen as challenging for spiritual care, where outcomes are not as easily demonstrated in objective terms, and at a time when some trusts have decided to scale down spiritual care services. However, the RPDW process gave us tools which enabled monitoring and review to happen naturally and effectively (ie the routine reviews at 30, 60 and 90 days). Although they were originally designed with different aspects of care delivery in mind, they worked well and demonstrated both need and benefit for addressing spiritual care needs.

THE WAY AHEAD

At the time of writing, experience based upon implementation of the spiritual care pathway at the pilot sites is being examined and reviewed. It would seem likely that some adjustments will be made to the pathway, to methods of assessment and perhaps to other interventions and practices, in the light of this feedback process. We are aware that the spiritual care pathway has been developed mainly by members of staff and service users who are supporters of the need to address spirituality in mental health care and that it will sometimes be implemented by colleagues who are unconvinced, or perhaps even antagonistic to this approach. Nonetheless, we are optimistic that the conversations that will emerge from the pilot process, and later from wider implementation, will at least improve awareness of the importance of spirituality as a part of mental health care. The care pathway itself, and the code of practice developed previously by the SWG will, we hope, provide clarity and security for both staff and service users in addressing spiritual needs during the course of providing mental health and learning disability services.

KEY POINTS

- ☐ Many health service users identify spiritual needs that they would like to be acknowledged and addressed in treatment
- ☐ Health professionals may feel inadequately trained, or lacking in time, or may experience other barriers to identifying and addressing the spiritual needs of the people for whom they provide services
- ☐ Identification of spiritual needs and provision of spiritual care is not solely the responsibility of chaplains, it is the responsibility of all health professionals, but sometimes specialist help will be needed
- ☐ An organizational approach to developing a code of practice and spiritual care pathways can make it easier for staff and service users to identify and address spiritual needs.

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