



your story. **your** time. **your** wellbeing.

Full report on the national Scottish action research project

First cycle: March 2010 – March 2011

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For



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“When people are faced with problems which don’t need medical intervention, sometimes they don’t know where to turn to. CCL gives people the opportunity to tell their story in a safe and uncritical environment. Talking to someone helps them to relieve the pain or burden they have in their chest but always enables them to discover the strengths they have to cope with difficult circumstances and situation”. (Community Chaplain)

1 The nature of the report

This document reports the first stage of an action research programme set up by NHS Education for Scotland (NES) which aims to develop Community Chaplaincy Listening (CCL) services in General Practice settings.

This report draws on descriptive materials about the process of establishing the service and the findings from data collected from listeners, patients, managers and referrers. It tells the story of the first cycle of action research as seen by each of these participating groups (listeners, patients, managers and referrers) and provides a narrative account of the services they developed and provided. This is the first cycle of this action research initiative and it is intended that this report helps to inform and structure the next cycle of Community Chaplaincy Listening services.

At the end of this first research cycle, in March 2011, a conference was held to look at ways in which communities could be encouraged and supported, and in particular, the work of the Community Chaplaincy Listening services. Comments were invited from the conference about this project and the questions and discussion points generated from this form the basis of the discussion section below.

2 Introduction

2.1 Listening is a core social activity

Since the beginning of man's dwelling on earth stories have been the method of transmitting, understanding and changing behaviour. In our society currently, there is a growing emphasis on the importance of story in developing our sense of self and others and in forming resilient and coherent communities.

Story telling and listening projects proliferate in various parts of social life; ranging from memory boxes for older people to victim support programmes, much of our social care processes involve hearing the story of others. Telling our story is both an individual and collective process and a natural part of being human. Our social relationships are guided through story telling. Our politicians indicate that they are increasingly determined to "listen" to the electorate and respond to what they hear in consultative exercises and through economic and social policy changes.

Ben Okri notes:

Stories are the secret reservoir of values. Change the stories individuals and nations live by and tell themselves and you change the individuals and nations. Nations and peoples are largely the stories they feed themselves. If they tell themselves stories that are lies, they will suffer the future consequences of those lies. If they tell themselves stories that face their own truths, they will free their histories for future flowerings.

(Commission on the future of multi cultural Britain 2000)

2.2 Listening is a healthcare service objective

The importance of listening and being listened to are displayed in current NHS values. Many of the health and social care talking therapies are based on story telling. The patient experience or 'patient journey' is seen as central to the process of healthcare that is offered in the NHS. The quality indicators of the Scottish NHS revolve around the quality of the patient experience. Patient Reported Outcome Measures (PROMS), which specifically use patient perception to inform change, development, rationing and targeting of services is one such example of recent directions.

Medical education in general practice and in specialist hospital care has specifically targeted good listening skills as being key to good medical practice and avoidance of complaint and litigation. Courses encouraging undergraduates and newly trained young doctors to apply the principles of good listening are present in every medical school programme in the country.

The majority of complaints lodged by patients against the NHS are to do with lack of communication skills rather than medical mismanagement.

2.3 Listening as a theological and values based practice

In theological terms listening and waiting are important concepts that are mediated by discernment. Reflective practice encourages listening to oneself and observing and understanding professional practice through reflection. Those trained in theology have learnt the importance of story as a vehicle to express knowledge, understanding, spiritual realities and faith.

The Scottish Healthcare chaplains consensus statement(see appendix 1) specifically identifies listening and story telling as a core function of the chaplain.

- ◆ Engaging in a therapeutic listening, talking and being present with people in difficult times.
- ◆ affirming that fear, anxiety, loss and sadness are part of the normal range of human experience in healthcare;
- ◆ establishing trusting relationships in which others can explore hard questions relating to mortality, meaning, and identity;
- ◆ helping people to (re)discover hope, resilience and inner strength in times of illness, injury, loss and death.

Healthcare chaplains in Scotland also engage in regular reflection on their practice, which includes reflecting on their values, beliefs and worldview as they are touched, challenged or transformed by practice. Such intentional engagement with this aspect of a practitioner's personal and professional personhood facilitates sensitivity towards questions of meaning, purpose and identity raised or hinted at by patients.

2.4 Barriers to listening

In contemporary 21st Century society in Scotland we find that careful listening is costly in terms of time and energy. Our personal stories can be complex and painful and require careful listening for which we have no time. Good health has been understood to be good physical health. The wholistic understanding of health as a relationship and balance between mind, body and spirit has been down played in particular by the modernist phenomena of the specialisation of everything. The medicalization of non medical dis-ease has meant that our expertise at listening to and telling the story has been compromised. Most complaints and difficulties between people in society result from poor listening and poor communication. This is mirrored in the health service. We have tended to devolve listening to a specialist group of therapists who, in various ways and to various degrees, can provide space to listen to our story, reflect upon it, make judgements about the story and come up with advice by which behaviour can change. Listening, or talking therapies are now seen as an integral part of the suite of help available to those in some kind of difficulty.

2.5 The link between listening and wellbeing

Being listened to, heard and dignified with respect for our story makes us feel better. We are able to experience a sense of well being despite suffering illness. Much of the work of palliative care is about listening and acknowledging the story of those dying and working with meaning-making and pain relief in the absence of a cure. However, all of us in one way or another feel better if we tell our story, it is heard and even better, understood. To be misunderstood and to misunderstand ourselves through lack of opportunity to tell our story can be demoralising and at worst life threatening.

The social context in which we find ourselves means that we have high and arguably unrealistic expectations of what our health and social care services can do for us; we have a reduced sense of our own capacity to improve our wellbeing and we attribute this to a loss of community. Michael Wilsonⁱ writing in the 1960's noted the importance of the hospital as a place where we can learn to acknowledge and manage illness and dis-ease and show others in our communities how to do so. He saw communities as a place where individuals can learn from each other, through story telling, how to be well.

It is in this context of an increasing interest in listening and a turn towards community wellbeing and resilience to help us in our troubles that health care chaplaincy listening services have developed.

3 The Background

In Scotland, healthcare chaplaincy has transformed in the last ten years. Each health board is now charged with providing spiritual care as part of the holistic package of care. Departments of spiritual care have been formed. Healthcare chaplains are now widely understood to have particular expertise in the assessment of spiritual need and the delivery of spiritual care. Chaplains have had opportunities to expand their horizons and their capacities and are responsible for facilitating spiritual care for those of all faiths and those of no faith. The Scottish Government have indicated that spiritual care is a wide concept which refers to all people whilst religious care comes under the general umbrella of spiritual care and applies to those belonging to particular religious traditions.ⁱⁱ

The direction of policy travel for health care in Scotland is to relocate care back in to the community, by "shifting the balance of care"ⁱⁱⁱ Most people experience their ill health or well-ness within the community rather than in hospital. The Scottish Government is promoting local care, care at home with support from a variety of healthcare professionals and in particular from General Practitioners who are typically the first ports of call for those feeling unwell.

As spiritual care departments have grown within Health Boards and Chaplains establish themselves as part of the multidisciplinary team (and this work continues), a number of creative ways of meeting spiritual needs and providing person-centred holistic support for patients have developed. One of these ways is through setting up listening services linked to general practice.

In particular Chaplaincy Departments in Tayside, Western Isles and Highland have experimented with a range of different ways of providing community chaplaincy listening services.

NHS Education for Scotland offered an opportunity to join an action research project which would support the development of these services and provide a methodological and data collection framework. In order for listening services to be embraced by General Practice they have to be seen to deliver outcomes for patients and the General Practitioners.

Four Health Boards joined this first round of action research and a fifth (Highland) was evaluated separately.^{iv}

4 The Method: an action research framework

The programme borrowed from the structure described by Swinton and Mowat^v and Coughlan and Coughlan^{vi}. Swinton and Mowat developed a form of action research that is useful for those embarking on a practical theological enquiry; this involves the process of looking, observing, recording, developing and feeding back and incorporates appropriate research methods and data collection techniques. This simple cycle allows the participants to learn from each other and to develop sensitive and appropriate interventions. Two experienced action researchers supported the chaplains and together they attended three residential meetings, funded by NES Education for Scotland. At these meetings the researchers encouraged the practitioners to engage in the action research framework and the practitioners were given texts to help them. This was also in keeping with the general ambition of healthcare chaplaincy in Scotland to develop its evidence base and research methods knowledge.

The team of chaplains and researchers co-created the publicity, the research data collection methods and the subsequent film, describing the project. The researchers also visited the sites and information generated by the group was circulated to support and encourage creative thinking and adjustments to the listening services that made them more successful.

5 The Process: The CCL Patient Journey

The patient journey through the CCL is a simple one. Patients are referred to the service most commonly by their GP; alternatively they can be referred by another healthcare professional or they can request an appointment themselves. They meet with the Chaplaincy listener who introduces them to the service and what to expect. They then meet with the listener for as many sessions as are needed for them to tell their story, consider the existential issues they are facing and feel some sense of resolution or peace with what is currently happening in their life. The patients decide on the number of sessions they need. Once they feel the burden of their spiritual distress has lightened in some way they discharge themselves from the listening service. Sessions last 50 minutes and patients are free to discharge themselves from the listening service at any time, without explanation. Cycle 1 found that patients on average attend 4 sessions with the Chaplain listeners.

No of referred patients who attended the CCL service	
Dumfries	8
Glasgow	2
Tayside	6
Western Isles	33
	49

6 Data gathered during CCL phase 1

The extended findings outlined below are derived from data gathered from patients, listeners, referrers and health service managers. Data was collected from September 2010 to March 2011 in the following ways.

Participants	Data Sources
Patients	16 CARE questionnaire responses (adapted) 2 semi-structured qualitative interviews
GP Referrers	8 Referrer questionnaire responses 4 semi-structured qualitative interviews
Chaplain Listeners	2 referrer questionnaire responses 6 semi-structured qualitative interviews (4 Chaplains, 2 volunteers)
Medical directors/Senior Health service managers	4 semi-structured qualitative interviews

The patient CARE questionnaire used was devised by Stuart Mercer and originally intended to act as a patient reported process measure for General Practitioner consultations. It was adapted for our purposes in evaluating CCL (see appendix 2).

The referrers' questionnaire is shown in appendix 3.

We asked the medical directors and senior health service managers how they understood the service; how they saw the service developing if at all; about the challenges it faced and the potential strategic position of such a service in the delivery of community health care.

The data set is small and for the sake of confidentiality we only identify respondents as being patients, referrers, listeners or managers (indicated throughout by symbols). Geographical location is not given for the same reason.

7 Summary of Key Findings

- ❖ **Patients overwhelmingly reported having a positive experience with the CCL service:** many gave examples of positive changes they had made in their daily lives as a consequence of using the CCL and would use it again if needed in future.
- ❖ **GPs found the CCL service helpful:** they welcomed an additional place to refer patients when patients expressed dis-ease rather than ill health; they found patients reported favourably on their experiences of the service; they predicted that their prescription patterns could change once more patients use the service; they liked the confidential nature of the service but also requested more information about which patients had attended.
- ❖ **Setting up the CCL service carefully, building good relationships and providing clear information/marketing materials was very important** in allowing the service to be well understood and accepted by GP referrers. Chaplains found that negotiating access and maintaining relationships with GP practices was a key part of the work at each site.
- ❖ **Clearly articulating the concept of spiritual listening and how it is distinct from other types of listening was essential.** This has been (and is) a complex process, which can take time to explain. Once referrers understood the distinct qualities of the CCL service, they referred patients. The time this took varied from site to site.
- ❖ **Listeners reported largely positive experiences of providing the CCL:** they saw the benefits and heard positive patient feedback about what they had gained from the service; they felt clear about the benefits to patients and easing the burden of spiritual issues on doctors.
- ❖ **NHS Managers would like to see the CCL as part of a suite of talking therapies.** They felt CCL 'filled a gap' between seeing the GP and being referred to psychology or other talking therapies. Issues of governance, confidentiality and competence can be addressed.
- ❖ **The use of chaplaincy volunteers as listeners in the CCL requires careful consideration.** In particular, GPs were keen that all listeners should be well trained and show expertise, experience and competence in listening skills.
- ❖ **Having a settled space to provide the CCL service helped patients and listeners;** uncertainty about suitable accommodation can undermine provision of the service.

8 Extended Findings

The structure of the extending findings is as follows:

Section 1: What the patients said

- a) How did patients understand and experience CCL and what did they expect?
- b) What impact did CCL have for patients? Does CCL help them make a difference in their lives?
- c) What did the Chaplaincy listeners and GP referrers observe about patients using CCL?

Section 2: What the GPs said

- a) How easy is it for GPs to refer patients to the CCL service?
- b) What issues are important for GPs in understanding the CCL service?
- c) What difference has the service made to GPs?
- d) How does the listening service take pressure off other services?
- e) What impact has CCL had on GP prescribing?
- f) What improvements would GPs like to see in the CCL service?
- g) What do GPs say about the use of volunteers?

Section 3: What the Chaplaincy Listeners said

- a) How can Chaplain listeners develop good working relationships with GPs?
- b) How do chaplain listeners explain the distinctive character of Community Chaplaincy Listening?

Section 4: What the Managers said

- a) How did the managers understand the service?
- b) What will the health care professionals need to trust this service?
- c) What are the challenges of the listening service for health service managers?
- d) What would be needed to show that the service had impact?

8.1 Section 1 - What do the patients say?

a) How did patients understand and experience CCL and what did they expect?

Overall, the patients reported very favourably about CCL. They felt that:

- ◆ their expectations and experience of the service was positive
- ◆ they had been able to do things differently as a consequence of the service
- ◆ they would go back if they needed the service again
- ◆ the spiritual and religious component expressed through the chaplaincy link of the listening service was at least not an issue and at best a helpful addition.

With one exception the patients reported a good experience of the service. They were asked to complete the CARE questionnaire, which asks questions such as the degree to which patients felt able to tell their story, were listened to and were treated with care and compassion. Using this measure, patients scored the CCL service as excellent or very good on almost every item. The written responses from the patients indicate how they experienced the process in more depth:



Patient questionnaire feedback responses on CCL



- ❖ *Good to talk to someone that wasn't closely involved.*
 - ❖ *It was good to talk to someone who doesn't know you.*
 - ❖ *I've been on a listening course before so I kinda knew what to expect.*
 - ❖ *Yes the experience has been so valuable to me "Thank you "for the opportunity.*
 - ❖ *The opportunity to reflect about my situation and prospects.*
 - ❖ *That someone would listen to my problems and give me a clear idea of what I needed to do or react to given situations.*
 - ❖ *I didn't expect to find such compassion and positivity. This experience was invaluable to my mental and emotional well-being. I can't praise it highly enough.*
 - ❖ *Didn't know what to expect but glad to go as the person I spoke to identified with me in one of my problems.*
 - ❖ *I was treated with respect and a very caring attitude, which was very calming.*
 - ❖ *That I would be able to let out all my feelings about what I was going through to someone who was not emotionally involved with me/my situations.*
 - ❖ *Yes, it's an excellent and very helpful service. Particularly good that there was no waiting list*
 - ❖ *I think it is a very innovative support structure which gives recognition to emotional and spiritual needs requiring to be met in a genuine "listening" situation.*
-

The two face-to-face interviews with a patient and a patient carer (who had witnessed her mother's experience of the CCL service) provide more detail of their experience with the CCL process. Both interviewees reported feeling comfortable and at ease with the listening sessions and felt they knew that solutions to their distress were available within themselves. Being ready to listen to oneself, seems to have been an important part of the listener/patient contract.

The patients also clearly understood the listening service to be confidential, about them, directed by them and available to them as they wished. They understood that the matters discussed by them could include spiritual issues and questions of life's meaning.



Patient interview feedback on CCL



- ❖ *When (the listener) introduced herself she explained that I would be doing all of the talking, she would occasionally interject with some ideas, but basically me talking about myself, finding where I was and coming to my own solutions. Never done anything like that before.*
- ❖ *Two sessions, first was telling my story, and the second session was going over in a bit more details and finding a way forward, inspirational moments, certain things said, I said that's really good, needed to move on that.*
- ❖ *You are allowed to be open and talk it through in your own way, own issues, solutions are there in what you say, if it comes out as a result of a spiritual counselling it can only be a good thing.*
- ❖ *I was able to be very open and completely straightforward. Openness made a difference for me. Solutions are in what we say. Its staring you in the face and you just don't see it. Spiritual counselling for me was like a smack in the head! Here we are, that's your answer.*



Patient Carer interview feedback on CCL



Mother was diagnosed with terminal cancer. No surgery possible. Progressive decline with no timescale. Mum became fairly depressed. She was shutting down mentally. (Listener) had said the project was open to anybody. GP agreed and (Listener) started visiting my mother. Built a relationship of trust, Mum was able to talk to (Listener) about approaching death and illness. Always a woman of faith, knowing that (Listener) was a Chaplain helped, she felt a freedom to express anger, doubt and certainty, knowing that it would be gently received. (Listener) has built up a fantastic relationship with Mum. Faced a lot of issues. So much so that she is having a real renaissance, she looks forward very much to seeing (Listener) because she knows that her night time thoughts can be offered in complete confidence. We as family members are not privy to that, but we can see in her whole demeanour and general state of health that it has been nothing short of a miracle really.

b) What impact did CCL have for patients? Does CCL help them make a difference in their lives?

One mark of a successful healthcare service such as CCL is that the patients who use the service feel able to change their behaviour as a consequence of the listening sessions in ways that enhance their wellbeing. The patient questionnaire asked whether or not patients were able to do things differently following their use of the Community Chaplaincy Listening Service. Patient feedback indicates a general theme of leaving the past behind and trying to live more in the present and future, their comments also show the importance of being more confident in themselves and kinder to themselves.



Patient questionnaire feedback on CCL



- ❖ *I am helping myself by stepping back from the situation and looking what I can do to look after myself instead of other people.*
 - ❖ *I am at ease with what I saw, I am able to sleep and get on with my life. I think about the situation I was in often, but with a positive view.*
 - ❖ *I now feel able to move on a little and to talk to my children about how I feel. We have talked and talked which has helped us cope with our grief.*
 - ❖ *Take each minute as it comes and deal with my moods as is, not worry so much about what people might think about me and just be “me”.*
 - ❖ *Not really: but maybe my present approach has been confirmed, and that is reassuring.*
 - ❖ *I feel more positive about my situation and I try and take one day at a time instead of looking too far ahead. I also realise that I’m not on “my own”.*
 - ❖ *I can now look beyond the situation and think clearly about where I want/need to be, what I want/need to do. I felt as if the situation had put walls round me and I couldn’t see a way out. This service has helped me to look round and beyond the current situation. I’m better able to manage the rest of my life outwith the particular problem/worry.*
 - ❖ *Being able to open up has given me a more positive outlook and I now can accept the situation I find myself in.*
 - ❖ *Leave past bad experiences where they are, in the past*
 - ❖ *Yes. Have a better appreciation of how the other person involved in my situation must feel. Being more objective/less emotional/more rational about my feelings and experience, able to be more patient with myself.*
 - ❖ *I think it helped me to evaluate my own self worth, through articulating emotional pain in the past, its negative effect on my present life, and have a positive structure for the future.*
-

These important sentiments were echoed and extended by the face-to-face interviewees. In particular the carer interview shows that it is not only change in behaviour that lifts the spirits of both the patients and the carer but also the reduction in the use of medication. We will see later in this report that GPs also reported the possibility of reduced prescribing for patients who have seen Chaplaincy listeners. In the second iteration of the action research cycle we will look at prescribing changes in more detail.

Patient Carer interview feedback on CCL



Brought out my own spiritual awareness in a lot more depth. Lot more ability to step outside of myself and be more impartial, evaluate situations and come to proper conclusions in a cool and calm way. Part of that is the spirituality side of it. Liaise with my brother quite a lot, he follows Buddhist ideas one of the things that became very important to me and useful was the idea of impermanence

Key differences yes. Mum has always been a woman of faith but in some ways had lost sight of that. It had become a head knowledge – she knew God and her faith should be an anchor point, but in reality it no longer was. Over dependence in going to the GP for prescription drugs, too many drugs because that was all the GP could offer. One of the things that is a clear manifestation (of using the CCL service) is that the “tin pill box” has a manageable amount of medication. Mum began to go to a small care home service, now she wouldn’t miss it for the world, now she goes to worship with men and women from all different faith backgrounds. Just this last weekend she has asked my husband to take her to communion. Turned back to an anchor point for her on this journey. Entirely because of the time the listener has given to mum.

In the past Mum’s had to have anti depressants, GP sorted out problems with breathing, sleeping pills, all the other boxes I dread to think how many, but the real fear is these anti depressants. She is not clinically depressed, she is an old lady, 83, facing the end of her life and that journey, she needed somebody to talk to about the fact of her cancer ...knows she’s not going to be having treatment, great deal of fear, MacMillan nurses have been wonderful, but its taken the listener to deconstruct and get down to the core of her being where there is spiritual being needing to be heard. GP admitted last week that she didn’t need anti depressants now. Her mental attitude has helped her look things in the face. Much more positive. Pin that on the fact that she has been listened to empathetically and sympathetically, some things have been picked up and moved back to the medics. You get a little bit of your mum back for a bit longer, which is very precious.

c) What did Chaplaincy listeners and GP referrers observe about patients using CCL?

Both GP referrers and Chaplaincy listeners reported very positive outcomes that they heard from their patients. The confidential nature of the service meant that some GPs were unaware of which patients, to whom they had recommended the service, had actually taken up the recommendation. This raises important points about access, referral route, note taking and confidentiality, all of which are discussed below.



Chaplaincy Listener interview feedback

Two of the clients who were struggling with loss of mobility. Struggling for about six months to come to terms with the reality of that loss. Resisting about that, and they used the words such as “frustration, depressing” and all such words. At the end of the first session they could come to the reality that this was the situation and they had to accept. After the second session they already started thinking about alternative approach to their life – this was the reality because they were not able to continue the jobs they were doing – lack of mobility, they had to change their lifestyle, job and routines. They were not able to do this because they were not able to accept the reality of the situation...living for six months with frustration and up and down to their GPs...in the first session they started to accept the changes ahead...they went back to the GP and he couldn't believe it, the change... so they were struggling for six months to just accept that message..



General Practitioners interview feedback

I referred one person who came for a chat, who had just found life was getting her down. Too many stresses and no one there at the end of the day to offload to. She felt that each day there was no release, everything had built up to the point where she knew she needed to talk and someone to listen.

It has certainly benefited two of my patients very much. They really needed time to talk and prioritise in their head on going issues. Their issues were both psychological, spiritual and family related.

8.2 Section 2—What do the GPs say?

The key question here is whether the service makes a positive difference to General Practitioners.

The data allows us to be fairly confident that *patients* have enjoyed and benefitted from the listening service. They have been able to make changes to their ways of doing and thinking which help them feel more in control of their lives and allow them to get on with their lives.

It also seems that the GPs have benefitted from the service in terms of:

- ◆ having an additional resource to which they can refer patients
- ◆ the subsequent consultations with the patients
- ◆ The possibilities of reduction in medication prescribing
- ◆ increasing confidence in how to explain the service to patients which covers the chaplaincy link and the idea of spiritual listening.

a) Ease of access

There seemed no doubt that the service was easy to use and that this was highly valued. This is particularly because the listener is located in the building, there is virtually no waiting time and the appointments can be made through reception at the front desk. In three of the four sites the relationship between GPs and listener was established prior to start up of the pilot and this greatly helped the smooth running of the referral process. The fourth site had more difficulty getting going. It certainly seems as though good, confident relationships between the chaplain listeners and the doctors is crucial. This links to question of the use of volunteers instead of chaplains, which is discussed later.

b) Understanding the nature of the listening service

Access and understanding of the service was greatly helped by strong relationships between the chaplain listeners and the GPs. This also helped the appropriateness of the referrals.

The doctors referring needed to have confidence in the listeners. They needed to see and know that the chaplain listeners were professionally competent, had the appropriate skills and training and could deliver the service offered.

The doctors also needed to understand the type of service that was on offer. Linking chaplaincy to religion and spirituality was an issue.

The way GPs described the service to their patients was important.



Depends on how you sell the service. If you start with spiritual counsellor you have to go in to stuff, we use (the listeners name) now! Tend to say that this is about helping people to find their own solutions, not going to tell you what to do.

We were a little bit reticent to start with. Concern was that "chaplaincy" suggests that it might be more religious that our clientele would be used to. We hummed and awed. Always been a bit of a need for a service that provides some sort of talking therapy, difficulties with waiting lists for psychology and psychiatry

aren't particularly keen to see people with general life difficulties so there is a bit of a gap. Our conclusion was that although we were hesitant about chaplaincy, there was a need to fill. Relatively new and I'm finding my feet. Patients who have undergone traumatic events, struggling to come to terms, solutions based approach isn't going to be effective. Bereavement is a typical scenario, unemployment, relationship split, economic stress, people who are asking why. With those patients I try to explore where they stand spiritually, the main reason for that is that someone who has had adverse experiences with a church or who is a strong atheist, may be put off by a community chaplain. Needs quite a lot of explanation that this is not a religious counselling but somebody who has had a lot of experience of listening to people who have been through adverse experiences in their life. We are explicit that the listener is a retired Anglican chaplain but acting not as a minister but as a skilled listener. That's worked quite well and people have taken that on board. I'll become more skilled at introducing it that so its both accurate and non threatening..

c) Is the service a good additional resource for GPs?

On the whole the service was welcomed by the GPs. There were a number of common reasons given.

- ◆ **An extra resource:**The length of the waiting lists for other talking therapies, particularly psychology. This listening service provided another resource
- ◆ **More time for GPs:** The freeing up of time for the GPs as their patients engaged in the listening service and needed less time from the GP.
- ◆ **Reduced prescribing:**The possibility of reducing or avoiding having to give medications for mild to moderate depression

Comments in the questionnaire responses reinforce these points.



❖ *It is well recognised by the patients and GPs that counselling services are very valuable but in extremely short supply from health board provision (currently waiting times can be in excess of one year). This service is an excellent and important addition.*



❖ *It is a desirable service. GPs are often stretched to limits with dealing with "non medical" social or spiritual problems. And often don't have time on their side so to have someone who could just listen to patients is often welcome*

❖ *I has been valuable in that we have a speeding up of the event to be seen (sic) and has stopped people being inappropriately referred to mental health services*

❖ *Yes!!! Many people need to talk to someone in confidence and 10 minutes with GP does not suffice*

❖ *People's mood improves and there is less need for anti depressants*

d) What differences has the service made to GPs?

We asked the GPs about the impact this service has had on them, their patients and also about their medication prescribing. Some of the GPs were not able to say how the service had affected their patients, partly because they did not know who had used the service.

A useful and effective service will produce good positive outcomes for the patient and also positive outcomes for the doctors. It seems that this service has the capacity to do both.



- ❖ *The patients I have referred have found it helpful. The patients have not come back to me to discuss the same problem at length.*
- ❖ *They have become more confident and are happy managing their own problems once more.*
- ❖ *The patients have not disclosed if they are using the service or not so not clear what change may have come about*
- ❖ *Unclear because there has not been any feedback as to who has attended the service. But I think that offering confidentiality including whether or not they attend is appropriate and integral to counselling.*



Whether or not medication is reduced is as yet a speculative response



- ❖ *People's mood improves and less need for anti depressants*
- ❖ *I did not use medication in two of the patients who benefitted the most. In the two others they were severely depressed and they also needed medication and ultimately psychiatric input.*



The face to face GP interviewees were asked about the benefits to GPs of the service. The comments below shows that the GP is clearly identifying the importance of having someone else to refer to who has different skills to the GP.



Patients who are distressed are not coming in with a 10 minute problem. Can try dealing with it in 10 mins but you make HEAT targets is to reduce anti depressant prescribing (ref). A variety of interventions have been introduced to try and achieve these targets. Early indications from the respondents at this stage in the programme are that it will probably make a difference. However it is a complex and subtle process as shown by the thoughtful responses below.





Probably has made a difference. Often person in distress wants something. Someone to talk to, a referral or a prescription. Its quite a transactional thing. Reluctant to leave without having achieved something from the consultation. Tendency to want to prescribe to help with the problem. Doctors tend to try and find medical solutions to problems. Often means a prescription. What you really need to do is to look at your life, a tablet might aid your motivation to change, but may not be the best thing. A lot of people who see the listener may also need medication. I think (the listener) has reduced our prescribing at the margin and made the prescription more effective by helping the person be more

e) Listening service takes pressure off other services

It also seems to help other services in terms of easing the pressure on the counselling and other talking therapies. It can be seen as service that is filling an important gap. In doing so it provides comfort and support to the GPs as well as the patients



Before the service existed..... tried to be supportive, always wary of opening up things which meant that consultations overrunning hugely. No benefit to other patients or myself. Resulted in me being a bit reserved about opening up avenues. Structured self help counselling offered a route for some patients. Single phobia would be helped by that approach. But patients who have had a tough time and asking the why question that approach often didn't help. Refer someone , raise inappropriately high expectations and ultimately the patient would not have been helped. The way that they could be if they had been provided with a listening service.



Certain patients I was seeing weekly for 15 mins per time. One I didn't see until 6 weeks later. Seeing her for something completely different and in and out in 5 /10 mins. Another patient, I was seeing her at the end of the surgery, sometimes I give patients an hour over my lunch break.

f) What suggestions for improvements to the service?

As we have seen the GPs are positive about the service and wish it to continue. Although it is early days they were able to envision the development of the service. The suggestions and comments related to

- ◆ expanding the service so that greater demand could be made on it;
- ◆ encouraging GPs to refer more frequently by explaining the link between chaplaincy spiritual care and wellbeing;
- ◆ providing a listening service that was open access and self referred.

Nobody suggested stopping the service. All the comments were about expansion and consolidation.



❖ *Yes, already there are people willing to be part of the development. Training and a neutral place for the service to run from so the service could be offered to a wider community as it would be very beneficial to many who need a listening ear*



❖ *Direct appointments on screen that GPs could make there and then so patients would not have to make appointments at reception desk*

❖ *It would be a useful service to engage with and it certainly fulfils a niche that is otherwise lacking. People who are not severely depressed but do need to talk and share their experiences and be listened to.*

❖ *Perhaps some feedback from the chaplain with some basic information eg. How often the patient was seen. Feedback from the patient.*

❖ *Can be useful if rolled out across the Board to cover all practices.*

❖ *Presumably asking for permission to track referrals*

The face to face interviews with the GPs also introduced some new and developing ideas. Some were keen on the idea of expanding the service to use volunteers. Perhaps adopting a two level approach to listening. Others were more cautious about the use of volunteers.



Do a hybrid and keep Listener on who is a chaplain, also use volunteers. Want to do that fairly soon, we would rather have volunteers who aren't being used rather than a rush of patients - then there is a waiting list. Once we feel confident in our group of volunteers, make it a direct referral service rather than referral by GP. Community council got excited about this idea and saw it as a resource for the whole community, but without having to go through the GP. Have to feel comfortable with our volunteers and make sure nothing is missed.



Other GPs in the practice haven't yet referred any one. In first instance like to see all GPs refer patients and the practice nurses. They see patients with long term conditions, routine follow ups, slightly different to the patients we see in our consultations, part of what we do includes screening from depression. Whilst a proportion of patients are depressed, greater number of people struggling to come to terms with the fact that they have this condition. Often a skilled PN can provide that support. Sometimes people need a lot more than that. Future source of referrals.

Looking further we would hope in time that we can open up the service to self referrals. Plans to recruit and train more volunteer counsellors. Community chaplain will start to mentor some of the newer listeners. As we rollout our

capacity to provide listening will increase. Have started to improve our links with the local churches. In many cases members of church who are patients need to have that opportunity opened for them. Want the churches to be able to freely ask patients to get in touch with ourselves. Should be a ready availability of referring patients via the churches for medical help.

g) What do GPs say about the use of volunteers?



Again causes a bit of concern. Don't know what you are getting. Don't know their training and approach. It is a bit of a pig in a poke. Folk who have been working in a managed service you know something about them. Volunteers its harder to judge. Cautious and conservative. Depends on what background is and what experience. Volunteering is very useful thing but if you've got complex patients with significant life difficulties I think you'd get more ...feel more comfortable if we had a greater certainty as to who it was and what sort of skills they had.

If there were volunteers ... huge confidentiality issue, Our chaplain listener is a minister and us as doctors we are bound by confidentiality – patients need to know that the person has the qualifications to deal with the sharing of the troubles. If someone wanted to speak to the volunteer they would go through the Samaritans. Need secure checks. Dealing with people's distress is a big thing; things come up that you don't expect. If you don't take the proper care with information or knowledge you can cause damage. Has to be done, gently supportively and within a very rigid structure.

8.3 Section 3 - What do the listeners / chaplains say?

Throughout this first pilot we captured the views and experiences of the listeners/chaplains and how they saw their work progressing and settling in. They were able to characterise their listening work as distinct from other talking therapies. We have reported these in other sections of the findings. Here we concentrate on how they developed the relationship with the GP practices and the specific nature of chaplaincy listening.

a) Relationship with GPs: appropriate referrals, GP understanding of the service

It became clear that the listeners needed to form close relationships with the GPs in the practices for the process to work. GPs would only refer to trusted colleagues and that trust had to be established. In one site the chaplain had already been working in the practice for two years. In another the chaplain utilised extensive PR and Marketing in setting up the service.



I repeatedly visited these GP surgeries and also practice managers and also met with most of these GPs and explained about this service. And the meeting we had when you were here last time was a great help – there were actually two GP surgeries represented in that meeting and most of the things were very clear to them, they went back to their practices and explained about this service, then I followed it up by meeting a few other GPs in those practices. All of the GPs have a copy of the laminated information we prepared.

The action research allowed for some PR materials to be developed which both helped the chaplains clarify their own thinking and which informed the GPs about the service (see appendix 4). However there were still a number of challenges in accessing the GPs and encouraging referrals.



Particular challenge is trying to get access to particular patients and carers. We work in given structures, its trying to make the inroads into that, GPs and other healthcare professionals don't know what you are about...trying to get credibility and need to take a step into the other world of the GP, because they are entrusting patients to you, want to know you are credible, I can understand that, but at the same time its difficult to establish that

The message and lessons learnt from this early pilot was that the effort spent in explaining the service and clarifying the process is worth it. This then means that referrals are appropriate and patients benefit. Clarifying the nature of spiritual listening as distinct from other talking therapies or counselling was also important.

b) Nature of spiritual listening

The interview extract below from one of the Chaplains explains the distinct nature of spiritual listening:



It is a bit different maybe because of two things. For me, I do have counselling skills and a certificate in counselling. I cannot distinguish too much but they are overlapping, the skills I gain in my counselling courses I tend to use them for

listening and probing and the model I'm using is actually Egan – he explains three clear stages

- ❖ *enabling a person to come to terms with where they are*
- ❖ *and where they wish to go and how to get there*

Maybe one of the differences is maybe I'm not so much focussing on how to get there. So basically listening, they are discovering and they are making alternative plans. In the counselling we usually take them through all those processes – maybe I'm not so much dwelling in the third process of helping them to get there

The emphasis on listening and helping the person clarify their situation to themselves is clear.



Allow the person to be who they are as a whole person. Invite the person to say, is there anything particular happening to bring you here today. Other things that matter ..allow the person to share a story. Right and appropriate to listen appropriately . Make suitable responses as are appropriate. Do summaries, revisit where they are. "how did you feel about that" explore their feelings, gently pursue their story. "Coming towards the end, draw things to a close seems that this has been happening, would that seem right with you. How does that seem for you to look at yourself." Then the person would agree and I would say well "how can we take a step forward here, anything that you can do at this point in time". Hopefully there would be something we could focus on an opportunity to take a step forward. Can offer a follow through appointment, suggest that the GP – important that its held within the practice system.



On the first appointment go through what the service is about. Its not formal counselling its a service provided by chaplaincy department. Make sure everyone is comfortable. And then the listener encourages the patient to tell their story, its their time and place, sometimes needs encouragement, people have a story to tell and want to tell their story. We use active listening, without interrupting people we would keep them in the right direction, summarise what they are saying to us and clear that we really are listening to them and hearing what they are saying.



Having established that they are quite comfortable I would ask them why they are there and why did they agree they would come to the session. What is your problem, what is it you want to talk about, at the same time saying to them unburden yourself. This is so important often we'll pick up a signal and then you can say am I right in saying that you are saying this. Then they can disagree or agree. Very valuable

8.4 Section 4 - What do the managers say?

a) How did the managers understand the service?

One of the medical directors, a former GP, spoke very eloquently of the importance of hope and the capacity for chaplains to represent hope. Hope he suggested was the basis of positive communities even in times of difficulties.



As a GP you realise that very few of things that people bring to you are about diseases that you can treat, quickly realise that, mostly about the impact of the stuff on their minds and bodies, interested in looking at more beneficial treatments and interventions.

When you look at the complexity of people's lives and worlds, one of the few things to hold on to from difficult place to less difficult is a sense of hope. I can try and instil hope as a GP by saying I think I can make you better. Increasingly clear that hope comes from within and the people around you and capturing that is the essence of this project.

The managers spoke in strategic terms about how they saw the potential of the CCL service; in particular, the way in which the listening service could fit in to a range of talking therapies as an additional resource.



I became aware of it because we were looking at our own mental health strategy and there is a lot of work around shifting the balance of care. Seemed to fit in to the tiered approach, talking therapy, close to home. Offers people a number of choices from CBT therapies – I saw some of the outcomes about how this service was helpful, didn't feel forced to talk, non medicalised, non labelling service and this gives them choices. Sounds to me like its carried out at the individuals own pace. No pressure to deliver the therapists outcomes. Certainly the feedback does seem to suggest that it has helped people access the service.

They were able to identify the listening service as distinct from other services.



There are different types of counselling based around particular models. Some types are directive focussed, empathy, non judgemental etc. How that compares with the listening service I don't know. I imagine its less directive, no pressure on the individual to give something. Big difference with the more established services...(in these established services there is).... a contract, if there are difficulties with engagement the contract is reviewed. Agreement can be that you need to part company. This (listening) is a bit different because there is a different contract.

Some people would say does it matter. Take CBT (cognitive behavioural therapy)-scientific basis and traditionally they don't get on with solution focussed therapy

(SFT). Two conflicting ideologies. SFT people would say does it matter as long as people get better?

b) What are the challenges of the listening service for health service managers?

At a managerial level the concerns are with the smooth operation of such a service. They felt the challenges of getting this service up and running relate to the acceptance of this service by health care professionals from a variety of disciplines who might feel threatened or confused by the service and the capacity to deliver the service with limited numbers of chaplains.



Challenges are around the perception of some of the health care professionals who have not seen the chaplaincy model as relevant. They have been more comfortable with counselling models and clinical context. There are challenges to us as a society to recognise that it is as valuable and sometimes more valuable than the higher end highly expensive interventions. There are challenges for patients to understand that the Doctor and the nurse may not be the right person to help them



How you manage expectations. Any new service there is always a risk that you are hit with an avalanche of new referrals. Challenge is how you manage the expectations with the few staff you have in place until it becomes established. I would like to see it as part of the communities directory of services, whether it's a GP or another health care professional, or the individual. When they think what their needs might be...like to see it in the directory alongside more established services.

We asked what it would take for a service like this to be absorbed and acceptable to other staff. From this managers point of view it would be important to have proper governance procedures in place and reassurance about the quality of the service.

c) What will the health care professionals need to trust this service?



The opportunity for staff to have personal development plan to work towards, obvious supervision, and a system where activities are being collated and managed in a professional way that remains confidential. The bottom line would be whats going to be best for the patient, the person. But clear idea of what people's roles are. No animosity created by somebody thinking that's my role...

d) What would be needed to show that the service had impact?



This seemed to be a persuasive report and tangible outcomes whilst acknowledging that it might be the intangible factors that show the most impact.

At one level need to see less of the patients who were regular returners, less sense of hopelessness. Not going to be able to produce RCTs – do need to be able to produce evidence around improvement, some kind of measurement around improvement, consultation patterns changing....Further down the line you might start to look at measurements of social capital and the extent to which wider communities felt valued by it or were adding value to their community. That's the exciting bit

Persuasive report – Tangible outcomes – what impact has it had on elsewhere. Has it resulted in a reduction of referrals to cpn – other types of counselling, reduction in outpatients appointments. Less tangible feel good factor. Some people go in and out of services fairly frequently. Does this intervention reduce the revolving door? That's a positive outcome. Psychological therapy might reduce anti depressant prescribing. Government issue.

Overall the managers saw the potential of community chaplaincy listening as positive with recognition that the service sat alongside talking therapies and CBT, freed up doctors time to see people who are more ill, and gave doctors another referral specialised option with patients.

9 Discussion

We have seen from the findings section that the service is on the whole very well received by patients and GPs, both of whom report that it makes a positive difference to their subsequent behaviour and practice. Listeners also report positive feedback from the patients.

At the *Building Resilience, Enhancing Wellbeing* conference in March 2011 the audience were presented with a descriptive analysis of the CCL pilot project. They were then asked to generate some questions and comments about the project which are recorded below.

We have categorised these and taken some of these as our headings for the discussion section.

9.1 Language

“Two words should be banned. 1) counsellor. 2) chaplain. Both words have so many meanings as to be all but meaningless!”

This is an important point and one which has exercised the listening project. Firstly there is a distinction to be made between spiritual listening and counselling but as we have seen from the comments of the patients and doctors the words ‘spiritual’ and ‘chaplain’ can be confusing and put people off.

The clarity of the relationship between chaplaincy and the listening service and the relationship between listening, religious and spiritual care and holistic wellbeing needs to be confidently understood and regularly articulated. As we have seen, one of the tasks during the set up of the project sites is to develop a good relationship between the listeners and the GP so that understanding of the precise nature of the service on offer is clear. This is public relations and marketing work, which may not be particularly familiar territory in spiritual care.

Those of the listeners who were established chaplains had also made their own transitions from ministry to health care chaplaincy. GPs and chaplains were aware of the need to explain the journey of chaplaincy and how spiritual care is relevant to healthcare.



The one thing I realised was that I had to speak with patients from a pastoral perspective, not from a religious perspective (in inverted commas) what I have to do now is translate that ...I'm having to make a transition with those patients who aren't Christians, because what I've got to do is use my skills from a pastoral perspective rather than a religious one. If there is one constant in the ministry I do its that word love. If people sense that they are being loved and that they matter. CCL is trying to show people that they are important, you matter you we care about you. (Chaplain interview)

getting GPs to understand what modern chaplaincy is, role and remit is very important. Have to slowly remind other GPs, partners and trainees about spiritual care. Old fashioned chaps much more faith based and denomination based with different ministers looking at the list from “theirs”. 70 percent regard themselves as spiritual. Chaplaincy needed to evolve to look after that spirituality. Development, moving away from faith based model to much more generic spirituality, sense of well being and purpose, where one fits in. For some people that's also faith based. Good that spiritual care can connect into faith but also that it can look after spirituality (GP)

The message here is to focus on establishing the relationship between GP and Listener, making sure that the practice of spiritual listening is understood and that the GP has the ability to make good referrals.

9.2 Methods to measure efficacy

“What process/evidence is needed in order to persuade GPs to buy into this? How do we measure the effect”

Given the complexities over language, the importance of finding good evidence for the relationship between listening, wellbeing and spiritual care is obvious. The methods by which this project operated were appropriate to stage one of an action research model. Action research frameworks provide the opportunity for change and development within a structured data collection environment. We have seen that GPs would like more feedback about patients but that it is difficult to retain the absolute confidentiality of the service if notes are taken and recorded and shared. These issues are the same for research methods. We know from elsewhere^{vii} that administration of a before and after measure is complex to the point of impossible. Thus a new method needs to be found that provides sufficient evidence to show that listening offers a tangible, cost efficient, new resource that helps GPs in their practices and supports patients in their personal lives. One such method is action research. This is now used widely by, health service researchers, sociologists and practical theologians. It can provide a narrative, qualitative account of the service as it evolves as well as points of quantitative data sets whilst not compromising the integrity of the service itself.

9.3 Volunteers

“How will volunteers be trained and supervised? Recruiting volunteers who are suitable/trusted by NHS staff in surgeries. Develop a national training scheme for volunteers; apply for accreditation from NES; supervision of volunteers; volunteers bring different skills; building capacity; training for volunteers, national resources? National standards? Will volunteers have limits as to depth or complexity they deal with and therefore refer on to chaplain? Do chaplains have capacity for this”

The issue of using volunteers is a complex one. The data from this project suggests that there are arguments for and against. The obvious argument for the involvement of volunteers is that it will build capacity because there are not enough Chaplains to cover the range and number of GP surgeries that would be involved. If the service is to aspire to a listener in every surgery, then volunteers have to be recruited.

We also however see that there is a delicate relationship between the chaplain and the GP, which is fragile in so far as the GP must be able to feel confident in the chaplain and their skills. The confidence is built and instilled when the GP knows that the chaplain is an experienced, health care professional and trained listener.

There is also suggestion as we have seen that there could be a tiered system of volunteers who refer up to the chaplain and are supervised by the chaplain. This would require careful selection and training of volunteers. It would also require a clear distinction between counselling and listening.

One of the listeners was able to provide a very clear definition of listening as provided by chaplains.



Chaplains bring their own special skills to deal with some existential questions of people. The listening service is provided in the pastoral care model, why me, why now, what is life about, chaplains have specialist skills to deal with existence stuff, human beings are more than physical. Not counselling, more than psychological clinical intervention. CCL is not a clinical intervention of medical care although it has same therapeutic skills to help people to cope with their problems. It is different to psychological counselling.

We have seen in the findings section that the precise nature of listening is clarified as something different from counselling and the other talking therapies. This is largely to do with the way in which the patient remains in control and there is no expectation of change or action on the part of the listener. It is not a therapeutic contract in the way that counselling and psychological therapy might be. The listener is the servant of the patient and brings this attitude to the listening relationship. Other health care providers bring specific clinical skills which focus on an aspect of the patient. This listening service may provide the only example of truly patient led needs based service.

9.4 Awareness of spiritual care

“Need for awareness training especially with community health workers. EG GPs.”

This comment suggests that the whole idea of spiritual care and support requires more attention and publicity. Health care professionals are still not sure what spiritual care might look like and tend to conflate spiritual care and support with religious care and support. These two are not of course mutually exclusive and often go hand in hand but chaplains are specifically trained to facilitate spiritual care to people of all faiths and people of no faith, recognising that illness brings with it spiritual concerns about meaning, loss and anxieties about changes resulting from illness.

9.5 Referrals

“inappropriate referrals, self referrals. What is a suitable client group? Any Stigma in being referred”

This point was raised and has to some extent been addressed above in the findings section. It is clear that clarity about who may be suitable and who should be referred is important. However patients were able to make self referrals and no listener in the study reported inappropriate referrals. It seems that both patients and doctors do understand the service on offer. The service seems to provide an in between haven for patients who are under some stress as a consequence of life events but are not requiring therapeutic interventions like psychotherapy or counselling. No body reported any sense of stigma at being referred. This is in marked contrast to patients who typically resist being given a referral to psychiatry. This is a well documented division between physical and psychiatric medicine which runs deeply through our health service culture. Being referred to a listening service does not seem to press the same alarm buttons.

9.6 Is CCL different to or part of psychological therapy?

What is different about CCL?

Community Chaplaincy listening provides a safe space for people to talk about everyday life stresses and strains in order that they can understand them better and help themselves get on with their lives. Community Chaplaincy listening does not provide a structured time limited intervention where a contract is required between patient and therapist and where non adherence to the contract indicates termination of the intervention. CCL provides unlimited space and time without expectations.

9.7 Venue

Space to meet. Does it have to be GP surgeries

All the four sites in this first round of CCL were based in surgeries. However, it may be possible to develop services in other settings. One of the pilot sites is intending to extend the service to a community group who meet in a public building. Specialist listening services have also been discussed where a particular group of patients such as those caring for people with dementia or those attending a sexual health clinic might benefit.

9.8 Staff

Could be a Service for staff?

The GPs have benefited from the service in terms of taking some of the strain from their exacting consultation lists. However, all staff in the health service are also patients and experience the stresses and strains of life that are reported by the patients. No one is exempt from life's complications and the knock-on effect on health. Listening to staff could well become a specialist role within the health service and provide a valuable release for staff. Potentially this could impact on sickness and attrition. The 'Here to listen' service in NHS Tayside is one example of a service currently provided by the local spiritual care department specifically for staff.

9.9 Is there a Chaplaincy agenda?

hidden agenda, cultural shift: Health promotion is about building personal spiritual resilience

The chaplaincy agenda is hardly hidden. Chaplains must look outwards towards the community where most health care is transacted (ref). Chaplains have the potential to offer a useful, meaningful and important role in health communities as the population ages and care is provided by family and friends. In order for chaplaincy to take its rightful role in developing healthy communities it needs to demonstrate and show its value. This is where research comes in. Not grasping this opportunity suggests that chaplaincy is not ready or not capable of making the necessary changes and adaptations to practice to contribute to meeting the changing demands of our society.

9.10 Is this a cop out for health professionals: should they be listening?

Spiritual needs should be acknowledged and addressed through whole health care team

All health care professionals are required to listen. However healthcare practitioners working at the sharp end of diagnosis, crisis and trauma are not given much time to do so. This is part of what they do. Healthcare chaplains see listening as central to their role. Healthcare chaplains have the potential

to offer models of listening to the multidisciplinary team and encourage good listening through their own practice.

10 Conclusions

We can conclude from the above that this first round has been a success. Patients, doctors and listeners have all reported positively and there is evidence of change in practice from both patients and doctors. These changes contribute to wellbeing in both patients and doctors.

The research reported here strongly indicates the need to continue this work, to encourage chaplains to grasp this opportunity to deliver targeted spiritual care and support to people who are trying to deal with life and its troubles and who benefit from a listening ear and the presence of those who have particular spiritual expertise.

We can leave the last word to the chaplains.

CCL is not based on any medical model, it looks at the whole person, it gives the patient control of what is happening. They make the decisions, they are encouraged to do something for themselves. In doing so they are beginning to find meaning, control and confidence in themselves and hope for the future. CCL is coming from a philosophy of hope.

11 Limitations

This is the first report of an action research programme. The methods used to capture the data were developed by the research team and the chaplains together. Some methods worked better than others.

It is difficult to know how useful the CARE measure was in this case. All the questions asked were directly related to good communication, holistic care and being heard. Given the nature of the listening service it would have been surprising to have found many “poor or fair” responses. In further action research cycles of this programme it will be important to develop a more sensitive tool now that we have a clearer idea of the process and expectations of the listening service.

The questionnaire return for both patients and GPs was not particularly good and top heavy in one site. There was enough spread however to say something useful in general terms.

The qualitative interviews yielded far more data and should be focussed upon in the next round.

12 The next steps

We are about to embark on a next round of the action research cycle using this report and presentations as the jumping off point. The data collection possibilities for this next round are considerable. The timescale is oneyear not 6 months and we now have some practice and understanding of what works and what yields the most information. Suitable data collection methods this time should include some kind of focus on prescribing habits of GPs and we intend to link work going on with PatientReported outcome measures for Chaplaincy(PROMS ref) with this study.

Appendices

Appendix 1: Chaplains consensus statement

Appendix 2: Adapted CARE Measure

Appendix 3: Referrers questionnaire

Appendix 4: CCL Information Card

ⁱ Wilson M (1971) The Hospital, a place of truth: study of the role of the hospital chaplain Unpublished thesis.

ⁱⁱ Spiritual care CEL 2008 49

ⁱⁱⁱ Shifting the Balance of Care. Scottish Government <http://www.shiftingthebalance.scot.nhs.uk/>

^{iv} This Report Mowat H (2011) "Do you need to talk: we have time to listen: an evaluation of the Highland Listening service" is available from Healthcare Chaplaincy Dept. NHS Education for Scotland.

^v Swinton J and Mowat H (2006) Practical Theology and Qualitative Research SCM London

^{vi} Coughlan P and Coughlan D (2002) Action Research for Operations Management International Journal of Operations and Production Management Vol 22, 2, pp220-240

^{vii} The Highland Study *ibid*

Appendix 1: Chaplains consensus statement

Best practice in 21st Century healthcare attends to the whole person – the physical, mental, social and spiritual aspects of human living. When emotional and spiritual needs are addressed, service users and staff experience a greater sense of wellbeing in dealing with ill-health.

Chaplains are employed as part of NHSScotland multi-disciplinary teams. Their primary responsibility is to promote the spiritual wellbeing of healthcare communities and all who are part of them – patients, carers, staff and volunteers - 24 hours a day, 7 days a week by:

- Engaging in a therapeutic listening, talking and being present with people in difficult times. In doing so chaplains:
 - affirm that fear, anxiety, loss and sadness are part of the normal range of human experience in healthcare;
 - establish trusting relationships in which others can explore hard questions relating to mortality, meaning, and identity;
 - help them to (re)discover hope, resilience and inner strength in times of illness, injury, loss and death.

- Helping individuals, families and communities in health care to mark significant moments in life and death using ritual and in other meaningful ways.

- Resourcing, enabling and affirming healthcare colleagues in their delivery of spiritual care - supporting them in reflecting on their own spirituality and that of patients and their carers.

- Meeting the particular needs of all in the healthcare community in relation to religion and belief by promoting creative links with faith and belief groups.

- Helping staff reflect on the relationship between their personal stories, including their values, beliefs, experiences and sense of vocational fulfilment, and the shared story of their workplace. The interface of the two influencing: behaviours, attitudes, decision making and well-being.

Appendix 2: Adapted CARE Measure

CCL: Patient Questionnaire: Care Plus five

1. Please rate the following statements about your listening service experience. Please tick one box for each statement and answer every statement.

	Poor	Fair	Good	Very Good	Excellent	Did Not
How was the listener at ...						
1. Making you feel at ease..... <i>(being friendly and warm towards you, treating you with respect; not cold or abrupt)</i>						
2. Letting you tell your “ story” <i>(giving you time to fully describe your illness in your own words; not interrupting or diverting you)</i>						
3. Really listening <i>(paying close attention to what you were saying; not looking at the notes or computer as you were talking)</i>						
4. Being interested in you as a whole person ... <i>(asking/knowing relevant details about your life, your situation; not treating you as “just a number”)</i>						
5. Fully understanding your concerns..... <i>(communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)</i>						
6. Showing care and compassion.... <i>(seeming genuinely concerned, connecting with you on a human level; not being indifferent or “detached”)</i>						
7 . Being Positive..... <i>(having a positive approach and a positive attitude; being honest but not negative about your problems)</i>						
8. Explaining things clearly..... <i>(fully answering your questions, explaining clearly, giving you adequate information; not being vague)</i>						
9. Helping you to take control..... <i>(exploring with you what you can do to improve your health yourself; encouraging rather than “lecturing” you)</i>						
10. Making a plan of action with you ... <i>(discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)</i>						

Patient questionnaire, Care Plus Five
Version 3
July 2010

Cont/...2

**11. Is there anything that you are now able to do differently to help yourself and your situation?
Could you explain this in some detail?**

12. In what circumstances might you want to go back to the listening service again?

13. What were your expectations of the listening service?

14. Were these expectations met?

15. If you have a religion or belief and feel comfortable to say what it is, please do so

If you want to write any more about the listening service please continue on the back of this sheet.

When you have completed the questionnaire please put it in the stamped addressed envelope provided.

We would like to thank you for completing this questionnaire.

Appendix 3: Referrers questionnaire

Community Chaplaincy Listening Service: Feedback Questionnaire for Referrers

Dear (Name)

You have recently referred some patients to the community chaplaincy listening service at your surgery. As you know this is a pilot service and we would like to understand more about how helpful the service is and how it can best be developed.

We would be much obliged if you could complete this short questionnaire with your feedback about the service.

Many thanks,

Dr H Mowat (Researcher for Community Listening Service)

Dr S Bunniss (Researcher for Community Listening Service)

Name	
Role (Position)	
Number of patients you have referred to the listening service	

1. To what extent have you found the service easy to use and the referrals easy to make?

2. Have there been any practical difficulties with how the service is delivered?

3. In your view has the service been a valuable addition to existing services? If so, in what ways?

4. Has the listening service made any difference to your consultations with the patients who have used the listening services? If so, in what ways?

5. Has the listening service made any difference to your prescribing practice with the patients who have used the listening services? If so, in what ways?

6. Have your patients given you any feedback about the service (favourable or otherwise) that would be helpful in evaluating this service? (Patients have also been given the opportunity to feedback about their experience of the service)

7. Have you any suggestions as to how the pilot service can be improved and developed?

8. How has this service impacted on your own practice?

Thank you for taking the time to feedback on this service!

Appendix 4: CCL Information Card



community
chaplaincy
listening

Community Chaplaincy Listening
...in a nutshell

CCL is a service that helps build community resilience and wellbeing.

Our method is active listening which offers the potential for transformation.

Many people have experienced hurt in their lives which means they may struggle to find meaning in life.

Sometimes, and particularly these days, it can be difficult to know who to turn to.

Community Chaplaincy Listening helps people explore their deepest hurts and ask why, in order that they can have confidence in their own inner strengths.

Chaplaincy services do this uniquely because of their spiritual care knowledge, skills and experience.

People tell their story, we listen. And in doing so community resilience grows.

Typical indicators for referral - patients asking:

- Why is this happening to me?
- What have I done to deserve this?
- Why can't I find a point in living?
- Why am I the survivor?
- Have I brought this on myself?
- I'm not religious but...
- Why does God allow suffering?
- How can I survive?

your story. **your** time. **your** wellbeing.



What is...

community resilience?

Resilient communities...

...demonstrate love, peace, gentleness, kindness, self control, joy, loyalty, integrity, patience and goodness.

Resilient communities...

...reflect understanding and acceptance that people suffer - that life is a challenge - that sometimes things cannot work out the way we want.

Resilient communities...

...cultivate hardiness: the ability to survive in adverse conditions (environmental, social, emotional, health, economic) and still remain hopeful.

Resilient communities...

...contain resilient people who foster hope by encouraging reconciliation and building stronger relationships. These people have a personal capacity to adapt their coping mechanisms to recover meaning from their personal story.

Resilient communities...

...work for the "common good".



your story. your time. your wellbeing.