

1
2

3 Do Oncology Outpatients Need 4 Chaplaincy Services? 4

5 S. H. Cedar¹ 5
6 London South Bank University, London, UK 6
7 cedars@lsbu.ac.uk 7

8 J. Mitchell² 8
9 London South Bank University, London, UK 9
10 cedars@lsbu.ac.uk <??> 10

11 J. Watts³ 11
12 Guys and St Thomas NHS Trust, London, UK 12
13 cedars@lsbu.ac.uk <??> 13

14 M. Hilborn⁴ 14
15 Guys and St Thomas NHS Trust, London, UK 15
16 cedars@lsbu.ac.uk <??> 16

17 **Abstract:** Holistic patient-centred care is the aim of health services in the United 17
18 Kingdom delivered through the 6Cs. Chaplains can offer aspects of this through 18
19 passionate care of the patient, particularly when a person is facing a life-limiting prog- 19
20 nosis. This study firstly evaluated patient awareness and use of chaplaincy services in 20
21 two oncology settings; Inpatient and Outpatient. Outpatients had not previously been 21
22 offered chaplaincy services. Secondly, the demand and needs for a chaplaincy interven- 22
23 tion was investigated with patients who expressed a spiritual or religious belief and had 23
24 received a chaplaincy visit. Results indicated that half of the patients seen in the first eval- 24
25 uation identified with a spiritual/religious belief and both Outpatients and Inpatients had 25
26 a similar demand for chaplaincy visits. Those receiving a chaplaincy visit before being 26

27 1. C. H. Cedar is Associate Professor of Human Biology and Reader in Biomedical Sci- 27
28 ences, School of Health & Social Care at the London South Bank University. 28
29 2. J. Mitchell is Associate Professor of Practice Learning, School of Health & Social Care 29
30 at the London South Bank University. 30
31 3. J. Watts is Chaplain at Guys and St Thomas' NHS Trust, London. 31
32 4. M. Hilborn is Hospitaller and Head of Spiritual Care at Guys and St Thomas' NHS 32
33 Trust, London. 33

1 evaluated generally requested further visits. Based on these results we have now estab- 1
 2 lished a chaplaincy visiting service in the Outpatient chemotherapy suites to try to match 2
 3 demands. 3

4 **Keywords:** 6Cs; inpatients; oncology; outpatients; pastoral; spiritual. 4

5 **Introduction** 5

6 There are many stages of an oncology patient’s journey starting from the 6
 7 discovery of their symptoms, through to tests confirming a diagnosis and 7
 8 prognosis, to treatments including chemotherapy, surgery and radiotherapy 8
 9 (Leydon *et al.* 2003). The patient can go into remission or relapse and face 9
 10 much of the journey again. Many health care professionals may be involved 10
 11 during this journey with the General practitioner (GP) often providing a 11
 12 first contact (Bulsara *et al.* 2005). 12

13 Compassion and care for the entire person, patient-centred care, has 13
 14 become a highly debated aim within the National Health Service (NHS) in 14
 15 the United Kingdom (UK) (Darzi 2008; Adlington & White, NHS 2015). 15
 16 With some long-term diseases such as cancer, it can be found that rather 16
 17 than being patient-focused care, managing the disease becomes the main 17
 18 focus. The disease can, therefore, become paramount in the care and the 18
 19 patient becomes subsidiary to the cancer even though there is some evi- 19
 20 dence to suggest that health outcomes improve with patient-centred care 20
 21 (Oates *et al.* 2000). 21

22 Chaplains offer expert care that is centred on the whole person, offering 22
 23 many of the 6Cs that form the basis of nursing care: Compassion, Care, 23
 24 Communication, Courage, Competence and Commitment. Chaplains are 24
 25 highly trained to offer compassion and empathy by therapeutic communica- 25
 26 tion (pastoral) or through ritual and observance (spiritual/religious) to those 26
 27 in need (Swift 2015). With long-term conditions this may provide a vital 27
 28 and cost-effective service, as shown in other areas of care (Hausmann 2004). 28
 29 The efficacy and effectiveness of health care chaplaincy is part of evidence 29
 30 based medicine (Jankowski *et al.* 2011; Lehair 2005; Fraser 2004). Various 30
 31 measures can be used to assess chaplaincy (Bodde 2008). According to the 31
 32 NHS Chaplaincy Guidelines 2015 (Swift 2015) the 2010 Equality Act (UK 32
 33 Government 2010) should be taken into consideration for all chaplaincy 33
 34 services regarding “patients, service users and staff must be made aware of 34
 35 the nature, scope and means of accessing chaplaincy services within their 35
 36 setting. Only with adequate awareness can a provider evidence equality of 36
 37 access” (Swift 2015). 37

38 A key component of this is that “Chaplaincies have procedures for evalu- 38
 39 ating their work, both in terms of quality and quantity, so that it is fully 39

1 accountable within the organisation” (Swift 2015). Section 14.1 of the guide- 1
 2 lines deals with how patients are informed about chaplaincy. However, when 2
 3 a patient comes to a tertiary hospital, such as one that is part of this study, or 3
 4 enters through Accident and Emergency (A&E) or by referral, such patients 4
 5 are not always in a state to access all the information they are given or 5
 6 remember all the data requested from them. Patient compliance and patient 6
 7 “informed” consent may be counter to the staff intention due to overload of 7
 8 information and poor communication (Sundar 2015; Leydon 2000). 8

9 **Background** 9

10 The emotional and spiritual state of patients plays a role in recovery and 10
 11 addressing these needs is partly the role of the chaplain. Chaplains and 11
 12 chaplaincy can accompany people on their journey, address spiritual and 12
 13 pastoral needs and offer a space for people to explore their emotions and 13
 14 feelings regarding their prognosis. The effectiveness of chaplaincy, however, 14
 15 is difficult to evidence. An evaluation of chaplaincy services helps to address 15
 16 this and to set a benchmark for future evaluations (Bodde 2008). 16

17 Clinical intervention seeks to restore a patient’s health and improve out- 17
 18 comes. In evidence based medicine, clinical interventions need to be evalu- 18
 19 ated to establish efficacy. Where indicated, changes are implemented at an 19
 20 individual, team, or service level and further monitoring is used to confirm 20
 21 improvement in healthcare delivery. 21

22 An evaluation should be generalizable, so that the extent to which the 22
 23 findings of a clinical study can be reliably extrapolated from the subjects 23
 24 who participated in the study to a broader patient population and a broader 24
 25 range of clinical settings (Health Research Authority 2013). The UK Board 25
 26 of Healthcare Chaplaincy has set out standards for chaplaincy to ensure that 26
 27 clinical governance aims are met (UKBHC 2009). UKBHC states that using 27
 28 this tool an evaluation of chaplaincy service itself should be undertaken 28
 29 every three years. 29

30 Oncology patients have a varied journey from their first visit, usually to 30
 31 a GP, through various clinics for tests to gain a diagnosis or confirmation 31
 32 of what they already may fear, and then onto a specialist consultation and 32
 33 prognosis for treatment. During this journey their bodies are examined, but 33
 34 they are also on an emotional journey. In the study hospital, Outpatients 34
 35 oncology had not been served by chaplaincy before, so there was no stand- 35
 36 ard to measure against. 36

37 This study therefore assessed the current service to find out what is 37
 38 offered and what is wanted. It compares oncology Outpatients to oncology 38
 39 Inpatients, an area that has well established chaplaincy visits. It conformed 39

1 to the aims of the delivery of best practice (Health Research Authority 2013). 1
 2 It sought to find whether the service matched needs and was available for 2
 3 all. It also sought to find out if there is a difference in demand between those 3
 4 who have a spiritual or religious belief and those who do not. A second 4
 5 evaluation was carried out a month later with patients who had received 5
 6 some spiritual care from a chaplain to see the effect of chaplaincy services 6
 7 on demand for chaplaincy services. 7

8 **Aims of the Study** 8

- 9 • To undertake an evaluation to assess whether patient needs for chap- 9
 10 laincy visits in an oncology Outpatient department were met. 10
- 11 • To evaluate the need for chaplaincy services for all patients, whether 11
 12 they had a spiritual or religious belief or none. 12
- 13 • To compare the service (intervention) offered in Outpatients to the 13
 14 service offered to oncology Inpatients chaplaincy service. 14
- 15 • To see the effect of chaplaincy service (intervention) on demand for 15
 16 further chaplaincy services. 16

17 **Method** 17

18 Patients evaluated were in a hospital which is a centre of excellence in 18
 19 cancer treatment in the UK and attracts patients from a wide geographical 19
 20 region with a diverse range of diagnoses, usually including complex cases 20
 21 and those with specialist needs. Some of them have been treated elsewhere 21
 22 before arriving at this centre. Some of them have been receiving treatment 22
 23 for months and some had been staying in hospital for days or weeks. We did 23
 24 not separate these out in our inclusion criteria in this evaluation. 24

25 The evaluation was carried out in two settings, Outpatient and Inpa- 25
 26 tient, using the same evaluation tool in each setting. While all patients were 26
 27 receiving treatment for cancer, the patients in each setting were divided into 27
 28 two groups: those who said that they held religious or spiritual beliefs, who 28
 29 are referred to as “Spiritual” in the evaluation, and those who said they did 29
 30 not hold religious or a spiritual belief, who are referred to as “Pastoral” in the 30
 31 evaluation. The evaluation was then conducted a second time one month 31
 32 later in both settings with patients who had expressed a religious or spiritual 32
 33 belief and had experienced some spiritual care from a chaplain. 33

34 Our inclusion criteria required the recruitment of patients who were 34
 35 awake (we did not interrupt sleep) and not having any other clinical visit 35
 36 in progress. We did not distinguish between age, gender or ethnicity as we 36
 37 sought to offer the service to all. In Inpatients, the patient was usually alone 37

1 when we visited, but not always. In Outpatients, the patient often had family 1
 2 or friends with them, but again, not always. We approached those alone and 2
 3 those with visitors. There were patients who decided they did not want a visit 3
 4 from the chaplain, or initially did not want a visit. If they stated that they did 4
 5 not want a visit they were, of course, not asked to partake in an evaluation. 5
 6 We introduced ourselves and said that we were doing a brief, anonymized 6
 7 evaluation which had yes/no answers for ease and speed of completion. We 7
 8 showed the patients the form. If they agreed to take part, they were then 8
 9 asked a series of questions about chaplaincy provision and their needs. The 9
 10 numbers evaluated are detailed in Table 1. 10

11 **Table 1.** Participants for Each Evaluation 11

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

12 12

13 The UK Board of Healthcare Chaplaincy (UKBHC) Standards for Health- 13
 14 care Chaplaincy Services Self-Assessment/Evaluation Tool was adapted for 14
 15 the purpose of this research. This tool was developed to assess and evaluate 15
 16 chaplaincy services. It has seven domains or standards (refer to Table 2). 16

17 **Table 2.** Standards for Healthcare Chaplaincy Services Self-Assessment Evaluation Tool 17

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

18 18

19 Note: Adapted from the UK Board of Healthcare Chaplaincy (UKBHC) Standards for 19
 20 Healthcare Chaplaincy Services Self-Assessment Evaluation Tool. 20

21 Each standard then includes various sub-criteria. The questions were selected 21
 22 from this tool to be able to assess when spiritual care was needed and where 22
 23 to fulfil the evaluation criteria at the cancer care units at a large tertiary 23

1 hospital. This tool is available to all UK registered chaplains and is used for 1
 2 assessments. We made minor alterations to assess the competencies of the 2
 3 chaplaincy standards of the UKBHC in line with the NHS in these settings. 3

4 As noted earlier, this evaluation involved two settings; Outpatient (OP) 4
 5 and Inpatient (IP). We wished to compare needs between the two settings 5
 6 as Outpatients had not been visited or evaluated previously. In the evalua- 6
 7 tion, patients' responses were separated in each of the two settings (OP and 7
 8 IP) into two groups of patients, those not holding a religious or spiritual 8
 9 belief.**[AQ: do you need to add: and those that held spiritual or religious** 9
 10 **beliefs?]** We established patients' belief by asking if they had a religious or 10
 11 spiritual belief or not. We explained that we were interested in patients' opin- 11
 12 ions as to whether they had a belief or not. Those who declared that they had 12
 13 a spiritual or religious belief, belonged to a religious group or held ideas that 13
 14 there was a greater power than nature, were termed Spiritual; those without 14
 15 these beliefs, who called themselves atheist or who thought this life was all 15
 16 there was, were termed Pastoral. 16

17 While evaluations fall outside ethical requirements, approval was sought 17
 18 and gained from all the departments and wards involved prior to undertak- 18
 19 ing any evaluation. 19

20 We chose to compare Inpatients and Outpatients on the same day and 20
 21 visited patients in the same clinical speciality, oncology, to assess needs. The 21
 22 wards included were male and female wards with capacity for 30 patients in 22
 23 each. We included three oncology wards. Outpatient/Day-care has capacity 23
 24 for 30 patients at one time. Most are there for 4 hours, but some for 8 hours. 24
 25 The same questions were asked in each evaluation as detailed in Table 3. 25

26 Each patient was first asked if they had religious or spiritual beliefs, or 26
 27 whether they did not. If they did they were then asked whether these needs 27
 28 were being met (Question 1 of the evaluation). If they did not have spiritual 28
 29 or religious beliefs they were asked if their pastoral needs, their needs as 29
 30 a person, were being met. The patients were then asked each of the other 30
 31 questions in the evaluation. 31

32 For the first evaluation, each setting, the Outpatient clinic or Inpatient 32
 33 ward, was visited for one hour each per day, once per week, for six weeks by 33
 34 one chaplain. The patient was approached and asked if they would take part 34
 35 in a very brief, anonymous evaluation about chaplaincy services, whether 35
 36 they held a spiritual belief or not. 36

37 For the first evaluation, the patients were asked if they would be willing 37
 38 to answer brief questions for an evaluation and each assessment was divided 38
 39 into Pastoral or Spiritual, by the patient's response. The evaluation was filled 39
 40 in by the chaplain while with the patient and the same questions were asked 40
 41 for each group. Each evaluation took less than five minutes to complete. 41

Table 3. Evaluation Questions for Both Inpatients and Outpatients

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

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

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

Results from the First Evaluation

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

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

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

1
2 Note: The table shows a comparison between pastoral and spiritual chaplaincy needs in
3 Outpatients and Inpatients. 1
2
3

4 When asked about any religious affiliation, patients described themselves as 4
5 either non-religious or spiritual, here called 'Pastoral', and those who expressed 5
6 a religious affiliation, here called "Spiritual". The results in each setting were 6
7 similar with over 60% of patients saying they had a spiritual affiliation. 7

8 *Question 1: Are your spiritual/pastoral needs being addressed?* 8

9 Of those in Outpatients, 84% of Pastoral patients felt their needs were 9
10 addressed while only 50% of those who expressed being Religious/Spiritual 10
11 felt their needs were addressed. With the inpatients, the numbers were 11
12 closer, with 88% of Pastoral and 77% of Spiritual feeling supported. 12

13 *Question 2: Are your family needs being supported?* 13

14 In Outpatients, many people felt that their families' needs were supported, 14
15 both from Pastoral (76%) and Religious/Spiritual (80%) patients. However, 15
16 with the Inpatient setting for both Pastoral and Religious/Spiritual patients 16
17 in this first survey, the numbers were lower than with the other groups, with 17
18 patients that were Pastoral at 66% and patients that were Religious/Spiritual 18
19 at 69%. 19

20 *Question 3: Were you aware of chaplaincy when you entered the hospital?* 20

21 The awareness of chaplaincy in Outpatients was low for both groups (23% 21
22 and 25%. Inpatient awareness was higher with Pastoral (55%) being lower 22
23 than Religious/Spiritual (69%). 23

24 *Question 4: Did you know how to contact chaplaincy during your time in* 24
25 *hospital?* 25

26 This was low in both Pastoral (23%) and Religious/Spiritual (33%) in Outpa- 26
27 tients while with Inpatients the numbers were Pastoral (55%) and Religious/ 27
28 Spiritual (46%). 28

1 *Question 5: Did you want to know more about chaplaincy?* 1
 2 For those in Outpatients, very few Pastoral (7%) patients wanted more infor- 2
 3 mation while 50% of Religious/Spiritual patients did. With inpatients, both 3
 4 Pastoral (11%) and Religious/Spiritual (15%) wanted more information. 4

5 **Results of the Second Evaluation** 5

6 Table 5 below shows the answers to the same evaluation questions, given 6
 7 after patients had received a spiritual visit. By this we mean that the patient 7
 8 had declared that they were a member of a religious or faith group and the 8
 9 visit they received included exploring their feelings. Some requested prayers 9
 10 be said. 10

11 **Table 5.** Patients Evaluated After a Spiritual Care Chaplaincy Visit 11

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

12 12
 13 After receiving spiritual care from a chaplain, more of the patients in Outpa- 13
 14 tients (73%) and Inpatients (83%) felt their spiritual needs were cared for, as 14
 15 were their families' needs. This contrasted with the Outpatients in the first 15
 16 evaluation, where only 50% felt their needs were being addressed, and the 16
 17 Inpatients in the first survey, where higher numbers (77%) felt their families' 17
 18 needs were being met. 18

19 Again, awareness of chaplaincy services, and thus the ability or knowl- 19
 20 edge of how to contact them, was lower (52% in Outpatients and 66% in 20
 21 Inpatients) than expected as the leaflets about chaplaincy are given to each 21
 22 patient. Outpatients had a very low knowledge (26%) of how to contact a 22
 23 chaplain. 23

24 About half of the patients (55% in Outpatients and 64% in Inpatients) 24
 25 wanted more chaplaincy visits. This was similar to Outpatients in the first 25
 26 evaluation (50%) but contrasted with Inpatients where only 15% had wanted 26
 27 more chaplaincy visits. 27

1 Discussion 1

2 This evaluation involved 95 people in two separate evaluations conducted 2
 3 over 10 weeks in two settings, Inpatient and Outpatient, to give an ini- 3
 4 tial estimate and comparison of spiritual needs. The selection criteria and 4
 5 approach after our introduction, showing the brief evaluation form from the 5
 6 start and asking whether they would be willing to participate in a very brief 6
 7 evaluation of these questions, resulted in a high response rate. 7

8 The majority of those with no spiritual affiliation reported their needs 8
 9 were met in a pastoral capacity. A majority of inpatients (77%) with spiritual 9
 10 needs reported their spiritual needs were being taken care of. However, only 10
 11 50% of those with spiritual needs in Outpatients felt their needs were met. 11
 12 This was the first time that they had chaplaincy visits. When this group had 12
 13 been offered a chaplaincy visit and then asked about their needs, this came 13
 14 at a similar level as the inpatients (73% Outpatient and 83% for Inpatients). 14
 15 Receiving chaplaincy services, even just this one time, seems to have served 15
 16 a need. All clinical interventions in hospitals are aimed at being brief and 16
 17 resulting in treating acute needs while making a patient feel cared for. This 17
 18 implies that even one visit is enough to make a patient feel valued, listened 18
 19 to or cared for. 19

20 Having spiritual needs met may affect recovery and well-being. Prompt 20
 21 discharge of patients is a high priority in the NHS. Koenig *et al.* (2001) 21
 22 found evidence for a positive link between a patient having spiritual or reli- 22
 23 gious beliefs and improved health. Marin *et al.* (2015) showed that patients 23
 24 who are visited by chaplains are generally more satisfied with their hospital 24
 25 stay. This indicates that chaplaincy provides a service for the patient and the 25
 26 hospital that improves patient outcomes. 26

27 This is a very busy tertiary hospital and the oncology areas are centres of 27
 28 excellence for the entire country. Chaplaincy staffing levels may not be ade- 28
 29 quate to meet the needs of patients, the transient nature of the outpatients 29
 30 and the turnover of the inpatients. While many were satisfied with the num- 30
 31 bers of chaplaincy visits, 50% of patients expressing spiritual affiliations in 31
 32 Outpatients said that they would like more Chaplaincy care. This may reflect 32
 33 the seriousness of their diagnosis, its effect on their lives and their need to 33
 34 come to terms with the consequences of this change. When the evaluation 34
 35 was completed, a number of them needed spiritual care to talk about their 35
 36 journeys and how they seemed to have lost themselves in being ill. 36

37 One finding that differed between groups was whether patients wanted 37
 38 more spiritual care. In Outpatients about 50% did in both evaluations. That 38
 39 patients in Outpatients wanted more spiritual than pastoral care could 39
 40 be due to a number of factors. These include factors such as having been 40

1 diagnosed more recently or having less contact with clinical staff outside of 1
2 the initial treatment moment and hence less interactions with carers. 2

3 With Inpatients, however, only 15% said they wanted more chaplaincy 3
4 services in the first evaluation while that number increased to 64% in the 4
5 second visit, after a chaplain had offered spiritual care. Perhaps inpatients 5
6 are used to having their own faith leaders visit and think this sufficient. 6
7 Being offered more may increase demand for more. If so this suggests that 7
8 there is a perceived value benefit of chaplaincy visits which is an area for 8
9 future studies. It may also be that the people in Outpatients who are reli- 9
10 gious, or observant, have their own ties to a community of worshippers or 10
11 faith groups and feel that this provides support, while the hospital chaplain 11
12 is less needed due to their hospital stay being of a short duration. 12

13 The timing of the evaluation may also affect the findings. For an inpatient 13
14 this evaluation may coincide with the only visit by a chaplain they receive 14
15 while in hospital, or it may be one of many if they are in hospital for many 15
16 weeks. For outpatients this was the first visit by a chaplain, but some of the 16
17 patients may have been attending chemotherapy over a number of weeks. 17
18 Chaplains are generally trained that clinical treatments may override all 18
19 other factors as the hospital has become focused on clinical care. Emotional 19
20 and spiritual needs may be thought of as secondary in all hospital settings 20
21 (Lake *et al.* 2016). 21

22 This timing may also be evident in the patient's response to their family's 22
23 needs being met. **While it we high for [AQ: please check meaning and 23**
24 **amend sentence]** the second evaluation, those having had a spiritual visit, 24
25 with the visit alone perhaps increasing feelings of well-being, the response 25
26 to the question on whether the family's needs were being met was quite low 26
27 for inpatients in the first evaluation of both Pastoral and Spiritual patients. 27
28 The patients in both groups may have been in for a while and they may not 28
29 have been sure how their families were coping or whether the families were 29
30 putting on a brave face in front of the patient. The patients might have been 30
31 anxious about their families on two counts: how the family was coping with- 31
32 out the patient, especially if the patient was previously working or caring for 32
33 the family, and worrying that the family was anxious about the patient. This 33
34 is an area that could be further addressed in chaplaincy visits, especially as 34
35 those who had chaplaincy visits had fewer concerns regarding their families. 35

36 The awareness of Chaplaincy services was very low in Outpatients for 36
37 both Spiritual and Pastoral in the first survey. This may be due to the patients 37
38 being overwhelmed with their diagnosis and not being able to process so 38
39 much information. Again, this increased in the second survey even though 39
40 it was the first time the patient had a chaplaincy visit in Outpatients. Having 40
41 the chaplaincy visit and then being asked about the awareness of chaplaincy 41

1 services, in this order, may remind people of what they had seen in the ini- 1
 2 tial induction to treatments in the hospital pack, giving them time to reflect 2
 3 on it. 3

4 Awareness of the availability of chaplaincy was over 50% with the inpa- 4
 5 tients. Patients' religious/spiritual beliefs is an optional question on the hos- 5
 6 pital forms and where they know they are going home and can access any 6
 7 other needs in their home environment. 7

8 This lack of awareness of chaplaincy services was echoed, as expected, in 8
 9 whether patients knew how to contact a chaplain. This may be low for the 9
 10 outpatients as they are not expecting to be in hospital long and do not make 10
 11 the same provisions as those expecting to stay as inpatients. They are only 11
 12 expecting to be in for the day and come with what they need for the day, 12
 13 such as food, drink and entertainment. When approached, most of them 13
 14 said they had some awareness of chaplaincy services in hospitals, but had 14
 15 not thought about it in their circumstances. 15

16 In this initial evaluation, no distinction was made in the time between 16
 17 diagnosis and treatment and whether this was the first round of treatment or 17
 18 much later rounds. Further work to distinguish this and relate it to spiritual 18
 19 needs would be of interest. 19

20 Being able to repeat the evaluation with larger numbers of patients 20
 21 may give greater reliability. For consistency, these results are all from one 21
 22 researcher but for reliability it would need to be repeated by other researchers. 22

23 A further study to gain more qualitative feedback is now underway as a 23
 24 patient evaluation of service. 24

25 **Conclusion** 25

26 This was the first time outpatients at this hospital had chaplaincy visits and 26
 27 this evaluation allowed the service to estimate the needs in this new clinical 27
 28 area. The measure was used to compare needs using the same evaluation 28
 29 tool on the same day with inpatients suffering from the same conditions. 29
 30 These findings suggest a need for chaplaincy to serve those with or with- 30
 31 out religious or spiritual beliefs in a health care environment, caring for the 31
 32 whole person. 32

33 These preliminary results point to a need in Outpatient areas for chap- 33
 34 laincy visits which have, up until now, been restricted to Inpatients wards. 34
 35 Of the 1.5 million workforce of the NHS, chaplains account for 500 full 35
 36 time equivalents and make one million visits (NHS Statistics 2011). Given 36
 37 the aim for patient-centred care and the chaplain's expertise in this area, 37
 38 increasing chaplaincy services may indicate a cost effective way to enhance 38
 39 patient outcomes, which this evaluation helps to establish. 39

1 Chaplains are professionals, trained to be alongside the patient in times 1
 2 of crisis. While outpatients are only in the hospital for a few hours per week 2
 3 and can return to their own support network, these networks are not always 3
 4 available and may be burdened with other needs. Outpatients in oncology 4
 5 are facing difficult life journeys, sometimes facing palliative treatments, and 5
 6 a trained professional offering holistic care may help to improve the quality 6
 7 of life of those in crisis. 7

8 **References** 8

9 Adlington, K., and J. White (2015) *NHS: Our Declaration: Person-centred Care for Long-term* 9
 10 *Conditions*. Publications Gateway Reference 03960 [https://www.england.nhs.uk/category/](https://www.england.nhs.uk/category/publications/)
 11 <https://tinyurl.com/y7glqx6f> (last accessed 7 December 2016). 10
 12 Bodde, R. (2008) "Towards Benchmarking in Health Care Chaplaincy and Pastoral Care in 11
 13 Australia". *Australian Journal of Pastoral Care and Health* 2 (2): 1–13. 12
 14 Bulsara, C., A. M. Ward and D. Joske (2005) "Patient Perceptions of the GP Role in Cancer 13
 15 Management". *Australian Family Physician* 34(4): 299–302. 14
 16 Darzi, A. (2008) *High Quality Care for All: NHS Next Stage Review Final Report*. Vol. 7432. 15
 17 London: Her Majesty's Stationery Office, 16
 18 Fraser, D. J. (2004) "Clarity and Cost Effectiveness in Chaplaincy". *Scottish Journal of Health-* 17
 19 *care Chaplaincy* 7(1). 18
 20 Hausmann, E. (2004) "Chaplain Contacts Improve Treatment Outcomes in Residential Treat- 19
 21 ment Programs for Delinquent Adolescents". *Journal of Pastoral Care and Counseling* 20
 22 58(3): 215–24. <https://doi.org/10.1177/154230500405800306> 21
 23 Health Research Authority (HRA) UK (2013) *Defining Research*. NHS Publications. UK. 22
 24 www.hra.nhs.uk. Last accessed 6 December 2016. 23
 25 NHS Statistics (2011) <https://tinyurl.com/ycct8w9d> 24
 26 Jankowski K. R. B., G. F. Handzo and K. J. Flannelly (2011) "Testing the Efficacy of Chaplaincy 25
 27 Care". *Journal of Health Care Chaplaincy* 17: 3–4, 100–25. [https://doi.org/10.1080/088547](https://doi.org/10.1080/08854726.2011.616166)
 28 26.2011.616166 26
 29 Koenig H. G., D. King and V. B. Carson (2001) *Handbook of Religion and Health*. Oxford: 27
 30 Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195118667.001.0001> 28
 31 Lake E. T., H. D. Germack and M. K. Viscardi (2016) "Missed Nursing Care is Linked to 29
 32 Patient Satisfaction: a Cross-sectional Study of US Hospitals". *BMJ Quality and Safety* 25: 30
 33 535–43. <https://doi.org/10.1136/bmjqs-2015-003961> 31
 34 Lehair, X. (2005) "Reflection on An Evaluation: Healthcare Professionals' Views of Spiritual 32
 35 Care". *Scottish Journal of Healthcare Chaplaincy* 8 (1): 23–26. 33
 36 Leydon, G. M., M. Boulton, C. Moynihan., A. Jones., J. Mossman., M. Boudini and K. McPherson 34
 37 (2000) "Cancer Patients' Information Needs and Information Seeking Behaviour: 35
 38 Indepth Interview Study". *BMJ* 320: 909–13. <https://doi.org/10.1136/bmj.320.7239.909> 36
 39 Leydon, G. M., J. Bynoe-Sutherland and M. P. Coleman (2003) "The Journey Towards a 37
 40 Cancer Diagnosis: the Experiences of People with Cancer, Their Family and Carers". *Euro-* 38
 41 *pean Journal of Cancer Care* 12(4) 317–26. [https://doi.org/10.1046/j.1365-2354.2003.00](https://doi.org/10.1046/j.1365-2354.2003.00418.x)
 42 418.x 39
 43 Marin D. B., V. Sharma, E. Sosunov, N. Egorova, R. Goldstein and G. F. Handzo (2015) "Rela- 40
 44 tionship Between Chaplain Visits and Patient Satisfaction". *Journal of Health Care Chap-* 41
 45 *laincy* 21(1): 14–24. <https://doi.org/10.1080/08854726.2014.981417> 42

- 1 Oates, J., W. W. Weston and J. Jordan (2000) "The Impact of Patient-centred Care on Out- 1
2 comes". *Family Practice* 49(9): 796–804. 2
- 3 Sundar, S. (2015) "New Law on Consent Will Overload Seriously Ill Patients". *BMJ* 350: 1787. 3
4 <https://doi.org/10.1136/bmj.h1787> 4
- 5 Swift, C. (2015) *NHS Chaplaincy Guidelines: Promoting Excellence in Pastoral, Spiritual and 5
6 Religious Care*. London: NHS England. 6
- 7 UK Board of Healthcare Chaplaincy (2009) *Self-Assessment/Evaluation Tool*. Cambridge: UK 7
8 Board of Healthcare Chaplaincy. 8
- 9 UK Government (2010) *Equality Act*. London: Her Majesty's Stationary Office. 9