

**CONSULTATIVE PROPOSALS
FOR A MINIMUM DATA SET
FOR SPIRITUAL HEALTHCARE**

The paper has been drafted to form part of the guidance to chaplains associated with the Caring for the Spirit strategy. This is guidance and, at this stage, consultative. When comments have been received and digested, a final paper will be published setting out decisions about data issues to inform future development. Comments on all parts of this paper are welcomed by the project team.

Abstract

Historically, healthcare chaplains have not been required to record activity to the same extent as other health care professionals. There is often a deep suspicion of identifying religious, spiritual or pastoral activity in the form of numbers, or quantifying them in data sets.

Spiritual healthcare, and the benefits to physical and emotional health are briefly touched upon in medical and nursing training but, in practice, this aspect of health care is often marginalized. This has led to a void in data collection about this aspect of care from all providers.

Data collection is essential for effective management; assessment of appropriate resourcing of what has traditionally been an under funded service; assessment of the effectiveness of service and value for money; and conformity to legal requirements as in the Working Time Directive. This paper suggests a starting point from which a more comprehensive data collection could be developed.

The paper¹ is in four parts: first, concerned with a medium data set as developed in Bolton; second, with proposals for a strict minimum data set for every chaplain; third, with the need to define spiritual healthcare in more detail; and, fourth, with the need to define a spiritual episode.

The paper itself has been drafted to form part of the guidance to chaplains associated with the Caring for the Spirit strategy. This is guidance and, at this stage, consultative. When comments have been received and digested, a final paper will be published setting out decisions about data issues to inform future development.

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Part 1: Proposals for a Medium Data Set for Spiritual Healthcare

Preamble

1. In common with many caring services arising from a religious background, healthcare chaplaincy has not historically been used to recording activity in the same way as the public sector professionals. There has often been a deep suspicion of identifying religious, spiritual or pastoral activity in the form of numbers, or quantifying them in data sets. Similarly, although the spiritual aspects of health care, and the benefits to physical and emotional health are briefly touched upon in medical and nursing training, in practice this aspect of health care is often marginalised in the actual care of patients or clients.
2. This has led to a void in data collection about this aspect of care, both within spiritual health care providers and within the nursing and medical health care providers. However, the necessity for data collection is inherent in the Orchard Report², chaplaincy occupational standards³ and the NAHAT document⁴
3. It is essential in the health care setting that the activity of all care givers should be monitored:
 - to conform to appropriate legal requirements;
 - to formulate, establish and maintain good standards of care;
 - To generate examples of Good Practice and communicate them to others;
 - To establish best use of resources;
 - To provide value for money;
 - To establish an agenda for research into improving the type and focus of care; and
 - To evaluate service delivery.
4. It is not clear that all Chaplaincies collect any data on activity, and few of those who do collect data do so in the same way. If a Minimum Data Set is to have any relevance at a national level, or to be accepted by Chaplains, the same type of data must be collected in the same way in all healthcare settings. There needs to be reporting mechanisms through departmental, directorate, Trust and national levels, and the data collected must be linked to possible change and development at all levels in order to promote spiritual healthcare.

²Orchard H. (2000); Hospital Chaplaincy: Modern, Dependable; Sheffield Academic Press Limited, Sheffield; ISBN 1 84127 215 9

³ College of Health Care Chaplains, Free Church Hospitals Chaplaincy Board, Hospital Chaplaincies Council, Roman Catholic Hospital Chaplaincies (1993) Health Care Chaplaincy Standards: National Health Service Training Directorate, Bristol; ISBN 1 85446 164 8

⁴ National Association of Health Authorities & Trusts (1996) Spiritual Care in the NHS – A guide for purchasers and providers; NAHAT, Birmingham; ISBN 1 85947 048 3

- Chaplains are unlikely to be convinced of the necessity of data collection if they do not see practical steps being taken to remedy what is generally recognised to be an under-resourced service, or that this data collection will improve the service they provide.

Suggested Medium Data Set (see also Part 2 for minimum data set)

- Since most Chaplaincies operate in distinctly different ways, and with different priorities depending on the culture of the Trust and the catchment areas from which they draw, the initial collection of data must be the minimum required for meaningful application. While these are suggested datum points, in reality, each of these can be subdivided by each hospital or department to provide relevant information for spiritual healthcare development or resource management in the particular environment and culture in which they function.
- This should be seen only as a first step in data collection, developing gradually into a form tailored to provide evidence for improving standards, good practice and improvement of patient and staff spiritual health care. Such data should have local application, but national influence through NHS channels.

The following are suggested:

	Data Collected	How defined	Relevance
1	Contracted hours per week	Contracts	Working Time Directive
2	Hours > contracted hours	Monthly records	Working Time Directive
3	Hours on Call	Definition of on-call period	Working Time Directive
4	Number & frequency of callouts	Definition of callouts	Working time Directive
5	Referrals	All referrals	Profile of Chaplaincy
6	Source of referrals	Define Sources	Accessibility and lines of communication
7	Religious Activity	Defined religious activity	Type/focus of work
8	Spiritual Activity	Defined spiritual activity	Type/focus of work
9	Pastoral Activity	Defined pastoral activity	Type/focus of work
10	Significant Spiritual healthcare Episodes	Defined Spiritual Healthcare Episodes	Demand for Service
11	Directorate, Corporate, Regional, Networking or National meetings	Total hours spent in each type of meeting and preparation	Input into extra-departmental areas
12	Education	Total hours preparing and delivering Education	Spiritual and cultural awareness issues
13	Actual Establishment	W/T Equivalents	Resource/HR Issues
14	Vacant posts	W/T Equivalents	Resource/HR Issues
15	Recommended Establishment	W/T Equivalents	Resource HR issues
16	% allocation of specific denominational/faith chaplains against local religion population	% Hours per week per denomination/faith chaplain against local religion population	Resource Issues Meeting the needs of local communities

Some of these would require to be collected weekly or monthly, others on an annual basis.

Rationale for specific data collections

1 - 4 Contracted hours per week – Number and frequency of callouts

8. Employers have a responsibility to implement the provisions of the Working Time Regulations, and the Health and Safety at Work Act, including hours of work and appropriate rest time between work periods. The number of contracted hours, coupled with time worked over and above contracted hours, hours on call and callouts, give a way of monitoring activity with respect to this legislation, the demands on the service, resource management and service pressures.
9. While individual details might only be appropriate for attention by the Chaplaincy Department, compilations of data might be appropriate for communication through line management to the trust.

5 - 6 Referrals and sources

10. Collection of number of referrals through structured or unstructured channels within the hospital/ healthcare setting or from outside provides an indicator of the level of knowledge of spiritual healthcare within the community and hospital, and the ease with which the service can be accessed. While some Chaplaincies work almost completely on a formal referral system in response to their interpretation of the Data Protection Act, others have a more informal system where referrals might come from a multitude of sources. It is suggested that all referrals of patients or staff be recorded. Such collection was envisaged by the Orchard report.
11. At Bolton Hospitals NHS Trust this collection has been successfully accomplished under five subsections; Referrals from – the patient themselves, relatives/friends of a patient, members of staff, local religious authority figures, or internally within the department from contacts made during ward visiting⁵. While this division of sources gives an indication of where communication development is needed for departmental educational programmes, a more general data collection gives an indication of the profile which chaplaincy has within the particular health care setting, and the channels to access the service.

7 – 9 Religious, Spiritual & Pastoral Activity (see also Part 3 for discussion)

12. While documents in the DoH frequently refer to religious care as a catch-all phrase to encompass all types of care of this nature, the word 'religion' has a very narrowly defined focus, which is being rapidly eroded in our present day society. More and more people are indicating that they have a spiritual belief system, which does not use the forms demonstrated in the various world faiths. This often uses the concepts of self-worth, self-identity within a complex web of inter-relationships, purpose in life etc. The formal prayers or activities associated with formal religion have no place in their conceptual systems. Such persons often have well-developed spiritual belief systems, and still exhibit need.

⁵ Gray NK (Sept. 2003) Numerology: A way of approaching Clinical Governance. The Journal of Health Care Chaplaincy Volume 4 No.1 pp 4-11.

13. There is some indication in newspaper comment that while formal expressions of religion are reducing, there is a greater understanding of non-formal spirituality and the needs associated with it. Data collection for defined religious activities such as attendance at various types of religious service is quite easy to accomplish. Data collection for the two other aspects of spiritual and pastoral health care is more difficult.
14. In the Bolton Spiritual Care Pathway, Spiritual need is defined as being when a patient or member of staff exhibits spiritual pain or distress such as:-
- Anger directed at God or other people
 - Bitterness: What have I done to deserve this?
 - Regret: I should have been a better person!
 - Guilt/punishment: I must have done something wrong!
 - Doubt: Is there really a God, really a purpose for existence?
 - Fear: I am not sure there is anything after death
 - Isolation: My family/neighbors, friends/God etc. have abandoned me.
 - Loss of hope: I see no future/ a negative future stretching endlessly ahead.
15. Also included in the definition of spiritual need are the patient or member of staff who appears to be on a life search/search involving:-
- Questions on the meaning of life
 - Personal identity
 - Loss of identity
 - Loss of role
 - Loss of independence
 - Search for something 'greater than' themselves or God.
 - Search for purpose in suffering
16. Pastoral Care is defined as those aspects of patient or staff care dealing with practical problems and their resolution. Advocacy of all types could fall within this category. This may or may not involve liaison with other disciplines or individuals.
17. These criteria could provide a useful basis from which to start data collection, particularly in those hospitals where little or no chaplaincy data collection has been previously made. The complexity of data could develop over time across the NHS as information relevant to the national development is required.
18. Collection of data under these three headings means that changing trends in the type of care required can be identified, and resources deployed accordingly. This type of data may influence the suggestion by South Yorkshire Workforce Development Confederation about the training and employment of chaplains⁶, and the type of training that existing Chaplains need to access in order to provide a relevant service within the health care environment.

⁶ Caring for the Spirit: A strategy for the chaplaincy and spiritual healthcare workforce; South Yorkshire WDC; November 2003; Paras 27-30

19. The development of spirituality appears to be away from formalized religion, and while faith bodies external to spiritual healthcare have a valuable place to fulfill, it must be recognized that the majority of spiritual health care need comes from outside their area of influence. It is not appropriate, therefore, to simply collect data on the denomination or faith of health care users. It is important to ascertain the type of care required, regardless of the faith group to which the person belongs. As with the next section, this could be seen as an important assessment as part of The Essence Of Care from the DoH⁷.

10 - Significant Spiritual healthcare episodes (see Part 4 for further discussion)

20. All professions within the NHS have some means of recording the number of face-to spiritual healthcare episodes as a measure of activity. Since almost all are also using a formal referral or appointment system data capture of this nature is relatively simple.

21. Most Chaplaincies do not work on this basis, there are many chance spiritual healthcare episodes, and care may be given to patients and staff outside the formal setting. It therefore becomes more difficult to determine what constitutes a spiritual healthcare episode and what does not. With members of staff, in particular, the lines of distinction may become blurred of necessity from the type of work undertaken. When, for example, does the help of a friend stop, and professional assistance begin?

22. The phrase face-to-face spiritual healthcare episode is not appropriate in this situation, and the term “spiritual healthcare episode” is recommended instead⁸. While a Chaplain may have many face-to-face contacts in a day, only a proportion of them will be therapeutically significant⁹. Indicators are required in order to assess meaningfully and consistently whether a spiritual healthcare episode has been truly significant¹⁰.

23. The following indicators have been piloted for two years at Bolton Hospitals NHS Trust, and have been found to be useful in deciding what is likely to be significant, and what is not.

- All Callouts initiated during the on-call periods.
- All callouts from the normal visiting program.
- All visits originating from a referral external to the department e.g. patient, relative, spiritual authorities or staff referral.
- All visits involving sacraments or other religious rites.
- All visits involving prayer.
- All visits where the client cries, shares spiritual pain, shares concern about a life-search/search for meaning, gives sincere expressions of thanks for the visit.
- All visits requiring further action by the Team Member.
 - To other internal staff.
 - To outside persons or agencies.
 - Advocacy
- All requests by individual staff for specialist knowledge.

⁷ The Essence of Care – patient-focused benchmarking for healthcare practitioners; NHS Modernisation Agency, Richmond House, 79 Whitehall, London, SW1A 2NS; 1003

⁸ The project team determined that the word episode was a better term in this instance.

⁹ Significance is discussed further in paragraphs 55-59

¹⁰ Gray NK (Dec. 2003) Significant Episodes Numerology. The Journal of Health Care Chaplaincy Volume 4 No.2 pp 54-61

24. While these criteria were used to determine what constituted a significant spiritual healthcare episode, these details were not recorded as part of the data capture. Instead, names, wards, date, time, duration, type of input (religious, spiritual or pastoral) and recurrence of input were recorded. This data, collected on a simple database, is extremely useful, but as a first step it should be possible to simply collect the number of people, dealt with each day, that fall into these criteria. The criteria used for deciding whether or not a spiritual healthcare episode is significant can also inform the decision as to whether the type of input is religious, spiritual or pastoral.

11 - Directorate, Corporate, Regional, Networking or National Meetings

25. Spiritual healthcare is not simply about providing religious or spiritual care directly to patients. There is an equally important role in communicating spiritual values, and awareness of need to all levels of the NHS. While the faith bodies may have excellent lines of communication to the DoH, with direct input there, in practice, the awareness of spiritual need needs to be constantly renewed at all levels within the organization. Important too is the integration of spiritual care services with all other service providers across all levels to provide the most effective and efficient service for the patient. The number of hours spent in this activity on an annual basis is a basic indicator of activity.

12 – Education

26. Raising the awareness of staff within the hospital system, and communities outside the hospital itself makes the chaplaincy more effective, and more responsive to the needs of the local community. The number of hours spent in preparation, delivery and follow-up on educational subjects gives an indicator of the level of activity given by Chaplains to raise the profile of spiritual healthcare and to teaching staff and others about it.

13 – 15 Actual Establishment, Vacancies and Recommended Establishment

27. This data provides evidence for resource allocation within the department, cost and other pressures on the service. It may also contribute to the evidence for Human Resource issues, and the Working Time Directive. Under Agenda for Change this data will give evidence of recruitment difficulties and the subsequent need for consideration of the level of necessary Recruitment and Retention Allowance. Establishment may be estimated using the Department of Health policy guidance annex¹¹.
28. Although this assessment tool is crude, and omits large portions of chaplaincy function, it may have to be used until such time as a more realistic tool for the assessment of a chaplain's work is developed. Comparison between this envisaged level of care, and the real level of staffing and resources provided for this work will give an insight into the pressures on the Chaplaincy service, and the individuals within that service.

¹¹ Department of Health; 2003 NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff; Guidance for Managers and those involved in the provision of chaplaincy –spiritual care;.

16 - % allocation of specific denominational/faith chaplains against local religious populations

29. Within Chaplaincy there has been a preponderance of Anglicans occupying whole-time and part-time posts. There are historic factors which brought the present circumstances into being. Over recent years the assumption that Anglicans should have the major role has been challenged by the understanding that all faith communities should be represented within chaplaincy, where numbers indicate, and that suitable links for support of individuals who belong to very small faith communities in any one area should be established.
30. That proportion of a Chaplaincy Manager's role which is pure management should be assessed, and the remainder used as part of the calculation to establish the proportion of Chaplaincy funded time allocated to each denomination or faith group. The hours assessed as pure management are not bound to any particular faith or denomination, and should not therefore be used within formulae to establish proportionality between faith groups or denominations.
31. The total number of funded sessions (other than management) should be compared with the ratio of denominations, faiths and cultures in the catchment areas, and adjustments made to bring the two into line when vacancies occur. There should be no automatic filling of a post by a person of the same denomination or faith group if there is a mismatch between the proportions in Chaplaincy and the proportions in the catchment area.
32. Ongoing assessment of this area of data capture will lead to the Chaplaincy being more responsive to the needs of the local community.

Data Capture Issues

33. Much of this information will be readily available in the Trust, but will need to be collated in one place. Contracted hours, real establishment and recommended establishment are unlikely to change over the year except where a proven business case has been funded, and will, therefore require minimal effort to record
34. The number of referrals, overtime, on-call time, callouts and significant spiritual healthcare episodes will give insight into workload. In Agenda for Change this data would need to be recorded in order to attract proposed payment for anyone providing on-call, callout or unsocial hours working (e.g. Sunday). Establishment, vacancies, recommended establishment and proportions of denominational and faith chaplains gives insight into potential demand.
35. All data can be held within Trust systems where these permit, or on simple spreadsheet or databases within stand-alone computers. The method of data input – by a single person or by each chaplain inputting their own data will depend upon the resources of the department. The data should, however, be arranged in such a way that summaries of activity can be readily available, and should be distributed to appropriate persons as required.

36. Although much of this information will be useful within each hospital or Trust for assessment, resource management and service development, there needs to be some ownership of this data at some higher level within the NHS. Since the NHS provides guidance in the form of the policy guidance document, and endorses the SYWDC workforce strategy, there also needs to be some feedback to those levels of management about the real nature and state of spiritual healthcare at the local level, so that development opportunities may be pursued.
37. Historically, there has been suspicion about data collection among Chaplains, and in the communities from which they originate (religious, spiritual and cultural), about measuring that which they regard as not measurable (God's activity). There will be a great need for education on this topic throughout Chaplaincy, and possibly some mandatory instruction through the NHS before national compliance can be expected.

Part 2: What do we mean by Minimum Data Set?

38. Part 1 of this paper has set out a medium data set which has developed over several years within the Bolton Hospitals. Apart from the interest shown within the spiritual healthcare team, there has been a long history of testing and evaluating proposals which are now seen as mature. Not every chaplaincy can simply adopt these proposals but all should make a start. That is the purpose of this section.
39. The majority of healthcare chaplains are part-time workers in the NHS and have an equal or even larger commitment to another service or employer. There is some evidence¹² that part-time chaplains whose major commitment is elsewhere also put their effort into data issues there and that the NHS does not always resource these chaplains with offices, personal computers or access to intranets etc. For this reason, the minimum data set assumes that no IT support is available.
40. The minimum data set is that which every chaplain should be able to collect. It is collected during the working day as one would a diary entry and collated into a weekly summary. That collation should take no more than one hour each week.
41. There is a discussion to be had about definitions of data and this paper has sections concerned with both defining spiritual healthcare and spiritual healthcare episodes. In addition, the Department of Health has developed a national dataset which covers workforce data but it has not yet been possible to incorporate these items in this paper¹³. The paper will be updated with agreed definitions when these have been clarified.
42. The minimum data set does not differentiate between aspects of spiritual healthcare but sees meetings and education activity as important components of activity undertaken by chaplains which should be differentiated from significant (spiritual) spiritual healthcare episodes. The duration of these activities needs to be captured.
43. For each day's activity, data about the number and duration of spiritual healthcare episodes needs to be collected. Whether these take place in or out of normal hours is important and whether one is dealing with individuals or with collective spiritual healthcare episodes also matters. The need to differentiate one's time between providing spiritual healthcare or being involved in educating others or dealing with office work is important both personally and for the Trust.
44. An additional and important data item is the origin of referrals to the chaplaincy service. This data enables the referral system to be monitored and areas of pressure within the healthcare service to be identified and the service re-profiled accordingly. A table of origin of referrals against month should enable patterns to be identified.

¹² Survey of Chaplaincies, South Yorkshire WDC, 2003

¹³ National Workforce Dataset v 1.0; Department of Health; October 2003

45. The collection sheet for activity would look something like this and the intention would be to total these daily figures each week and then for the year.

DAILY SUMMARY OF (SPIRITUAL HEALTHCARE) SPIRITUAL HEALTHCARE EPISODES	Normal working hours				Out of hours			
	Individual		Collective		Individual		Collective	
	Number	Duration	Number	Duration	Number	Duration	Number	Duration
Spiritual Healthcare								
Education activity								
Meetings/ Office work								

46. The collection sheet for the origin of referrals would look something like this. The intention would be to total these figures for each week and then for the year.

DAILY SUMMARY OF (SPIRITUAL HEALTHCARE) REFERRALS	Normal working hours	Out of hours
Ward A etc referral		
Clinic B etc referral		
Special Unit C etc referral		
Patient/ Carer referral		
Referral from community Ministers etc		
Other sources of referral		
Etc		
Etc		

Part 3: Defining Spiritual Healthcare

47. There is no readily agreed definition of spiritual healthcare other than that it comprises spiritual, religious and pastoral care. This part of the paper suggests definitions which could be used as the basis for data collection and analysis. They do not necessarily have to be everyone's ideal but do need to be robust enough to enable consistency of data collection and its analysis.
48. Spiritual care is defined as being provided when a patient or member of staff or visitor exhibits spiritual pain or distress such as:-
- Anger directed at God or other people
 - Bitterness: What have I done to deserve this?
 - Regret: I should have been a better person!
 - Guilt/punishment: I must have done something wrong!
 - Doubt: Is there really a God, really a purpose for existence?
 - Fear: I am not sure there is anything after death
 - Isolation: My family/neighbors, friends/God etc. have abandoned me.
 - Loss of hope: I see no future/ a negative future stretching endlessly ahead.
49. Also included in the definition of spiritual need are the patient or member of staff who appears to be on a life search/search involving:-
- Questions on the meaning of life
 - Personal identity
 - Loss of identity
 - Loss of role
 - Loss of independence
 - Search for something 'greater than' themselves or God.
 - Search for purpose in suffering
50. Pastoral care is defined as being provided when a patient or member of staff or visitor needs support and care to meet personal and emotional challenges. This care includes the giving of time, attention and respect to whatever the patient or user presents as well as dealing with practical problems and their resolution. Advocacy of all types could fall within this category. This may or may not involve liaison with other disciplines or individuals.
51. Religious care is defined as being provided when a patient or member of staff or visitor receives one of the accepted rites or rituals of a faith community.
52. Comments are welcomed

Part 4: Defining a spiritual healthcare episode

Title

53. All professions within the NHS have some means of recording the number of face-to-face spiritual healthcare episodes as a measure of activity. The consultant spiritual healthcare episode is an example. Since almost all are also using a formal referral or appointment system data capture of this nature is relatively simple.
54. The phrase face-to-face spiritual healthcare episode is not appropriate in this situation, and the term “spiritual healthcare episode” is recommended instead. While a Chaplain may have many face-to-face contacts in a day, only a proportion of them will be therapeutically significant. Indicators are required in order to assess meaningfully and consistently whether a spiritual healthcare episode has been truly significant.
55. The phrase face-to-face spiritual healthcare episode is not appropriate in this situation, and the term “spiritual healthcare episode” is recommended instead.

Significance

56. While a Chaplain may have many face-to-face spiritual healthcare episodes in a day, only a proportion of them will be of obvious significance. Again, it is often not possible to gauge whether a spiritual healthcare episode has been truly significant, as that may only emerge after a considerable period of time, and after the individual has left the care of the Chaplaincy Department. Indicators that the spiritual healthcare episode may have significance are required, in order that the data captured has some meaning and not all chance meetings are captured. (Gray NK 2004)
57. The following indicators have been piloted for two years at Bolton Hospitals NHS Trust, and have been found to be useful in deciding what is likely to be significant, and what is not.
 - All callouts initiated during the on-call periods.
 - All callouts from the normal visiting program.
 - All visits originating from a referral originating external to the department e.g. self, relative, spiritual authorities or staff referral.
 - All visits involving sacraments or other religious rites.
 - All visits involving prayer.
 - All visits where the client makes significant gestures.
 - Crying (where this is not a usual part of the illness).
 - Sharing of spiritual pain e.g. worries, anger, loss of role, identity etc
 - Sharing concerns about a life-search/search for meaning.
 - Giving sincere expressions of thanks for the visit.
 - All visits requiring further action by the Team Member.
 - To other internal staff.
 - To outside persons or agencies.
 - Advocacy
 - All requests by individual staff for specialist knowledge.

Individual and collective spiritual healthcare episodes

58. The point needs to be made that there is a difference between meeting individuals and meeting groups or gatherings of people. It is not the intention to count all spiritual healthcare episodes as individual as to do so would not acknowledge the variety of skills necessary in dealing with groups and meetings, to say nothing of leading rituals which involve several gathered together.
59. Individual spiritual healthcare episodes are taken to be those which are intended to focus on the care of only one person. Thus a meeting with an individual patient in the presence of their carer would be an individual spiritual healthcare episode. A meeting with the patient and the carer would be collective.
60. Collective spiritual healthcare episodes are those planned to affect more than one client/ user. Acts of worship, organised rituals, debriefing meetings would be regarded as collective.

New and continuing spiritual healthcare episodes

61. There are often distinctions made between the initial spiritual healthcare episode and the follow-up spiritual healthcare episode. This is based on the assumption that the first time takes longer and is more intense because of history taking and familiarity gaining. The follow-up is then simple and less resource intense. The alternative view may be that the depth of trust developed during the initial assessment spiritual healthcare episode may lead to longer, more intense and deeper spiritual healthcare spiritual healthcare episodes in follow-up meetings.
62. Such distinctions have not been suggested (yet) for spiritual healthcare. For the purposes of this paper and the current discussion, new and continuing spiritual healthcare episodes are taken as being the same.
63. Comments on all the above points are welcomed

Conclusions

64. A minimum data set is required at a national level if religious, spiritual and pastoral care is to be evaluated across the NHS, and for the best use to be made of resources, level of provision and service development are to be identified. The data suggested for capture in this document has practical application at all levels, but should only be regarded as an initial step to establish the principle. Ongoing research is required to continually update the relevant data for capture in order to inform the future development of spiritual health care across the NHS.
65. Part 1 of this paper has described progress with data collection and analysis at the Bolton Hospitals without the benefit of a national system. This is a medium data set and demonstrates groundbreaking progress which has been essential for the advancement of information about spiritual healthcare.
66. Part 2 of this paper steps back from the medium database to suggest what a single-handed chaplain needs to collect as data. All chaplains need to make this step and to begin both to examine the data collected by themselves and then to widen their enquiry with colleagues. In due course, collection and analysis of this data can be automated and the data items extended. For now, the minimum is essential and practical.
67. Parts 3 and 4 suggest definitions for data items concerned with spiritual healthcare (religious, spiritual and pastoral care) and for spiritual healthcare episodes. However woolly these sections appear, some measure of agreement is now necessary to ensure consistency.
68. The paper itself has been drafted to form part of the guidance to chaplains associated with the Caring for the Spirit strategy. This is guidance and, at this stage, consultative. When comments have been received and digested, a final paper will be published setting out decisions about data issues to inform future development.

Caring for the Spirit Project Team

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