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How are Chaplaincy Departments Responding Amidst the COVID-19 Pandemic? A Snapshot of UK Responses to a Questionnaire

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Abstract: This is a brief reflection on how chaplaincy in the United Kingdom is responding "on the ground" to COVID-19. It is based on a short questionnaire responded to by 27 chaplaincy teams, who were providing ministry during COVID-19, in April 2020. It notes significant changes in practice and captures some variation and similarities in chaplaincy experiences. It also highlights emerging concerns with respect to chaplaincy practice that may require additional research in the future.

Keywords: COVID-19, chaplaincy, spiritual care, pastoral care

Resumen (Español): ¿Cómo están respondiendo funcionalmente los Departamentos de Capellanía en medio de la pandemia por el Covid19? Una instantánea de las respuestas del Reino Unido a un cuestionario. Esta es una breve reflexión sobre cómo la capellanía en el Reino Unido está respondiendo "sobre el terreno (in situ)" contra COVID-19. El artículo se basa en un breve cuestionario respondido por 27 equipos de capellanía, que estaban prestando ministerio durante el COVID-19, en abril del corriente año (2020). Señala cambios significativos en la práctica, y captura cierta variedad y similitudes de experiencias. También destaca preocupaciones emergentes, con respecto a la práctica de capellanía, que pueden requerir investigación adicional en el futuro.

Palabras clave: COVID-19, capellanía, cuidado espiritual, cuidado pastoral

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Résumé (Français): Comment les aumôneries répondent-elles au coeur de la pandémie de covid-19? Aperçu des retours à un questionnaire d'enquête réalisée au Royaume Uni. Il s'agit d'une brève réflexion sur la manière dont, au Royaume Uni, l'aumônerie répond "sur le terrain" à la crise de la COVID-19. À la base, un court questionnaire auquel ont répondu 27 équipes d'aumônerie en fonction pendant le mois d'avril 2020. L'enquête révèle des changements significatifs au niveau des pratiques et met en évidence à la fois une diversité et des similitudes dans les expériences que rapportent les aumôniers. Des préoccupations nouvelles en lien avec les pratiques d'aumônerie ressortent aussi de ce travail, qui pourraient justifier des recherches supplémentaires dans le futur.

Mots clés: COVID-19, aumônerie, accompagnement spirituel, accompagnement pastoral

Zusammenfassung (Deutsch): Wie reagieren die Krankenhausseelsorge-Einrichtungen auf die COVID-19 Pandemie? Eine Momentaufnahme von Reaktionen im Vereinigten Königreich mittels eines Fragebogens. Dies ist eine kurze Reflexion, wie Krankenhausseelsorge in Großbritannien auf Grund von COVID-19 reagierte. Diese Reflexion basiert auf einem kurzen Fragebogen, der von 27 Seelsorgeteams, die in dieser Zeit der Pandemie, im April 2020, im Einsatz waren. Sie zeigt eindeutige Veränderungen der Seelsorgepraxis, sowie auch Unterschiede und Ähnlichkeiten in den gemachten Erfahrungen. Es wurde deutlich, welche ganz neue Herausforderungen und Anliegen der seelsorglichen Tätigkeit in Zukunft weiter erforscht werden sollten.

Schlüsselworte: COVID-19, Krankenhausseelsorge, Spiritual Care, Seelsorge

Introduction

COVID-19 is having a significant impact on the UK health service. By April 30, there were approximately 4,419 deaths in the United Kingdom, with seemingly no end in sight. Similar to other chaplaincy services around the world (as noted in this issue; e.g., Bramstedt, 2020; Drummond & Carey, 2020; Wierstra, Jacobs & Schuhmann, 2020), it is important to consider how chaplaincy personnel in the United Kingdom initially responded "on the ground" to COVID-19. This brief reflection is based on a short questionnaire completed by 27 chaplaincy teams in April 2020. It notes significant changes in practice and captures a range of experiences – some varying, others similar. It highlights chaplaincy practice and emerging concerns that may require research in the future.

Purpose

The purpose of the survey was to enable us to assess how chaplains had been affected functionally during the first few weeks of the COVID-19 pandemic.

Method

A 12-point questionnaire was sent out via JiscMail[3] asking for a snapshot of how things were working on the ground. A JiscMail forum, "Chaplaincy-Spirituality-Health," was established in 1999 as "a network for chaplains, educationalists and researchers to share information on education, training and research requirements and provision" (JiscMail, 1999). It has in recent years allowed broader sharing of "best practice" and an exploration of any questions across the UK chaplaincy community. During the COVID-19 outbreak, JiscMail has recorded an increased amount of communication. In overall terms, the questionnaire sent out via JiscMail was considered to be an ideal medium for seeking a "snapshot" of how things were working on the ground within UK chaplaincy settings. The questionnaire was deliberately simple and open. It was not intended to be formal research, but rather a rapid cross-sectional qualitative exploratory and descriptive assessment, to gain a quick overview from existing freely consenting subscribers, who were under no obligation to complete the survey. While it was possible to gain some quantitative results from the questionnaire, the responses sought and thematically analysed for this snapshot overview were qualitative.

Questionnaire

The questions, which were formulated by the researchers, were based on our experience of over 20 years of working within healthcare chaplaincy. It comprised 12 questions (see Table 1).

Within 48 hours, 27 UK chaplains had responded on behalf of their teams. Most were from acute hospitals; however, we also had replies from hospice, community, pediatric, and mental health settings. The response, while limited from a research perspective, triggered reflection and suggested further questions to be asked of chaplaincy practice.

Participants

As noted in Table 2, in total, 27 chaplains responded. Of these, 18 were from general acute hospitals; five were from combination acute and community health organizations; one was a purely community hospital; one was a dedicated hospice; one was mainly a mental health facility that also had a hospice; the final one was a children's hospital, but others have large national centers for pediatric care. If we had intended the initial questions

3. JiscMail Chaplaincy-Spirituality-Health: https://www.jiscmail.ac.uk/cgi-bin/webadmin?A0=CHAPLAINCY-SPIRITUALITY-HEALTH

Table 1: JiscMail COVID-19 snapshot questionnaire

Chaplaincy-Spirituality-Health COVID-19 – 12 questions
(1) Team on shorter working days/intentionally limited time on wards?
(2) Maintained on call?
(3) Team in scrubs. Yes/no/not yet?
(4) Using technology regularly for patient care?
(5) Offering enhanced or "rebadged" staff support?
(6) Are you more integrated into staff support networks?
(7) Fit tested team members?
(8) Visiting ICU (intensive care unit) patients when requested?
(9) Feel well supported and loved by Trust/Board?*
(10) Feel chaplaincy staffing is adequate for the present moment?
(11) Any major obstacles?
(12) Any local initiatives?

* "Trust" is the term used in England and Northern Ireland for an institution running a healthcare service. "Board" is the term used in Wales and Scotland.

Table 2: Survey respondents by type of care

Type of care	*Participants*
Acute	18
Acute and community	5
Community	1
Hospice	1
Mental health and hospice	1
Pediatrics	1
Total	27

to feed into research, we would have asked for clearer self-designation, but we were pleased with the apparent breadth of settings arising from such an open sample.

Results and Reflection

In considering how to frame our results and reflection, we have highlighted that which was of particular interest *to us* from the responses, but we have also reflected on the remaining questions. For simplicity's sake we decided

to adopt the two key questions from Values Based Reflective Practice[4] (VBRP®, 2020), "What do I notice?", "What do I wonder?" These are in keeping with the rather scant nature of the material with which we were working. One clearly cannot base substantive claims about the nature of the UK chaplaincy's COVID-19 response on such a snapshot, but one can always notice things, wonder about what we are doing and how it might affect the future. Responses were almost universally short and to the point – often one-word answers within the reply email.

(1) Team on Shorter Working Days/Intentionally Limited Time on Wards?

Responses to the first question gave a mixed picture of current practice. A number were choosing to adopt shorter working days, but for different reasons; low staff numbers, spreading out cover, reducing the number of chaplains in a small office space were all cited. We wonder if there is future scope for a more in-depth review of working patterns which considers practice prior to COVID-19 – that during the active pandemic stage, and perhaps also later changes in the months to come. In our own Trust, we will discuss (at some point) whether we will ever go back to five or six days' working and, funding permitting, to what extent we will retain flexibility of hours, what we will do with volunteer team members, and more. There is certainly scope for a considered piece of work on this issue in the future.

(2) Maintained on Call?

The second question regarding being "on call" received a broadly "no change" response, although several noted that the *nature* of on call had shifted firmly toward telephone provision. We wonder if this question was simply too broad. More interesting would have been a question on the level of *use* of on call, and whether face to face had been retained *in extremis*. Despite explicitly flagging enhanced staff support, call-outs have been low in our Trust in recent weeks, including calls for end of life situations. We wondered, what is the experience elsewhere?

4. VBRP®: this is a model of reflective practice developed within Scottish chaplaincy that extends beyond the chaplaincy profession and enables practitioners to develop their working practice through applying a standardized reflective approach in group settings. http://www.knowledge.scot.nhs.uk/vbrp.aspx

(3) Team in Scrubs. Yes/No/Not Yet

A majority of teams had already moved into scrubs. Combined with those few who already had a "uniform," we note a very real question for the future. Clothing is such a significant and symbolic identifier. Do we go back to our "regular" clothes at some later point? We wonder how the impact of being seen in scrubs has affected the perspective of patients and non-chaplaincy colleagues toward us. Some chaplains have been combining religious dress (such as a dog collar) with scrubs; others have not, and now simply wear scrubs.

We wonder if such a transition to a mixed uniform is an opportunity to make progress on the thorny dilemma for teams, whereby many UK chaplains still wear "religious" items, yet espouse a "spiritual care" service focused on the patient. In acute settings, might scrubs provide the unifying professional identity that allows some to retain religious symbols (when appropriate) without skewing the patient and staff perspective? We also wondered if this is another impetus for qualitative research on what to wear, research that is long overdue despite the sensitivities it raises. Of course, if scrubs were shown to be a better option in most settings, the next discussion would always be, "what color?", a question that would keep us going for a good while longer.

(4) Using Technology Regularly for Patient Care?

While many teams had adopted some remote models of working for patient care, involving the use of video calling at the bedside on a tablet or smartphone, the take-up and use was clearly very low and was very specific to COVID-19, and was not overly successful for end of life conversations. We noticed that this is in contrast to the image portrayed in media stories at this time, which focused on novel IT use *in extremis*. We wondered if this potentially offered false comfort regarding the level of chaplaincy provision actually delivered on a daily basis. Going forward, however, we did wonder if it would be worth every chaplaincy developing this model for the limited situations it could support (e.g., some emergencies where a minority faith leader[5] is too far away, or patients who are distant from families). We also wondered if there is a real risk to chaplaincy in the future if some organizations seek to promote remote IT-based provision as a long-term substitute for physical on-call provision.

5. Faith leader: a common, if somewhat ill-defined term, for someone representing a tradition other than the majority Christian faith in the United Kingdom. It can also indicate a tradition that is sufficiently small and not represented within the chaplaincy staff team.

(5) Offering Enhanced or "Rebadged" Staff Support?

We noticed a clear, positive change here. The only teams not to have significantly boosted their profile and scope of their staff support were those already highly engaged with offering foodbanks,[6] staff welfare chaplains, a chaplaincy hound,[7] etc. There is a significant issue here for teams tied in to the next question. We wonder if there is any justification in this changing back to a stronger patient focus in the medium or long term. If there is not, what might teams need to do in terms of training, protocols, policies, self-description, and recruitment to embed this in a post-COVID-19 world?

(6) Are You More Integrated into Staff Support Networks?

As with question (5), we noticed a significant change, with most teams more formally recognized in communications and working more closely (formally) with other staff support teams. We also noticed that some made a feature of those elements of the staff support which had a distinctively "chaplaincy feel" (supporting those found in the chaplaincy center, walking around the wards, working with "spiritual care champions"[8]). We wonder what the new balance will look like when the "emergency" focus around staff support begins to be withdrawn; will we remain part of a new "core group" working closely with counseling, occupational health, psychology departments? Further, for those who have shifted their focus of work toward staff, how many might retain this new balance of focus, and how many might return to predominantly supporting patients and relatives?

(7) Fit Tested Team Members?

Fit testing is where a specialist face mask is tested on an individual in readiness for use when working in the highest risk situations. Almost all had this in place, if required, for at least some of the team. We wondered if all Trusts and Boards would maintain this in the longer term to enable support for infectious patients to continue.

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6. Chaplains support staff foodbanks that have been created to address work poverty among healthcare staff.

7. Chaplaincy hound: this refers to a chaplaincy team that has "employed" a therapy dog as a team member to enhance staff and patient support (e.g., see Carlyle & Watson, 2020).

8. Spiritual care champion: colleague within the MDT (typically a nurse or Allied Health Professional) who takes a particular interest in spiritual care, supports with the profile of Chaplaincy and encourage awareness and training within the MDT of spiritual aspects of care.

(8) Visiting ICU (Intensive Care Unit) Patients When Requested?

We were pleased to notice that almost all were able to do so (where they had an ICU), and that the reason some could not was more to do with the health of team members and not an unwillingness among healthcare colleagues to enable chaplains to visit. We are aware, through wider conversations within JiscMail and the UK media, that some teams found local and faith community barriers in ICU (such as doctors refusing to allow chaplains to attend patient reviews, or faith groups unwilling to allow their members to attend COVID-19 patients). We wondered whether these teams and faith groups were aware of this almost universal access even at the peak, and how affected teams might support themselves in addressing such barriers in the future?

(9) Feel Well Supported and Loved by Trust/Board?

We noticed an almost, but not quite, universal feeling of being supported by senior managers and colleagues among those who responded to this subjective question. COVID-19 opened up new opportunities for some teams to be highly recognized by their leadership. We were left wondering how things may feel for those few teams that have felt marginalized or under-used, and how we as a profession can support them personally and professionally. This also relates back to the issue of staff support.

We wonder how teams will feel if most other chaplaincies have radically increased their staff support dimension as a long-term result of COVID-19 when their model has had to (or chosen to) remain patient focused? We also wonder how much of the "love" felt was as a result of the increased staff support focus, or whether it was related to patient care. This was not asked and suggests a possible area of qualitative research in the near future – what does senior leadership value in their chaplaincy team?

(10) Feel Chaplaincy Staffing is Adequate for the Present Moment?

A much more mixed picture. Demands on some teams have decreased due to "routine" healthcare work being radically reduced; for example, less oncology demand. This left many feeling okay, but others are struggling without volunteers or honorary chaplains,[9] along with those teams that have existing staff shortfalls or ill-health among the staff. Almost all

9. An honorary chaplain in the United Kingdom is an individual who functions at the same professional level as a paid chaplain, but is not funded by the Health Board/Trust. An example might be a Roman Catholic sister (who cannot receive payment) or a respected and trained individual formally representing a particular faith or belief position in the

organizations have had to withdraw all those working on a volunteer basis, those aged over 70 or with a range of health issues, from direct work. We wonder how the longer-term impact of this will work out, especially if a large number of older volunteers and honorary chaplains do not return. We also wonder if the teams hoping to maintain or increase the voluntary element of their delivery will find this a watershed moment, when they can reimagine what voluntary support they want and from whom.

(11) Any Major Obstacles?

Alongside a number of practical or local COVID-19 related barriers, we noticed that a single thematic issue of *communication* was raised by several teams. Delivery was hampered by an inability to communicate what chaplaincy *does* and what it is *for*. We wonder if there is a need for greater energy and emphasis on this, and whether the challenge of COVID-19 has highlighted the need for us to paint a better picture of the concrete and practical work we do (rather than framed using the more conceptual language of "spiritual care"). In our own healthcare setting, the authors have been working with a broader approach that emphasizes the wide range of roles and competencies within chaplaincy (the CRISP model: Cultural care, Religious care, Individual care, Spiritual care, Pastoral care).[10] We are not aware of any research to date correlating the recognition and status of a chaplaincy team with the clarity of models being adopted and communicated internally.

(12) Any Local Initiatives?

A wide number of local initiatives were shared by respondents, from supporting staff foodbanks to a whole new way of working beginning within weeks. We noticed that several had rapidly developed a greater relationship with local faith/belief groups, and we wondered about the significance of this. Was it because faith groups (among many) took exceptional interest in the NHS? Was it because many teams realized that they might need faith community support to help them deliver the work if the pandemic escalates further? Was it because thy had been dependent on single volunteers to "represent" such groups and needed stronger links in the face

chaplaincy team on a voluntary basis; for example, honorary humanist chaplain, honorary Quaker chaplain. This role has approved access to patient records (unlike all other volunteers).

10. CRISP model: for more detailed information, see chapter 1, 'What is a mental health chaplain for?', in Harrison (2019).

of unprecedented demand? Whatever the trigger, it will be interesting to reflect in a year if some or all of these closer relationships remain.

Conclusion

Much of what we noticed simply gave rise to new questions. When taken as a whole, it suggests a need, as a profession, to rapidly take stock and reflect in more depth on our pandemic practice and the potential for long-term changes in practice. Indeed, during reflection, the answers to questions brought up several more issues we did not raise and yet stand out as future lines of research. These include the following.

- What was the average age of teams pre-COVID-19?
- How different has the impact been across different sectors?

Furthermore, some areas we did look at needed urgent research, both in terms of practice and theory. For example:

- What does best practice around the wearing of scrubs look like?
- What does best practice look like regarding staff support?

Some of the changes in recent months will no doubt be of great value in the years to come, but some others may also offer a threat as the pandemic subsides. Our hope is that the profession considers these in a collective and research-oriented fashion, rather than each individual reinventing the wheel based on local experience. Discussion groups such as JiscMail may be a vital component of this cross-learning, as will focused research on practice.

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