Reconfiguring the health-promoting hospital: the role of chaplaincy in England

Abstract
This paper sought to explore how hospitals can be reconfigured to adopting more 'health-promoting' approaches and values. Specifically, the paper focuses on the role of hospital chaplaincy and argues that spiritual care should be considered alongside other health domains. Using semi-structured interviews, the aim of the paper is to explore the experiences of patients who accepted (n=10) and declined (n=10) hospital chaplaincy services. Data were analysed drawing on principles of Interpretative Phenomenological Analysis (IPA). The findings suggested that participants who accessed chaplaincy services reported using the chaplains for pastoral, religious and spiritual care which contributed positively to their sense of well being. This included religious rituals and supportive conversations. The majority of these participants had existing links with a faith institution. Participants who declined chaplaincy services reported having *personal* religious or spiritual beliefs. Other reasons cited, included: that the offer was made close to discharge; they had different support mechanisms; and were unaware of what the chaplaincy service offered. Participants identified a number of skills and attributes they associated with chaplains. They perceived them as being religious but available to all, somebody to talk to who was perceived as impartial with a shared knowledge and understanding. The paper concludes by highlighting the important role of chaplaincy as part of a holistic health-promoting hospital. This has implications not only for the design, delivery and promotion of chaplaincy services but also for health promotion more broadly to consider spiritual needs.

Contribution to Health Promotion

- Hospitals excel at managing ill-health and treating patients, but hospitals should also be about promoting health.
- Health-promoting hospitals is an established idea that looks holistically at the setting and seeks to support patients, visitors and staff.
- Hospital chaplains are a part of the workforce who are equipped to deal with the spiritual and emotional health of patients.
- Using interviews, this paper reports on the experiences of patients who accepted and patients who declined hospital chaplaincy services.
- The paper highlights the importance of hospital chaplaincy services on creating health-promoting settings.

Introduction

There have been consistent calls for almost forty years for health services to move to become more 'health promoting' (WHO, 1986; Pelikan *et al*., 2022). Despite such calls to action, health promotion is not a term that is generally associated with the operational priorities of a hospital; instead, reactive healthcare addressing acute need is often synonymous with these settings. Hospitals must re-orientate both conceptually and practically if they are to be health-promoting organisations, making a transition from curing disease to promoting all aspects of health. This can include moving from patient compliance to empowerment; from a narrow concern with patients to including relatives, staff and the wider community; and from being inward-looking to being outward-looking. The rationale for such an approach has increasing legitimacy, given the fact that many hospitals are integral to community life both in terms of the economic and social economy (Pelikan *et al*., 2022). Indeed, there has been wide-spread

commitment to the health-promoting hospital (HPH) concept and a growing global network of academics, policy-makers and practitioners. The premise of the HPH is manifold, but crucially relies on a focus on health with a holistic approach and not only on curative services (Pelikan *et al*., 2022; Ref.).

The notion of spiritual health is comparably under-developed in health promotion when compared to other domains, such as physical, social and mental health dimensions. Indeed, in a HPH the concept of spiritual health is very much in the background (in comparison to physical and mental dimensions) and yet can contribute much to the well being and health of individuals and communities. That said, spiritual care is delivered in many hospitals and acute settings, primarily driven through hospital chaplaincy services which have been a long-standing feature of hospitals in England. Hospital chaplains are employed directly by NHS organisations and originally came from a Christian background, but this has now widened to include other faiths and humanists. Chaplains provide a 24/7 service to the whole of the hospital population. In June 2017 NHS digital reported 840 full time equivalent posts in England (Hurley 2018). Hospital chaplaincy within the NHS in England is a small profession that, over the last twenty years particularly, has been developing its identity as a healthcare profession and seeking to build its research base to provide evidence for its effectiveness (Mowat, 2008; Fitchett & Nolan, 2015; Ref; Cobb, 2008). Hospital chaplaincy is provided to meet the religious, spiritual and pastoral needs of patients, their families and carers and staff and has a coherent 'fit' with the values of a settings approach in health promotion (Kokko and Baybutt, 2022). 'Choice' is a key concept within the health promotion discourse and the offer of chaplaincy support, whether it is taken or rejected, enables individuals to have greater control of their health outcomes. This is a vital aspect of person-centred care which recognises that patients' social, emotional, psychological and spiritual needs must be addressed. More recently there has been a wider recognition of the role that spiritual and religious care can contribute to people's well-being, particularly for those with chronic diseases (Kelly & Swinton, 2020).

This paper seeks specifically to explore the rationale underpinning patient's usage of Chaplaincy services in a hospital context. The research contributes to recent calls for re-focusing on the HPH (Pelikan *et al*., 2022) by exploring factors influencing patient choice when accessing the chaplaincy service. These data can potentially enable the notion of a HPH to be expanded further offering insights into how it can be reconfigured with a greater focus on the spiritual needs of patients.

Methodology

Based on wider research examining the role of chaplaincy in the NHS (XXX[1]), the research reported here was based in an acute hospital in the north of England. Drawing on qualitative interviews (all aspects of the study were approved by the Health Research Authority: REC ref. 18/NW/0268), the research utilised gatekeepers to access and recruit participants. In this case, an experienced chaplaincy volunteer acted as gatekeeper to the study site and the participants – both those who accepted and those that declined chaplaincy services at the time of their stay in hospital. The gatekeeper provided initial awareness of the study and participant information to all individuals. As part of the gatekeeper's usual duties, they visited a particular ward each week and offered chaplaincy services to every patient. Those who declined chaplaincy were asked if they would take part in the study. If the participant agreed, then a permission to contact form was completed and an information pack given.

[1] Anonymised for the process of peer review

Permission to contact form was then passed to the researcher who completed consent forms and conducted the interview.

The recruitment strategy for the group who had accepted the offer of chaplaincy services differed. Chaplaincy contacts were recorded in a routine database and the chaplaincy administrator provided a list of potential participants who were then approached by the gatekeeper. The permission to contact form was completed and passed to the researcher and an information pack left with the participant. One of the limitations of this strategy was that all the participants were from a Christian background. Unsuccessful attempts were made to broaden the sample by approaching the other faith chaplains for potential participants.

Data collection took place over a six-month period and an interview schedule was developed and used with both groups. It was decided to interview the respective samples consecutively, beginning with those who had declined chaplaincy. The researcher attended the hospital on either the same day as the gatekeeper or the following day, to be available to conduct the interviews after consent to contact was obtained and before patients were discharged. It had been anticipated that this group would be difficult to recruit, however participants were willing to take part and the data collection for those who declined chaplaincy was completed within eight weeks. Once this group was completed, data collection began for those who had accepted chaplaincy. Data collection required multiple visits to the site by the researcher and took three months to complete.

IPA was selected as a methodology because ideography plays an important role in which each case is examined in detail individually and then all cases examined side by side to note similarities and differences. IPA takes seriously the role of the researcher by employing what Smith (2009) describes as the double hermeneutic as "the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (p.3). Therefore IPA has a specific set of processes that are suggested for data analysis (Smith *et al*. 2009). The interviews were transcribed verbatim by the researcher and each case examined individually.. Finally, all the cases were examined, side by side and emergent themes identified.

For example the superordinate theme of access to religious, spiritual and pastoral care was developed by making. initial notes of activities associated with practising religion. These were then gathered into clusters such as holy communion and prayer and finally incorporated into the superordinate theme of accessing religious, spiritual and pastoral care.

Findings

The sample profile

The demographic data for the two groups is shown in Table 1.

[Insert Table 1. Demographic data for the sample - here]

The patient experience of chaplaincy

Accessing religious, spiritual and pastoral care

The participants who had been active in their faith and still connected with their churches said it was important to them to be able to access religious rituals whilst in hospital and this enabled them to keep practising their faith and promoted well being, healing and resilience The rituals requested by patients were holy communion and prayer.

The benefit people gained through being able to practice their religion through religious rituals was being able to be connect with their faith and doing something familiar and regular which can give ontological security. This is particularly important in hospital as illness and thoughts of death can be sources of anxiety.

> *I say my prayers on a night before I get in bed. (Lucy)*

The regular practice of rituals such as holy communion helped to connect people to their faith and there was something familiar and routinised which brought comfort. Provision of holy communion at the bedside was cited by most of those who had seen a chaplain as an important means of maintaining their religious practice. Grace said that holy communion helped to keep her connected with other Christians and especially the church she was now unable to attend while in the hospital.

> *…..I feel like you're all, together aren't you? Yeah, togetherness sort of thing. Yeah, you can always join in wherever you go because you always know what you know, you got the routine of it and if you feel part of it….*

Some participants noted the importance of the practice of prayer being enabled by chaplains. Prayer took a number of forms, patients praying themselves regularly, patients and chaplains praying together and chaplains saying they will remember patients in their personal prayers and leaving prayer cards with the patients.

> *Oh yes, yes I do cos when I said you you when I've been in before someone's come you know they asked me if I'd like someone to come and I said yes and say a prayer and that (Lucy)*

Chaplains are particularly associated with end of life care and Tom talked about an experience when he had been in hospital previously many years ago and had been extremely ill and a chaplain had come and said prayers, commonly known as the last rites, as he wasn't expected to live.

> *And eventually I ended up on diamorphine four times a day injection, two antibiotics a day; I spent two months in hospital. I went down to about eight and a quarter stone and I was given the last rites by a Catholic priest for a while*

Promoting wellbeing

Some of the participants described how having contact with the chaplains helped them feel better and helped to meet their psychological, social and spiritual needs and so develop their well-being. The main focus of care in an acute hospital is on the physical aspects of treatment and cure. Increasingly people, especially older people, are presenting with multiple conditions many of which are chronic and therefore treatment is more about managing symptoms than physical cure. Therefore, it is important that a person's sense of well-being is not just linked with cure, especially in cases where this will not be possible, and therefore promoting a sense of well-being is important. For a person to have a sense of well-being a number of physical, mental, social and spiritual needs will have to be met. The chaplains can help promote well-being through making a connection with the patient, by taking an interest in them as a person rather than as a patient who is sick and helping to meet any spiritual needs and help them identify and draw on their existing internal and external resources. This

was evidenced by Lucy when asked how she found the chaplaincy visits she said they made her feel better.

> *Er I feel better? You know what I mean, feel better. You know yeah. Yeah.*

Maria described seeing the chaplain as giving her a boost and helping her to be more positive. Maria had been seeing the same chaplain for many years and said she didn't think she could have got through all the difficult times she had without her support.

> *It helps I think she's actually helped cos I was just at one point losing everything just I didn't want to....but I think, you know, she's really nice, really nice and I think, you know, I need that bit of a boost.*

The opportunity to connect with someone on an ordinary level seemed to help promote well-being amongst the participants. This was described in terms of having a conversation or someone to visit them personally without any other agenda.

Patients reasons for declining chaplaincy provision

Temporality

According to some participants the time at which chaplaincy was offered had an effect on whether they accepted or declined. Almost half of the patients who declined chaplaincy were due for discharge within the next two days and for some this influenced their decision to decline chaplaincy. Some of the participants said that they may well have accepted the offer of chaplaincy if it had been made earlier in their hospital admission or at a different time in their illness journey. James had been very ill and may have appreciated talking to someone when there had been uncertainty about what the outcome of his illness might be.

> *Yeah, I did because well, I'll say I'm happier now, my mind sets better. I mean, I'm not sure whether two weeks ago that I would have not erm whether I would have engaged, and I know I may have done. Erm I don't know. You know I had more on my mind then that's for sure.*

Rachel said she may, under other circumstances, have accessed the chaplaincy service. She said she did not feel the need, when asked what she meant, she said somebody to talk to who you could say anything to. Rachel felt that when chaplaincy was offered, she had completed her treatment, not received any worse news and as she was due to go home did not feel the need for the chaplaincy service though acknowledged the importance of knowing it was available if and when she did want it.

> *Well, I didn't feel the need of it. Maybe if I'd felt the need then I would. But er as I say, I'm hoping to go home. I haven't had any worse news than what I'd got anyway. And er so yeah, I think if I needed it, it's nice to know it's there.*

This suggests that people's emotional, spiritual and religious needs change over time and are not static. People may decline chaplaincy on one day but the next day their situation could have changed, and they would value contact with a chaplain.

A hierarchy of support mechanisms

A strong theme amongst those who declined the chaplaincy service was a sense of their being able to cope and feeling that they had both internal and external support mechanisms.

Internal support mechanisms were those understood to give personal strength and resilience and included religion and coping strategies. Lily was someone who described having a strong internal strength that she attributed to her religion and faith which she referred to as being

within her and gave examples of very difficult times in her life where this faith had sustained her and enabled her to build resilience to cope with her current illness.

> *.....It was horrendous so erm but again it were just my faith that kept us going, kept us both going. I, I remember saying to XXXX be alright, things'll work out don't worry, it'll work out so and that's why I think I know I don't need the chaplaincy cos it's in here, I've got it in here. (patting chest)*

It is recognised that some people will have more internal resources than others and will have built resilience through different experiences and this will affect how they cope in a given situation and whether or not they will seek external support.

In terms of external resources many of the participants spoke of family and the support that they received from them through visits and practical help both with their needs in hospital but of looking after homes and pets outside of the hospital which helped them to feel supported and reduce their anxiety.

Participants suggested that the fact they had family support meant that they had less need for chaplaincy and a number mentioned that it would be good for chaplains to visit those who didn't have many visitors or family support.

> *Er Not really? No. No, I mean most of me two sisters have been helping me, bring things into the hospital er they've made sure that me dog was taken into a kennel because obviously he, he couldn't look after himself. (Fred)*

Awareness and knowledge of the chaplaincy service

Participants were asked what they knew about the chaplaincy service and nearly all the participants who declined the chaplaincy service said that they knew little or nothing about the service. There was a general awareness that there was a chaplaincy service but little knowledge of what the service offered. Some participants were aware of there being a chapel and saw this as part of the provision of the chaplaincy service. James had seen chaplaincy services advertised on previous admissions but had never been offered the service or had any experience of it.

> *No, erm I've seen when I've been in hospital before chaplains' services advertised but no it's the first encounter I've had.*

Millie spoke about a time previously when her mum had been brought into Accident and Emergency and had died. Millie and her mum had not been aware of the chaplaincy service and she wondered if that would have been something her mum would have accessed. Millie had a conversation with the volunteer who offered chaplaincy, and this was how she was now more aware of the availability of chaplains. This illustrates that the offering of chaplaincy, even if declined, is important in terms of raising awareness and knowledge of what the service offers and could be accessed in the future. As noted earlier, people's experiences and needs change over time, and it cannot be assumed that accepting or declining chaplaincy on one occasion holds for the whole of the current admission or for future hospital admissions.

> *Er I don't really know, to be truthful I don't really know much about it. My mum died in this hospital erm but it were like late at night, you know in A&E er and I don't know, I honestly don't know whether I'd have asked about the chaplaincy, you know, because I didn't know about it, you know, maybe she'd have wanted something, you*

know, with her being a Catholic but at the time I just wasn't aware to tell you the truth and at that time early hours of the morning, you wouldn't think, you know, that it was available. Obviously now, I know.

Perceived attributes and competencies of chaplains

All of the participants commented upon the skills and attributes of the chaplains that contributed to the interactions being health promoting.

Perceived as religious but available to all.

All the participants perceived chaplains as being religious but that they were not limited to dealing with matters of religion. The religious background and experience enabled conversations to happen as it was felt they could talk to chaplains about anything.

No it [the chaplaincy service] deals with everything, I mean if I've got family issues that I'd like to talk about or anything at all really. (Ron)

Good listeners

A strong theme from both sets of participants was that chaplains displayed excellent listening skills and this illustrates the fact chaplains' interactions with patients are entirely patient centred. The chaplain does not have an agenda or a set of questions but allows the patient the time and space to speak about what is concerning them. This can contribute to a person's ability to build resilience and promotes recovery.

She's a very caring person, she understands, she listens to you which is the main thing. With a lot of people, they wouldn't listen, she listens to you, she listens to you. (Maria)

Impartiality and shared knowledge

A number of participants perceived the chaplains to have an impartiality which they felt was important. This was in the sense that chaplains were not seen as being the same as other staff who were responsible for their direct care. There were topics such as spirituality, grief and bereavement that participants felt they could only discuss with chaplains.

I think it's helpful in the fact that it erm you feel there's somebody outside the medical field coming to, to talk to you and in some ways there's things that you can say to them they you can't say to [doctors and nurses]. (Emily)

To me I'm on ta spiritual path. And when you are on a spiritual path, I can't just go out and talk to one of them nurses. (Evie)

This sense of being able to talk to chaplains about wider topics and issues was reinforced for some participants by a shared knowledge and discourse which allowed a deeper discussion and reflection on their situation. Tom used a story of a biblical figure to illustrate how he experienced the reaction of his visitors.

When I came back with a kind of drain I felt like, I says I feel like Moses cos they all parted out of the way (both laughing) like they didn't want to go near it.

The value of the chaplain's impartiality also stemmed from the fact that they were not family and this was highlighted by both sets of participants. Participants said that there were topics

and issues that it was difficult to discuss with families and which they were not able to talk about with staff.

> *And I think there is a place sometimes you need someone you can talk to that isn't a member of the family if you're poorly. Because er then you can say the things you want. And you haven't got to pretend to be positive when you're not. (Rachel)*

Discussion

In order to address and advance the notion of a HPH – a call to the research community for some decades now (Pelikan *et al*., 2022) – this study sought to explore the rationale underpinning patients' usage of chaplaincy services and looked more holistically on the role of spiritual health need. More specifically, the research explored reasons why patients accessed and refused the chaplaincy service in one NHS Trust. Overall, the findings suggest that participants with active faith-based affiliations were more likely to access the service due to a perception that it is a religiously led service for the benefit of religious people. However, those who declined chaplaincy did so for a myriad of reasons including the timing of their stay in the hospital or because they chose to access other support mechanisms. Some of the participants described how having contact with the chaplains helped their psychological, social and spiritual needs which is an important consideration for HPH practice and policy. Indeed, providing a well-managed and compassionate chaplaincy service within a HPH framework, whether rejected or used by patients, enables greater choice for patients and a stronger sense of control over the factors determining their health.

While the number of participants (n=20) were modest, though large for an IPA study, the data demonstrated a clear difference in the age profile of the two groups. In the group of those who accepted chaplaincy the majority were aged over 70 years of age and there was no one under the age of 30 years of age. Whereas the group who declined chaplaincy services all, except one, were under 70 years of age. Those accessing the chaplaincy service were more likely to have existing links with a church, though most were unable to attend due to ill health.

Research of this nature does draw some caveats when making conclusions. There are a number of factors that could have influenced these findings such as the population of an acute hospital which will be predominantly older. Surveys around religious activity such as the British Social Attitudes Survey 2018 (Voas & Bruce, 2019) note that the decline of religious affiliation is generational and therefore older people are more likely to declare themselves as having a religion and attending a place of worship whereas successive generations are increasingly declaring no religion and are less likely to attend a place of worship. This has implications for the recruitment and delivery of a chaplaincy service that is based on predominantly religious care. In future, if religious affiliation continues to decline, there will be far less likelihood for the provision of a chaplaincy service based on religious care. An awareness of this is reflected in the move towards defining chaplaincy more generically as pastoral and spiritual care services (Mowat and Swinton, 2007; Beardsley, 2009; Pesut *et al*., 2012) though the data in this study suggests that even those who are not actively affiliated to a religious group have beliefs and value the support of a religiously affiliated chaplain.

Those interviewees who declined chaplaincy services were in the younger age categories and this may have been influenced by the fact that all participants were recruited from one ward which admits a higher proportion of younger people than other wards. Although the majority of participants reported having involvement with a church in the past, they no longer

attended. This however did not equate to them having no religious belief, but many described themselves as having their own beliefs or being spiritual. The chaplaincy team were perceived as being from faith institutions which some of the interviewees were not comfortable with and this led them to decline the offer of chaplaincy. However, they did feel comfortable talking to a chaplain of a different denomination. The fact that chaplains are generally from a religious community is both an opportunity and a barrier.

Woodhead (2016a; 2016b) discusses in detail the rise of what has been termed the "nones", those who state they have no religion and now form the largest group in census and survey data. Chaplains in England perceive themselves as delivering a generic pastoral care service to all faiths and none though many chaplaincy teams will provide specific chaplains for other faiths such as Roman Catholic, Muslim, Hindu and Sikh patients. This seems to be a mixed message where guidance documents are promoting a spiritual/pastoral service, but practice is reflecting a religiously led service. Linked to this is the use of religious data to determine the constituency of a chaplaincy team. There are issues around how this data is collected, how accurate it actually is and if it truly reflects the patient's beliefs. In the research data a number of the interviewees who declined chaplaincy identified a religious denomination that they had no contact with and described their beliefs as being personal to them. This is captured well in the title of a letter to the British Medical Journal where Appleby (2019) describes chaplaincy "as tackling a mosaic of agnosticism and provisional beliefs" (p.1).

The implications of this ongoing challenge of identity within chaplaincy services is important when considering the concept of the health promoting hospital as it highlights the complexity of the needs of patients. They do not have just physical needs but may have spiritual, religious, emotional and psychological needs and all of these need to be considered together. Chaplain's work within a framework of belief or philosophy (some of which are religious, and some are not) that enables them to bridge that gap and to contribute to the overall health and well-being of patients, families and staff.

Perceptions of chaplaincy

The data strongly suggested that the patients perceived the chaplaincy service to be a religious service aimed at religious people though with an understanding that chaplains were available to all and could fulfil the role of offering non-religious support.

The NHS Chaplaincy Guidelines (2015) states that "modern healthcare chaplaincy is a service and profession working within the NHS that is focused on ensuring that all people, be they religious or not have the opportunity to access pastoral, spiritual or religious support when they need it" (p.6). These guidelines and much chaplaincy literature promote chaplaincy as being for all staff, patients, relatives and carers whether or not they are religious. The majority of chaplains are from religious communities, the vast majority being Christian, though in recent years there have been a growing number of Humanist or non-religious pastoral care workers appointed to substantive posts and working as volunteers (Savage, 2019).

The data in this study suggested that this perception/understanding of chaplaincy services is not shared by patients who still view it as a religious service mainly for religious people. A previous study on which this one was based noted that 84% of patients in the chaplaincy database had a religion recorded in contrast to 55% for the general hospital population. This is an on-going challenge for chaplaincy teams and how they promote themselves.

Closely linked to this perception was an acknowledgement by those that declined the service that they knew very little about it. Most were aware of the chapel or prayer room within the

hospital but admitted to knowing little about what chaplains actually did. Those who declined chaplaincy had been offered it by a chaplaincy volunteer who had explained the service to them, and a number of the interviewees reflected that if chaplaincy had been offered to them earlier in their admission they may well have accepted the offer. This was based on the knowledge of what the service was offering as well as their needs at that time. This highlights ongoing issues for chaplaincy services of how they promote the service and what it can offer to patients, families and staff.

Promoting well being

There was evidence from the research with both those who accessed chaplaincy services and those who did not that the chaplain played or could potentially play an important role in promoting health and well being within individuals. This has important implications for the HPH and broader recognition of the role of spiritual health in health promotion discourse. Indeed, the Vienna Recommendations on health-promoting hospitals stresses the notion of constant quality improvement; enhancing patient well-being; and facilitating the healing process (WHO, 1997). The study demonstrated how those who accepted chaplaincy services described how they felt better and more able to cope with their situation and how their overall sense of well being was boosted. This has been evidenced in previous studies where chaplains working in primary care have provided a safe environment in which patients felt safe and supported and then enabled to experience improved well being (McSherry *et al*., 2016; MacDonald, 2017; Snowden *et al*., 2018). This was evidenced in the skills and attributes of the chaplain identified by the participants.

The most cited role of the chaplain that contributed to well being was as someone who was available to talk to and who was a good listener. The participants were clear that it wasn't that they wanted to talk to just anybody but that the attributes that the chaplain had enabled conversation to occur that in turn promoted their well being and helped connect them to their own inner resources. McSherry *et al*. (2016) report how the active listening of the chaplain enables patients to express their feelings and be heard but more than that "chaplains working phenomenologically: actively encountering the patient's world, journeying with them. Chaplains were attempting to attend to what was not said, in addition to what was said." (p163).

These attributes included a perceived impartiality. Chaplains are employed as NHS staff but there was a sense that they were perceived as being different from other staff on the ward. This could stem from the fact that they are not directly involved in the patient's day to day care needs so were able to visit with the intention of listening without an agenda or list of questions. A number of participants noted the impartiality in the sense of chaplains not being family and therefore being able to speak openly and candidly about how they were feeling that was not always possible with family members. This perceived impartiality promoted well being as patients were able to discuss concerns and feelings in a safe environment and without fear of upsetting anyone and so able to build their own resilience.

Those who had accepted chaplaincy care also highlighted the way in which chaplains were able to have a shared knowledge and discourse that helped promote well being. This was particularly so in cases where patients were seeking religious care and the religious knowledge and background of the chaplain contributed to a shared discourse and meeting those specific needs. The ability of chaplains to offer continuity of care and build on-going relationships was noted by some of the participants who had been in receipt of chaplaincy care on multiple hospital admissions and indicated that a visit from the chaplain was an important part of their care whilst in hospital and many described how it contributed to their

well being. A number of studies have reported improved patient satisfaction and shorter hospital stays when patients have received chaplaincy visits (VandeCreek, 2004; Piderman *et al*., 2008, Williams 2011, Marin *et al*.,2015, Sharma *et al.,* 2016.)

Participants who accepted and declined chaplaincy also highlighted a number of topics that they would only feel comfortable discussing with chaplains, and these were bereavement issues and spirituality. There was a sense that chaplains would be experts in these fields and have the necessary skill and knowledge base to offer support and build well being.

Limitations

The limitations of this study are that the sample was predominantly Christian though attempts were made to recruit patients of other faiths however the study did not set out to compare different faith groups, the inclusion criteria was that the offer of chaplaincy had been made and either accepted or rejected. Also, the sample is small, but this was determined by the IPA methodology and in fact the sample size was large for an IPA study.

Conclusion: the potential to reconfigure the health-promoting hospital

This study identified the role chaplains play in an acute hospital in providing for the spiritual religious and pastoral needs of patients. These needs were met in a number of ways including providing religious ritual which helped to keep them connected to their faith community and enabling patients to be able to talk about any concerns they had. Chaplains were seen to have a particular expertise in religion and spirituality that enabled patients to discuss issues such as spirituality and bereavement that they were not comfortable discussing with other staff. Having the opportunity to discuss such matters contributed to their health and well being. This study also identified reasons why patients did not access the chaplaincy service, which were a lack of awareness of the service, being close to discharge when it was offered and having other internal and external resources on which they drew.

Chaplains were identified as being impartial and having a shared discourse and experience which enabled patients to address existential issues that would promote their health and well being that they felt unable to discuss with staff or family.

There is a challenge here for both chaplaincy and health promotion. There is evidence that attending to a person's spirit can promote resilience and well being and the ability to cope with challenging situations. This is achieved through enabling patients and staff to understand and embrace the concept of spiritual care which is given in a one-to-one relationship and is person centred. It embraces aspects of meaning, purpose, connectedness and hope. The challenge for chaplaincy is to clearly articulate how the spirit can be attended to and the subsequent benefits not purely in terms of religious language and experience. The challenge for health promotion is to widen and broaden its understanding and recognise how promoting spiritual health can contribute to the overall health of individuals as it can influence all aspects of a person's health which in turn could encourage engagement with more specific health promoting activities.

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