 **We work together to get results**

As part of our review we have met together and discussed the opportunities and difficulties facing us. See the notes of the chaplains’ meeting discussing our strengths, weaknesses, opportunities and threats. We have also consulted our volunteers and how they feel about their role.

In this section we look in detail about how it feels as a team doing the work, whether we are adequately staffed to do our work, and how well the on call system works. We also consider volunteers.

We base our thinking here on the results of applying the formula to calculate allocation of chaplaincy resources contained in national Guidelines. The detailed workings of this can be found in the sections “Current Staffing and Activity Level” and “Suggested Staffing Level”, where the formula is given in full.

**Staffing Levels**

The level of staffing of Chaplaincy Departments has long been determined by the application of a formula. This is contained in ‘NHS Chaplaincy – Meeting the religious and spiritual needs of patients and staff, (2003) D o H, which is currently under revision. The 2014 draft Guidelines with a revised formula are the subject of a consultation period under way at the time of writing. For the proposed formula and its application to CHFT Chaplaincy, please see the section “Suggested Staffing Level”.

**Conclusion from the Application of the Formula**

* On an application of formula proposed by the new draft Guidelines the chaplaincy is understaffed.
* The calculation suggests 34.35 sessions being required as opposed to the actual resources of 31.6 sessions. It could be argued that the figures need tweaking upwards because bed occupancy seems low in the week sampled: if another session is added to represent the 32 empty beds, making an entitlement to a total of 35.35 sessions. This means we could be said to be about 4 sessions - or 2 days - a week down in chaplaincy provision, even after our current vacancies are filled.
* Since the summer of 2011 we have lost a total of 7 sessions and the band 7 management element (comprising 2 sessions after the Free Church chaplain in Halifax moved on, 3 sessions in Huddersfield as Rev Di Ellerton has reduced her sessions from four to one session, and two sessions at Calderdale Royal as the once full time post has reduced to four days a week. A further loss of resources lies in the fact that a band 6 chaplain now undertakes management responsibilities.)
* Factors such as the need to travel between sites, the extra time spent on Sundays and problems of actually taking time back would endorse a generous interpretation of the result the formula gives.
* It certainly feels that we are under-staffed and struggling: this may be partly because we are living with a vacancy of 15.75 hours from a Free Church minister who retired at the end of last year. It was felt advisable to keep this vacancy open whilst this review was undertaken. One consequence of this at HRI is that we have had to drop the objective of seeking to maintain a chaplaincy presence on the wards by ‘link chaplains’ and visiting every ward every week. But it is also proving difficult for chaplains in Calderdale to provide a comprehensive generic service in the time allocated there. Volunteers have become more and more pressed into undertaking the role of ward-link and it is questionable whether their befriending role can be re-cast as one of assessing and seeking to meet a variety of needs. The co-ordinating chaplain finds himself increasingly called to work at a strategic level on behalf of the department and to participate in training for staff, all of which is important and a good use of time but takes him away from covering the ground clinically. The worry is that at ward level we become so thinly spread that we are no longer seen as a resource to call upon.
* Should we be hidebound by a formula? The Guidelines themselves state that they are just that – guidelines to assist commissioners in determining local service provision but recognise it is important that “standards common to all chaplains are observed, and that local determination of services is reviewed against the best available shared understanding of spiritual care”. Our co-ordinating chaplain attended an early discussion about the desirability of a formula and the consensus amongst (largely experienced) chaplains present was that the allocation of one session for 35 in-patient beds – though arbitrary and perhaps lacking any logical foundation - was useful . The Guidelines point out that international studies have advocated a staff-to-patient ratio approximating to that, and that the ratio advocated is similar to the one used in Scotland and Wales too. It simply seems about right.
* If you do not have a formula to follow, how are the resources required to be assessed? One possibility might be to use an activity analysis but there is a risk here that the resources are dedicated to current activity and activity levels. Furthermore, resourcing may be defined in relation to post holders’ interests and skills, and possibly not in the interests of patients nor the needs of the Trust, who indicate they favour a broad-based generic approach to meet a broad spectrum of needs. Such localised development has the further disadvantage in possibly making recruitment difficult as existing post-holders leave their jobs which have become fashioned in their image.
* A further consideration is what the make-up of the Department should be. In larger hospitals it is easy to allocate chaplaincy sessions to different faith communities but not so simple in small teams. For example, we quite often have just one or two Sikh in-patients. Is it justifiable to fund a single session for this, and at whose expense? To some extent this could also be an issue for the Muslim chaplaincy whose numbers are small in terms of inpatients, but we know those patients’ needs are often complex and have wider implications for the hospital as an institution. And our Muslim colleagues have identified areas for development which defy quantifying by formula (see below for a wider discussion of this).

**Conclusions**

a) Using a formula based on in-patient numbers, staff numbers and other calls on chaplains’ time seems as good a way of calculating staffing levels as any other.

b) We are not simply ‘religious people doing religious things for other religious people’. The scope of chaplaincy is wider than that. We value our work with those of little or no faith commitment (this is a fluid concept at a time of illness and distress anyway) - and so do they, as our Patient Satisfaction Survey tells us. An adequate level of resourcing is required to enable us to fulfil this role effectively. It tends to be the ‘soft’ area of work which is lost in the face of more pressing tasks, such as baby funerals and corporate work.

c) There are strong and compelling reasons for chaplains to be the people to deliver general spiritual care, as opposed to secular healthcare staff:-

1) Our Co-ordinating chaplain leads on the protected Equality Act characteristic of religion or belief which includes a remit for those with no belief. There is a duty on him to show what is being done for those of no faith. In other ways the Department leads on advocating for patients and their wellbeing.

2) The line between being a person of faith and of no faith is not clear cut. People change especially in the face of illness and the need to seek meaning in adversity. We offer the following:

Insights into the spiritual life and difficulties of faith,

Some experience of how to talk about moral and ethical dilemmas ,

Familiarity with pastoral issues such as loss, dementia, bereavement, loneliness,

end-of life care, and mental health problems such as low mood and depression,

As well as the more general offering of friendship and ‘normality’ in the de-

personalising and stressful hospital environment.

A knowledge of, and experience in, delivering care within a healthcare environment. We work at establishing our credibility and trustworthiness with fellow healthcare colleagues and have a commitment to the Trust.

Specific counselling skills are being developed by one member of the team, and we have a wealth of secular backgrounds and skills to draw on.

We take spiritual care for all seriously and our experience suggests that patients value this input, whether they belong to a faith community or not.

3) Our commitment is to support people with sensitivity and compassion at a time of need. Our Code of Conduct specifically prohibits the use of the chaplaincy role to ‘convert’ patients.

4) We do not hold ourselves out as the sole deliverers of such care and encourage all staff to see the offer of emotional and spiritual support as part of their role – but we can promote it and help facilitate it.

d) We value being a multi-faith chaplaincy and want to uphold those from minority faiths who seek both to minister to those from their communities and ensure the Trust is aware and responsive to their religious and cultural needs. We need to be imaginative about the use of resources to support this, and consolidate our work with Interfaith Councils and other community-based groups.

e) We recognise that our co-ordinating chaplain is often required to represent the Department in meetings as well as manage us. Yet he is also the one expected to deliver much of the hands-on care, particularly in HRI. These roles are difficult to combine with one being at the expense of the other. Further resourcing is needed to support the management/strategic role.

f) Our part time chaplains working very few hours experience similar pressures in fulfilling tasks for the team which use up all of the time they could be putting to patient care – devising publicity, baby funerals. etc

**Working together - On Call**

Our staff survey results tell us that 82 % of staff are aware that there is an on call service for evenings and weekends which can be accessed via the Switchboard. There is an awareness that this is available for patients of all faiths, and that there is a list of contacts for those of faith communities for whom we do not have a chaplain.

These details are available on the Trust Intranet, as are guidelines for the care of patients of all the major faiths – useful for the middle of the night when something happens?

In effect the CHFT Chaplaincy Department has three chaplains on call at any given time – Roman Catholic, Anglican/Free Church and Muslim. The number of call-outs last year were Roman Catholic 164; Anglican/Free Church 48, and Muslim 26. Though in practice we do what we can for those of other denominations and faiths (and there is a long history within hospital chaplaincy of the Church of England/Anglican church and the Free Churches together covering out of hours work, as in CHFT) , we need to respect the expectations of patients and the stance of our Churches. For the dying Catholic patient only the sacramental ministry of a Catholic priest will be acceptable. Likewise, for obvious reasons of language, culture and faith, it is difficult for anyone other than an Imaam to minister sensitively and effectively to a critically ill Muslim patient.

As the new Guidelines point out the European Working Time Directive has a bearing here, and many chaplaincies fall short of the requirement that workers must have at least 90 hours of rest on average per week. The Guidelines recommend that hours be averaged over a 17 week period, excluding periods of annual leave. The Guidelines also recommend that one day a week is free of all hospital duties. The use of bank chaplains is suggested to facilitate this.

The Guidelines also recommend remuneration for being on call (a percentage salary uplift as per Agenda for Change, as happens in CHFT) plus remuneration or recompense via time back for actual time spent responding to an out of hours call.

Our current working practices are:

Roman Catholic – HRI: on call shared between the three members of clergy in the parish (only two of who are priests). CRH: on call undertaken by R.C. hospital chaplain with some informal back-up from other local priests as required.

The situation with remuneration is that payment is made to the Diocese and this includes the salary uplift for on call. The hospital work apart from the regular weekly session in each hospital is carried out as and when required (and the HRI priests receive an extra session’s pay in respect of this). In Huddersfield hospital visits are viewed as part of the parish’s pastoral work. Many of the patients the chaplains come in to minister to are members of their congregations. The chaplain in Calderdale submits time sheets for extra hours work. So with regard to the Working Time Directive, whilst the priests may well have a day or two away from hospital this is not guaranteed.

The Anglican/Free Church consortia looks on average to comply with the European Directive as we have two bank chaplains assisting us (making 6 staff in all). The number of call-outs represents about the national average. This part of the service often finds itself responding to situations where patients are unsure about what support they need or uncertain about what they believe, but feel they need something at a time of crisis. Time is also sometimes spent helping staff to sort out where to access support on behalf of Roman Catholic and Muslim colleagues and where a person’s needs are more unusual.

The Muslim Imaam shares the on-call with his brother, Osman, covering three weeks to his one. Salary uplift is paid and regard had to the long hours on call by both clergy. Since he is at work for 11 hours per week only this leaves long periods when he is effectively on call and the co-ordinating chaplain has to seek him or Osman. Sometimes in cases of great urgency, usually involving the Maternity Unit in CRH, one of the female chaplains is approached. Issues can sometimes be resolved over the telephone with patients’ families when the request is for guidance or an explanation of hospital protocol. Clearly the situation falls outside the Working Directive.

The Chaplaincy has a role in the MAJAX provisions to support patients requiring their services and care and to support relatives generally. Such a broad remit is welcome and we await the revised Plan for major incidents which will confirm our role.

**We need to**

* **review our working arrangements to cover on call especially with regard to the European Work Time Directive and good practice, having regard to activity levels, patients and staff views.**
* **Consider if there are other ways of working together to support with on call cover. The Guidelines invite consideration of this between neighbouring Trusts.**
* **Ensure we can meet the requirements of the revised MAJAX, and all staff are aware of what is expected of us.**

**Working Together - Volunteers**

The Chaplaincy Department is fortunate to have a volunteers giving of their time and skills in both Trust hospitals. More than that they give of themselves, and patients and their families have a further opportunity to express their hopes and concerns in confidence to a person who will respond with care and sensitivity.

Our volunteers share the general ethos of the Department of being available to all and seeking to be primarily present as a listener, where the patient can set the agenda. They undertake either general ward visiting under the direction of a chaplain, or assisting with bringing patients down to the hospital services on Sundays (and taking them back to the wards!). A recent development has been to recruit from local schools in Halifax to help on Sundays.

Volunteers are selected and vetted in accordance with the Trust’s practices for all volunteers and receive specific training for their work within the Department. There is ongoing support and informal supervision from the chaplains with the intention that all volunteers doing ward visiting meet with the chaplains when in the hospital. We hold at least one practice sharing session per year and an Annual Quiet day of a more reflective nature. Experienced volunteers assist in the training of new recruits, sharing their experience and insights.

All training includes reference to the UKBHC Code of Conduct for Chaplains, which has been adapted for volunteers: whatever the volunteer’s motivation, it is made clear that the role is one of compassion and support, not evangelising.

Our volunteers come from a range of faith communities: we have volunteers working as honorary Sikh and Buddhist chaplains, and Christian, Muslim and Sikh volunteers totalling about 50 in all. Some have been working for a few months, other for years. Some undertake (with consent) to continue visiting patients after discharge from hospital, thus providing good continuity in the community.

Our visitors from Bolton Hospital Chaplaincy reflected that volunteers needed more formal recognition on posters and publicity. Perhaps the role needs clearer definition too. They thought the role of honorary chaplains needed consolidating. The new Guidelines stress the appellation should only be used where ‘their NHS training and status in their faith community match the criteria for paid chaplaincy staff’.

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| **Case Study**  For a long time Anthea had been a patient in a far-away side room. On general visiting a chaplain discovered her. She professed she had no faith but established a rapport through her wry sense of humour, and asked the chaplain to come back as someone to talk to. Her seemingly unresolveable health problems and few visitors led to many repeat visits and she was offered and accepted the support of a chaplaincy volunteer from the chaplaincy to break up the long hospital day. As her frail health see-sawed so did her husband’s and he was admitted to following a fall. Anthea started discussing matters of faith and asking for a prayer at the end of each visit. In a traumatic and awful few days, Anthea’s husband died and it was decided she needed 24 hour care. By this time chaplain and volunteer were offering close support and were a link with her son who lived away. By good chance the care home Anthea moved into was near to where the volunteer lives, and she was able to offer ongoing friendship and support to her.  Here we see how chaplaincy moves beyond offering friendship into providing a forum for exploring ideas and faith, and a means by which emotional support is freely offered to support through many losses. |

**What Volunteers tell us:-**

As part of the Review we asked volunteers what they felt about working in the Department:-

Some practical difficulties were highlighted

* what to do if ill on the Sunday you are rostered to help
* problems with getting into wards
* parking
* more publicity on the Chaplaincy needed

Deeper issues

* volunteers feeling isolated or unsupported
* not being clear about where they should visit.
* not integrated into wards
* record-keeping of attendance and patients seen is inconsistent

This may reflect the fact that there has been a period of change at HRI where chaplains have not been available to support volunteers regularly. Provision for volunteer support at Calderdale during the week is made through bank chaplains.

**Action Required:-**

1. **We need to work at ensuring volunteers have contact with chaplains and they know what to do if stuck. Fortunately most volunteer visitors at Huddersfield attend on the same day and we can identify a chaplain to set time aside to be in the office when they arrive and return from visits to offer support. This may be more difficult at Calderdale where volunteers visit across the week. We need to investigate this.**
2. **Consider setting more regular evaluation of volunteers’ performance as envisaged by Guidelines.**
3. **Look at record-keeping and ensure it is in keeping with Information Governance rules. (We learnt from Bolton hospitals that volunteers have their note books supplied and kept locked secure in the office.)**
4. **Look at the role of Honorary Chaplains.**