

Refreshing Chaplaincy 2014

Review of the Chaplaincy Department

Calderdale and Huddersfield NHS Foundation Trust

Summary and Offer

**Refreshing Chaplaincy**

This is a summary of the review of Chaplaincy Services undertaken in late 2013 and 2014. The review is a response to two vacancies which occurred in 2013 and the relatively recent appointment of a new co-ordinating chaplain (December 2011). It responds to the ever-changing nature of the wider community in which our Trust operates, and the pressures and forces at work both within CHFT and Chaplaincy nationally.

**This Summary of the work undertaken in our Review contains our ‘offer’ to the Trust and our thinking behind it. Our reasoning (using the famous “3R’s”) can be found in the next section.**

**Further information which backs up our conclusions can be found on our webpages at** [**http://nww.cht.nhs.uk/divisions/corporate/nursing/chaplaincy/**](http://nww.cht.nhs.uk/divisions/corporate/nursing/chaplaincy/)

**Such information includes**

* **Results of the surveys**
* **Content and conclusions we draw from the new national recommendations for chaplaincy**
* **Activity analyses, and**
* **Consideration of demographic change in relation to faith communities**

**An index will signpost you to the relevant page, and supporting documentation.**

**We are also producing a summary of findings from our patient and staff surveys which we hope to make widely available. Paper copies can be obtained from either chaplaincy office in CRH or HRI.**

**The Four Pillars**

The review was undertaken with reference to CHFT’s Four Pillars of behaviour. We have sought to put the patient first by undertaking patient surveys and learning from other chaplaincies. Chaplaincy operates very much as a team of different faiths and denominations within healthcare and we have reflected on how we need to develop to work together effectively within healthcare, trying to understand what the future holds for us. Finally, we have interpreted ‘must-do’s’ broadly, reflecting not only on the obligatory but on what belongs to the core of our work.

**Compassionate Care**

We hope that in our work it is evident we seek to show compassion within a framework of offering holistic care. Throughout the webpages there are case studies to give a flavour of our work. We are people-centred practitioners and it is our encounter with individuals that gives us our enthusiasm for the work, but we know we do not have a monopoly on that, and seek to assist in facilitating such care-giving by all.

The Chaplaincy Department has long been involved in seeking to offer training to all staff to explore spiritual care as a concern for us all. Our staff survey results contain a call for us to do more of this. We seek to model compassionate care too, which includes having a care for the corporate life of the Trust.

**Make it Happen**

The message we have heard loudly in the course of our review is that chaplaincy is widely valued and welcomed. It has a far broader scope than ‘religious people doing religious things for other religious people’.

Whilst we seek to respond swiftly and skilfully to requests for assistance, we are also encouraged that proactive, generalised visiting of in-patients meets with a positive response.

We do not just work with individual patients: we have an important role in advocating for patients and representing their interests in the Trust’s strategic work to improve the patient experience. This is an expanding role.

What follows is the response we have agreed on as a team and the action plan for making it happen.

1. **The Vision**

The vision we have is of a chaplaincy service that is able to deliver compassionate patient-centred care in a comprehensive and timely way. The service is also a resource for staff, and has a part to play in the life of the organisation in promoting patient’s interests and concerns.

Characterised by:

* a service with a broad appeal offering spiritual care to all
* prompt and effective response to referrals for religious or pastoral support
* being pro-active in work with patients and staff as we support many more people through being out on the wards and departments than specifically ask for our help
* participation in the corporate work in CHFT to promote patient wellbeing and a positive experience of care
* seamless service involving well-trained, confident and competent volunteers
* on-call service for out of hours emergencies
* specialist support for those experiencing the loss of a baby in pregnancy
* high quality regular worship and ‘one-offs’
* committed team-working with other healthcare staff
* involvement in training with staff on our areas of expertise, and facilitating staff to feel confident as holistic care-givers
* offering confidential support to staff
* as patients become increasingly cared for in the community to be clear about our contribution in holistic healthcare, and how that dovetails in with existing community services
* networked into local faith communities and interfaith bodies
* efficient administration and safe record-keeping

**b) The Reality**

At present the service is fragmentary and patchy. We need to define a joint understanding of our role and present our ethos clearly to patients and staff.

We hope this example gives a flavour of our work and helps illustrate the issues we face:-

***The Typical Week – w/c 30th June 2014***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Mon** | **Tues** | **Weds** | **Thu**  | **Fri** | **Sat/ Sun** | **Total****Wards visited** | **Hours available** |
| **Ward visits – chaplain**wards visited | 2a CRHMat-----------3 HRI5151920 | 4A-C6B-D------------101520 | 5A-D6B-D--------21 | 8A-D------1222 | 19 |  | **CRH: 19****----------****HRI:12** | **CRH:10 sessions****--------------****HRI:12 sessions** |
| **Ward visits –volunteer**Wards visited |  | ----------46817 | 2AD3A-D--------- | ------20 | ------------ |  | **CRH:6****----------****HRI:5** | **CRH:****1 session****----------------****HRI:****3 sessions** |
| **Funeral work – chaplain** |  |  |  |  | Home Visit to family 60min |  |  |  |
| **Meeting / Training-chaplain** |  | “Prevent” Team Meeting 60minsVolunteer Training 2 hours | Palliative Care Team 90 minutes End of Life Training 90 mins | 1:2:1-line manager 45 mins |  |  |  |  |
| **Chaplain - other** | Supervision given 1hr 40 mins (2 x chaplains at 50 mins) plus travel | Lunchtime service – 40 minutes | Mass – 40 minutes |  | Clinical supervision for co-ordinator60mins /Urgent call to CRH from HRI 60 mins | HRI SundayService + visit to ward for patient care90 minutes |  |  |

**Notes: 1.** This week is unusual in that there is no ‘baby funeral’. There was just a visit to prepare for a funeral. We undertake contract funerals for babies who die in pregnancy or around time of birth**:**  this generally involves a home visit to meet parents wishing to attend the funeral in order to meet them, offering support and preparing the service and, of course, conducting the service. As a department we perform up to three baby funerals a week. To date (12-09-14 - week 36) chaplains have undertaken 53 such funerals in 2014. We also undertake adult contract funerals – about one a month.

**2.** The co-ordinating chaplain is involved in the delivery of Prevent Training, End-of-Life Training for Nursing and Healthcare staff on a regular and recurring basis. He also participates in the Equality and Inclusion Board, Sensitive Disposal of Foetal Remains Meeting, and the Patient Experience and Quality Group. Further training is given once a year together with a Muslim spiritual advisor at Huddersfield University for midwives in training. Being the one full-time member of the team, the co-ordinator also undertakes the day to day management of the department and support of the team. He has also supported the development of the local SANDS Group, and with colleagues prepares and leads group services of remembrance in the summer and at Christmas. As well as all that the co-ordinating chaplain is currently undergoing Leadership Passport training.

The point we want to make is that whilst all of this activity is valuable, and supported by the Department, working in one type of work necessarily reduces time which can be spent in another!

**3.** In the typical week above the numbered of wards visited was:

In Calderdale Royal Hospital, 19 out of 32 wards were visited by chaplains in

the week, equating to 59% of inpatient areas. 6 wards were visited by

volunteers: 18%.

In HRI, 12 out of 21 wards were visited by chaplains : 57%, and 5 wards

received volunteer visitors - 23%.

A ‘visit’ can vary from a general ward trawl to a specific visit to a patient or

family requesting our support.

We need to be aware that the “hands-on” work with patients, relatives and

staff is therefore patchy and inconsistent at present.

**4.** One chaplain who works two sessions a week was on annual leave this week.

**5.** This was a ‘thin’ week for volunteer visitors. In each hospital there is a committed core of approximately 5 volunteers with others visiting more occasionally. They offer a befriending service to all patients and religious care to patients known to practice a faith.

**6.** Our figures do not include the wards visited by our Roman Catholic chaplains – such details are not to hand, but they visit once a week patients declaring themselves to be Catholics. Muslim details are included.

**7.** We run three separate out-of-hours on call services: the Roman Catholic chaplains run theirs from the local parish and come in on average twice a week. Our Imam and his brother (also an Imam) respond to on call requests, some of which can be dealt with over the phone – about once a week. The Free Churches and Anglicans chaplains share on-call, again being made use of about once a week.

**8.** There is no such thing as a typical week!

**Conclusion**

* We have worked a system of individual chaplains responsible for each ward in the past, ensuring each ward is visited every week but that is not tenable with current staffing-levels.
* The details above do not discriminate between ward visits where one patient is seen (as a result of a referral) or virtually everyone.
* We know we often end up working with patients who first think it unlikely they will have much to say to us.
* We think it is valuable (as our surveys confirm) to be as high profile as possible and available to as many patients as possible.
* There can be a negative perception on the part of staff that if not seen visiting patients, we are not doing anything!
* We need to be realistic in prioritising our work, recognise we cannot be everywhere at the same time and have good strategies in place to ensure urgent and serious need is met.

* ***We deliver well on:-***

Offering a supportive, helpful and caring service to patients,

Seeking to understand and make a useful contribution to CHFT activity on matters that affect patient dignity and care, and co-working with others to affect change for the better,

Providing high quality support to patients in the opinion of staff,

Discovering and addressing spiritual needs of patients which no-one else has flagged up,

Meeting tight deadlines for services for bereaved parents,

Responding to referrals from patients themselves, their families, staff and community clergy,

Sensitive, conscientious and well-trained volunteers who offer befriending to all and support for members of faith-communities,

Responding competently to emergencies on-call,

Providing high quality training sessions which are well-evaluated,

We have an efficient administrator to support the team and voluntary assistance in this regard in CRH

Leading regular Sunday, Tuesday and Wednesday (HRI) worship,

Celebrating the life of the Trust community (Carol Service, memorial services, Nurses Day input, etc)

Maintaining Hope Centres which are well-used as places of quiet and prayer.

* We think we are:-

Approachable and helpful to many patients and staff

In-touch with patient concerns and themes

Team-players within healthcare

Able to promote an inclusive concept of spiritual care as being that which affects wellbeing

Able to train volunteers to a good standard

Seeking to encourage all staff to see they have a part in offering holisitic care

Able to model compassionate care within and to the Trust

Able to model Christian unity and interfaith harmony to others

Able to work well with each other as a team, respecting difference and affirming commonalities

* ***The difficulties which face us are:-***

See the conclusions to the Typical Week above for the competing claims on our time.

We need to balance the differing demands on us and agree roles and priorities as a team. We need to think and act smart to devise ways of addressing conflicting demands.

Staff and patients are not aware of our potential, yet we wonder if we could cope with growth in demand.

Some patients and staff are unaware of what we do, and what we can help with. Some will have preconceived ideas of what we stand for.

Our volunteers feel they are not adequately supported and their role is unclear.

Some chaplains (especially those from minority ethnic communities) find their work is carried over into the community and it is not clear if the Trust should resource this

Our co-ordinator has a management and strategic role but is also the one expected to undertake a lot of the hands-on care. The one is at the expense of the other.

We need to be honest about the demands of the work we do. It can be intense and relentless calling for resourcefulness and resilience. We need to acknowledge the need for training, professional support, time out in retreat, taking time back, engaging in research and generally looking after ourselves.

In looking to the future we believe we can contribute to supporting patients at home. We are not sure of the interface with resources in the community to respond to this trend and need to explore this issue. To many patients we offer something distinct from the support they would receive from a local church.

1. **The Response**

To help us to achieve our vision, we need to build on the positive responses our patient and staff questionnaires have given us. We also aspire to offering a quality service based on national standards and good practice. This is contained in the newly revised (and at present draft) NHS Chaplaincy Guidelines 2014 (‘the Guidelines’).

In particular we need to:-

* Affirm our vision and objectives together. We believe that we should offer as broad a service as possible – both to patients and the Trust.

We affirm our commitment to compassionate and respectful patient-centred care. We understand that due to limitations of resources and time some of us work primarily within the bounds of particular faiths and culture but we are committed to support each other as a team to help realise our common vision.

* We need to ensure compliance with best practice as outlined in the new Guidelines to ensure we offer a safe, and effective professional service. This means we need to look at how we offer a quality service, and agree standards of performance. We can do this by benchmarking our service against the revised the Guidelines (some of which we already meet).

* Develop our training and support for volunteers to enable them to perform their role with confidence and competence. Identify ways in which volunteers can lead in certain areas.
* Staffing

At present we have one 0.8 FTE post vacant (currently filled by bank chaplains)

and a 15.75 hour vacancy (from November 2013)

We need to fill both vacancies to support our work.

The Guidelines suggest that with both these posts filled we are still about 4 sessions below the recommended staffing level (see our webpages for the calculation with comments).

We acknowledge that we are unlikely to obtain new resources at this time of financial restraint.

Here are the competing priorities:-

1. Complementing the work of the co-ordinating chaplain, based at HRI. We acknowledge that a good proportion of his time is spent working corporately within the Trust to promote patient-centred care, or on management issues. In the example of the typical week approximately 9 ½ hours are spent in specific training, giving or receiving supervision, and participation in strategic meetings. When routine management is added in it would be fair to say at least a day and a half (sometimes much more) per week is spent in corporate work or management.

Resources are needed to boost the amount of work undertaken directly with patients and staff in HRI.

Potentially all of the 15.75 hours could be used for such work: the formula in the Guidelines suggests a hospital of 370 beds requires 11 sessions of chaplaincy to respond to patient care alone, before we start adding in sessions for supporting staff and baby funerals.

1. Resourcing further work within ethnic minorities. Involvement within the Maternity unit and the Child Development Unit has revealed the need to provide further support, particularly within the Muslim community to reduce isolation and promote confidence in using services amongst young parents.
2. Scoping how the chaplaincy might respond generally to the increasing trend of caring for patients in the community.

It may be possible to unlock funding from elsewhere to promote reaching into the community, but a detailed proposal needs to be developed for this.

1. Further resourcing of work at CRH. Again, the formula suggests CRH is under-resourced. One of the bank chaplains working there has many strong links with staff from previous employment there, which can be capitalised on. There are ideas for innovation and development within such areas as rehabilitation and dialysis.
2. However these priorities are juggled, we need to work smarter with volunteers, appreciating that their input is a distinct contribution rather than a fortuitous add-on. Further training is required to skill them up:
3. to act as lead representatives of chaplaincy on some wards, and
4. for them to be able to assess more clearly which patients need referring on for the more specialist care of a chaplain
5. we recognise such developments need support and supervision for volunteers working with greater responsibilities

**Conclusions on staffing**

On the basis that all we can do is fill our vacancies:-

1. Make permanent the 8 sessions at CRH
2. Of the 15.75 hours which are vacant –
3. apply 7.5 hours to support co-ordinating chaplain at HRI

1. and of the remaining hours dedicate 4 hours for development work based at CRH or HRI to further work within ethnic minority groups.
2. 4.15 hours for developing the role Trustwide of chaplaincy provision for those of any ethnicity and faith background (and none) to be cared for in the community / at home, as envisaged in the Joint Strategy – a time limited post for 2 years.

 Were further resources available (four sessions as per

 the draftGuidelines):-

1. We would look to a further 2 sessions support for the co-ordinating chaplain - primarily at HRI – possibly on a band 5 (training level)
2. Adding an extra day for generic chaplaincy work at CRH – to also complement community development Trustwide.

It would not be necessary for the community liaison/developmental work to be carried out by an ordained member of a recognised faith community but they would have to have a broad knowledge of chaplaincy and the intricacies of inter-faith working. Our Equality Act obligation of developing opportunities for those of no faith needs to be embraced too.

Further developments include:-

* Rejuvenate our publicity and information so that everyone knows our role and how to access the service. Many of the resources produced about 18 months ago appear to have been lost in clinical areas.
* Develop staff training – we need to develop and deliver training to staff on a rolling programme so that they can develop an awareness of when it is appropriate to refer to us both for patients – and, perhaps more significantly, for themselves.

It is increasingly important and helpful to us when we may have to expect that less than 70% of wards are covered each week (as per our example) that clinical staff are skilled in identifying need and summoning us to patients.

The Chaplaincy Team, September 2014