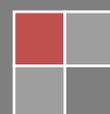


2014

# Evaluation of the Muslim Chaplaincy Service

Calderdale and Huddersfield NHS Trust

This report extends beyond its aim to evaluate the adequate provision of spiritual care and to set out a rational basis to improve the delivery of health care to Muslim patients. Using data from interviews, personal accounts, demographics and workplace statistics, it provides valuable insights into ways in which 'The services we offer as Chaplains' may be truly recognised so that the NHS and its highly skilled and dedicated staff are better equipped to appreciate the spectrum of diversity in which we offer our care.



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Huddersfield

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# 1 Introduction

We live in a multicultural world where religious labels can be seen all too often as sources of tension and division. Within healthcare communities, as with wider society, our differences can, and should be seen as part of an enriched human diversity. We are now more aware of ethics and ideals generally understood as 'humanistic'. Over the last few years developments in the understanding of pastoral and spiritual care within the NHS (National Health Service) have evolved. Many people have a rich array of beliefs but would not describe themselves as belonging to any one particular group or faith community. Many others however, profess strong religious beliefs and identity that are integral to their spirituality. Over the last few years developments in the understanding of pastoral and spiritual care within the NHS (National Health Service) have evolved. Pastoral and spiritual care in the NHS must be inclusive, accepting human differences and based on mutual respect. We continuously learn to improve our listening where it concerns the needs of the different people around us in the hope to provide genuine patient-centred service and to enhance the patient experience. This provides us with the tools to deliver care that is both effective and fulfilling.

Although religions are diverse, they share a claim to divine inspiration and the imparting of moral truths and guidance. Beliefs, symbols and ceremony can help religious communities and individuals in times of celebration and tragedy. To the unfamiliar, these practices may seem rather rigid and irrelevant, but to those within the tradition, these practices are very symbolic and hold deep meaning.

Chaplaincy is a wide ranging support service that reaches beyond the scope of this report. It would be inappropriate to try to tackle the whole of the chaplaincy strategy, without the depth that is required to appreciate the service, given the time constraints. In order to make the patient's care our concern, Chaplaincy with all of its flavours needs to be accommodated. Arising from this need, a request was put forward to evaluate and plan for the part of chaplaincy that falls under the umbrella of 'Islamic belief' or caring for patients that relate to this faith. The following aims illustrate the themes explored by this report: -

1. Highlight the importance of adequate provision of Muslim chaplaincy, to help build a culture in which spiritual values and spiritual care for service user and staff groups from all diversities is seen as a key part of service planning and delivery within the organisation.
2. Provide guidance for relevant pastoral support and spiritual input for Muslim patients, inclusive of any efforts to form an integral part of a whole person centred approach to care. Whilst being able to fully support and influence key agendas around wellbeing, recovery, engagement, sustainability, inclusion and diversity.
3. Identify a roadmap for the promotion of a spiritually aware and skilled workforce achieved through a staff training and development programme related to the specific spiritual care and spiritual needs of the service user. Such a programme is the key to ensuring service users' religious and spiritual needs are taken into consideration in assessment and care pathway planning and delivery.

In essence the importance of this report extends beyond its aim to ensure adequate provision of spiritual care and to set out a rational basis to improve the delivery of health care to Muslim patients. It provides valuable insights into ways in which 'The services we offer as Chaplains' may be recognised as instrumental in leading the NHS and its highly skilled and dedicated staff with enhanced tools and confidence to appreciate the spectrum of diversity in which care is provided.

Good practice from other surrounding trusts, academic literature, relevant reports (including forecasted statements from the upcoming review on NHS Chaplaincy nationally) and in house case studies have been used to compile this report.

## 2 Local Demographics

The 2011 Census illustrated that the estimated Muslim population (37,686) in Huddersfield and Halifax almost doubled since the 2001 Census (20,978) and stands above the national average. In addition there has been an increase in international students coming to study at the University of Huddersfield and Calderdale College. In 2013, The University of Huddersfield accommodated 2400 international students just from Muslim countries.

Both Huddersfield and Halifax host a population that is in relative industrial decline and its geographical location for employment does not offer a significant percentage of skilled labour jobs or high level managerial positions. This socio-economic disadvantage coupled with relatively poor employment generally indicates that the health and mortality rates would be undesirable. This is based on the correlation of the 7 categories of employment of which the lower three are most popular, particularly amongst the BME community (ONS, 2011). To add to this pattern there is a high unemployment rate of Pakistani and Bangladeshis, who predominantly belong to the Muslim faith.

This document is formed on the premise that there is a significantly larger Muslim population that is served by these two hospitals at present (37,686, Census, 2011) than that was present over 10 years ago (20,978, Census, 2001), when the Muslim chaplaincy was introduced (in 2002).

### 3 Chaplaincy: The bigger picture

To facilitate the multi-faith approach to chaplaincy, a chaplain needs to have the ability to understand the patient's faith or spirituality, have some understanding of their culture and understand the reason they were admitted to hospital (Francis, 2013). This would also enable the chaplain to work with other health care professionals to provide the best possible patient care. The delivery of such care needs support from faith specific leadership to provide resources on issues like culture, religion and spirituality.

One of the main findings of the Francis report was the detachment of organisational culture from patient care. It emphasises that the patient should be put first. This includes the cultural and religious needs of each patient as contributors to the holistic wellbeing of a patient. This relationship with other aspects of identity (for some cultures, ethnicity and religion are virtually inseparable), need to be brought forward and accommodated. Service data shows that more people from BME backgrounds identify themselves as religious. By failing to address religion, services disproportionately affect people from BME backgrounds.

The potential for people who hold religious or other beliefs to have poorer experiences of services is relatively high because core aspects of their identity are overlooked, or they have no means of religious expression (for example the provision of ablution facilities). This may cause anxiety and prove detrimental to their recovery from a spiritual perspective.

Spirituality and pastoral care respond to the needs of the human spirit when in trauma. Ill-health or sadness in modern society can invoke the need for meaning and self-worth. These negative mental states or attributes can be addressed through the provision of pastoral care, provision of religious prayer or rights, or something as simple as a listening ear from a person that the patient can relate to.

*“Health is not just the absence of disease; it is a state of physical, psychological, social and spiritual well-being”*

(World Health Organisation, 1998)

The above quotation emphasises the importance of the services provided by the chaplaincy. This is further strengthened by the need of empathy and compassion that are seen as vital ingredients, even prerequisites in the provision of effective health care.

#### 3.1 Legal Implications

Since the introduction of the Chaplaincy many years ago, there have been several legal acts that have been introduced that have an impact on the health service. Some of these may need to be considered by the chaplaincy in its service provision. The legal implications are usually set as a minimum requirement. As a service provider, it is the Chaplaincy's decision as to whether they meet the minimum requirement, or as it currently does, provides a service that exceeds the minimum. The third option could be to strive for excellence, far beyond the legal minimum.

The Equality Act 2010 incorporates prevention of discrimination on grounds of religion or belief. This Act defines 'religion' as any religion and 'belief' as any religion, religious belief or similar philosophical belief. Part 2 of the same Act makes it unlawful to discriminate in the provision of goods or services on the grounds of religion. The Equality, Engagement and Experience Board sits above specific work streams related to service improvement for patients and staff with each of the protected characteristics. This initiative relates the Chaplaincy to work with the EEE group and acknowledges the identity of patients that are being treated, ensuring an equal level of service to each user. This is not the same as treating them 'equally', as some users may have different needs for them to 'feel comfortable' in an environment. For a Muslim this may mean that their cultural needs are accommodated for, such as directed to the prayer room or assured of halaal food.

These acts acknowledge the importance of both religion and spirituality in the healthcare trusts, whilst religion itself when seen in isolation of spirituality maybe in general decline, there is an increase in discussion around spirituality which would include religion for those who see their religion as an integral part of their spirituality. The legal implications provide a minimum core that we meet. However, it is important to revisit these as a benchmark for the evaluation of the service that we provide.

## 4 Muslim Chaplaincy - A local narrative

“Muslims seek spiritual and religious care alongside medical attention according to Islamic tradition, which views a healthy body and spirit as gift and trust from god. “

(Isgandarova, 2011)

The Chaplaincy at Calderdale and Huddersfield NHS Trust was set up over 25 years ago. A Muslim chaplain/imam was introduced in 2002, providing 15 hours of support per week. His key role was to provide the generic pastoral, religious and spiritual care for patients, relatives and staff with specific a focus to responding to the needs of Muslim patients and staff.

Discussions took place around the provision of female Muslim Chaplains. This was initiated from needs expressed by service users, staff and feedback from volunteers. Another emerging need was from some female patients that prefer to consult another female on matters that are sensitive and personal (this is particularly true of Muslim women); Due to limited resources and tight budgets, it was decided that no extra provision/sessions could be allocated for female Muslim Chaplaincy.

From the perspective of patient-centred care, the Imam felt that the absence of female chaplains meant many patients and staff were excluded from valuable support. The Imam proposed to give up four of his fifteen hours to make space for the provision of two female Muslim chaplains, one at each site. Two very carefully selected female Muslim chaplains were then employed by Calderdale and Huddersfield NHS Foundation Trust in November 2011. They were allocated 2 hours per week as Bank Chaplains.

### 4.2 The Role of Muslim Chaplaincy

The Muslim Chaplain’s role consists of a multitude of responsibilities that demand thought, time and energy. It involves a multi-dimensional model of service delivery that far exceeds the normative working model which leads to the complexity of trying to set the appropriate pay banding for Muslim Chaplaincy. The role’s responsibilities bring a unique yet complex aspect to the work, a very significant, nevertheless modestly recognised contribution to a constructive, well-formed chaplaincy department. Over time, the Muslim Chaplaincy has been assumed to a position that seems underestimated and certainly undervalued with reference to its importance and adequate provision within the wider context of chaplaincy roles.

The Muslim Chaplaincy has mainly adopted a pro-active ‘make sure’ approach to ensure a high standard of service. This section aims to summarise the role and brief summary of work that the Muslim Chaplains have been involved in at Calderdale and Huddersfield NHS Trust since coming into post.

#### 4.2.1 Networking, awareness and promotion

The spectrum of the Muslim Chaplaincy is wide-ranging and includes contributions that have a positive ‘knock-on’ effect like active involvement in the reconfiguration of prayer and ablution facilities across both sites. These emerged from facilitating a positive and constructive dialogue between the Trust and the Muslim community. This rapport enabled sufficient funds to be raised

from the community for the provision of the facilities. Such contributions were the result of effective teamwork including the involvement of volunteers and Estates Services. Pro-active project leadership and co-ordination was provided by the Muslim Chaplain/Imam the hospital.

Many of the tasks that are carried out by the team result in the 'knock-on' effect to provide greater impact from sustained efforts. To exemplify this, good relationships built with staff from Maternity, Children's ward, departmental leads and general ward visiting, resulted in staff referrals and effective support to ensure the Trust's policies were adequately informed in areas where there seemed to be conflict between Trust guidance and religious ethics.

Attending MHCCN (Muslim Health care Chaplaincy Network) meetings enabled networking with other Muslim Chaplains in the region and sharing issues that the other chaplains had encountered and how they were addressed. Learning from experiences of other professionals helped to develop a better understanding of dealing with issues effectively, if and when they arise. The MHCCN meetings provided some CPD and examples of good practice for areas such as catheter removal, bare below the elbow, halal meat, euthanasia and Islam, and review of the Liverpool care pathway, organ donation and other issues of relative importance.

Figure 4.1 provides those activities that have been targeted by the Muslim Chaplaincy team. It is important to note that the activities or follow-up tasks that emerge as 'knock-on' effects have not been mentioned. As with the examples above, the activities in Figure 4.1, particularly those in the realm of patient and staff facing, have resulted in a 'holistic' approach to patient wellbeing. This encompasses the model of practice emphasised by both the Francis Report and the four pillar engagement model recently adopted by the Trust.



Figure 4.1: A distribution of the contribution made by the Muslim chaplains in 2 key dimensions of service delivery collaborative working and engagement, divided into 4 core areas: - **Patient Facing**, **Staff Facing**, **Publications and Networking and Outreach**.

Figure 4.1\* 'National Board of Chaplaincy Assessors panel'. The panel of assessors is a resource available to assist all trusts in making chaplaincy appointments. Good practice in recruitment indicates that fair and effective appointments are most likely to be made when an assessor is deployed. An assessor is usually identified as soon as a vacancy becomes apparent, to provide maximum opportunity for advice on issues such; as job descriptions, advertisements, skill sets and job evaluation.

### 4.3 Evidence base for effective outcomes through engagement

An interview with midwives in the Trust regarding Muslim chaplaincy was conducted to ascertain their perception, impact and possible enhancements that can improve the service. The full transcript can be found in Appendix A. Below are some excerpts that contributed to Figure 4.1 above.

Midwifery comments:

*"Midwives we are required to offer and provide appropriate support and services to individuals and families from a range of ethnic and religious backgrounds. Provision of the right support at the right time is essential; hence the availability of specialist help and support is invaluable in allowing us to provide a complete and caring service to bereaved parents. ....the ability to offer on-going support from Muslim Chaplains is essential in each case."*

The availability of the Chaplaincy Service was pivotal for the 'Care' of those that had suffered a loss. This helps to build an understanding and relationship with those requiring the care. The need for ongoing support was also expressed, which is currently a limitation in the service we provide due to the time constraints. The Muslim Chaplains were also seen key as players in bridging the service between the patient and the Trust. Impact from effective communication was expressed as...

*...We regard this [understanding] as a continuously evolving subject and as such, communication with the Muslim Chaplains is absolutely key to helping continuously develop our knowledge and understanding of the needs of bereaved Muslim families....we have already seen a much improved structured approach which has already led to a significant improvement in our working relationship with yourselves [Chaplains].*

This goes beyond just spiritual and religious understanding to an extent where linguistic barriers are also addressed, all in a systematic way where the Muslim chaplaincy is seen as part of the 'care' service. Good relationships with staff have a positive effect on the patient, demonstrating an exceptional and seamless care service. Whilst the foundations are being developed, the staff expressed the need for a continuous dialogue through meetings...

*..It is clearly essential that the foundation we have created is developed into something which is sustainable for the future. Key therefore, is to continue to develop our dialogue through regular scheduled meetings to help ensure our processes are continuously reviewed...*

The continual improvement process indicated above, further strengthens the need for regular meetings. These meetings should incorporate feedback from patients

*...We are acutely aware that the needs of individuals differ depending on ethnicity and/or religious belief... so feedback is absolutely vital to our future development. We see yourselves [Chaplains] as potentially invaluable in helping to collate information and helping in the provision of feedback....*

The midwives also commented on potential further developments. This included a greater physical presence, more literature on dealing with patients, faith specific matters and a nominated contact point within the Muslim Chaplaincy.

*...greater visible presence of all Muslim Chaplains on LDRP, perhaps supported by supporting literature/material to help develop awareness of all staff in the unit, including the provision of a nominated contact with appropriate availability and interest in pregnancy loss & bereavement....*

There was also a request for follow up visits to the homes of patients along with the call for greater input from the Chaplaincy department for professional development

*..This could in the future perhaps be developed via training/mentoring/counselling sessions with staff run by the Chaplaincy department..*

This model of development expressed by the midwives for their department can and should be replicated to other departments across the Trust. The request for training and mentoring are skills that need to be embedded within the Trust. The midwives acknowledged that the staff that deal with bereavement also experience high levels of trauma. Adequate levels of training and mentoring would also act as a positive support mechanism for them.

#### **4.4 Local Case Studies**

The following examples of case studies illustrate the involvement and complexity of the chaplaincy service provided. These cases are from a Muslim perspective. They all demonstrate the need for faith-specific perspective on intervention for patient-centred care.

##### **Case 1**

*A Muslim Patient on the intensive care unit on the ventilator. The Doctors wanted to remove the ventilator but the family are not allowing as they view this as denying the patient the right treatment. The Staff at the intensive care unit wanted to clarify what the Islamic perspective was as the family felt that they were not listened to, hence the Muslim chaplain/Imam was involved in the discussions to give the Islamic ruling and provide support to the family. Good teamwork with the Medical Staff helped to answer the questions effectively and accurately for the patient's family.*

Case 1 shows the importance of a timely response and effective communication to reduce suffering of the patient and the additional burden on staff on the ward. The family was also put at rest with

regards to following the correct decision for both the patient and their moral duty to him. Had the Chaplain/Imam not been available the whole process would have been delayed and further inconvenience would have been caused.

## Case 2

*A question was raised by a Muslim doctor on the neonatal unit regarding the permissibility of giving donor breast milk. The doctor had been asked this question by a number of Muslim parents and wanted to clarify what the Islamic perspective was, in order to convey the correct information. From a medical perspective, the doctor had felt giving donor breast milk to neonatal babies was the best option.*

*The question was picked up by a female Muslim Chaplain on a ward round. Due to the small number of hours given to Chaplaincy, visiting the same department will often result in meeting new staff as was the case here. The doctor expressed she was unaware of the Trust employing Female Muslim Chaplains.*

*The Female Chaplain recognised that this question would need the expertise of the lead Muslim Chaplain/Imam. The question was referred to him and an appropriate answer was conveyed to the Doctor.*

The importance of medical staff having access to information related to the ethical practices based on religious values, demonstrates a high-level of patient-centric awareness. As in the case above, patients will often ask the medical staff on the ward for advice on issues that may stem from a religious perspective. Whilst an option may be reasonable for a patient from a medical perspective, it is important for the medical staff to refer to those that are well-aware of the religious matters that help to instill a feeling of a patient doing the 'right thing'. In addition, the Imam is skilled and knowledgeable in the extent of 'striking a balance' between critical situations and those that are less critical.

The above cases not only demonstrate the impact on patients but also highlight how unaware some of the staff are regarding the Muslim Chaplaincy part of the service. To demonstrate this, the medical staff in Case 2 was unaware of the existence of the Muslim Chaplaincy. The value of the Service as part of the wider Trust can also be appreciated from the above cases.

## 4.4 Evidence of Collaborative Impact

This subsection incorporated information on the hours that have been allocated to members of the (whole) Chaplaincy service by faith. This allows the apparent impact (including that above), to be contextualized according to its relatively modest proportion of the Service.

A mechanical framework of allocation of sessions based on bed ratio or number of inpatients at any given time may indeed form the base line from which discussions around provision take place but one would be compelled to ensure adequate resources and provision of Muslim Chaplaincy is in

place based on local trends, Trust needs, staff feedback/expression of support, and measures that ensure that ‘compassion’ is at the core of any dimension of care offered.

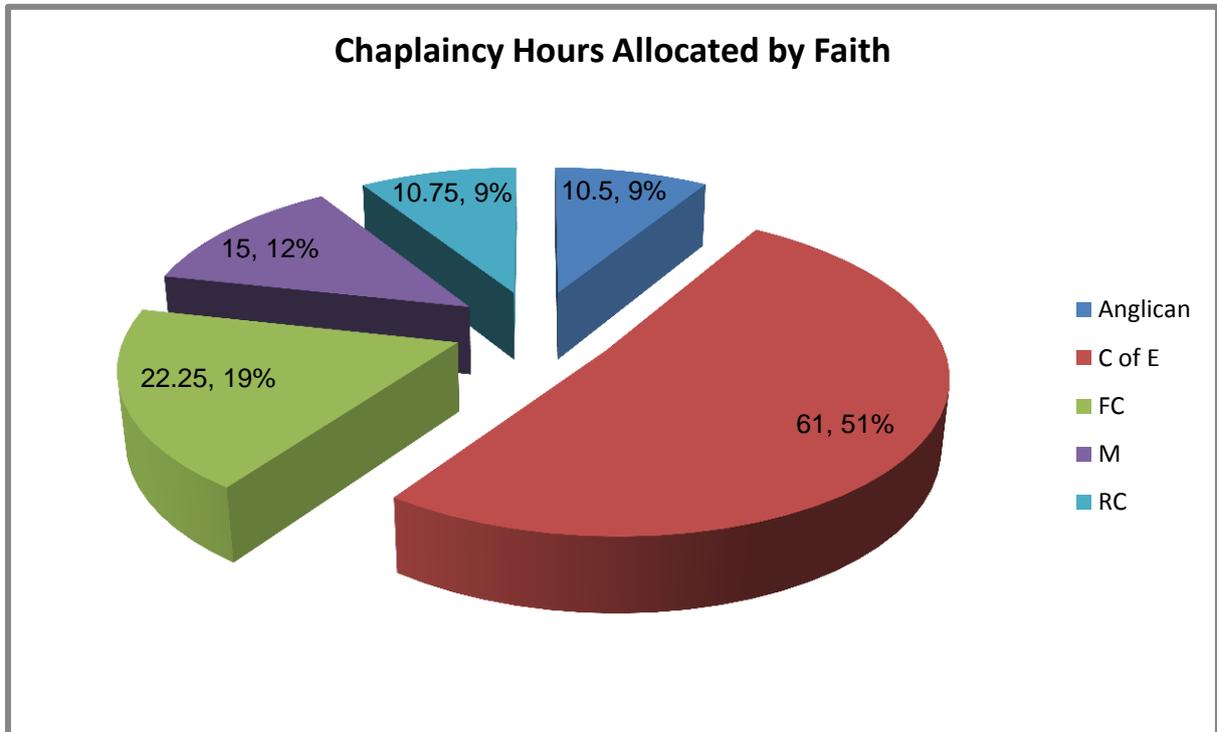


Figure 4.5: An estimated proportion of the hours of chaplaincy by religious affiliation

Figure 4.5 shows the makeup of the Chaplaincy. The Muslim proportion of the service consists of 15 hours per week. This adds up to around 12% of the total time allocated to members of the Chaplaincy. It is important to note that this does not incorporate data on the actual *hours available* to the Service as there may be hours that are yet to be allocated to members/faiths represented in the team.

The following commentary or emails are those collected by members of the Chaplaincy team from staff across the Trust. These are examples of qualitative data highlighting the impact that that the Chaplaincy team makes in the sphere of networking across the Trust and with external organisations. The full letters or emails can be found in Appendix B. The following comments were received from the Child Development Centre:

*“Having the Muslim Chaplin’s visit our environment has been beneficial because they have been able to engage with families on an informal level, sharing information and offering support on cultural issues as well as understanding family life in the community. In addition, the Chaplains have provided us with correct and up-to-date display materials.”*

*“To have a presence from the Chaplaincy Team has given families from diverse cultural backgrounds the opportunity share family life experiences and offer emotional support.”*

The Catering Department stated...

*“Chaplaincy has been involved in the selection process for the supply of halal patient meals; this has included verification of the certificates and speaking directly with current suppliers on a range of issues and products.”*

This was specific support provided to the Catering Department to ensure the provision of halal food was appropriately supplied to the Trust. This strengthened the trust and comfort that the patients experience.

Presentations by the Muslim Chaplains were delivered to the ‘End of Life’ team covering ‘The Rites of the Dying Muslim patient’ and ‘Grief and Bereavement’. Further collaboration involved work with the Mortuary Manager and other members of staff, raising awareness of Muslim issues surrounding death. The Training Lead for End of Life Care mentioned the following:

*“.....I believe it would not have been a success to complete the different issues without having the Muslim Chaplains in CHfT for me to work with.*

*It is a valued service that is greatly needed as our organisation caters for all people from different faiths that focuses on a patient-centred approach.*

*Being able to address people’s spirituality, culture and religion in times of distress is paramount to the care that is given and will be given in the future.”*

The above comments reflect the value placed on the diversity of patients. They are also indicative of the increase of the importance of spirituality, culture and religion in the future.

The Dementia Matron stated the following:

*“.. I feel it would be truly beneficial for me to have some support from the Muslim Chaplaincy to help me support patients and relatives of people with dementia.*

*I have had several referrals recently from the Asian Community and I find it very difficult for them to understand that prevalence of dementia in the Asian community is quite high, as there is high risk of strokes, heart disease and diabetes. Therefore there is a role for education.*

*If I could take some support from the Muslim Chaplaincy to engage and assist in communication, I feel it would be beneficial to the Asian community and increase wellbeing and reduce stress for both the person with dementia and there carers. My understanding of the Asian community is that spirituality and religion are a key part for the community and as a whole it would also increase my knowledge and help me to find the best way to provide support....”*

This is an area that needs more awareness for both the patient’s relatives and staff in the Trust. Dementia is not recognised in the Muslim community which leads to neglect of the patient and stress for the carers. Ideally, a project to raise awareness of dementia in partnership with the Chaplaincy would be a very effective method in tackling this situation.

## 4.5 A Patient Perspective

*“Do you not see how god has given the example of a good word? It is like a good tree, whose root is firmly fixed, and whose branches reach the sky, ever yielding its fruit in every season with the leave of its Lord. God gives examples for mankind that they may take heed”*

(The Quran 14:24-25)

Work carried out by staff or carers involves meaning through words. When our words are rooted in cultural awareness, knowledge, and sensitivity, they have the potential to stimulate positive growth like the tree described in this verse. Words can have a powerful and far reaching impact, even beyond the lives of the immediate clients. Unfortunately, when caring for Muslim patients, often staff are unsure of what words to use, and what prevailing cultural/spiritual or religious practices may mean in the context of the patients own understanding of their pathway to care. A lack of knowledge regarding the beliefs and values of a religious group which the popular media has tainted with misconceptions, prejudice and on-going scrutiny can be problematic within a health care setting.

In attempting to fulfilling our promise ‘make your care, all of our concern’ it needs to be recognised that a person centred holistic approach to recovery and wellbeing must engage deeply with spiritual issues and so respond effectively to the spiritual needs of service users carers and staff. It is not acceptable to engage with people with anything less than complete respect which honours their individuality and uniqueness, recognising that each possesses particular resources of belief, belonging, values, relationships and life context which will make a crucial difference to their ability to recover from illness or to maintain wellbeing (Lachlan, 2009).

An NHS Scotland publication builds on these ethical and moral imperatives of providing spiritual care. It suggests altogether four broad headings in summarising the clinical and organisational benefits of adopting a strategy for promoting spiritual care:

*“Ethical – because it is the right thing to do, to treat people well and appropriately whatever their faith, belief, gender, age, ability/disability or sexual orientation.*

*Clinical – because there is a level of evidence that when people are well cared for they have greater opportunities for recovery and for the maintenance of wellbeing.*

*Legal – because there is now a regulatory framework which forbids discrimination and therefore encourages the equal and fair treatment of all from any culture or background.*

*Financial – because there will be greater satisfaction and better outcomes among patients and less stress and absenteeism among staff.”*

(NHS Scotland, 2008)

As our engagement strategy suggests, it is not about ‘how do we want to save money’ but rather ‘how do we want things to be’.

A letter of acknowledgement received from a service user whose wife benefitted from the services of the Muslim Chaplaincy provided the following anecdotes:

*"...the Chaplains support for me as a husband who thought he would lose his wife was fantastic..."*

*"..without the service in the hospital I feel that I would have crumbled as an individual and my wife mentally would not have made the progress that she did whilst in intensive care.."*

(service user letter received, October 2013)

This illustrates the value placed on the support provided by the Chaplaincy. Although it is speculation, one can assume that were such support not provided, then the cost of actual recovery could be much higher for patients that happen to allow issues to escalate.

## 4.6 Interfaith and Excellence

***"All four fingers are not equal but they all work together. We are students, life is our teacher, daily we shall learn from each other"***

This section provides one of the many dimensions that apply to work as a Muslim Chaplain in Huddersfield and Calderdale. The excellent standard set by the Imam and Muslim chaplaincy can be appreciated from the following anecdote after participating in helping and supporting a research student who was investigating spirituality and healthcare. The research was part of a Masters dissertation.

*..."Your insight into Chaplaincy work is excellent and it was a thoroughly informative interview. You were able to draw upon your experience and knowledge of Islam and healthcare Chaplaincy and relate it NHS practice and patient care. ..Your input has made a valuable contribution to the field of understanding the impact Muslim Chaplaincy work has on improving the patient experience. I commend you on your work, it is a benchmark approach because you are able to understand the needs of patient's on personal and existential level which helps provide care in a more thorough and holistic manner."*

(Unpublished, 2013)

The following anecdotes were brought together to express some of the multi faith work that the Muslim Chaplaincy is involved in. This demonstrates the level of understanding promoted within the service and it provides good practice which forms the base for multi faith chaplaincies and fostering good interfaith relations within Chaplaincy teams.

The following was extracted from a speech by the Chaplaincy Lead appointed at the time. The speech was delivered at a Church in 2008 where both the Imam and the Chaplaincy Lead were asked to come and talk about the Multi Faith aspect of their work as Chaplains.

*"...Now that may make you think that I made the decision for employing a Muslim chaplain simply because the Law said I had to – that's not true. I truly believed that for the benefit of the Muslim patients and staff it was important that we had a Muslim religious leader."*

*When the NHS was founded in 1948 it would have been rare to find people from any faith other than Christian and Jewish. By 1970 there had been an increase in the number of people from different faiths and cultures, but they were still very much in the minority. However, the last 35 years have seen quite a shift as more people made their home here.*

*Now there are trained personnel who can be employed beyond the walls of the mosque or temple and some faiths now have training courses to equip their religious leaders to work within Chaplaincies – one of the first faiths to do this was Islam and others are now beginning to look at the whole chaplaincy issue so many chaplaincies up and down the country are multi faith and reflect the multi faith aspect of the area that the hospital serves.”*

(Chaplaincy Lead, Calderdale and Huddersfield NHS Trust, 2008)

It was in recognition of some of this outreach work within the community that the local newspaper was also interested in covering the news story. The Daily Examiner requested an interview around our ‘interfaith working within Chaplaincy’ that would form the basis for an article in the local newspaper.

This I believe was a great opportunity to help boost the image of the trust and the work that Chaplains do. The full article can be found in Appendix C.

The Chaplaincy team is catering for people of all faiths including Christians, Muslims, Hindus, Sikhs and Jews – as well as those with no faith at all. Comments by the Imam quoted below express the value and strength in bringing faiths together. Here is a summary of the interview published in The Examiner:

*“It is wonderful to work with people of different faiths. Every day is a new experience. We have situations that just come up. It’s so diverse. We are here in the spiritual sense for patients and staff, but we also get called on for specific advice about religious customs, for example at the time of death. The staff really appreciate the fact that they have been able to learn how to make it easier to offer holistic care to patients.”*

(The Huddersfield Daily Examiner, 2010)

The team that had informed this article go beyond the call of duty to understand the wishes of patients and their families. Illustrated below by the Imam....

*“One of the highlights of my experiences on the interfaith aspect of our work is that, I can recall a time when I found myself standing behind the altar at a church in Newsome with my Christian colleague at a funeral service of a patient who had passed away at the Hospital. We were able to work together in aspiration to cater for the wishes of the bereaved family which had both Islamic and Christian inclinations.”*

Further support of Interfaith work was evidenced by feedback from one of the local Ministers..

*“Your informative talk regarding the Muslim faith made a great impression on them especially as we clearly began to see what united us as people of different faiths. I will remember the day your invited the chaplaincy team to your Mosque and also the wonderful hospitality afterwards, again uniting us in friendship and hospitality. “*

This section can be summarised by a Quote taken from a document, 'Review of the DoH Central Funding of Hospital Chaplaincy'

*"I have attended three meetings of the Chaplaincy Multifaith Group and met separately with members of the faith groups represented there. I have been struck by observing mutual respect for others of different faiths, and the genuine friendship. At a time when tensions between ethnic groups, in this country and elsewhere, appear often to take on the guise of religious intolerance, it has been heartening to observe people able to rise above the differences in order to seek a common and shared good. I believe that the Department can, by continuing to support multi-faith chaplaincy, contribute to the wider Government objectives in relation to creating a genuinely multi-faith society."*

(John H James, 2004)

The seamless progress made by the Chaplaincy demonstrates exceptional practice that has an impact not only within the Trust but also within the wider community.

## 5 Conclusion

The Muslim chaplaincy role has evolved over the years and has required greater attention as it has become more prevalent and understandable within the wider Muslim community. This stems from the Muslim community's understanding, that Muslim Chaplains serve their needs and represent their interests.

In addition, with the growing Muslim workforce in the Trust, the spiritual and pastoral care of staff has also increased. There are many additional responsibilities such as halal food and jurisprudential matters that have demanded time and research to ensure appropriate responses for both staff and patients. In fact, there are many nuances involved within Muslim Chaplaincy that is not applicable to any other denomination as is evident from the above case studies and interviews with staff.

The data that we have collected, analysed and presented has provided an insight in to the Chaplaincy service provided to Muslim patients, support to departmental staff and the surrounding structures within the Trust and those that surround the Trust in the wider community. It has managed to investigate the aims set out in the introduction.

The adequate provision of Muslim Chaplaincy is of utmost importance to help build a culture in which spiritual values and spiritual care is at the centre for service user and staff groups. The care that is available from the chaplaincy perspective for Muslim patients is highly appreciated by patients, relatives of patients and staff. The impact from a spiritual perspective was significantly efficient than if the provision of spiritual support for Muslims was outsourced an external consultancy in terms of financial cost. In fact, there would need to be some form of ongoing refresher training for onsite staff that work with Muslim patients. The presence of the Chaplaincy means that expert advice is not only available to staff but is also available to patients directly at a fraction of the cost for consultancy.

The staff that were involved in this review expressed their appreciation the importance of the spiritual, cultural and religious support that was provided to them. Efforts made by the Chaplaincy until now have managed to partially embed their function as a support mechanism for the patients. They are known as a contact point for issues on support for Muslim patients within the Trust, although there were still occasions when staff were surprised to know of the Muslim Chaplains, particularly the females.

The interview with the midwives provided a good example of the level of support provided that incorporates spiritual, religious and cultural aspects for Muslim patients or the bereaving relatives. There is strong potential that this model of good practice can be rolled out to other departments within the Trust.

This approach supports inclusion and engagement emphasised within the core values modelled by the Trust. The approach also focussed on inclusive practice for patient wellbeing by making them feel comfortable with their surroundings with specific attention towards food (halal), linguistic needs, religious and spiritual needs. This demonstrated a true commitment from the Trust in honouring the diversity of their patients.

There is a need to re-think how the patient centred support can be further embedded beyond the departments that have been penetrated thus far.

The experiences of the Muslim chaplaincy have been well-placed to identify areas for development to equip the workforce with skills that are imperative for the spiritual care and needs of service users. This is proposed through a targeted staff training and development programme.

The staff development that has been performed so far has had a very positive impact and serves as a sound base for the rationale for support from the Trust for this development. Evidence from the feedback and provided by staff that has been quoted in the previous sections suggests an indication of the type of positive impact we can expect throughout the Trust.

The following subsection contains some recommendations that have been suggested as a way forward for the Chaplaincy that embarks on a pathway that will lead to the transformation of the Trust to one that is well-aware of the needs of its service users from a spiritual perspective.

Findings thus far indicate that no longer should the Muslim Chaplaincy be viewed as a minority role or secondary role because of the demands placed on Muslim Chaplains being so overwhelming and great. This leaves no doubt that there is a greater need for this Trust to appreciate and value Muslim Chaplains as much as any other denominational chaplains. Hence, the appreciation should equate to supplementation of hours for the Muslim Chaplaincy team so that they can equip themselves and offer the services that the community as well as the Trust staff wants and demands.

It is believed that the Muslim Chaplaincy hours should be increased in order to represent the needs and demands of Muslim patients, visitors and staff. There should be fairness and equality represented across all denominations based on wants and demands of patients and staff. Other Trusts have increased the hours for their Muslim chaplains, understanding and reflecting the significance of Muslim chaplaincy. Therefore, it is firmly believed that there should be additional hours allocated to this Muslim Chaplaincy team in order for them to fully serve the Muslim community on account of the overburdening responsibilities mentioned above.

With the additional hours acting as a stepping stone in moving forward, the following section outlines some recommendations that should be followed by the Trust.

## **5.1 Recommendations**

These recommendations categorised as short and long term have been formed after consideration of demographic data related to Huddersfield and Halifax and have incorporated good practice from several surrounding Health Care Trusts. It also incorporates advice from the Francis report, academic papers and global organisations such as The World Health Organisation to truly improve the service to make the patient's care, all of our concern.

The main recommendations from this report stem from an increase in Muslim chaplaincy hours. Whilst generic support can be provided by any chaplain, non-generic support requires specific input from Muslim chaplaincy. This is due to the fact that practising Muslims are on the increase in the UK and Europe (Esposito, 2012). Their requirements are often beyond fulfilment by those from a mono-linguistic background (English) as prayers and scripture consist of Arabic and other South-Asian

languages where required. Similarly, spirituality can be addressed by chaplains of different faiths. However, Muslims prefer that spirituality is addressed from an Islamic perspective.

We have indicated above using data from the Office of National Statistics that there has been a disproportionate increase in the Muslim patient population in both Huddersfield and Calderdale without any increase whatsoever in Muslim chaplaincy services. Comparing this to Dewsbury and Bradford, where Dewsbury provides a total of 35 hours of chaplaincy services. Bradford provides one full time Muslim chaplain and two Female chaplains doing 16 hours each, cumulating to 67 hours per week. Huddersfield only provides a total of 15 hours albeit between 3 chaplains, where Bradford and Dewsbury also have three chaplains.

**5.1.1 Short Term Recommendations**

The following aims should be targeted within the first 18 months providing appropriate hours, resources, and support mechanisms are in place commencing February 2014.

*Table 1: Short term aims for foundations of a sound service*

| <b>Aim</b>   | <b>Reason</b>   |
|--|---|
| Forming displays of Islamic events for staff and parents with the Child Development Centre.  | Promote the Chaplaincy service and raise awareness for the department and patients.                           |
| Arrange meetings with relevant departments   | Ascertain the actual hours required for the needs of each department  |
| Assess support needed  | Rationalise findings from the Department with regards to needs  |
| Sign post training needed  | In-line with needs identified   |
| Identify and deliver 'care and compassion' guidance where needed.  | Enhancement of service  |
| Gather reading material etc. for effective delivery of training  | Preparatory work for CPD activity   |
| Provide effective networking of Muslim chaplaincy inclusive of the wider objectives of chaplaincy                                    | Set up monthly/bi-monthly meetings of Muslim chaplaincy provision to streamline direction                     |
| Help improve well-being and the service user experience  | Principle aims of this service. A measuring tool will need to be adopted. This exercise can be done annually. |
| To adopt and maintain an ecumenical approach in service delivery.  | To increase a united approach. This will need a lead  |
| To attend external/internal training with aim to build on CPD.   | To professionalise the service and increase skill set of chaplains.   |
| Networking with other NHS hospital Chaplaincy departments and Charity organisations and adopting good practice models into our work. | Wider promotion of service and acquire ideas from other departments   |
| Promoting and publicising Chaplaincy throughout the Trust  | Raise awareness in other parts of the Service   |
| Participating in CPD for personal development and to help adopt good practice models   | Develop staff in Chaplaincy and those that are patient facing   |

### 5.1.2 Long Term Recommendations

On-going needs analysis and CPD of chaplaincy staff is imperative once they have initially been provided with the foundational development identified in Table 1. Competence in the longer term is in the form of a reflective model that is continually seeking improvement via a built-in review mechanism. This would be only possible through open communication where we have the courage to identify, relay and challenge those issues that are seen to impact patient wellbeing. The commitment to address the issues that have been identified in this report needs support in the form of financial and human means. Only this will help us embed a mechanism that is proactive, focussed and competent in a challenging time. The aims in Table 2 are those that lead to the evolution of the Chaplaincy service to a delivery model that is well embedded across the Trust.

Table 2: Long term aims for on-going development and embedding a patient-centred service

| Aim   | Reason   |
|---|--|
| To be able to effectively demonstrate good practice.  | To act as mentors to volunteers and new members of staff as well as improve the overall perception of the service. This will also allow us to share ideas with other bodies. |
| To have and set up regular training sessions where relevant for the Chaplaincy staff  | A consistent model of CPD  |
| To be able to input positively into the wider objectives of the trust achievement targets   | A holistic approach needs to be adopted. This way chaplaincy leader can easily identify where the service can bridge any gaps  |
| To act as a support mechanism for any issues specific to South-Asian culture and religious attitudes.   | The majority of Muslim population happens to emerge from South-Asia.   |
| To enhance the ethos of spirituality within patient care from a faith specific orientation where needed.  | Muslim patients tend to require deeper scriptural connection within their spirituality.  |
| To have effective relationships within the community and the trust regarding provision of halal food.   | Ensures Muslim in-patients are confident with essential provisions such as food.   |
| To help co-ordinate issues of grievances through effective communication with staff and patients e.g. large amount of visitors against last rites of dying patient. | To approach this in a faith and culturally sensitive way, would increase both staff and visitors understanding of any requests made by the trust.                            |
| To be able to provide structured services for Friday prayers.   | Ensuring that spiritual needs of Muslim people are met on regular basis, without needing to leave the premises of the trust.   |
| Arrange and set up proper bereavement support inclusive of South-Asian cultures and practices.  | Accommodation for cultural differences.  |
| Provide dementia services for Muslim patients.  | To increase the understanding of the illness amongst family members and provide steps for patients to ease this burden upon them.  |
| Setting up resources and access for hospital staff in looking at caring for Muslim patients, birth rights, death rights, the naming system                          | To incorporate the spiritual and religious care aspects for Muslim Patients  |

|   |   |
|---|---|
| Attending CPD courses to improve the way we deliver care  | CPD for the Muslim Chaplains themselves, ensuring that they are up to date with their own skillset.             |
| Networking with other organisations and adopting good practice. For example 'Children in Jannah' which is based in Manchester and provides bereavement services for Muslim families who have lost children. | To express a patient-centred approach in understanding the patients loss from a spiritual perspective.          |
| Recruiting and training bereavement volunteers from the local community to support bereaved families  | Provide a wider-reaching support service that can operate within and outside the boundaries of the Trust itself |
| Promoting volunteer chaplaincy and working as a team to deliver training  | Increase the physical presence and contact points to access the service   |
| Evaluating the service we provide by getting feedback from departments and using the constructive feedback to improve our services.   | Periodic review and monitoring of the effectiveness of the service  |
| Providing better support to Muslim patients with dementia and the staff caring for them   | Penetrate areas with the service that we have not yet managed to access.  |

The recommendation would transform the Trust in a cost-effective method, avoiding external consultancy but investing a relatively small amount of resources would mean that the existing expertise to be fully utilised to transform the service within the Trust for better longevity and reputation for its stakeholders.

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