 **We do the must-do’s**

Must-do’s exist in various guises –

* the Trust’s mandatory practices affecting chaplaincy which contribute to patient safety: risk management, fire safety, information governance and safeguarding.
* our professional standards which ensure safe and professional chaplaincy.

We subscribe to the UK Board of Healthcare Chaplains Code of Conduct for Chaplaincy.

* recommendations for good practice which make for a high quality and informed service.

The Revised Guidelines set out the considerations for a fair and compassionate chaplaincy service, which we subscribe to wholeheartedly: See NHS Chaplaincy Guidelines (draft) 2014. This also includes recommendations for best practice for quality spiritual care.

We have quite a long way to go in meeting all these recommendations but we can commence by aspiring to them and setting about achieving them step by step:-

Action Required:-

*Standards* - we have undertaken as part of our Review to commence devising departmental standards. Some of these, such as a protocol on conducting funerals, lone working policy and risk assessment of the Hope Centres have already been developed

*Operational policy* – we hope to compile this following adoption of the recommendations in this Review. The level of resources we have will affect the service we can offer.

*Assessment* of spiritual, pastoral and religious needs – adoption of a tool to assess and record such needs is becoming a part of good practice.

Development of *an audit tool* – both in terms of quantity and quality – to ensure accountability

*Regular supervision* for team members

*Develop opportunities* for reflection on practice

* core activities, without which we would be failing to provide a responsive and effective chaplaincy.

We have explored these areas already, namely, general ward visiting, on-call and a service to our minority ethnic patients

* We feel a further important must-do is:-

Reading the Future and Preparing for It

“Major changes are needed to the health and social care system in Calderdale and Greater Huddersfield to combat increasing pressures including a rising in population, people living longer, conditions relating to old age and modern lifestyles becoming more prevalent " (Strategic Outline Case – CHFT).

At present our chaplaincy is targeted at the in-patient population of both hospitals. Much of our work with staff is to enable them to see their role as fellow spiritual care-givers and to support them in their work for patients. But our review of our service has to be seen in conjunction with the developments envisaged by the Trust at a strategic level.

Our concern over resources has to be discussed in the context of very restricted budgetary options.

We do not want the considerable amount of work in consultation and evaluation involved in the preparation of this report to be lost as healthcare provision changes its shape.

Calderdale and Huddersfield Health and Social Care Services Strategic Review

We have before us the Trust’s Strategic Outline Case for a strategic restructuring of services. It is beyond the scope of this review to respond to the Case in detail but we can make the following broad responses to its themes:-

|  |  |
| --- | --- |
| **Feature of the Outline Case** | **Chaplaincy Response** |
| ‘Promote patient-centred care and joined up services’ | Chaplaincy is an acute service in healthcare and is seen by patients and staff as such. At the heart of our work lies a concern to value the uniqueness of each person and to give them an opportunity to express their deepest selves. Whilst we do not lay unique claim to such an approach, we have a role in modelling it in the healthcare environment. Patients value it (see Patient Satisfaction Survey).  We can assist in facilitating such an approach in others through co-working, training and representation on healthcare bodies and working parties . |
| ‘Improved safety and quality’ | We allow patients to set their agenda in discussion with us and this can lead to better identification and management of risk or other issues. This improves safety and enhances patient experience. |
| ‘People in control of their own health and wellbeing’ | Good spiritual care fosters confidence and resilience. It can encourage a deepening of supportive relationships between patients and carers, and promote recovery (see ‘Chaplaincy in General Practice’ - in the draft NHS Guidelines quoting the findings of research that chaplaincy in primary care improves mental health and well-being). |
| ‘Improvement and development of workforce and investment in it’ | The role of chaplains as both models and facilitators of holistic care is mentioned earlier in this review. This is offered in both formal (i.e. educative) and informal settings. |
| ‘Large scale use of information technology, new ways of working’ | Although chaplains are skilful in working in depersonalising and highly stressful situations, there is a great flexibility within it to adapt to new settings and new ways. In essence it is about the interpersonal encounter and can be effective in any setting. But the chaplain could be used to add the personal touch (literally hand-holding) to compliment teleworking by others.  Access to electronic recording of involvement is important for chaplains to be able to contribute within a holistic framework of care for each patient. |
| ‘Locality teams / two specialist hospitals’ | Support to inpatients can be provided as at present with the approval it meets with. Chaplains could bridge the hospital/community gap. Our experience is that many people experience isolation at home. Chaplaincy can offer support in the home and if desired a referral to local faith communities or the engagement of a volunteer for ongoing support. It is unlikely that faith communities alone will have the resources or responsiveness to be proactive in identifying and meeting any increased demand for home-based support. |
| ‘Promoting self-care’ | As the Case says, self-care is not about leaving people on their own and chaplains can be effective in providing support at times of crisis and exploring the emotional and spiritual resources of a person which provide the basis for good health. |

On the very day this question was being considered the local Clinical Commissioning Groups have declared that a decision has been taken to delay the public consultation on the Case. The press release states: “The decision reached means more time can be spent developing and delivering care closer to home and understanding the impacts will have on our hospital services.”

With things in a state of flux it is difficult to predict the shape of chaplaincy in any new structure but features to be expected are:-

® ongoing commitment to inpatient care, both planned and unplanned

®development of community support which assists in maintaining the patient in their own home, offering support to them and their families

®development of existing links with specialties, e.g. palliative care, dementia, foetal and baby-loss to provide care at home

®development and co-operation with local faith communities to enhance community-based support

**Conclusion**

* Further work is required to ascertain how chaplaincy may support people in the community
* There may be lessons to learn from our colleagues in mental health who have developed a role within ‘care in the community’
* Exploration of how to dovetail our service with existing faith groups within the community to provide effective support is needed
* We need to develop a specific action plan to help us meet the future as it comes towards us