RDUH Chaplaincy Report 2022/23

Delivering pastoral, religious and spiritual care to patients,

relatives and staff,

24/7

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Pastoral and Spiritual Wellbeing at the RDUH

April 2022 – March 2023

Introduction

In the last few years, healthcare chaplaincy has developed in many ways within our Trust. Integration across Eastern and Northern services has brought with it a brand new structure, different challenges and a team that is learning to work together. Since the onset of Covid19 *ways* of working have also radically shifted, with greater emphasis on staff wellbeing and a focus on daily, proactive visits to critical areas. Chaplains now appear in scrubs much of the time (Eastern), and operate with far fewer volunteers to support us. We also work much more closely with colleagues in the staff wellbeing team. All of this has had an impact on the shape of what we can, and sometimes cannot do.

Despite changes in practice and culture, we have retained the core delivery model set out in the Trust Spiritual Care Policy (Eastern) and applied this model across the whole Trust. Healthcare chaplaincy remains "a portfolio profession," delivering a range of interventions based on assessment and need. Our remit covers staff, patients, and relatives. Delivery is based on the CRISPER model of working (see section1.1), a broad and flexible approach including cultural advice, religion/belief input or referral, rituals when required, individualised and existential care, spiritual assessment and provision, pastoral, emotional, and relational support.) All Healthcare Chaplains are expected to assess and enable support across all these domains, working together to deliver 24/7. Our task, at its heart, is to work with the complexity of person-centered need in challenging situations, but alongside this professional input we also draw in voluntary and community support when required.

In the report below we set out, in greater detail, how we have gone about this task during the last year. We have included some of the new metrics we are developing to monitor and illustrate the work that we do. The report finishes with an outline of future plans, as well as the challenges and ambitions we face. I hope you find this report of interest, and please get in touch if you have any further questions.

Dr. Simon Harrison *tssf*

Head of Pastoral and Spiritual Care

1. Chaplaincy Support for Patients, Visitors and Staff

There is a named “duty chaplain” each weekday at NDDH and seven days a week at RDE (Wonford). Each community hospital is visited weekly. The duty chaplain is responsible for triaging new referrals, following up patients, and coordinating staff support. They are also normally the “on call chaplain” for the day and therefore deal with emergency situations, and manage workflow for the following day. For the team, most days begin with on-call at 7am, and include on call till 10pm or (frequently) cover through to 7am the following day.

1.1 Patient Visiting

It may come as a surprise, but the work of modern healthcare chaplaincy shares many characteristics with other healthcare professional within the care team (the MDT). Each patient on our referral list is assessed according to an assessment tool: Nolan’s Spiritual Assessment Interpretive Framework (SAIF)[1]. This includes history taking: what is important and gives meaning to life for them (this may include some understand of a formalized religion or belief structure, it may be more spiritual, or it could be much more practical); and what external support they have. Assessment is then made in relation to this history and any requirements during this admission; and from this a care plan is created and kept under review for the duration of the admission.

EASTERN

1537 new referrals received between April 22 and March 23

An average of 24 wards/teams made 3+ referrals per month

An average of 50-60 patients on the work list at any time

NORTHERN*

552 new referrals received between July 22 and March 23

An average of 20-30 patients on the work list at any time

***Due to MyCare launching in July 22 the metrics are not a complete set**

[1]Nolan, S. 2023 Spiritual Assessment Interpretive Framework (SAIF): Four Minimally Directive Questions

CRISPER MODEL©

Our services assess and deliver CRISPER care:

Cultural Care
Religious Care
Individual Care
Spiritual Care
Pastoral Care
Emotional Care
Relational Care

We are a portfolio profession delivering a range of interventions based on assessment and need.
Our remit covers staff, patients and relatives. All Healthcare Chaplains are competent to assess across all domains.
Delivery involves working with complex need and can draw in voluntary and community support when required.

Care delivery is shaped by the CRISPER model, a broad and flexible way of explaining what our service provides including cultural advice, direct religion/belief input or referral on, rituals when required (especially around death and dying), individualized and existential care- addressing the ‘why me?’ and the ‘what now?’ questions, spiritual assessment and provision that is unique to the individual as well as broader care such as listening, bereavement support, and working with complex family situations. Whilst many colleagues across the team deliver aspects of this on a daily basis, our unique role is to bring all of these skills to bear and adapt provision as required to meet the individual needs in front of us.

1.2 Supporting family and friends

Most patients have at least one person who visits and is significantly involved (and affected) by the outcomes of the patient's care and wellbeing whilst in hospital. Often chaplaincy is involved with the family and friends of a patients as much as with the patient themselves. Support ranges from emotional and wellbeing checks to mediating between family members in stressful decision-making moments. It can also bring family a huge amount of comfort to know that their loved one is being seen by chaplaincy in those times when they can't travel in to the hospital.

In addition to direct support, many family and friends find great comfort in the quiet/sacred spaces we maintain at both main sites.

From 2024, MyCare (our patient record system) will be able to monitor how often we support patients on their own, how often we do so alongside family, and also any encounters we have with family on their own, either on or off the ward. What will be more difficult is to capture the many supportive encounters in corridors or in the chapaincy centre that occur each day with family of unknown patients.

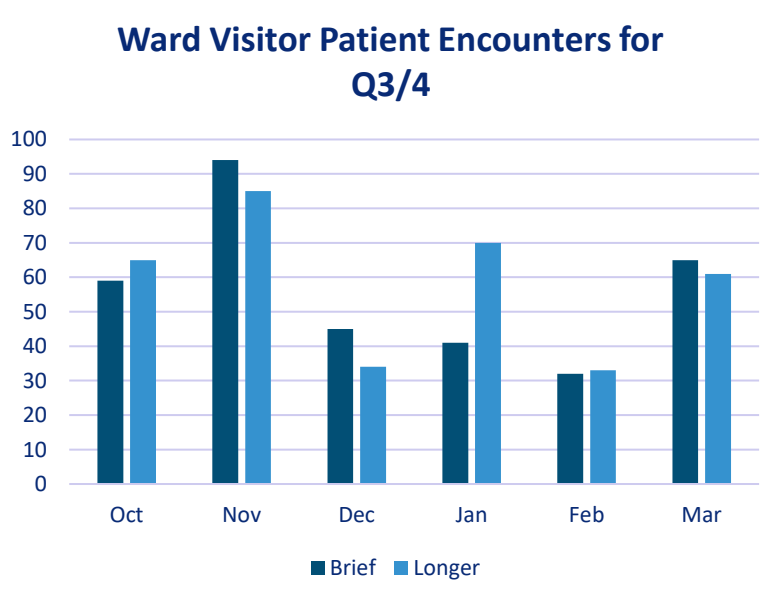
1.3 Befriending support

This provision was introduced several years ago in Exeter and aimed specifically at those with few or no visitors. Post Covid19 we have not re-recruited a fresh team of Exeter befriending volunteers, and have not yet established such team in NDDH, but we continue to take befriending referrals through MyCare at both sites on a regular basis. This language seems to resonate well with some staff and patients; often 'befriending referrals' turn out to be less about loneliness and indicate more about urgent need, such as end of life support.

1.4 Ward Visitor Volunteers

Another significant loss during the Covid19 pandemic was our large cohort of volunteers, who each committed to given a morning a week to visit a specific ward(s) and do a bed to bed “hello” to patients. This was beneficial in many ways. Firstly, wards had weekly contact from chaplaincy and a reminder that we are there to support them and their patients. Secondly, each patient was given the opportunity to have a visitor to chat with, or potentially explore deeper areas of concern. Thirdly, it was a source of important referrals for chaplaincy. This team would regularly make over 5000 patient contacts a year in Exeter alone.

The hospital has reopened its doors to volunteers, but it takes time to recruit the right people to this role. We are delighted to have held on to a core of five volunteers, all dedicated and trustworthy hands (and ears). Between them they support some of the busier wards and visit patients around the hospital based on need. They will visit their assigned patients, but will often also make a wellbeing check with the staff and ask if there are any other patients the staff wish them to see. From this we can record some basic statistics of how many patients have a brief ‘hello’ and how many had a ‘longer’ visit, and how many referrals were made. The following is this information from Q3/4 of the year April 22 to March 23. We will endevour to include the figures for the referrals made by the ward visitors as well for April 23 – March 24.



The fluctuation in numbers is due to when there are common periods of holiday breaks for the volunteers. But as you can see over 6 months, our 5 volunteers had 684 patient interactions, with 348 of them being significant encounters.

1.5 Spiritual support as part of End of Life Care (EOL)

Although we are often trying to raise awareness with patients and staff that chaplaincy is not just about the last few days of life, is does play a significant role in the work of a chaplain. You will see in the information about call-outs, that the majority of call outs are EOL related. (Section 1.7)

This is only to be expected; just as a patient who is experiencing a life-changing diagnosis might need our support, so do those who are facing the end of their life. This is often where we see the full breadth of chaplaincy CRISPER care model, as support is often emotional, relational, and individual, but may shift to also include religious, spiritual and practical forms of support within a few short moments. Often the person dying, or their loved ones, can feel that there should be 'something' to mark the end of a life. Sometimes this has been very well thought out by the patient. Sometimes, whether due to sudden events or a reluctance to dwell on it, the patient, or family are unsure of what should be done. Chaplaincy is there in such situations to guide or advise patients and family about the different options they have and, if specific ritual (religious of not) is required, we ensure this takes place.

This work is carried out in a very integrated way with the palliative teams, both Eastern and Northern, with a chaplain attending both palliative MDTs – ensuring we support as many patients as possible and review care to learn how we might do things better on a week by week basis. We also review the butterfly list (those in their last few days) on a twice weekly basis to ensure that patients and families are aware of chaplaincy support should they wish to access it.

Through MyCare and palliative MDT data, we aim in the coming year, to have clear picture of how many patients and families we support (and how many are offered support in line with best practice) across the Trust.

1.6 “21 Day Wellbeing Review”

During Covid19 it became apparent that many patients were struggling profoundly with the length of time they stayed in the hospital and a sense of deep isolation. So many were struggling that our referral rate from nursing and medical colleagues was significantly reduced (“who do we refer when everyone is struggling?”). In response we developed an innovative screening process, called the “21 Day Wellbeing Review” or more informally the LLOS review (long length of stay).

This particular pattern of working has become an established part of what we do (at Wonford) and there has been interest from other Trusts in the country to see if they can replicate it. We do have plans to share the model as a best practice example, albeit we would love to be able to undertake some research as to the positive impact on patient experience before doing so.

How does the 21 day wellbeing review work?

We aim for *every patient who has been in the RDE for 21 days* to have a wellbeing review (currently once a week on Wednesday).
We exclude certain patients (such as those receiving EOL care, who we review differently)

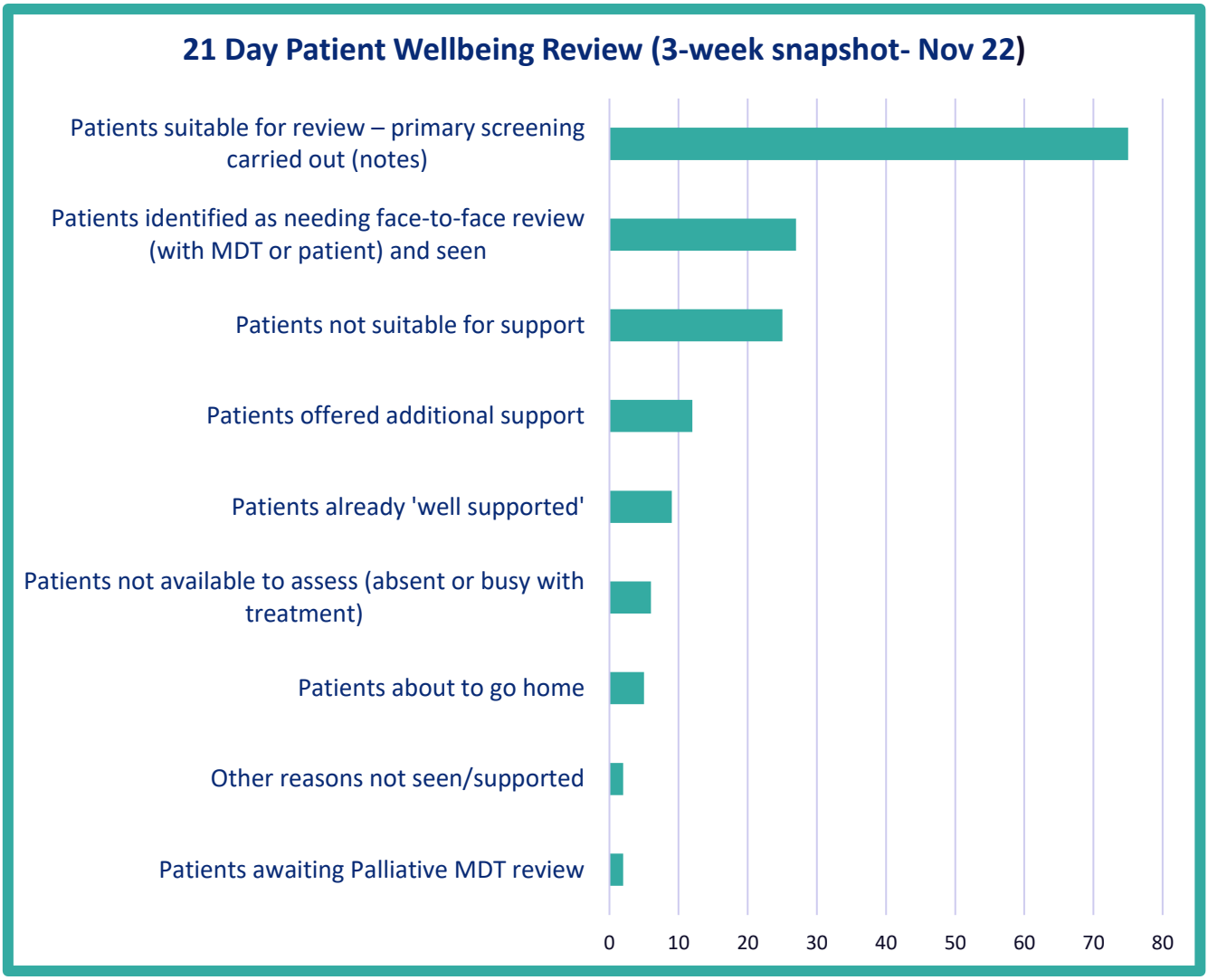
Screening is carried out as follows depending on what is most appropriate:

a) Review of notes
b) Engagement with the MDT or
c) Directly with the patients

Our 21 day review is introduced as a routine part of overall care: “Hello. We touch base with everyone who has been in for a long time just to see how things are for you or those that support you…” Clearly the exact approach made is shaped to individual circumstance, clinical need, cognitive function etc. but our intention is to gently evaluate how each patient is coping and identify if further pastoral support is helpful.

The results of the 21 day project have been very significant for the department.

a) It has led to an increase in the number of patients and families supported who did not previously know we were here for them
b) It has led to a marked increase in support for patients and families with no identified religious belief
c) It regularly identifies patients (unknown to our team) with complex and significant needs (including palliative and end of life patients who have not been flagged) and enables chaplaincy support to be put in place
d) Even when a patient decides they do not want additional support, they often express their gratitude for being asked and our acknowledgement of how difficult it is to be in hospital for a prolonged period



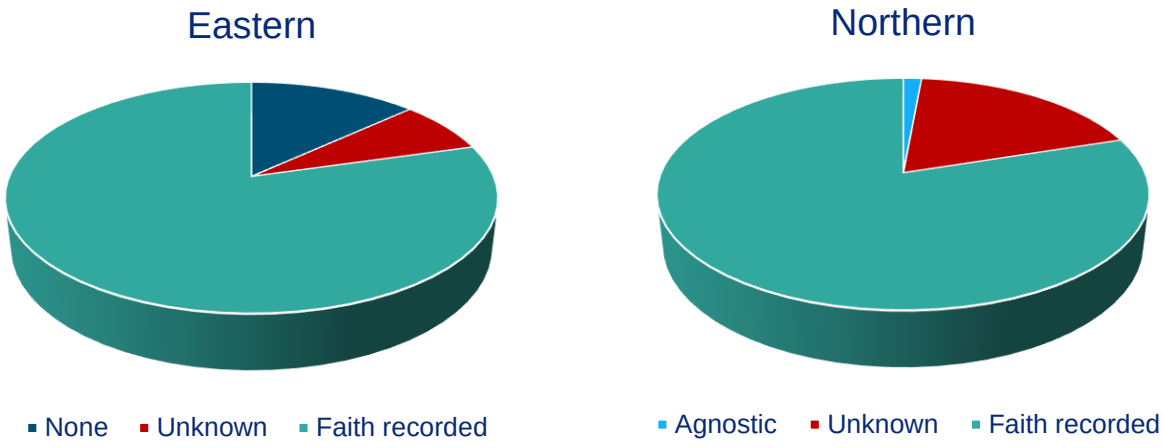
In early 2023 we were joined by a second Honorary Chaplain who has dedicated his time to this work, so since this Nov 22 snapshot was captured we have been able to further increase the total number of reviews, increase the proportion of *in-person* reviews and include more patients with dementia. The pattern of finding those who need support previously unknown to us continues to grow.

Left: Caroline who has led the 21 Day Wellbeing project
Right: Jackie our Humanist Chaplain who has led the Befriending project

1.7 Meeting faith and belief needs of all patients (and staff)

There are two key features of our work that need remembering when we consider the religious profile of those we see and how we meet patient needs. Firstly, a significant proportion of our work with patients recorded demographically as having a religion is *not* religious care. Indeed, many encounters do not include a religious dimension at all (even if the patient has a religion recorded on MyCare). Secondly, the demographic of these we see is often disproportionately high (for example, the median age for referrals to NDDH chaplaincy in Jan 23 was 82 years old). This is a group with far higher recorded religious activity and affiliation.

Snapshot of Referrals in January 22 and the Religion Recorded



It is interesting to look at the two referral sets above, both taken from January 2023. Both have a predominantly religious demographic (noting the comments above that just because patients *have* a religion recorded does not mean that this is the *focus* of our support).

In Northern services we do not yet have the befriending service up and running, which may in part account for the total absence of any patients indicating 'none' on their admission. Further there has been a focus on demographic data quality over the last ten years at the RDE, (patients attending outpatients are asked to update ethnicity and religious belief data) so the percentage on 'unknown' is better managed, and a higher percentage indicating 'none'.

Whilst we work in a consciously ‘inclusive’ way (a model that does not exclusively try to match the faith/belief position of the healthcare chaplain with the patient – focusing instead on spiritual and pastoral needs of the individual encounter) we are still very much aware that for a number of our patients and our staff there will be a need for distinctive support that matches their religious tradition, as a key part of our role. This said, the continued presence of a humanist chaplain among our staff team is also a valuable sign to many that we are not seeking to be an exclusive faith-based service. We operate an open recruitment model whereby most posts will be open to applicants of all faith/belief traditions so long as they have the relevant skills experience and qualities. So, although the majority of the team are from within the Christian tradition, we expect the faith mix of the staff team to change over time.

We have also been proactive during the year in offering work experience placements for faith leaders and those exploring vocation, with a view to fostering a greater understanding in the community of how we operate and potential future healthcare chaplains.

Many of our night time/weekend call out our seeking specific religious rituals (see Section1.7), and whilst this has had to be reduced in NDDH during the year, we have managed to maintain 24/7 at the RDE. In particular we have also funded and maintained 24/7 Roman Catholic support across all sites, thanks to the ongoing flexibility of the Plymouth diocese. With regards to minority faith traditions, we have maintained and renewed contacts with a wide range of communities, from Pagan to the many Orthodox traditions, and extending beyond faith groups to group such as ‘Farmer Crisis Network’ and ‘Veterans support’.

Fr Kieran Kirby (our Roman Catholic lead at RDE, who sadly died in March 23) We have been very grateful for the work of Fr Albert who has carried so much of the Catholic responsibilities in Exeter during this last year.

1.8 24/7 and Weekend On-Call cover across the Trust

24/7 cover provided 365 days a week is a key feature of any chaplaincy service in an acute hospital, especially ones with ED and Maternity facilities. Situations such as an unexpected baby loss, rapid deterioration of a loved one or road traffic accidents do not limit themselves to office hours, and both staff and patients/families can need urgent support at these times.

In Eastern services we are able to deliver this support despite having a small team by using bank chaplains on evenings, nights and weekends. This reduces the pressure on permanent staff. We also have also had some community faith leaders (with chaplaincy experience) offering back up support. We have also shifted work patterns to enable 7 day working which also strengthens the offer over the weekend.

NDDH is primarily covered by one individual (total chaplaincy funding at the site is only 1.3 WTE), which put a strain on both them and on service cover when they are away. This model is untenable, and to mitigate from Jan 2022 we stopped all on call (in person) after 10pm at NDDH. As we moved into 2023, we also suspended weekend cover to further protect the wellbeing of the chaplains on the team. The Eastern based on call team will provide 24/7 advice and guidance, and in extremis, will seek to contact an off-duty Chaplain who might be able to attend on either site. This is, of course, far from ideal, and restoring adequate on call will be part of our business planning as we go forward.

1.9 Perinatal Support

During the year April 2022 to March 2023, chaplaincy responded to many calls to support women and their partners during the difficult process of perinatal baby loss. Of these calls, 17 families wanted to have a ceremony to mark to existence of their child.

Of these 17, this is the breakdown of the circumstances:

- 16 were for a blessing, naming or dedication
- 1 was for the Roman Catholic ritual of Prayers for the Dead, for a full-term stillborn baby
- 3 were for ≥12/40
- 10 were 13/40- 24/40
- 4 were full term
- 1 was an elective termination linked to a likely diagnosis
- 1 was due to a very rare condition within the baby
- some were due to the discovery of no FHB at a scan
- others were spontaneous miscarriage

As you can see, both gestation and the reason for loss will vary. Yet the human reaction to such loss is a shared human reaction to profound loss. For those who have been offered chaplaincy services and have accepted, religion and faith don't necessarily play a part, the important thing is that the child is acknowledged and remembered. For those families this is a significant part of the process and without it their emotional recovery from the trauma could be more challenging. It is a key element of care pathways.

1.10 Sacred/quiet spaces

During this year we have worked to both maintain and improve our quiet and sacred spaces. In NDDH, we have refreshed the garden area with new plants and seating, and we are exploring how it can be more accessible to wheelchairs and beds. It is in almost constant use by

staff and visitors when the rain allows. We have been exploring how to improve the Muslim prayer space in NDDH (which is too small) and the quality of our ‘quiet space,’ aiming to leave the ‘Chapel area’ much as it is.

In Exeter we have now reduced the seating to maintain the rather minimalist layout used during Covid19, and the spacious feel seems to be working well, with regular use throughout the day by patient, staff, and relatives alike. Our mobile screen allows space for Friday prayers, and our Hindu Deity is tended weekly and visited by many. The more secular space by the window is also in regular use both for quiet reflection and for quiet conversation which is so hard to achieve in ward areas.

Muslim Prayer Area

Hindu Deity

Secular Space

Mother and Child

Staff Memorial

We have not re-introduced regular Christian worship since Covid19, but we have been able to mark festivals such as Christmas, Lent and Easter as well as Remembrance Sunday.

During the last year, sadly, we have had to mark the loss of a number of staff, and this is often done through the simple lighting of candles in the chaplaincy centre. (See Section 2)

2. Staff Support and wellbeing

One positive outcomes of working models during the Covid19 pandemic was our engagement with staff. There was an intentional shift in the way that chaplaincy made itself available to staff from the passive to the *active*, which came in the form of seeking out areas and teams across the sites and making a schedule of visiting to those areas. This includes, but is not limited to: ward teams, admin offices, outpatient areas, housekeeping, the post room, etc.

One of our Team, Caleb, who helped maintain staff support in areas such as Mardon, Heavitree and many hidden areas of the Trust during Covid19 and beyond.

As Covid19 restrictions eased, demand for patient and relative support has increased, and with this has come a reduction in time that we can allot to staff visiting without the funding to do so. However, we do continue to make this a priority and keep ongoing records of both our team and individual support.

"I wouldn't want to go back to those days when chaplaincy and staff wellbeing services worked in separate silos. It just makes sense to work this way as we work so well together."
Staff Support Colleague

As with many things, it is helpful to be able to show in what way this work is being done. To that end, we have begun anonymously documenting our interactions with individual staff and with staff areas.

In addition to this planned work, we also respond reactively to trauma within staff teams. During a year this will involve supporting teams who have lost colleagues (both team support and organizing memorial events as required) as well as individuals who present themselves on a regular basis for one-to-one for pastoral or emotional support.

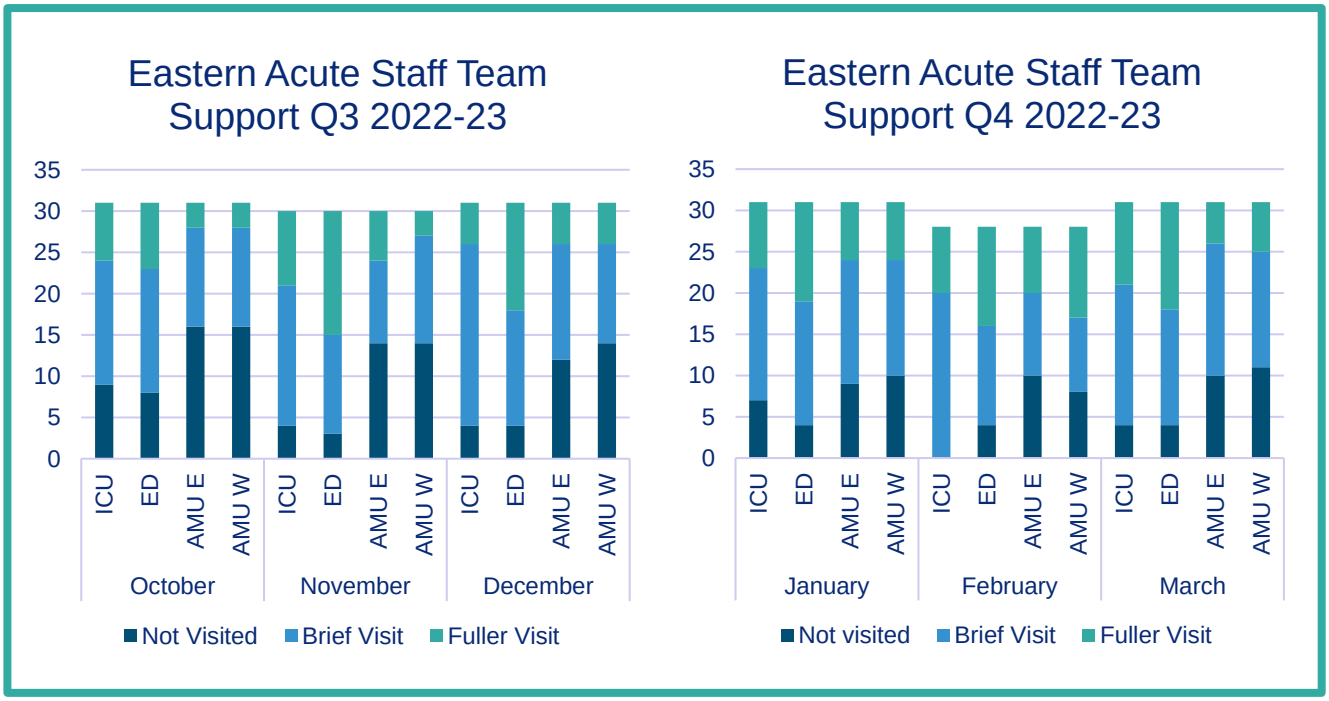
2.1 Planned and Routine Team Support

Each day (Wonford) there are areas that the duty chaplain should assign to a member of the team for visiting. High acuity areas, namely ED, ICU and AMU are scheduled for a daily visit, 7 days a week. Other staff areas are then assigned weekly or as capacity allows.

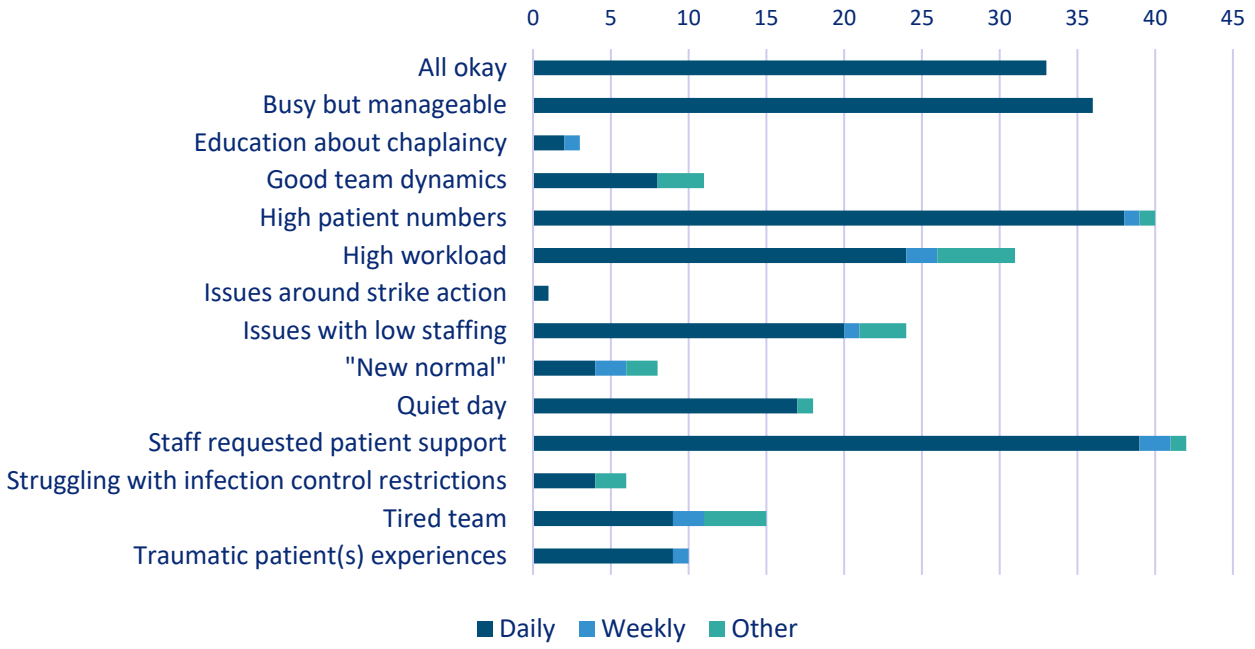
Such 'light touch' visits are a significant feature of how Chaplaincy delivers staff care. It is in the moment, natural and informal. Often staff will have seen us paying close attention to patients in distress and it may be that this increases the likelihood that staff will take the opportunity to share with us. It is evident that such gentle, regular visiting is very warmly received.

The following data shows the frequency of these visits, but what is harder to record numerically are the conversations that occur during these visits. A chart of general themes shows the range of support given and an idea of how often those themes are brought up.

NDDH does not have the staffing capacity to replicate this model, albeit there is a conscious effort to make sure that all wards are visited at least weekly (often many times more) and a particular emphasis on ED, MAU and ICU has been introduced during this year. With capacity would come a more consistent pattern of support.

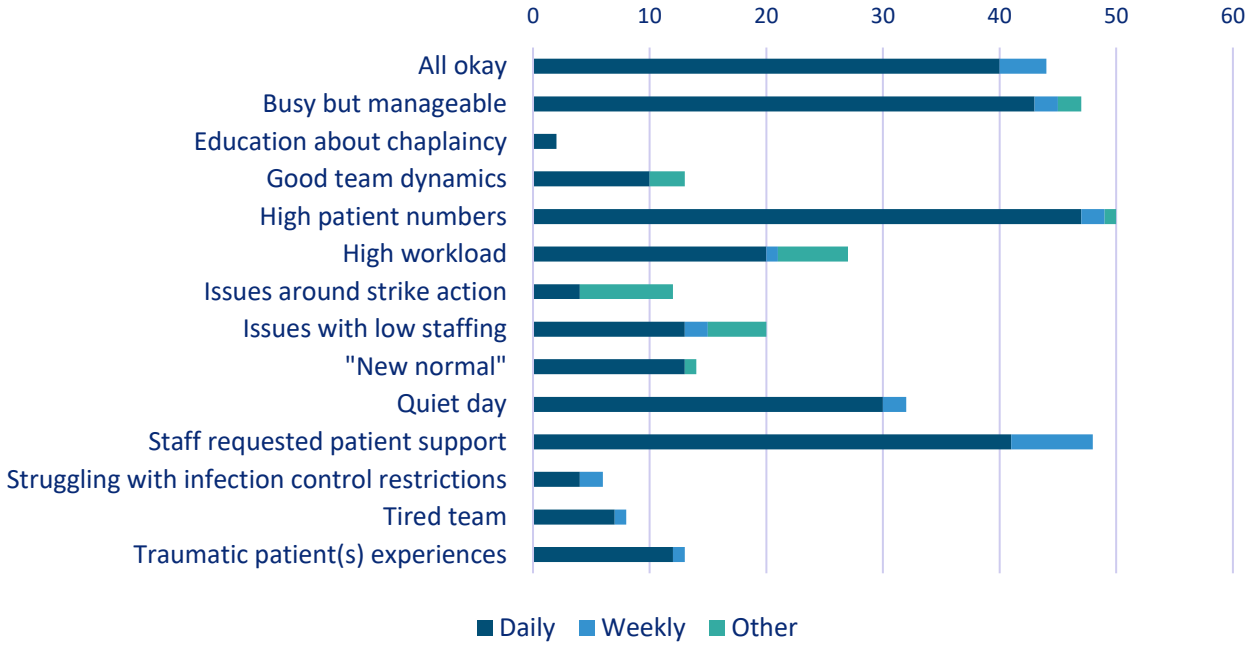


Eastern Staff Area Support Themes Q3 2022-23



Weekly: Bramble, Clyst, CWH, Renal, Yarty, Yealm, Yeo
In Q3 the other areas visited were: Abbey, Ashburn, Culm, Discharge Lounge, Housekeeping, HSDU, Okement, Pain Team, PALS, Site Management, Torridge

Eastern Staff Area Support Themes Q4 2022-23



Weekly: Bramble, Clyst, CWH, Renal, Yarty, Yealm, Yeo
In Q4 the other areas visited were: Abbey, Ashburn, Avon, CCU, Dart, Discharge Lounge, Durbin, Endoscopy, Breast Care, Exe, Lowman, Lyme, Mere, Okement, Otter, PALS, Picket Line, Robin Ling, Site Management, Stoma Team, Taw, Torridge

There are various trends that can be seen in this data. Firstly, it is clear that many teams struggle to varying degrees, whether due to patient numbers, low staffing or general workload. Some days are shaped by considerable 'weariness'. That being said, there are also a measured number of teams reporting in a more positive light, 'good team dynamic', 'quiet day' or 'all okay.'

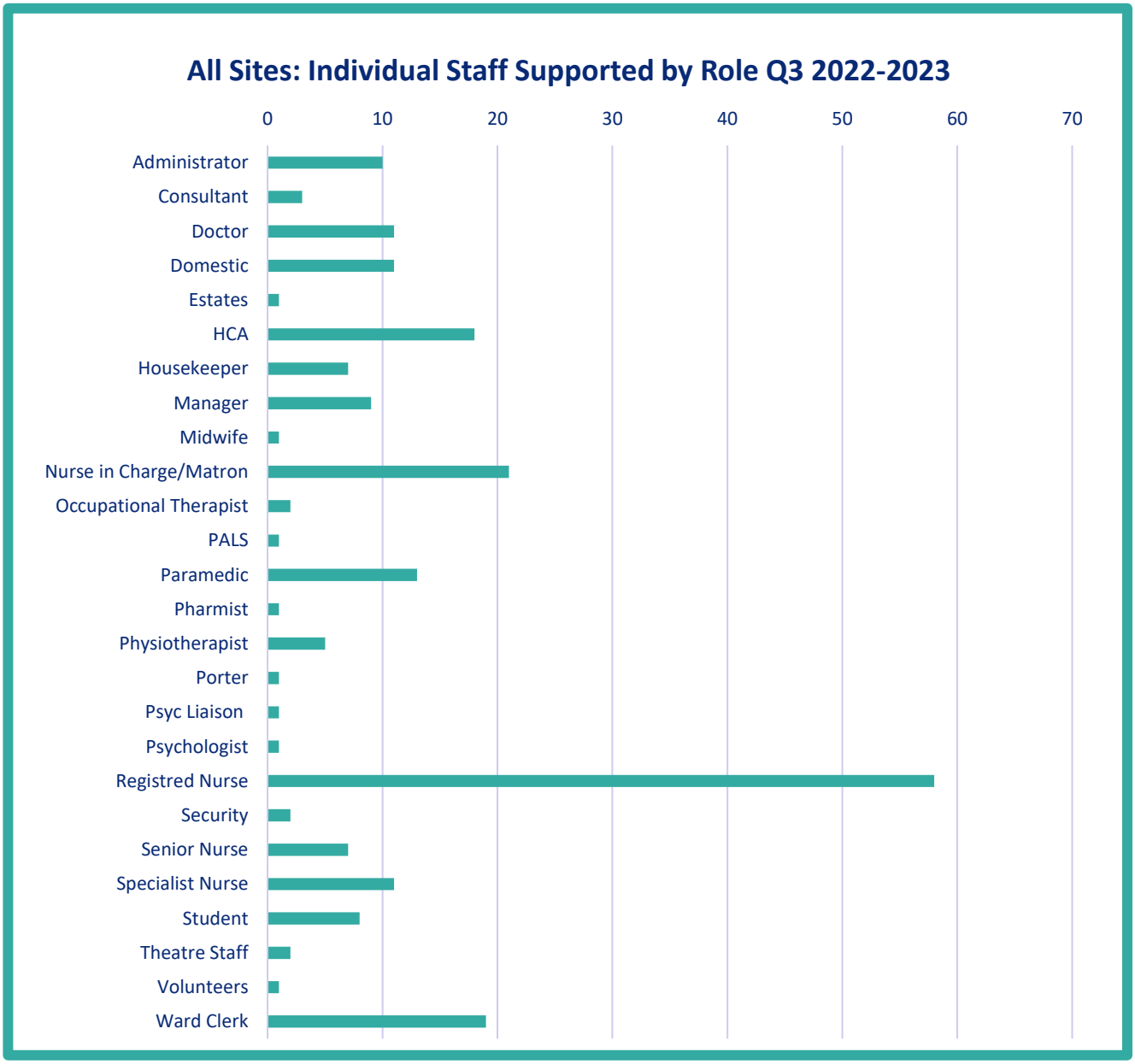
Secondly there are changes across seasons as to what is particularly pressing. For example, in Q3 across the autumn and beginning of winter, we see more concerns around infection control and issues with low staffing. As we come out of winter and into spring in Q4, those issues become less prominent, but we see the impact of the strike action beginning to affect staff wellbeing.

As seen in the data, we have made a huge effort to ensure key areas received regular support. Currently this is not reported through any formal mechanism but we are looking to remedy this in 2023/24 as a matter of some urgency, as this level of staff wellbeing work should not go unnoticed given the priority of such support at this time.

2.2 Individual Staff Support

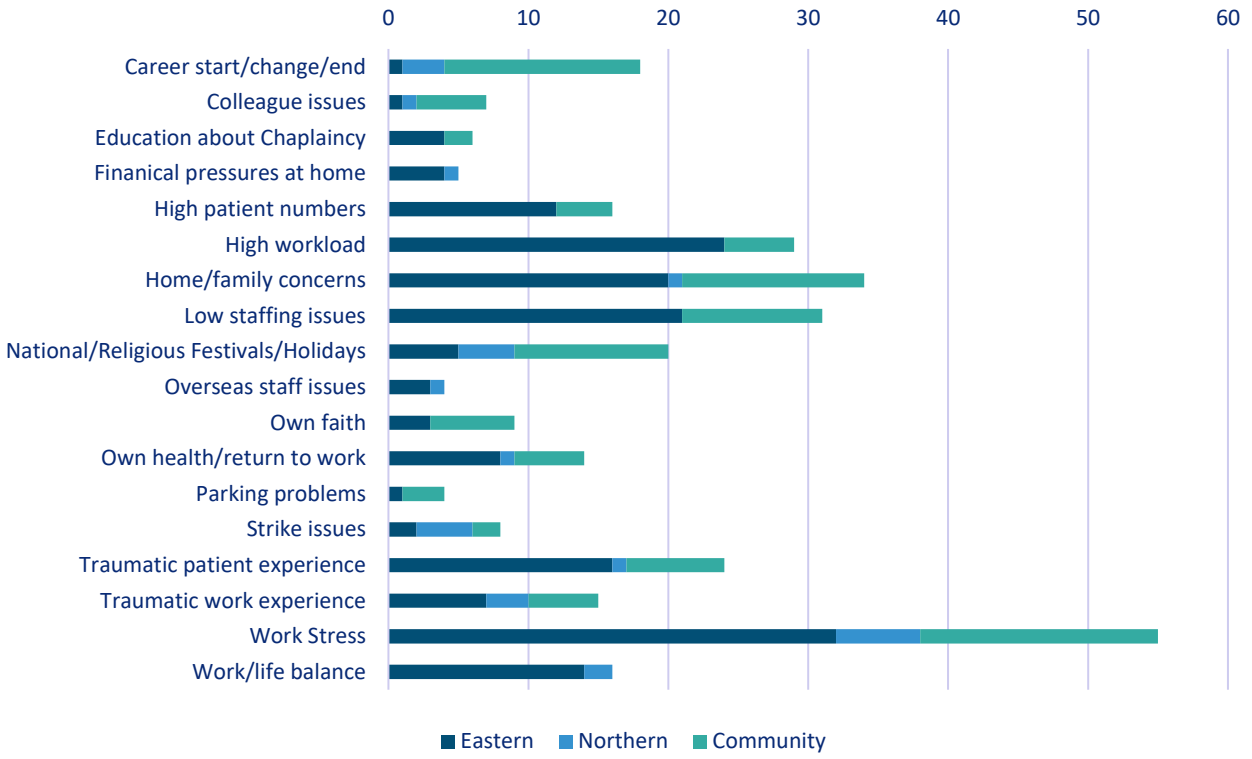
Individual staff support happens on a more case-by-case basis. It would clearly be beyond the realms of practicality to seek to support all staff proactively; however, chaplains are constantly aware of the staff around them whilst visiting wards, aware of the challenge facing certain teams at key times and so often can identify a person requiring support. This data also captures any staff support where the individual has deliberately sought out chaplaincy. This metric is evolving – as we have need to decide whether it is most important to have a sense of who is being supported (thinking of roles and grades) or what themes/issues they face (home/work/stress etc.)

The following data shows the various roles and the themes of conversation that were raised by the staff requiring support.

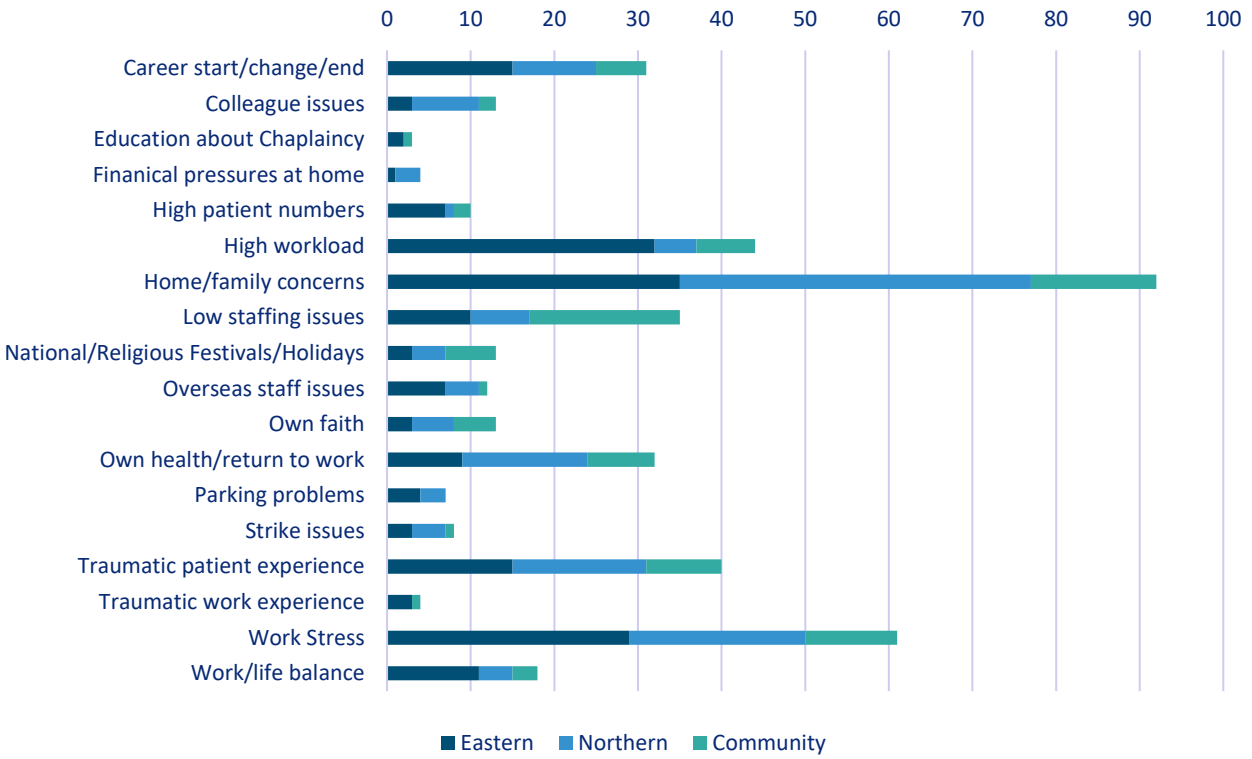


As you can see, individual staff support given covers a range of different roles and bands within the trust. This is obviously weighted heavily towards nursing staff, although that is a natural outcome of the general weighting of nursing staff to other roles within the Trust and the locations that chaplaincy spends the majority of their time. Having identified that staff from all areas are being supported by chaplaincy, it was felt that this particular set of data didn't need to be recorded beyond this quarter going forward.

Individual Staff Support Themes Q3 2022-2023



Individual Staff Support Themes Q4 2022-2023



As with the staff area support, these charts give an indication of the themes of conversation, flagging a range of areas which form recurring points of pressure for staff. There will always be concerns that dominate our life in of healthcare, and for the year April 22 to March 23, both the ongoing pressures linked to the Covid19 pandemic, and that related to strike action is notable. It is also clear, that as well as pressure at work, many staff are facing challenges in their personal lives which can quickly lead to a tired workforce.

'I didn't know where to go, this [the chaplaincy centre] felt like the only safe place.'
Non-Clinical Manager

'good to talk, I didn't know how much chaplaincy did.'
Nurse in Charge

'Thank you for all your support, both personally and professionally.'
CNS Nurse

It's been good to work together and feel supported in caring for our patients.
Housekeeper

Things are okay today, but it's so reassuring that you are able to come and check.
ED Consultant

It was so valuable to be able to come to the chaplaincy centre and pray with a chaplain whilst [my relative's] funeral was taking place. It allowed me to give it a place of significance during my work day.
Healthcare Assistant

2.3 Staff Debriefing Support

Chaplaincy has also worked alongside (or in coordination with) Staff Wellbeing team, OccH and Maternity to offer more formal staff support forums following a significant event, such as the death of a team member, patient violence or a particularly stressful patient episode. Over the past year there have been a number of occasions when the chaplaincy centres at both sites have also been used by staff teams to enable significant conversations to be had. To date we have not captured the number of such events.

2.4 Staff Training

Staff training takes a wide number of forms including, but not limited to: preceptorship, induction, EOL care for HCAs, spiritual care awareness for nursing, spiritual care for F1 medics, Compassion in Management, and spiritual care for overseas recruits.

In almost all our training we cover three objectives:

- Teaching on the immediate subject
- Awareness of spiritual needs among patients and how chaplaincy can support
- How chaplaincy can support staff directly

During Covid19, Abbey developed online training to ensure spiritual care training was still available across the Trust.

Again, at present we do not capture the number of staff training events or staff that attend, albeit it will be several hundred during the year. We are reviewing how best to record this in the coming years and hope to more systematically embed spiritual care awareness into training across all professions.

2.5 Staff Away Days (Quiet)

These have been less frequent since Covid19, and now sit alongside a whole number of ‘away day’ initiatives within the Trust, which is warmly welcomed. We have continued to offer a few, with the focus on a quiet day to reflect and recover, and open to staff across the whole RDUH.



Going forward, we will continue this progress with a stronger focus on offering days for staff teams than need to recover after a difficult time, with the occasional reflective days open to all.

3. Looking forward

As we move into 2023/24 there are a number of key challenges that face us. These have all been included in our revised departments workplan.

These include:

- Capacity
- Workforce stability
- 24/7 on-call
- Weekend cover
- Rolling out best practice across all sites
- Provision in community settings and teams
- Addressing the new NHS England guidelines

4. How we measure what we do

It is sometime said in the NHS that “if you don’t record it, it didn’t happen”. Said to encourage good and accurate record keeping, this does indicate a culture within the NHS that over-values measurable data when compared with softer and more intangible outcomes. As a team we have sought to identify metrics which can be easily captured and have *some* meaningful story to tell and have included them above. Whilst we know that patient experience is improved when good pastoral and spiritual care is delivered, there is no simplistic correlation between such care and faster discharge, for example. Similarly, our radically increased availability to support staff wherever they may be working is clearly a valuable addition, but it cannot be directly correlated to better staff retention. This said, we have been able to introduce a number of metrics to both demonstrate the range of work that we do and provide metrics for improvement quarter on quarter, and do plan to identify far more in 23/24 and 24/25.

Final words

I do hope you have found elements of this annual report useful. Healthcare chaplaincy has come a long way in the last 25 years and as the NHS turns 75 it has a challenging but exciting future ahead. Whilst integration has brought many challenges with it, it has also given us the opportunity to refresh all that we offer, embracing NHS guidelines and delivering improved quality of care for all. That is the key challenge and ambition we face going into the next financial year.