Northern Ireland
Healthcare Chaplains' Association

"PAST, PRESENT FUTURE"

SEPTEMBER 2022

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A/ NIHCA summary

The NIHCA is a professional body of healthcare chaplains, formed in 1953, comprising full-time and part-time, salaried and voluntary/honorary chaplains from a variety of faith/belief backgrounds. In February 2021 membership of the NIHCA was 82 chaplains, with 52 employed and 30 voluntary chaplains.

Membership of the Association is open to all chaplains (salaried or voluntary) working in healthcare settings in Northern Ireland. In 2020/21 membership costs £25 for salaried chaplains and £10 for voluntary chaplains.

Oversight and running of NIHCA is carried out by the Executive Council, comprising maximum 18 chaplains.

The NIHCA shall exist to promote and develop the personal, vocational and professional well-being of healthcare chaplains, supporting them in exercising a professionally competent and ethical ministry, and to promote public confidence in healthcare chaplaincy.

Recognising the inherent dignity and worth of the human person, the Association shall seek to ensure that faith, religion and spirituality are recognised as essential dimensions of each person. The Association shall desire to see and be committed to working towards a healthcare system where these needs are met with equality, inclusivity and justice.

The aims and functions of the Association are:

- To support healthcare chaplains in the exercise of their ministry
- To encourage continued professional and vocational development through the promotion and provision of appropriate training, dissemination of resources and supporting research in the field of healthcare chaplaincy
- To encourage reflective practice through the provision of opportunities for sharing, increasing knowledge, and theological and pastoral reflection
- To be a representative and consultative body for chaplains
- To establish and promote good working relationships with other organisations concerned with healthcare
- To regularly communicate and consult with chaplains, church and faith communities, DHSSPSNI and other national and international organisations

The primary funding for NIHCA is from the Department of Health NI. In 2020/21 the grant was £33,000.This, along with membership fees, enables the NIHCA to arrange suitable professional training for healthcare chaplains and others. Training has included one and two-day events, zoom lunchtime training, Clinical Pastoral Education (CPE) units (3 months) and an annual Healthcare pastoral visitors' training course (18 hrs). The NIHCA has also given grants to chaplains who wish to undertake relevant further studies, such as PG certificate or Masters. In the past two years 4 chaplains have received funding towards Post Graduate Chaplaincy studies, with 2 further chaplains being funded from September 2022.

As well as training, the NIHCA promotes and supports research through the NIHCA Research Network.

NIHCA is a founding and core member of UK Board of Healthcare Chaplaincy (UKBHC), established in 2009, which holds the register of healthcare chaplains in UK.

The primary aim of UKBHC is the safety and wellbeing of the public, which it achieves by setting high standards for the professional practice of healthcare chaplains that are on the register

In August 2017 the Professional Standards Authority (PSA) recognised UKBHC as an Accredited Register. PSA is the regulatory body for all registers of health and social care professionals. At present, chaplaincy registration is voluntary.

B/ Chaplaincy training 2014-2021

All training events are accredited by UKBHC, working with a wide range of partners.

Date	Venue	Topic/Speaker
16/5/14	South West Acute Hospital, Enniskillen	AGM - “Standards, Competences, Code of Conduct” - Rev Derek Fraser, UKBHC
30/9-1/10/14	Drumalis Retreat Centre, Larne	“Faith & Mental Health” & “Mood matters” & “Pastoral support” - Flourish!
27/11/14	Seagoe Parish Centre, Portadown	“Understanding self-harm” - Flourish!
4-5/2/15	Dromantine Retreat Centre, Newry	“Resilience & self-care” - Mrs Sharon McCloskey & Rev Derek Johnston; “Use of art in spiritual care” - Rev Norman Harrison; “Abortion” - SPUC
6/5/15	Knockbracken Healthcare Park, Belfast	AGM - Patient & Client Council
8/9/15	Ballyclare	"Theological & pastoral reflection" - Rev Ruth Craig
18/11/15	Musgrave Park Hospital, Belfast	Multidisciplinary training day organised by NIHCA, Belfast Trust Chaplaincy Department and the HSC Bereavement Coordinators - "Coaching at end of life" – Rev Don Eisenhauer (USA)
24-25/2/16	Dromantine Retreat Centre, Newry	Reflection day - Canon Raymond Fox "Spirituality in healthcare" - Prof Fiona Timmins
11/5/16	Seagoe Parish Centre, Portadown	AGM - "A phenomenological exploration of the attitudes and beliefs of Health Care Chaplains in Northern Ireland regarding the delivery of denominational ministry in a changing society" - Paul McCloskey, Bereavement Coordinator S.E. Trust
13-14/9/16	Dromantine Retreat Centre, Newry	"The Shepherd in pastoral care - a model for chaplaincy" - Mrs Carolyn Patterson; "Arts in spiritual care" - Rev Norman Harrison
22/11/16	Knockbracken Healthcare Park, Belfast	Multidisciplinary training day -"Holistic care at end of life"
22-23/2/17	Drumalis Retreat Centre, Larne	"Healthcare Chaplains - symbols of hope" – Rev Rosie Morton; "Ministering to those with Intellectual Disabilities" – Mrs Gillian Carlisle
24/5/17	Tara Centre, Omagh	AGM - "Community Chaplaincy" - Rev Sheila Mitchell, Programme Director for Health and Social Care Chaplaincy and Spiritual Care, NHS Education for Scotland
12-13/9/17	Drumalis Retreat Centre, Larne	"Dealing with traumatic situations" - Dr Marion Gibson; "Self-care" - Rev Mervyn Ewing, Flourish.
23/11/17	Musgrave Park Hospital, Belfast	Multidisciplinary training day - "Healthcare ethics" - Rev Dr Brendan McCarthy
8/2/18	The Iona Carmelite Retreat Centre, Termonbacca, Derry/Londonderry	"An introduction to dementia awareness and support" – Carla Mulholland, Alzheimer's Society NI & Michael McMillan
23/5/18	Ulster Hospital, Dundonald	AGM - "Data protection & it's implications for chaplaincy"
26-27/9/18	Dromantine Retreat Centre, Newry	“Roles & boundaries in Healthcare Chaplaincy" - Mary Kearney, "Theology & practice" - Chaplains' Personal reflections
28/11/18	Knockbracken Healthcare Park, Belfast	Multidisciplinary training day - "Vicarious trauma" - Wave
30/1/19	Omagh	Multidisciplinary training day (repeat of 28/11/18)
26-27/3/19	Drumalis Retreat Centre, Larne	"Chaplaincy with children" – Rev Paul Nash (Birmingham Children's Hospital)
29/5/19	Project Echo Hub 1 Shore Road, Belfast	AGM - Rev Prof Max Watson

9-10/10/19	Drumalis Retreat Centre, Larne	Spiritual and Theological Reflection on the theme of "The Shepherd, Psalm 23" - Rt Rev Bishop Ken Clarke
25/11/19	Musgrave Park Hospital, Belfast	Multidisciplinary Training Day - Rev Dr Steve Nolan - "Hopeful Presence at the End of Life"
27/1/20	Omagh	Multidisciplinary Training Day (repeat of 25/11/19)
4-5/3/20	Dromantine Retreat Centre, Newry	SWAN Nurses (Manchester) - Fiona Murphy & Alice Davies - A palliative pathway - "A Good Death"
09/20-11/20	Ballyclare	CPE unit (3 months) supervised by Sr Mary Jo Corcoran, ACPEI
8/12/20	Via Zoom	Life Limiting Illness and Bereavement – Pastor Alain Emerson, (Service User's Perspective)
12/01/21	Via Zoom	Offering care as a sharer in suffering – Pastor, Writer and Broadcaster Rev John Ortberg (USA)
27/01/21	Via Zoom	Principles and Practices of Pastoral Care – Newman University Lecturer Helen Bardy and University Chaplain Margaret Holland
17/02/21	Via Zoom	Chaplaincy and the Soul of Healthcare – Professor University of Glasgow, Rev Dr Ewan Kelly
13-14/10/21	Dromantine Retreat Centre, Newry	Changes in Legislation on Abortion and the right of Conscientious Objection – Karen Murray RCM Retreat – Reflections on emerging from the Pandemic – Bishop Router
15/12/21	Via Zoom	Rev Prof Chris Swift (England) Ministry to those in Later Life

- ***Clinical Pastoral Education (CPE):***

CPE is a tried, tested and internationally accredited form of pastoral training.

CPE is a method of reflecting on actual ministry in which a supervisor together with a group of students formally agree to reflect critically on the student's ministry as a means of growing in self-awareness, professional competence, theological understanding and spiritual commitment. This provides a learning situation in continuing education for all who have the desire to minister to people in need. Thus, as chaplains, they may develop an awareness of the psychological, theological and spiritual concerns of people. This further assists students to become increasingly alert to the dignity and potential of those to whom and amongst whom they minister.

CPE confronts the student with the human predicament. It supplies the milieu for students to understand themselves more fully in the role of chaplain and to integrate their theology more meaningfully into life and ministry.

CPE provides for supervision of this experience by a supervisor trained in the CPE model of learning and practice. The supervisor brings to the learning situation his/her own unique experience, insights and competencies. This assists in the stimulation of individual initiative and growth. The supervisor will encourage the student to express their own natural abilities and talents that will allow them to be channelled into more meaningful pastoral relationships in a professional and caring manner, operating within a professional multi-disciplinary team.

From 2006-2020 the NIHCA has facilitated more than 10 CPE units, using Belfast City Hospital, Ballyclare, Holywell and the Ulster Hospital as venues. 36 chaplains have completed 1 unit at level 1; 17 have completed 2 units at level 1; 3 have completed 3 units at level 1; 3 have achieved level 2. Total number of participants = 57.

Structure and Content of a CPE programme

- A full-time Level 1 (Basic) Unit is a programme with a minimum of 400 hours of theory, safe and effective use of self in therapeutic relationships and supervised clinical practice (200 hours) within a period of 11-13 weeks
- Ministry involves direct relationships between the student and those to whom he/she ministers. Ministry sites are chosen based on the learning needs of the individual student. The supervisor should be familiar with each ministry site. For offsite placements the supervisor will visit the placement site.
- Supervision entails:
  - Individual supervision, which is to be scheduled regularly, of each student by a Supervisor (50 Minutes per week). Video Conferencing may be used for supervision
  - Group supervision
  - Inter-Personal Group Experience. (40-50 hours)
  - Sharing of written evaluations by the student and Supervisor
- Written assignments including:
  - Verbatim reports of students' ministry (min of 6)
  - Personal Reflection papers
  - Case Histories
  - Evaluations (Mid Unit & Final)
  - Theological reflections
  - Book reviews
  - Ethical paper
  - Critical incident reports
  - Research paper (Level 2)
  - Individual personal reflection papers
  - Papers in preparation for Certification as appropriate
  - Integrated autobiographical paper
- Formal lectures cover such areas as:
  - History, Theology, and Models of pastoral care
  - Spiritual and ethical dimensions of pastoral care
  - Training in specific skills in ministry
  - Orientation to various aspects of hospital care
  - Ministry / Spiritual care in multi-faith context
  - Child protection/ Care of vulnerable persons
  - Institutional specific lectures such as Fire safety, Health and Safety, Hand Hygiene, Infection control

- ***Healthcare pastoral visitors' training course:***

This 9-week course is aimed at lay people who are interested in healthcare pastoral visitation, either within the local church context or within a chaplaincy context, or who already visit hospitals or other healthcare places as part of their church responsibilities. This started in 2008, based at Edgehill College, Belfast. It is a partnership between NIHCA and Edgehill College, but is open to people of all faiths, denominations or beliefs. NIHCA members lead most of the sessions. On average, 10-12 people participate each year, attending one night each week during the course. Some participants have gone on to become chaplaincy volunteers.

Topics covered include:

Week 1: Introductions/Learning Objectives/Group Contract. Why care? Reasons for hospital visitation.

Week 2: Communication; Opening & closing; Empathy and Silence

Week 3: Models of Pastoral Care; Awareness & Assumptions/Do's & don'ts)

Week 4: Thinking reflectively; Pastoral Role Play

Week 5: Death and Dying; Palliative care

Week 6: Loss histogram; Grief and Loss

Week 7: Theology and practice; Rituals/Liturgies/Sacraments; Ethical dilemmas

Week 8: Spiritual Healthcare: Spiritual Pain; Where is God when it hurts?

Week 9: Personal and Pastoral Reflections; Evaluation

- ***NIHCA Research Network:***

Aims -

1. To educate and up-skill chaplains to be able to approach research with confidence

2. To assist and help chaplains in undertaking research

3. To encourage each other.

6/5/19 Inaugural Research Workshop led by Professor Kate Pidderman, Associate Professor of Psychiatry and Certified Chaplain at the Mayo Clinic, Minnesota, USA. The theme of this session was a broad introduction to chaplaincy research.

2/9/19 A Workshop was facilitated by Rev Dr Steve Nolan - ‘Case Studies: how to get started’.

‘Healthcare Chaplaincy Research: A Practical Guide for Chaplains’ was published by the NIHCA Research Network in May 2020.

This has further lead to the development of a Chaplaincy Journal club which meets online several times per year to discuss academic papers and articles of interest.

Over 30 NIHCA members are now subscribed to the Journal of Health and Social Care Chaplaincy as part of their NIHCA Membership.

C/ Recommendations (based on the following studies D & E)

❖ ***The NIHCA should***

- Continue to arrange 1-day and 2-day in-person training, along with online training opportunities
- Continue to fund chaplains to undertake CPE training, Post Graduate courses, etc..., particularly where this enables chaplains to apply for registration with UKBHC
- Explore further opportunities to engage with partners in research and development
- Continue to support and equip chaplains to provide high quality, professional, competent, safe and caring practice, thereby also ensuring the safety and wellbeing of the public
- Continue to promote the aims and functions of NIHCA

❖ ***NI Healthcare Employers should***

- Recognise the value that chaplaincy can bring to patients, families, staff and the wider healthcare environment
- Seriously consider having a full-time Lead Chaplain, at band 7 or 8a, depending on the size and workload of the department
- Agree minimum essential and desirable criteria for chaplaincy employment
- Facilitate opportunities for chaplaincy supervision and reflection
- Note the willingness of chaplains to carry on, even through the challenges and risks of covid
- Support and enable holistic care that includes pastoral, religious and spiritual care
- Encourage chaplaincy participation in local multidisciplinary teams
- Support continued innovation from chaplaincy
- As part of the Job Description, encourage all their chaplains (paid and voluntary) to join NIHCA
- Encourage all their chaplains to participate in the different opportunities for learning, sharing, development and research
- Include NIHCA training as part of their Training Matrix and therefore part of on-going training and Continuing Professional Development
- Facilitate their chaplains to attend NIHCA training as part of their working hours, rather than chaplains needing to do so as annual leave
- Encourage their chaplains to register with UKBHC or other relevant registration bodies
- Explore with their chaplains what are the most appropriate models of practice within their context, e.g. denominational, generic, site specific, etc... One model does not fit all.

❖ ***NI Department of Health***

- With additional Department of Health NI funding in 2021, NIHCA was able to purchase large stock of helpful resources that were distributed to all Chaplaincy departments in NI hospitals and hospices, for the benefit of patients, residents, staff and the wider healthcare community. It would be very helpful and appropriate to be able to repeat this resource bank on a regular basis every few years
- While NIHCA is fortunate to have some financial reserves, along with membership fees and Department of Health NI funding, that will sustain the above work for several more years, the pot has a limit. Continued and additional Department of Health NI funding, perhaps with increased membership fees, will be needed to sustain and develop the work. In real terms, the funding provided is a drop in the ocean, but it has a proportionally greater impact on chaplaincy and through chaplaincy for the benefit of others.

D/ Healthcare Chaplaincy across Northern Ireland Health and Social Care Trusts and Hospices during the first wave of the pandemic COVID-19 Chaplaincy Questionnaire

INTRODUCTION

During this unprecedented time of the COVID-19 Pandemic, chaplaincy teams across Northern Ireland showed great adaptability and flexibility in developing new ways to continue attending to the spiritual and pastoral needs of patients, staff and their families. This is illustrated by the actions of chaplains who maintained contact with one another and shared ideas of good practice and who used their creativity to develop new resources. It has been very edifying to have observed their commitment and to be in a position to acknowledge their ingenuity.

As a means to documenting the impact of the Pandemic on chaplains and chaplaincy services, the NIHCA Executive, consulting the NI Ethics Committee and with the endorsement of the Department of Health Chief Nursing Officer, sought to gather evidence, using a questionnaire, of chaplaincy responses to the pandemic for future reference and to aid the development of a more unified approach, an evidence-based model which could be proposed for implementation across all Trusts/Sites or at a regional level in the event of further COVID-19 surges or similar crisis in the future. The responses were collated and anonymised by the NIHCA. The following pages document the responses to the questionnaire.

1. TARGET AUDIENCE

Through the NIHCA, and with the backing of the Department of Health, Healthcare chaplains across Northern Ireland who work for the Health and Social Care Trusts or Hospices were asked to voluntarily participate in this questionnaire. The questionnaire was open to all Healthcare Chaplains regardless of membership of the NIHCA. We received 50 viable responses to the questionnaire; one additional response that didn't answer any of the questions was discarded. The first four questions of the questionnaire refer to the provenance of the participants, which resulted as follows:

Employer	Number of participants
Belfast Health & Social Care Trust	26
Northern Health & Social Care Trust	8
South Eastern Health & Social Care Trust	4
Southern Health & Social Care Trust	4
Western Health & Social Care Trust	2
Northern Ireland Hospice	4
Blank	2

Contract status	Number of participants
Employed	33
Voluntary	15
Blank	2

Hours worked per week	Employed	Voluntary
1-8	10	6
9-16	7	4
17-24	6	2
25-32	1	3
33+	8	--
Blank	1	--

2. WORKING DURING PANDEMIC

During the first wave of the pandemic the majority of the chaplains were continuing to work at their hospital or hospice (Q.5):

Age	Still attending	Working from home	Isolating/Shielding
20+	2		
30+	4	1	
40+	2		
50+	9	5	
60+	5	3	2
70+	1	3	7
Blank	2		

For those who had to work from home, or were shielding, only two had shown any symptoms of Covid-19 and only one of them was tested (Q.6).

a. Working from home.

While at home, either working or shielding, chaplains were able to reach out to patients, families and staff in various ways (Q.7):

Ways of reaching out
• Answering phone calls from patients, staff and families through dedicated phone lines
• Preparing spiritual resources for chaplains, staff and patients
• Keeping in contact with other chaplains on-site and across other hospitals using Zoom and other media
• Using emails, Facebook, other social media through the NIHCA website
• Praying for others

However, working from home, and indeed, office-based work, was a new concept for chaplains who are used to face-to-face interactions with patients, families and staff. The questionnaire asked the chaplains if guidance and interest shown from Management and Church authorities had been offered, how was it offered, and if it was helpful (Q.9 & 10).

Contact and help offered by	Thought was helpful			How it was offered
	YES	NO	N/A	
Service Management (Q.9)	28	12	10	Contact was chiefly by email and phone call, while few received letters. Two had noted a direct personal contact with line managers.
Church/Belief Group (Q.10)	39	11		50% mentioned receiving a phone call from their Bishop or Church Leader. The use of platforms such as Zoom was innovative. Some received emails and/or text messages or information in the post.

What Chaplains found helpful by the contact and help offered	
Service Management	The chaplains who were contacted were appreciative of the effort that was made by Management to enquire about their wellbeing. They felt encouraged, supported and reassured. They felt more included in the developments within the Department and appreciated the human contact. The offer of online stress management resources was welcomed.
Church/Belief Group	There were many similarities with the contact and support received from Service Management: the appreciation of the human connection and genuine concern for their wellbeing. What was highlighted was the prayerful support in being present to one another, the fact that their Church leaders reached out to them, and that their ministry as Chaplains was being recognised. The opportunity that this contact provided, including forming a WhatsApp group, led to a sharing of ideas, and was particularly helpful.

b. Working on-site.

While chaplains were generally not allowed on the wards during the first lockdown, there were some specific requests for Chaplaincy services. The chaplaincy waited for specific referrals to visit individual patients (Q.17); only four chaplains noted doing routine pastoral visits.

Requests for Chaplaincy Services	
Working by referral only	22
Both specific and routine pastoral referrals	4

During the period mid-March and April 2020 (Q.8). 58% of the chaplains (29 out of 50) commented that they received specific pastoral referrals to attend to.

Numbers of specific referrals during no visiting period on the wards		
	Mid-March to April	May
Patients asked to see a chaplain	242	203
Staff supported	299	246
Relatives/families	241	213

While working on-site, some chaplains have been involved in multidisciplinary groups or been deployed to help elsewhere (Q.11 & Q.12):

Assisting other departments	Multidisciplinary/agency involvement
Rainbow Room (staff support)	Regional Ethics Committee
Bereavement support (calling relatives)	Palliative Care team
Meet and Greet Support Officer	Domestic Abuse support
User and patient experience	Staff support and guidance for nurses
Assisting at other Trust sites	Regional Bereavement Groups
	Multiagency team for mortuary placement

3. ATTENDING TO COVID-19 PATIENTS

Few chaplains were trained in the use of Personal Protective Equipment (PPE); generally, only employed chaplains would have had experience with PPE. However, the demands of the pandemic saw an increase in chaplains proficient in the use of fit-tested masks and PPE (Q.13 & Q.14):

	Percentage of chaplains
Trained in the use of PPE	52% (26/50)
Fit-tested for a respiratory mask	56% (28/50)

During this period, 18 chaplains (36%) had contact with Covid-19 positive patients (Q.15). 117 patients were visited in the period mid-March to April, and 118 were visited in April (Q.15); it is interesting to note that 105 patients were in an Intensive Care setting (Q.16). This shows that the few fully-trained chaplains were able to visit Covid-19 patients from the outset of the pandemic, having been trained in the complete use of PPE.

4. CHAPLAINS SELF-CARE AND SUPPORT

a. Use of Personal Protective Equipment (Q.18).

One of the headline news items in the first months of the pandemic was the use or lack of PPE availability. When asked if they felt they had the appropriate PPE at all times, only 10% of chaplains responded that they didn't feel they had the appropriate PPE, although it was noted that sometimes the quality of the PPE was poor.

b. Concerns about visiting patients (Q.19).

When asked about concerns for their well-being while attending the hospital, 12 chaplains responded saying they had concerns:

Concerns expressed by chaplains
Fear of bringing the virus back home to their families
Afraid of spreading the virus
Fear of not taking the appropriate precautions
Higher risk of infection as a frontline worker
Some felt that there was a lack of consistency in criteria among different wards/sites
Lack of consistency regarding access to patients

c. Guidance from NIHCA and Service Management (Q.20).

The Chaplains were asked if they received guidance from NIHCA and/or Service Management about chaplaincy during this time. 80% of the Chaplains said that they had received guidance during this period; 10% said they received no guidance at all. They received guidance in the following formats:

	Various means of guidance received
77.5%	By email
22.5%	At a staff meeting
12.5%	By an online resource (website)
10%	By phone call
10%	By letter

When asked if they felt there was anything else the NIHCA and Service Management could have done to help them, 92% of the Chaplains did not respond. The few responses were:

What else could have helped you?
More support and guidance needed from the outset of the pandemic
More proactive support from team management
To have had earlier team meetings by Zoom
To have been more in touch with what was going on

5. INNOVATIONS WITHIN CHAPLAINCY.

The last question (Q.21), a more reflective question, asked the Chaplains to comment on what innovations within their Chaplaincy Department were introduced by them, and what they have learned that could be shared with others to help future practice.

a. Innovative tools.

Chaplains came up with creative means to reach out to and engage with staff, patients and families during this time of intense restrictions at healthcare facilities:

• **NIHCA online support website**: Our members contributed to the Chaplains NI webpage developed for this period of restrictions on visiting. Many reflections, inspiring and consoling material was made available for chaplains, staff, patients and families. Various illustrated reflections were published on how to keep strong faith through a crisis. Video clips were made to increase awareness of the presence of the chaplaincy department, within and without the hospital, during these challenging times.

• **Outreach helpline for staff, patients and families:** During the pandemic, chaplains have tried to keep in contact with those families who were not able to visit their loved ones in the hospital. This has proved very helpful and has been a great way to provide spiritual support in a wider form. Various teams had direct-dial phone support for patients, families and staff which proved useful, although it was slow on the uptake. One Chaplaincy department was issued with mobile phones so that Covid and other wards were able to contact chaplains who were able to speak directly with patients, especially those at end of life or in need of spiritual support. The use of apps such as Facetime allowed patients and chaplains to interact face to face, albeit virtually; this was particularly helpful when chaplains were unable to physically be near the patients or would appear almost anonymous while dressed in full PPE.

• **Using social media:** Use of FaceTime, WhatsApp and regular phone calls. Email seems to be a safe way for some staff to respond to the offer of prayer support in that they are in control of what to share and how, and when they are ready.

• **Broadcasting materials:** One Chaplaincy Department produced a video message (with Irish Blessing background music) for the Trust through the Hub, Twitter, Facebook, etc.; it received some very positive responses at a local level and, indeed, further afield. Another Chaplaincy team held a five minute morning reflection for Emergency Department staff twice a week using the *Vocera* communication system to broadcast from the non-covid side into the covid side of the Emergency Department; this had huge support and it is hoped to develop it more widely in the hospital. Other teams provided recorded hymns for patients in end-of-life care to listen to which staff felt helped the patients to relax.

• **Interviews on Television, Radio and the print media:** A few chaplains made appearances on national television and radio and some had articles published in local newspapers. This all proved to be a great opportunity not only to promote the presence of healthcare chaplains during Covid 19 pandemic but to assure patients and families that religious, spiritual and pastoral care was available.

• **Hope Tree**: Staff on one site wanted to focus on the positive aspects emerging during the pandemic. A 'hope tree' was constructed to allow the healthcare staff to leave and display their reflections on the positive aspects that they witnessed emerge from this time of crisis. These reflections will be collated and shared at a later date by the chaplaincy team.

• **Laminated prayer cards for patients and staff**: Pocket prayer cards for both staff and patients were produced and laminated for easier disinfection. These cards got lots of positive feedback showing how well they were appreciated by patients and staff. Chaplaincy packs for patients were also produced which contained a message from the chaplains, a Gideon's New Testament and a Trust Prayer booklet which were distributed individually in a sealed wipeable package. On various sites, individually wrapped religious items such as rosary beads and holding crosses and a range of multifaith prayers were distributed – real, tangible gifts.

• **Support materials for healthcare staff**: A box from the Chaplains was presented to staff with cards to show their concern and assure that the team was praying for them; the boxes contained religious and spiritual materials and items to help with prayer. Placing posters, prayer cards and contact numbers on each ward was a simple yet effective way of communicating the presence and availability of chaplaincy support. Also, prayer resources on the Hub for staff were revised, updated and redistributed to the wards.

• **Art Pack:** This project, devised in conjunction with multidisciplinary teams, became a means to place a care pack with chaplaincy materials into the hands of patients in wards when routine visitation was not permitted. The pack contained an activity booklet with coloured pens which, through artistic means, helped patients to actively reflect on their time in the healthcare facility.

b. Multidisciplinary teamwork.

• **MDT Rainbow Team**: This innovative team were trained to make phone calls to newly bereaved families; they called the bereaved relatives some 24-48 hours after the death of their loved ones and again some 3-4 weeks later). The feedback was positive. Chaplains noted how some people found that they were more open to talking about feelings via a phone call than previously thought.

• **Bereavement team**: Post-bereavement chaplaincy calls to all bereaved families who accepted the offer meant there were many useful and helpful pastoral encounters, given the restrictions on families and chaplains to attend to dying patients in the hospital.

• **Multiagency teams:** Different chaplains had the opportunity to get involved in multiagency teams, such as the Covid 19 Regional Ethics Forum & Bereavement groups.

• **Prayer times:** The offering of moments for team prayer, as a means of mutual support, was an encouragement to many of the staff. They would approach the chaplain and ask for specific prayer requests.

• **Presence on the wards and in staff areas:** While visiting the wards was not permitted in some cases, chaplains began to maintain a presence in the main areas of the hospital and provide an opportunity to meet staff and relatives, who often stopped to chat with them formally or informally. Loitering with intent is often the best way to be present and be able to encourage busy staff and worried relations. Chaplains noted that they have learned to observe staff and just be about when they need to sound off, a skill some have better developed during this time. One chaplain noted the belief that part of the role at the end of a patient's life is to support the staff who may have to dig deep and do it all again! Just being there to reassure staff was welcomed. Some chaplains noted that they have had deep, meaningful and significantly important conversations with staff who would not ordinarily engage with Chaplaincy. Indeed, conversations do not have to be very long to make a difference.

• **Booklets:** One Chaplain wrote, produced and distributed 10,000 copies of a booklet called "Hope in a Crisis" - a bereavement resource that has been distributed with the hope it will be used widely throughout Northern Ireland and the United Kingdom in bereavement support packs by chaplains, bereavement coordinators, funeral directors and care homes for families of patients who have died. A planned reprint will be produced with some amendments so that it can be used more appropriately in the post-pandemic era.

• **Hub materials:** Liturgies were produced (Christian & Other Faiths) for staff to use in the absence of a chaplain. A series of multi-faith training powerpoints were reproduced for the E-learning site for general use and with a specific section on Covid-19.

• **Prayer requests:** Some chaplains left flip chart sheets of paper on a table in the Church where staff could write their prayer requests, Scripture quotes or thoughts, all of which indicated a community of people who visit the church despite not being able to have formal gatherings.

• **Contact cards for first responders:** It was difficult for first responders to tell families that they were unable to accompany their loved ones to the hospital. To assist them, some chaplains designed contact information cards for ambulance staff to give to families who had to say goodbye to loved ones being taken to hospital. This meant that families could get in touch with chaplains directly about looking after the pastoral, spiritual and religious needs of their loved ones.

c. Future considerations.

• **Crisis preparations**

i. Several chaplains felt that they should have been fit-tested for masks at an earlier point.
ii. The wearing of scrubs helped some chaplains be seen as part of the team by other staff.
iii. The advertising of chaplaincy services often did not reach the patients in Wards.
iv. Many chaplains felt the need to play a more active role in the planning and responding to crises. Some chaplains commented that the spiritual care policy was not adhered to in crisis moments.

• **Communication**

i. Ways of meeting - Zoom meetings and WhatsApp groupings with other Chaplains was seen by many to be a helpful means to network with other colleagues and share ideas on good practice and criteria.
ii. There will undoubtedly be more learning to emerge from the experiences of chaplains during Covid19 and further reflection will be needed. The greater use of technology in Chaplaincy and other new ways of working will continue, however, further consultation with wider Chaplaincy networks, will help inform future learning.
iii. There was an expressed need for an internal review of chaplaincy practice within the local teams and time for planning.

• **Chaplaincy Volunteers**

i. Greater consideration needs to be given to utilise chaplaincy volunteers better. They can be trained in protocols and the use of PPE as easily as a paid chaplain. While remunerations are different, the motivations and professional experience are broadly the same. At a time of global crisis, many volunteers felt cut off from offering pastoral care when it was most needed.
ii. Some chaplains commented that they took advantage of the downtime during part of the pandemic to focus on upskilling, networking with other chaplains across the UK and reading journals and research papers.

• **Response to Chaplaincy during this time**
i. Some chaplains commented how patients have valued chaplaincy visits during this difficult time; it helped to encourage them through listening, caring and praying. Also, family members have appreciated the Chaplaincy department being involved in their loved one's healthcare when neither they nor their own minister/priest have been able to visit.
ii. Mental Health: a major area that will require ongoing attention as a result of the pandemic involves the mental health consequences for society as a whole. Chaplains know how much faith can be a great source of strength and solace in times of stress and grief. They felt somewhat bereft of the opportunity to provide this service when they were more than able and willing to but access was restricted.
iii. Domiciliary visits: Some chaplains commented on the role of palliative care in the community and how chaplaincy could play an important role in offering such support.

CONCLUSION

Undoubtedly, as with all aspects of healthcare during this time of the pandemic, chaplaincy departments across Northern Ireland have had to face unprecedented challenges. As with staff in other departments, chaplains have gone above and beyond in rising to the challenges of having to respond quickly to the obstacles of offering holistic care in restrictive circumstances.

What many chaplains take away from reflecting on this period, is that their presence is needed and valued, and they can have a positive impact on the healthcare environment as a whole. Spending time with patients, staff and relatives in conversation, intentional listening and prayer has helped them deal with the emotional pressures and strains all were experiencing. Reaching out to receptionists, catering staff, cleaners, porters, security, ambulance staff and so many others, allowed chaplains to have the privilege of grasping the pains, the concerns and the fears healthcare staff experienced and their need to be heard within the walls of the hospitals and seek understanding about the things they cannot talk of at home.

As the vaccination process offers great hope of coming out of the pandemic, like so many of our staff, chaplains will continue to re-evaluate their practice during this time and look to the future with all the great learning and experience gathered during this period; it is hoped that the outcomes of this questionnaire contribute to the treasury of learning being documented and assimilated from the experience of the pandemic. The world has, indeed, changed; and chaplains, too, appreciate, more than ever, that their role in healthcare is an essential part of the care and wellbeing of all who pass through the doors of our healthcare facilities.

E/ Professional Chaplaincy Survey

Purpose:

The NIHCA Executive Council wanted to outline to our members, the wider healthcare chaplaincy community and chaplaincy line-managers, who we are and what we do. At the same time, we wanted to ensure we are ready to play our part in healthcare chaplaincy today and in helping to shape healthcare chaplaincy for the future.

We therefore invited all NI healthcare chaplains and chaplaincy line-managers to participate in this survey.

Primary aims to -

- identify and highlight good practices
- share insights with the wider healthcare chaplaincy community
- compose a set of evidence-based guidelines to recommend to Trusts/employers
- promote the safety and wellbeing of the public, by ensuring high standards for the employment and professional practice of healthcare chaplains
- improve the outcomes for all who work within healthcare chaplaincy and for those who normally receive the benefit of our services.

Process:

The survey took several months to put together, with a number of drafts and revisions before the final version was approved by the NIHCA Executive Council.

Initially it was sent out to NIHCA members and Chaplaincy line-managers by email; soon after, the addition of SmartSurvey version enabled online responses.

Further pieces of work may follow from this report.

Responses:

- 3 posted returns
- 6 email returns
- 15 online responses

24 in total

Anonymity:

While some sites may be identifiable, we have sought to remove any information which could identify specific chaplains in the responses.

Format:

In the full version, for each question there is a page of Key messages, followed by edited responses.

The summary version highlights the key messages for each question.

Question 1
Key messages – Summary

What does Chaplaincy look like in healthcare in 2020/21?

(Briefly outline your normal models of practice and any variations on your site, e.g. denominational, generic, ward/site, employed, voluntary... Also include involvement in any multidisciplinary teams, changing context, widening of roles, etc…)

- Primary model is denominational, but significant number of sites where generic model is practiced to varying degrees, particularly in more specialised units
- Being part of a team is vital
- Trusting your team
- Communicating well
- Raising professional profile
- Generic does not mean denying our rootedness in our Faith tradition
- Some examples where generic means covering all patients, or covering Protestant/Other patients
- Local context can be helpful to determine the most appropriate model of practice
- The majority mention participation in different Multi-Disciplinary Teams, though acknowledge this takes time and commitment which is not always easy to give from a largely part-time service
- Where MDTs are practiced, there are clear benefits to patients, staff and chaplaincy
- Local and regional impact of chaplaincy
- Making a connection is more important than the denomination
- Many formal and informal opportunities to share with and support staff
- Chaplaincy volunteers play a vital support role, though many had to withdraw due to Covid
- Chaplains have been willing to be redeployed or to redirect their services where needed
- It is suggested that some chaplains still don't consider themselves accountable to the Trust and may struggle to justify their paid hours. Honesty and integrity are required
- Noted that the Healthcare community is becoming less religious or less affiliated to particular faiths/beliefs, which is both a challenge and an opportunity to chaplaincy
- Importance of connecting with external Church/Faith/Belief groups
- Need to be seen as professional and to practice professionally
- Look for new opportunities within and beyond inpatient wards
- Production and distribution of new patient and staff resources
- New ways of working, e.g. online, behind a mask
- Covid has brought many challenges to our working practice, including the need for PPE and infection prevention and control measures

Question 2
Key messages – Summary

What are the benefits (if any) of investing in a professional chaplaincy service?   **(Please give some reasons why chaplaincy should receive continued funding and support and how that adds value to healthcare)**
➢ Holistic, person-centred care   ➢ As part of a holistic approach to health care, where spiritual care is vital in assisting so many people as they deal with and work through their health issues, it is imperative that Chaplaincy continues to be resourced and receives continued funding and support   ➢ Chaplains can come alongside patients in ways other staff can't   ➢ Chaplains bring a ministry of hope and comfort to patients and staff   ➢ Chaplains can take and make the time to create precious moments of listening, talking and praying (if requested)   ➢ It is essential to maintain a professional chaplaincy service. Both patients and their families frequently spoke of how much the chaplain's visit meant to them   ➢ The funders and management would be confident of a skilled and professional member of the team   ➢ Chaplaincy provides "the space" in the system for patients and families to chat   ➢ We are an asset to the MD team helping support and equip our colleagues as they seek to care for patients   ➢ There is research that shows the speed of recovery of a patient can be quicker if they have access to spiritual and religious care and there is evidence that it is important in coping with illness   ➢ Chaplains are the specialist pastoral & spiritual care providers for patients, families and staff in the hospital and community settings   ➢ Chaplaincy is a service which brings spiritual benefit to a large number and large proportion of patients and staff in health care settings   ➢ The pastoral encounter can be a therapeutic encounter   ➢ Chaplains can act as a confidential listener and reassuring presence to many people with faith or none   ➢ Good chaplaincy can enhance wellbeing for patients and staff with many positive benefits, e.g. reassurance, peace, hope, friendship, support, purpose, prayer, etc..   ➢ Doctors, nurses, & other health care workers are paid, and receive on-going training. This recognizes their professional competence. It is the same for Chaplaincy. We cannot give time, support to patients and to staff without properly funded training, and remuneration   ➢ Supporting the continued funding for the training of healthcare chaplains allows them to offer the professional level of support that the patient/client requires   ➢ Like any other healthcare professional, Chaplains require education and continuous professional development   ➢ The Scottish Lothian report showed that patients experienced a greater sense of peace through Chaplaincy engagement, they required less time in hospital, they recovered quicker at home, they relied less on prescription medications, and created less demands on the Health Service because they were happier and more satisfied with their care. Absence of a Chaplaincy service costs more than investing in one. Chaplaincy is good value for money.

Question 3
Key messages – Summary

What qualifications and accreditation do you believe are necessary for professional chaplaincy, (e.g. ordination or not, CPE (Clinical Pastoral Education), degree, Post Grad certificate, CAB (Chaplaincy Accreditation Board)/HCB (Healthcare Chaplaincy Board) (RoI) or UKBHC (UK Board of Healthcare Chaplaincy?)
➢ Ordination gives relevant experience for chaplaincy but does not qualify you; specific hospital chaplaincy experience should be expected of all applicants. ➢ Be registered with and a member of the NIHCA ➢ Have at least 2 years healthcare chaplaincy experience, not just pastoral visiting ➢ Demonstrate a commitment to continued professional development ➢ Have or be willing to attain a some form of specific chaplaincy qualification - CPE or a post grad ➢ Up to date knowledge of current issues in Healthcare chaplaincy ➢ UKBHC registration should not be the gold standard – other bodies should be considered on par. ➢ Knowledge of and training in pastoral care is the most important. Compassion is a key quality in a chaplain. ➢ A degree and knowledge of denominational needs and differences. ➢ Reflective practice supported by supervision and evidence of CPD. ➢ Chaplains should be suitably professionally qualified. The rigours of ordination are a good foundation but specific healthcare qualification and training is needed. ➢ Training in sacramental ministry is essential. Ordination is not a pre-requisite for chaplaincy. All chaplains should be qualified in theology. ➢ Pastoral leadership and CPE training with a minimum of 600-1000 hours patient contact time before being allowed to operate independently. ➢ Chaplains are not seen as equal in the MDT, this is a problem. There is a need for accreditation with a professional body and ongoing training. ➢ Active participation in your team and being willing to play your part. ➢ Vocation as well as profession. A degree may exclude people who have a call. A recommendation from their church and a willingness to study further. ➢ CPE offers a different style of learning to degrees. I find it is more suitable to chaplaincy. ➢ CPE is important for the welfare of chaplain and patient. ➢ Regular team meeting and wider chaplaincy community meetings. ➢ Lead chaplains should have additional qualifications. ➢ A professional chaplain does not have to be ordained. ➢ More responsibilities for catholic lay chaplains. Priests are under a lot of pressure and very often carry parish responsibilities. ➢ Women should be given a higher profile in pastoral care within both hospital and church, as they are most likely to be blessed with a skill set which lends its energy to love and care. ➢ Those with long life experience, including family crisis, are the best qualified for the demanding emotional and spiritual load. ➢ A heart for people, gentle in his manner of work, they could still be in post, with the proviso that they would endeavour to have some of the above list. ➢ Professional Chaplaincy needs a mix of both lay and ordained Chaplaincy from the diverse spectrum of Christian denominations, other Faiths and Humanists.

- All paid chaplains: One basic CPE Unit. For those Ordained - proof of this and Degree Certificate. For Lay - portfolio of role/ experience/ learning. Some Chaplains will go on to Masters, Postgraduate Certificate, PhD.
- Emphasise modern healthcare culture.
- Importance of evidence based practice/ research for all healthcare professionals, which includes Chaplains.
- The pandemic has highlighted the need to have ordained Chaplains on staff.
- Whilst many in Northern Ireland have sought accreditation via all-Ireland bodies, such as CAB or HCB as listed in the question above, these have no formal standing within the UK, so the ideal pathway is to seek UKBHC accreditation.
- I think it is more about the person and gifting of the Chaplain than their personal qualifications.
- The multi-faith and secular contexts of many patients must be treated with particular sensitivity and respect.

Question 4
Key messages – Summary

Recommendations to Trusts/employers in respect of Departmental structures. How do you think Chaplaincy should be structured and organised?

- Lead chaplains should be a Band 8 with two Band 7 deputies. All chaplains should start at Band 6 only if they are suitably qualified, regardless of ordination. Lead chaplains should deputise more.
- Greater accountability - chaplains should not be allowed to do as they please! Considerable tension within teams as some do all they can and others slack.
- Managers should feel able to discipline properly and effectively. Nurses at band 5 & 6 would not be allowed to come in and do a few hours (less than their contract and then go home!)
- Not enough input into the mental health wards of the trusts.
- Managed by someone who has a knowledge of what chaplaincy involves, rather than simply inheriting a role in which the chaplains come under their governance.
- A strategy of developing professional chaplaincy across healthcare rather than what appears at times individual Trusts working independently.
- Each Hospital needs to have a Lead chaplain who will liaise, set standards, encourage training, devise and implement policy with local chaplains and work with Hospital authorities (and N/H and Hospices or other healthcare facilities) and implement guidance from the Directors/Line Manager level.
- Supervision and support, and access for such support to be available for other chaplains.
- Deputies on each site as the Trusts cover many hospital.
- Add some volunteers but be careful by doing so employed chaplaincy is not threatened.
- Make chaplaincy more visible and professional - raise the bar and have expectations of excellence.
- Clear guidance re boundaries, expected practice/hrs, etc...
- Trusts/ employers need to recognise and see chaplaincy as part of the Health Care provision to the sick, and appropriately manage, appreciate, challenge, empower, recognise, and support.
- I am happy with the present structures of Chaplaincy.
- It is disappointing that in some Trusts, chaplains do not have a Lead Chaplain to coordinate their pastoral work or oversee their ongoing formation.
- Trusts should invest in Chaplaincy departments, not on the traditional basis of 25 or 35 beds per session, but based on Caseload, as you would assess the need for social workers, OTs and PTs for example. It would be better to have Chaplains embedded more on wards.
- Departments should have the potential for a Managing Chaplain (Band 8), supported by one or more Lead or Senior Chaplains (Band 7) who manage the day to day needs of the department. Theologically trained, ordained and/or accredited Chaplains should be employed (Band 6) to service the denominational/generic needs of their particular locations, and Chaplains entering the profession while in the process of acquiring higher level qualifications and working toward accreditation should be employed (Band 5).
- The way forward is generic chaplaincy - people, in general, are becoming less denominational in their spiritual and religious outlook and one generic Chaplain can visit more patients on a ward or unit covering all denominations and faith groups.
- Chaplaincy to be able to make changes to PAS system in relation to denomination.
- Importance of regular Chaplains' meetings.

Question 5
Key messages – Summary

What is the future? How/where would you like to see Chaplaincy develop?
➢ All chaplaincy jobs should be advertised well and openly. Posts should be filled with the best personnel and not filled by the first person regardless of skill mix. ➢ Greater emphasis on training and recruitment. Aiming for younger chaplains with input from one of the universities and a clear career path otherwise we will have many empty posts and no one to fill them. ➢ Training opportunities for younger chaplains to acquire the necessary qualifications for accreditation so that a development plan for more paid chaplains can be enabled. This will give greater assurance to Trusts that their Chaplaincy Department can meet the professional standards expected of any of their departments. ➢ Less reliance on very good people who work voluntarily; no other disciplines within the healthcare settings have so many volunteers. ➢ There is an entire generation of Church people who have had a working life or family and have discovered through their Church life that they have much to give in service to their Church family and community. These people are the future of hospital pastoral care. ➢ Full time chaplains on large sites, part-time on smaller or more specialised units. ➢ Greater understanding amongst other staff to the role and purpose of chaplaincy. ➢ Although we have a ministry to family and staff members, primarily we need to focus on time with patients on the wards. ➢ This year has taught us the need to be flexible. The need to develop links with patients, staff and families is extremely important. ➢ On admission, the record of patients' denomination/faith/belief should be clearly recorded so it can be passed to the Chaplains for appropriate support. ➢ Adequate hours and funding for chaplaincy - fulltime chaplaincy provision across 7 days – may need to be a mixture of denominational and generic. ➢ Specific times when chaplaincy personnel are available in the hospital church/ office just for a chat with staff/relatives etc. ➢ Chaplaincy to become more embedded in all areas and have greater presence in specialized areas, such as Maternity, Children's, Mental Health, Palliative care, Bereavement, etc. Could also be included more in MDTs. ➢ Chaplaincy development should be progressive and not return to a clergy based model only or that a service is allowed to narrow/limit its provision rather than look at ways to keep the wider vision of chaplaincy. ➢ To continue to see Chaplaincy services being made available to as wide a range of people who come into healthcare facilities and who can find benefit from the services shared. ➢ Establish a specific NI chaplaincy research base as evidence for continued funding. ➢ Due place being given to research and audit. ➢ Support and reflective practice opportunities in place for Chaplains, formally and informally. ➢ A Study of what patients want from Chaplaincy e.g. do all patients expect denominational Chaplains? ➢ Develop new ways of working e.g. Tele-chaplaincy. ➢ Denominational chaplaincy is still important. We can minister to anyone but the link

within the denominations to religious practice and expected pastoral ministry is helpful to families and patients at challenging times and when things fall apart.

- While recognising there is still some value and need for denominational chaplaincy, it does seem that more and more patients are less concerned with the denomination and more concerned if the chaplain actually cares and helps them. There may be more opportunity for ward-specific or generic chaplaincy. This needs handled with care.
- Liaise with chaplains on other sites and local clergy/Faith/Belief groups as a patient leaves our setting to follow up care or make a referral (obviously with patient consent).
- There are clear gaps in where chaplaincy could work, including services such as mental health, children's, maternity, community, residential/nursing homes, GP surgeries, etc... These gaps may be caused by focusing too much on acute care or be caused by insufficient funding. These areas would also require more specialist training.
- A properly funded and invested in department, recognized as an Allied Health Profession, working to similar standards to other Medical Humanities, and therefore accredited to PSA Standard.
- Investment based on lessons from recent research, such as the Scottish Lothian Report. In caring for the whole person, HSCNI is effectively committed by its core values to provide spiritual, religious and pastoral care rather than a referral service. This means we need core time with patients, staff and families, not just a five-minute “hello.”
- A mobile service for those in rural communities.
- Would like to see a professional structure with professional personnel within it.
- A defined progression structure for Healthcare Chaplaincy.
- Have a leading body to oversee the education and training and professionalism of the chaplains within it.
- Chaplaincy to be actively included and involved in policy-making rather than just receive the feedback, if ever.

Question 6
Key messages – Summary

What is the future? How would you like to see NIHCA develop?

- NIHCA has improved greatly in recent decades.
- NIHCA has played a very important role for the chaplains. NIHCA provides training to improve the quality of the service and give the opportunity for chaplains to meet for peer support and refreshing too.
- It has been an excellent resource and a place of encouragement and fellowship. There is always some teaching and devotional element and this is important.
- NIHCA needs to take a breath and consolidate all the work it has achieved in recent years. Like Chaplaincy, it has come a very long way.
- We have a quality team on NIHCA management who are very committed.
- Would like to see NIHCA develop but caution against expansion in too many different directions at the same time.
- It is good to see more chaplains taking the professional side of their role more seriously.
- It would be good to get clarification on what time we need to devote to professional development and if we can get time-out to fulfil this. It is also pleasing to see how much the NIHCA is doing to develop a variety of courses to suit a variety of needs.
- Less money spent on overnight stays.
- Ask for a more professional registration fee, which would "waken" some among us to the professionalism of our role.
- Certification similar to UKBHC and CAB etc.
- It should expand its training role. The regular one-hour Zoom seminar is an excellent format. The seminars/training programme could be more systematic, ensuring that all aspects of chaplaincy are covered.
- Core training on mental health issues and training on vulnerable groups, the use of APP1 documentation.
- The NIHCA to be a training body but also to look at steering the direction of chaplaincy in Northern Ireland.
- Can we be a stronger advocate for issues within chaplaincy or healthcare settings - or is this too political?
- Communication with members is necessary and could be improved.
- Would like to see NIHCA being more transparent in decision-making and representation.
- Wider representation on the Board and in Officer roles, though that depends on willingness of chaplains to get involved. Perhaps even advertise our Director of Training role beyond NIHCA.
- Further develop our research element.
- Encourage and support training with other bodies and organisations, including academic training partnerships, which may include establishing a Post-Grad training course in Northern Ireland.
- Look again at criteria for funding external training - limit number of times personnel can access funding and advertise this brilliant resource more widely among the membership.
- Helping to prepare potential new chaplains as well as train existing chaplains.

What is the future? How would you like to see NIHCA develop?

- Grateful for the training offered and for the high calibre of our speakers. Would like to see that continue.
- Delighted we have been able to offer grants to CPE and Chaplaincy post-grad students, and hope this will continue into the future.
- Continue to resource and encourage chaplains in their day-to-day responsibilities, tasks and ministry.
- Express warm appreciation of its work, and encourage it to develop appropriate support and gatherings (including on-line provision) to advance training and encourage good practice.
- We need to keep our province-wide focus, looking also at UK and Republic of Ireland experiences.
- Would like to see the NICHA develop the possibility of offering a homegrown accredited group of chaplains that could work across Northern Ireland's Trusts in paid roles. This will undoubtedly involve discussions with the various accreditation boards and academic institutions.
- Would hope that the organisation would continue to explain the meaning and value of the work of chaplains to hospital administrators and others in decision-making positions so they can understand. To offer continuing education to chaplains and provide credit for training.
- We need to bring on young chaplains, but also train, challenge, and keep our links with the churches.
- We are a training body that sets standards that call forth from us the best that we can be - that we are known by our NIHCA status - that there is a minimum brand of chaplain, as well as spiritual support volunteers.
- NIHCA at present is primarily funded for training Chaplains. I think there is also scope for a more advocatory role specially to come along side chaplains in smaller hospitals when dealing with management etc.
- NIHCA needs to represent its members' interests and the interests of the Chaplaincy Profession at the highest levels of management in Trusts and with the DoH and the PHA. NIHCA needs to be a Training Body, a facilitator of accreditation for professional Chaplaincy, but also a voice negotiating for and defending the interests of Healthcare Chaplaincy.
- NIHCA could play even more important role such as making regulations and rules for chaplaincy practice and chaplaincy employment. All employed chaplains should become registered NIHCA members.
- NIHCA could have representatives on different Forums or provide feedback from where members are involved so that the wider membership can benefit.

F/ New opportunities

- ***Academic training partnership:***

In May 2022 the NIHCA entered into a partnership with the Cambridge Theological Federation (CTF) to work together to provide the education and training that is required for chaplains working in Northern Ireland to register as members of the UK Board of Healthcare Chaplaincy (UKBHC); and that offers further professional development.

The programme

CTF teaches a Chaplaincy and Pastoral Care post-graduate degree that is validated by Anglia Ruskin University (ARU). The degree is offered at three levels:

- The Postgraduate Certificate (PG Cert) comprises two 30 credit modules. This provides the relevant qualification for UKBHC registration.
- Students who successfully take two additional 30 credit modules receive a Postgraduate Diploma (PG Dip).
- Adding a 60 credit major project (15,000 words) on a relevant topic chosen by the student enables students to receive a full masters (MA).

NIHCA will

- Promote CTF's PG Cert to healthcare chaplains in NI, as the Association's preferred supplier.
- Encourage suitable members who want to deepen their knowledge to progress to the PG Dip or MA.
- Seek funding from the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS) for chaplains to take the PG Cert, PG Dip or MA.
- Facilitate tutorial groups in Northern Ireland (which may be in person or online).

CTF will

- Teach, assess and administer the PG Cert, PG Dip and MA.
- Provide publicity material for NIHCA to use to promote the PG Cert.
- Admit chaplains recommended by NIHCA to the PG Cert, PG Dip or MA, provided they meet Anglia Ruskin University's admission requirements.

Research

- The partners' ambition is that CTF becomes the preferred supplier for NIHCA members who want to take a Theology PhD, MPhil or Professional Doctorate.
- A further ambition is to provide opportunities for suitably qualified NIHCA members to supervise doctoral students at CTF and for CTF/ARU to provide development activities to enable this.

- ***Values Based Reflective Practice (VBRP)***

NIHCA has entered into a partnership with NHS Ayrshire & Arran (Scotland), whereby 9 NI chaplains will participate in accredited VBRP training between August-October 2022.

This will involve attendance at 3 training days plus a 6-part portfolio.

This partnership may lead to further training opportunities in the future.

NIHCA Executive Council 2022/23	
PRESIDENT Rev Derek Johnston	**SECRETARY** Mrs Heather McCracken
DIRECTOR OF TRAINING Mr Michael McMillan	**TREASURER** Mrs Sanna Mallon
VICE-PRESIDENTS The Venerable Dr Stephen McBride Rev Mervyn Ewing Mrs Vivienne Manley Fr Damien Quigley * One vacancy	**MEMBERS** Mrs Marie Kennedy Rev Ivan Neish Rev Ken Connor Sr Rosa Wang Rev Jonny Campbell-Smyth