**Covid-19 and Healthcare Chaplaincy**

Update from the UKBHC, CHCC, AHPCC and NIHCA (16th March 2020)

At present, our focus, and the focus of chaplaincy managers across the UK is to balance the care and safety of patients/staff with our duty of care to our chaplaincy teams. We have therefore issued the following statement jointly with the professional bodies. Individual bodies may also be issuing their own guidance in coming weeks as we navigate our way through the new territory we find ourselves in. As national plans move towards social isolation, we recognise how countercultural this can feel for Chaplains, given how much we all work towards social cohesion and community. We recognise all teams are developing local plans and there is no single one size fits all response, but hope the following guidance may be helpful.

The UKBHC, CHCC, AHPPC and NIHCA are mindful that those working within Chaplaincy face specific challenges with Covid-19 due to the very nature of our profession:

A) We have many small teams and single-handed Chaplains already dealing with a challenging workload, now faced with an unprecedented change in demand and models of working.

B) Many working in chaplaincy have dual responsibilities with competing demands at present.

C) A disproportionately high percentage of healthcare Chaplains may fall into the higher-risk categories.

D) The level of risk to exposure in healthcare settings is always going to be higher than for the general population.

E) We are expecting a significant increase in demand for acute and end of life care.

F) We are expecting a significant increase in demand for staff support.

###### In the light of these, we are suggesting the following broad measures that may be considered in coming days:

###### Urgently freeing up capacity

Review services with a view to stopping non-core services (e.g. 1:1 Bereavement Support, Community Engagement, CCL, teaching, community / home visits).

It will be important to revise the criteria for referral to ensure capacity is not overloaded.

We should not be going bed to bed.

We may need to clarify what is an appropriate ‘urgent referral only model’ for our situation.

Each Board/Trust needs to decide when volunteer visiting and any existing worship services are suspended – for many this has already happened.

###### Temporary changes to On-call

This will depend on the capacity of teams and how that will change when team members become infected, or if those at high risk move into isolation in the coming days.

There may be an exceptional role to play for honorary chaplains and chaplaincy volunteers (who would not normally be part of any on-call system) if they have the right experience and are Fit to Practice in those key areas during the critical phase.

Smaller teams may chose not to retain 24/7 on-call services, may need to change to a simple cascade system or reduced cover – (e.g. stopping at 10pm) in order to reduce burnout).

###### Significantly different patterns of working

Different responses may be required to patients who are Covid-19 positive – and all team members will need to be well informed of safe practice as guidance changes almost daily.

We need to think clearly in advance about how any restrictions on chaplaincy support delivered directly to patients is **communicated sensitively** to staff, patients and relatives, e.g. if a Chaplain is not permitted to attend in person.

Alongside operating on (or near) a major Incident footing for a sustained period of time in the coming weeks, we need to consider how we will maintain support and respond to other critical incidents such as trauma and pregnancy loss.

It is critical that teams work very closely with the senior management to agree what support we offer and what we can't. This may be particularly important in specialist units (such as Hospice settings).

In some areas it may be possible to work collaboratively with neighbouring teams or merging distinctive faith/belief on call rotas.

Support may need to be by phone/video rather than in person.

We may need to proactively engage with local faith/belief groups, advising them on best practice and potentially working more closely with them to enable support for patients (retaining the need to ensure that they are experienced and competent to practice).

Flexible changes to working patterns may be inevitable. It may work better, for instance, to change to ‘X days on / X days off’ for some teams for a period. The model has to work well for all staff concerned.

It may be decided, for example that **a 7 day working week** will become a better provision to provide visible support to staff – with shorter shifts required daily.

It may be that many of all staff will at some point be working from home, and resources for this will need planning in advance. Do all team members have what they need to work from home, admin, telephone support, relevant contact details?

Review communication within the team – e.g. establish a daily telephone conference call?

Review the use of Chapel/sacred space in terms of staff support and space for grieving, including infection control issues.

Whatever the models we put in place, we must allow for decent rest periods for the Chaplains involved. Teams will be carrying a great deal of emotional distress of others and their own.

We must pay particular attention to self-care and team care, especially as this outbreak may last for several months.

###### Enhanced focus on staff

During the critical phase we will need to target most of our response / areas of work and limited resources at staff support.

Such work will require creativity – can we offer telephone support to staff in a way that is harmonised with Occupational Health?

We may consider strengthening ‘named chaplains’ to be assigned to critical areas or teams (ED, AMU, ICU, respiratory wards) for regular check-in with staff, understanding local pressures and building relationships.

We may further enhance visible ‘walk-arounds’.

Staff colleagues will be working under enormous stress with professional (and indeed ethical) challenges. They are also parents, and children and partners and they will be worried about their own loved ones.

We need to ensure senior managers are aware of evolving plans we have in place and our revised focus…

###### The most important point is to plan now and make communications robust in the coming weeks

We recognise that much of this is obvious- but we would strongly encourage teams and individuals to be proactive – making plans and contacting neighbouring Teams to share ideas. Not many senior health leaders fully understand all that we do, or could do, so we need to be creative in finding how we might best support our staff and patients at this time, whilst also looking after our teams and ourselves.

With warmest regards,

Mark Stobert / Simon Harrison / Karen Murphy / Robert Sloan

UKBHC – UK Board of Healthcare Chaplaincy <https://www.ukbhc.org.uk/>

NIHCA – Northern Ireland Healthcare Chaplains Association <http://www.nihca.co.uk/>

CHCC – College of Health Care Chaplains <https://www.healthcarechaplains.org/>

AHPCC – Association of Hospice and Palliative Care Chaplains <http://www.ahpcc.org.uk/>