NHS
Lincolnshire Community and Hospitals NHS Group

Chaplaincy Engagement Report

Dec 2025

Caring and building a healthier future for all

Contents

Executive Summary

This engagement exercise explored perceptions and experiences of Chaplaincy services across Lincolnshire Community and Hospitals NHS Group to inform future improvements. The approach combined an online survey, targeted outreach to faith and community networks, and site visits to ensure accessibility for patients and carers who might otherwise be excluded. Responses were gathered from patients, the public, and staff over an extended timeframe, with equality, diversity, and inclusion central to the design. Feedback reflects a broad range of ages, cultural backgrounds, faith perspectives, and life experiences.

Findings show that many people value Chaplaincy for its emotional support, listening presence, and inclusive approach beyond religion. Most respondents who used the service reported positive experiences, particularly with in-person support, while few accessed digital or telephone options. Awareness of Chaplaincy services is limited among both patients and staff, with many unsure of what is offered or how to access it. Barriers are largely linked to visibility and understanding rather than reluctance. Site visits reinforced these findings, highlighting practical issues such as space constraints, privacy concerns, and the need for better signage and amenities. Overall, Chaplaincy is valued but underutilized, with opportunities to strengthen its role through improved awareness, access, and integration.

Recommendations arise from two sources: direct suggestions from service users and staff, and thematic analysis of engagement outputs. These range from simple actions like clearer information and routine offers of support to strategic priorities such as governance clarity, cultural competence, integration with clinical pathways, and robust impact measurement. Implementing these using the accompanying workbook will improve patient and staff experience, demonstrate compliance with quality standards, and ensure Chaplaincy remains responsive, inclusive, and well-led.

Introduction

This report presents findings from the Lincolnshire Community and Hospitals NHS Group Chaplaincy services engagement exercise. The exercise was designed to assist in shaping Chaplaincy services to better reflect the needs of service users, in the present and the future, and identify areas for service improvement and barriers to access.

Engagement Design

The engagement was co-designed by the LCHS Stakeholder Engagement Manager and the Chaplaincy Operational and Strategic Manager. A survey was developed to gather insight into Chaplaincy services from patients, the public, and staff, identify barriers to access, and inform future improvements. The survey combined closed and open-ended questions to capture both quantitative data and qualitative feedback.

To ensure inclusivity and accessibility, we supplemented the survey with targeted site visits. These visits were planned following insight within the chaplains' team to identify areas where feedback was limited or the chaplaincy offer was unclear. The selected sites represented priority areas for engagement, enabling us to hear from voices that might otherwise have been missed. During these visits, we also captured staff views opportunistically.

Survey Distribution Channels

The survey was distributed online via internal communications channels across the Group, NHS and partner websites, including the ICB Contributor (system wide with 10,000 contacts), social media platforms such as staff Facebook groups, hosted on ULTH and LCHS Websites, it was also sent directly to email networks as GDPR permits. Paper-based versions were made available upon request to support inclusivity, although none were requested. Targeted engagement was undertaken and as many faith and spiritual and faith communities and networks as publicly accessible were contacted and invited to share their views or distribute the survey to within their own contacts databases.

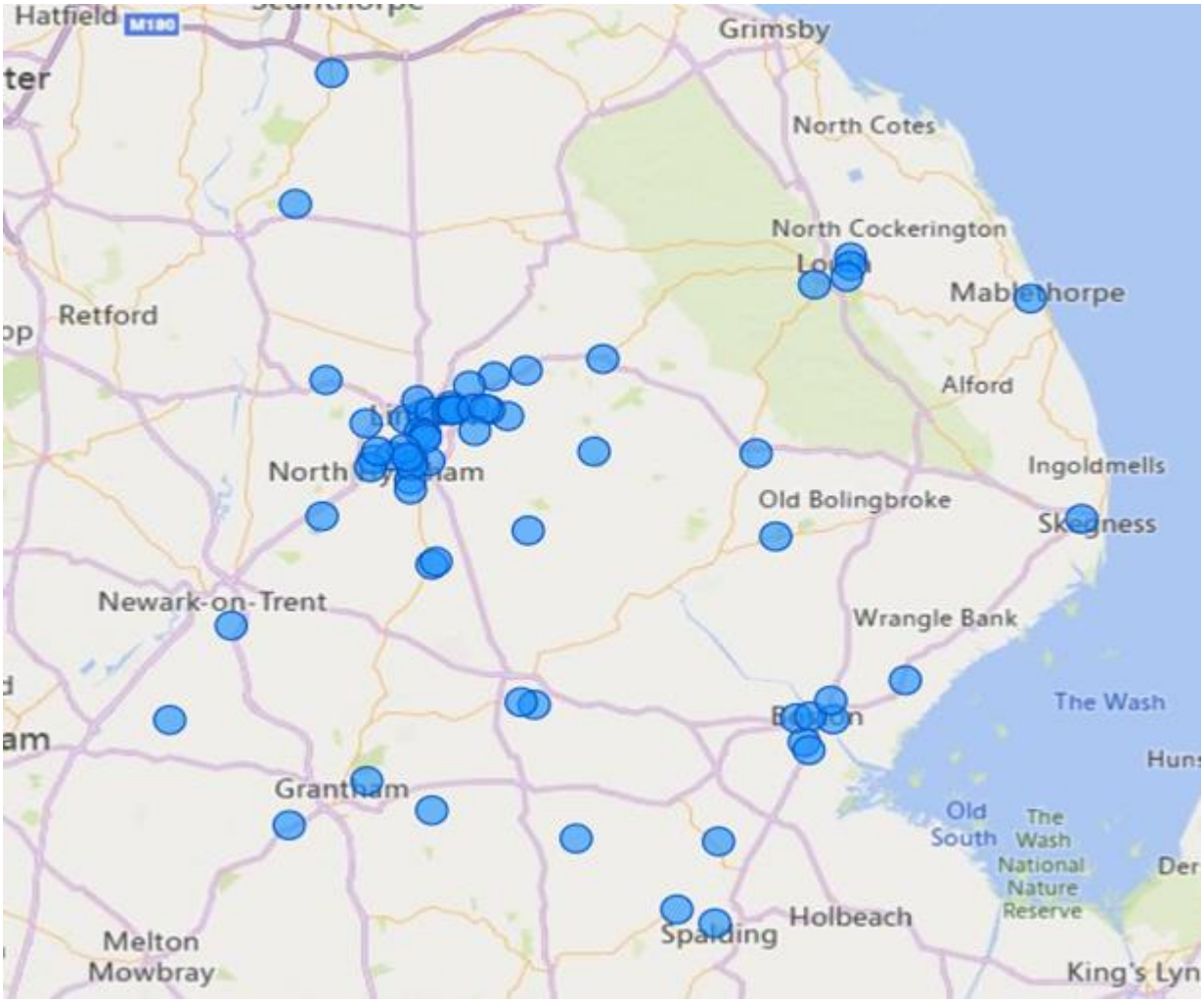
Timeframe

The survey was open from 11 September 2025 to 28 November 2025, providing an extended window to maximize participation of the cohort of interest.

Sample and Response Volume

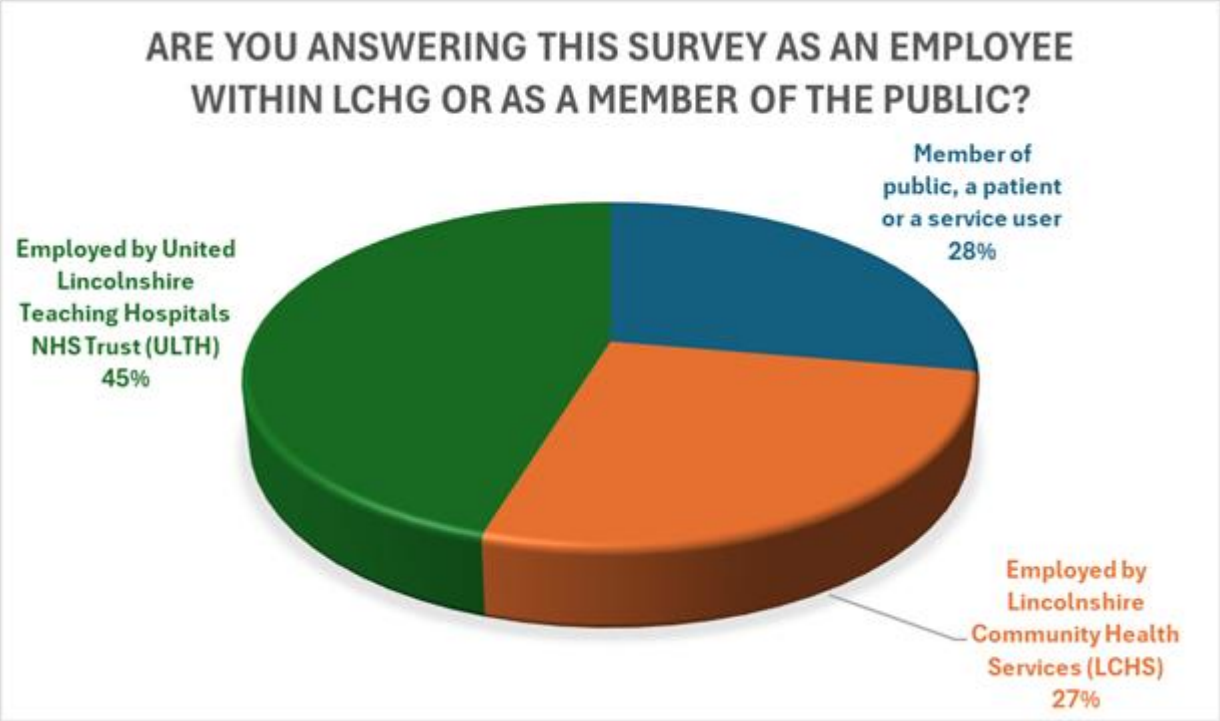
The survey was distributed widely over a fair time frame and promotion was boosted periodically.

172 people initially accessed or opened the survey, 132 filtered through the entry questions with many people sharing postcode data - Lincoln centric views are noted but we think we saw a positive engagement reach with responses from all four quadrants of Lincolnshire.



The following show number and proportion of people entering the core question sets;

Are you answering this survey as an employee within LCHG or as a member of the public?	Number = n	%
Member of public, a patient or a service user	38	28
Employed by Lincolnshire Community Health Services (LCHS)	37	27
Employed by United Lincolnshire Teaching Hospitals NHS Trust (ULTH)	62	45



Scope and Limitations

This survey used a cross-sectional, opportunistic sample, capturing views at a single point in time. While this approach provides useful insights into current perceptions, it does not establish any sort of causality and results cannot be generalised across the population, but they are a legitimate, reliable and a valid source of information for service evaluation and improvement.

Overall, LCHG's shared view is that engagement is continuous, this survey is not exhaustive and there are other consistent opportunities for public feedback are always available such as FFT, Care Option, PALS, Complaints, Hearing It Your Way, Healthwatch et al.

Action Planning

Constructive suggestions derived from the analysis of answers were compiled into worksheets for the Chaplaincy team; the report was also shared with responsible budget holders/senior managers to ensure public involvement in commissioning decisions

These included:

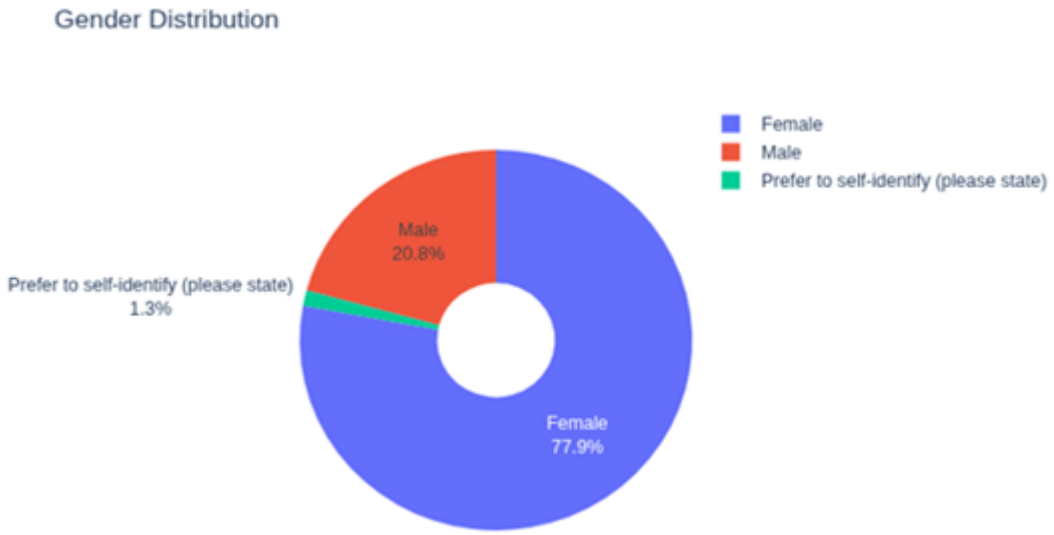
- Direct public feedback.
- Prioritisation of achievable actions for service improvement – see recommendations.

Equality, diversity, inclusion

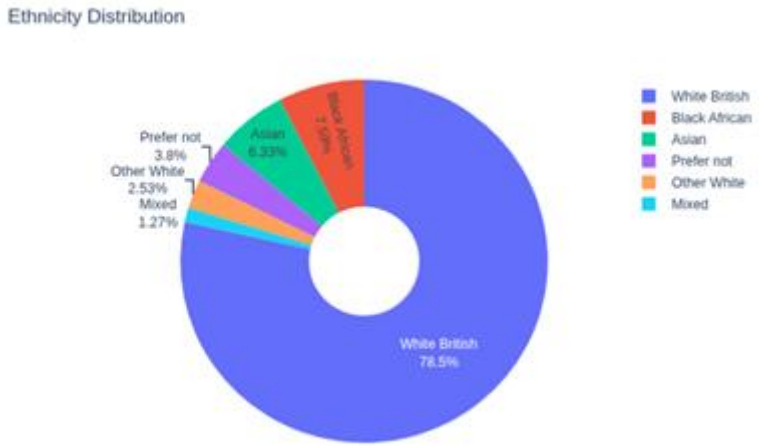
Who Took Part in the Chaplaincy Survey?

The following figures describe respondents who chose to answer equality, diversity and inclusion (EDI) questions within the survey. They do not represent the full survey sample because not everyone chose to answer them.

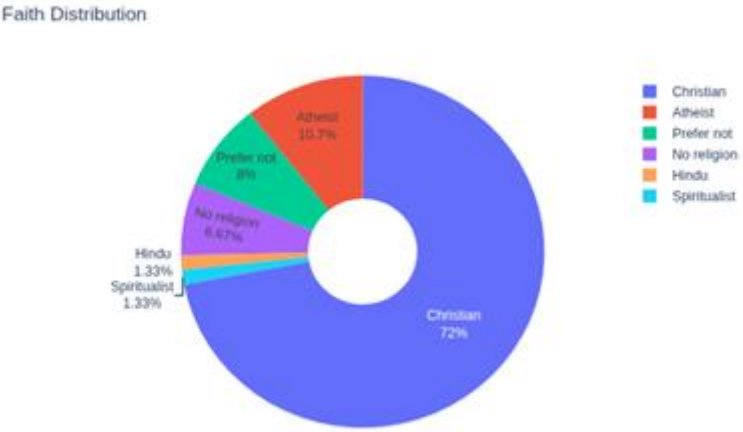
Accounting for EDI, this survey reflects a broad range of perspectives from across our community. Among those who answered EDI questions, most were women (60), with 16 men and 1 person who preferred to self-identify. Ages ranged from 20 to 79, with the largest groups in 50–54 (13 responses) and 60–69 (11 responses), followed by 45–49 (10). Younger adults were represented too, including 20–29 (7) and 30–34 (7). Many respondents were in employment (47 full-time, 18 part-time), though we also heard from those who are retired (6), students (1), and not currently working (1).



Importantly, survey responses included cultural and ethnic diversity beyond the typical Lincolnshire average. Of those who answered this part of the survey, 62 identified as White British, 2 as other White backgrounds, 4 Asian Indian, 1 Other Asian, 6 Black African, and 1 Mixed Heritage. Three people preferred not to state ethnicity. We also received write-in responses such as Filipino and Dutch/English, showing a mix of cultural identities.



Faith perspectives were varied in similar proportions: Christian (54) was the largest EDI reporting group, but others described themselves as Atheist (8), No religion (5), Hindu (1), or Spiritualist (1), with 6 preferring not to say. This matters because Chaplaincy services support people of all faiths and none.



Language diversity was also present, with English (68) as the main language for most, but responses included Polish (1) and other languages (3) such as Shona, Igbo, and Malayalam, highlighting multilingual needs.

We heard from people with disabilities and long-term health conditions, including physical impairments (2), mental health conditions (3), learning difficulties (1), and long-standing illness (3), as well as those with additional needs such as hearing loss, immune system challenges, and epilepsy history.

This aligns closely with data on local disability prevalence and is trying to ensure that service accessibility considerations are being informed by lived experience of the cohorts responding.

Finally, this survey captured voices from seldom-heard communities, including individuals with experience of homelessness (2), refugee or asylum seeker status (3), armed forces service (1), and agricultural work (2). These perspectives enrich understanding of Chaplaincy's role in supporting people from different walks of life.

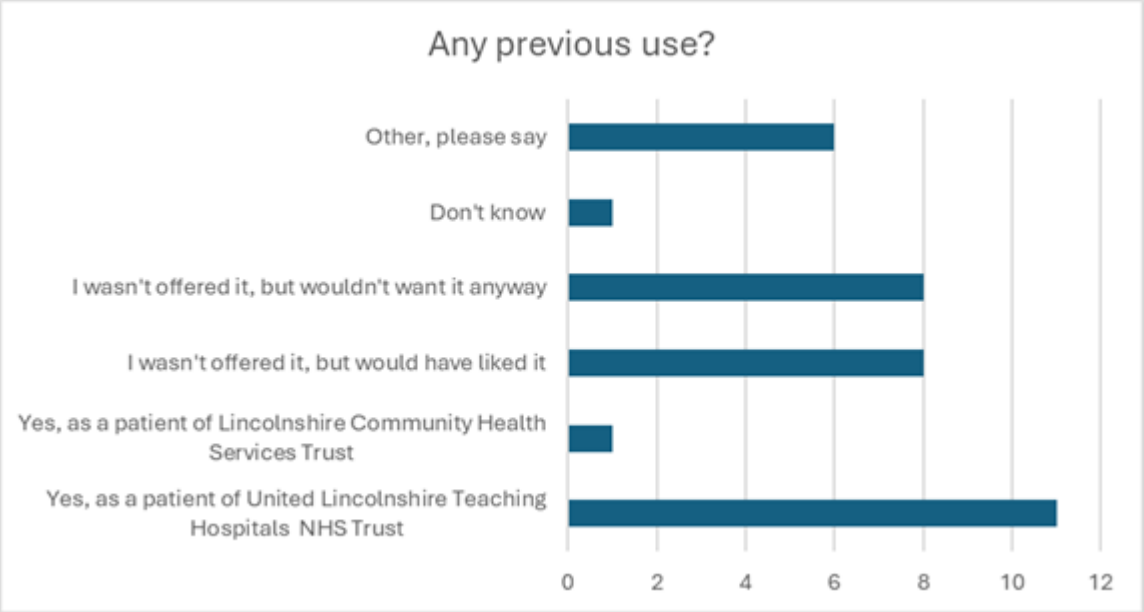
While these EDI responses lean towards older people, Christians, and employed women, they demonstrate meaningful diversity across ethnicity, faith, language, disability, and life experience providing a fairer voice foundation for inclusive service planning.

This shows that, within the practical limits of this short engagement exercise, we have enabled and captured a wide range of voices in line with the Equality Act 2010 and findings need to be respected and as far as possible responded to.

Core Questions

Patients, service users, public responses

Previous use:

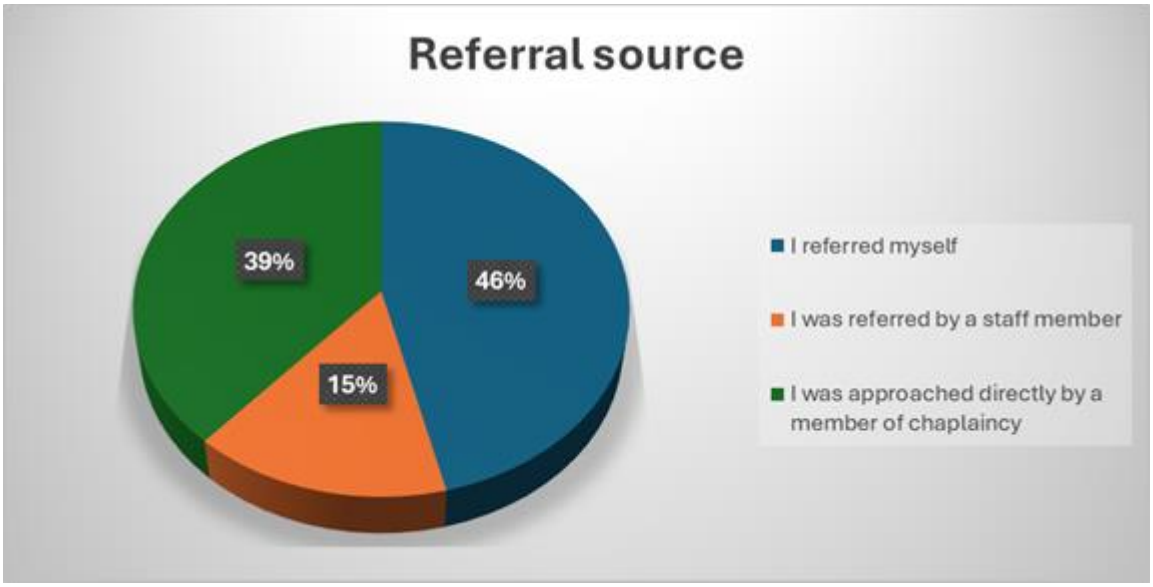


Previous use	Number of responses
Yes, as a patient of United Lincolnshire Teaching Hospitals NHS Trust	11
Yes, as a patient of Lincolnshire Community Health Services Trust	1
I wasn't offered it, but would have liked it	8
I wasn't offered it, but wouldn't want it anyway	8
Don't know	1
Other, please say	6

Other, please say:
Something I've not thought about whilst a patient, think not that important when I have so many other things to worry about
Never needed but would want to use if I was ill.

Confidential
Yes, as a bereaved relative
As a member of staff at Butterfly Hospice Trust
Hospital volunteering who uses the hospital Chapel space for prayer

Source of referral



Source	n
I referred myself	6
I was referred by a staff member	2
I was approached directly by a member of chaplaincy	5

Other referral sources:

Routine offer from service
Confidential
Not applicable
Prayer space

How did you use the service?

10 people said they used the service in person, with one stating that they had used the Sunday service at the Peter Hodgkinson Centre. None said they used facilities online, or phone calls

How was the frequency of contact from the service?

11 people answered this question, 10 thought the frequency was just about right, one person said that they had enough contact would have liked more. No one opted to say that there was not enough or there was too much contact.

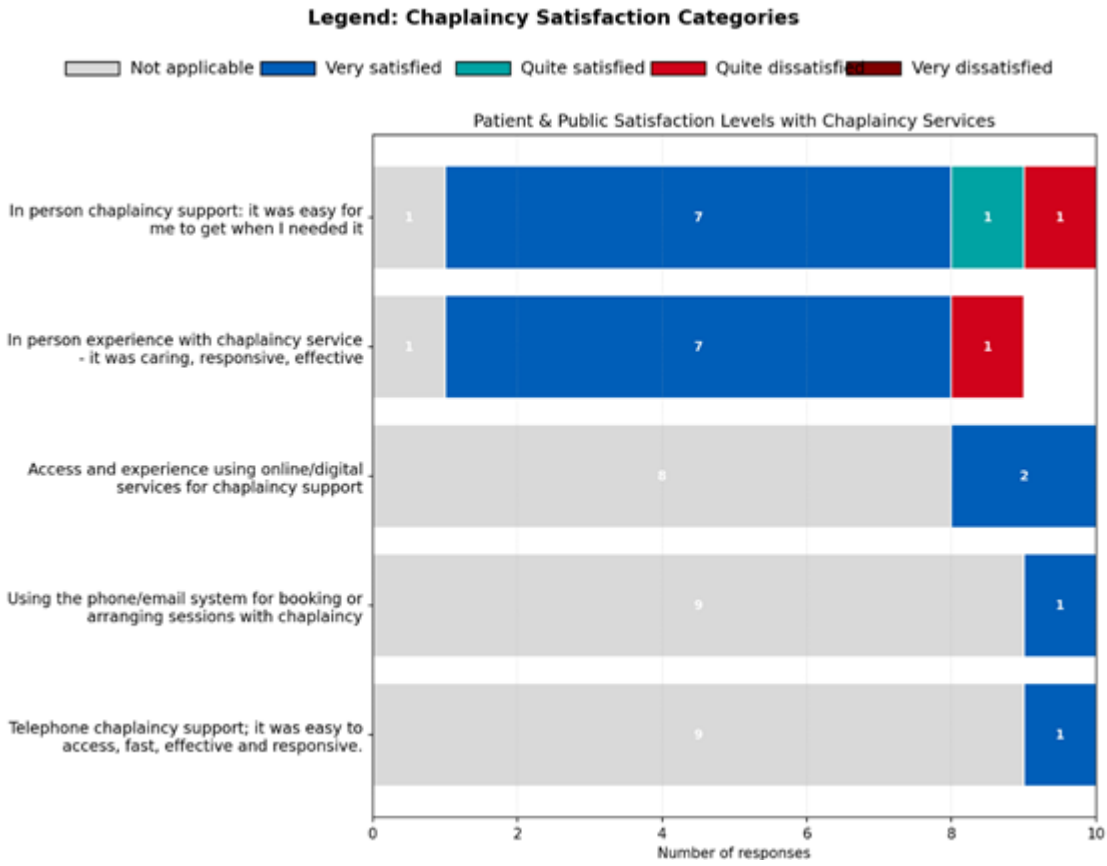
Did you receive an assessment of need from the service?

Six people said they did get an assessment, three said they did not get an assessment, and two people stated that they were not sure if they had an assessment or not.

Experience ratings and service user feedback

We wanted to understand how well our Chaplaincy services meet the needs of patients and staff. Chaplaincy plays an important role in emotional, spiritual, and cultural support, especially during times of stress or illness. By asking about experiences across different access routes (in-person, online, telephone, and booking systems), we can identify what works well and where improvements are needed.

10 public/patients/service users responding to the survey had used the service and responded to the questions with the following domain ratings



Domain	Very satisfied	Quite satisfied	Quite dissatisfied	Very dissatisfied	Not applicable
In-person access	7	1	1	0	1
In-person experience	7	0	1	0	1
Online/digital access	2	0	0	0	8
Booking by phone/email	1	0	0	0	9
Telephone support	1	0	0	0	9

In the 10 Chaplaincy service users responding to this question, overall Chaplaincy was effective and appreciated when accessed and delivered in person. Remote and digital channels have low uptake, suggesting either low awareness, limited digital need, low digital literacy or enablement, some chaplains may prefer in person, service users may prefer in person Chaplaincy.

There was a “quite” dissatisfied report expressed by one person (10% of responding cohort). In the event of negative responses, we asked for more details about why the person was dissatisfied with the Chaplaincy service. Non were provided at this stage.

What works well in Chaplaincy?

This question was directed to those who had experience of the survey, their feedback can be themed and has been grouped as follows:

Themes and Examples from Chaplaincy Feedback

Theme	Example from Feedback
Emotional and Mental Health Support	“Within half an hour of her being with me and speaking to me I felt better and not the way I had been feeling.” (extremely low)
Inclusivity Beyond Religion	“I don’t have faith/religion, I accepted the help… wouldn’t want it to be made about religion as such.”
Staff Role in Referral	“Camilla noticed how low I was and offered the referral to chaplains.”
Impact of Listening and Presence	“He sat with me and didn’t say anything but by the time I had stopped crying I felt a lot better.”
Professionalism and Empathy	“Reverend Ali Amelia is very supportive and very professional and showed the utmost empathy and respect.”

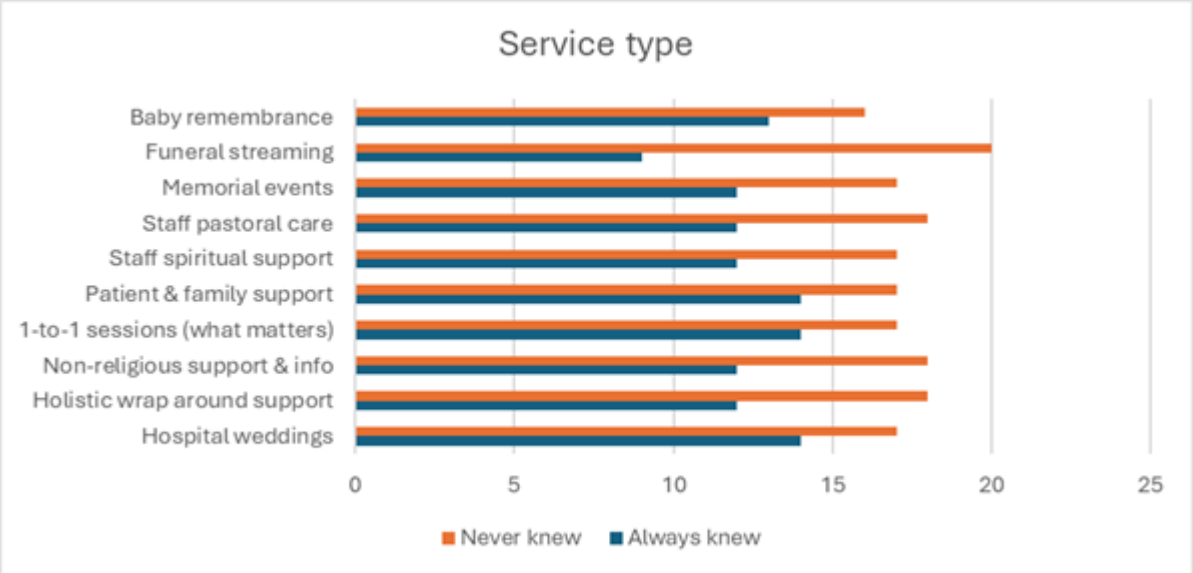
Environment Matters	“The room needs lots of TLC… too small and doesn’t aid dignity or privacy for users. Needs better seating and décor.”
Responsiveness During Crisis	“Chaplaincy were responsive when I was admitted to LCH… helped bring calm into my difficult time.”

What could be improved in Chaplaincy

We also asked what could be done to improve our Chaplaincy offer, we asked people to be as detailed as possible. It is important to note that there were no comments from public, patients or service users who have used the Chaplaincy service expressing any details such as this in any way.

Awareness of services provided by Chaplaincy

All patients, public and service user respondents were asked in general if they were aware of services provided by LCHG Chaplaincy team. 2931 people responded to each element, as such:



Biggest knowledge gaps (ranked by size of gap)

Service	Gap (Never − Always)	% Unaware
Funeral streaming	11	69% (20/29)
Holistic wrap-around support	6	60% (18/30)
Non-religious support & information	6	60% (18/30)
Staff pastoral care	6	60% (18/30)
Staff spiritual support	5	59% (17/29)
Memorial events	5	59% (17/29)
Hospital weddings	3	55% (17/31)
1-to-1 sessions (what matters to you)	3	55% (17/31)
Patient & family support	3	55% (17/31)
Baby remembrance	3	55% (16/29)

For those responding to this question, awareness was lowest for Funeral streaming (largest gap, 69% unaware). A cluster around 60% unawareness includes holistic wrap-around, non-religious support, and staff pastoral care. For exploration as to what these gaps may exist, please see recommendations

Barriers to accessing the Chaplaincy services

We want to improve access to our Chaplaincy offer, which would be helped by understanding what the public, service users and patients identify as barriers.

32 people interacted with this question, and it was set so people could choose as many options as to what they see as obstacles. This can be seen in the table and the chart; the top three most frequent selections are:

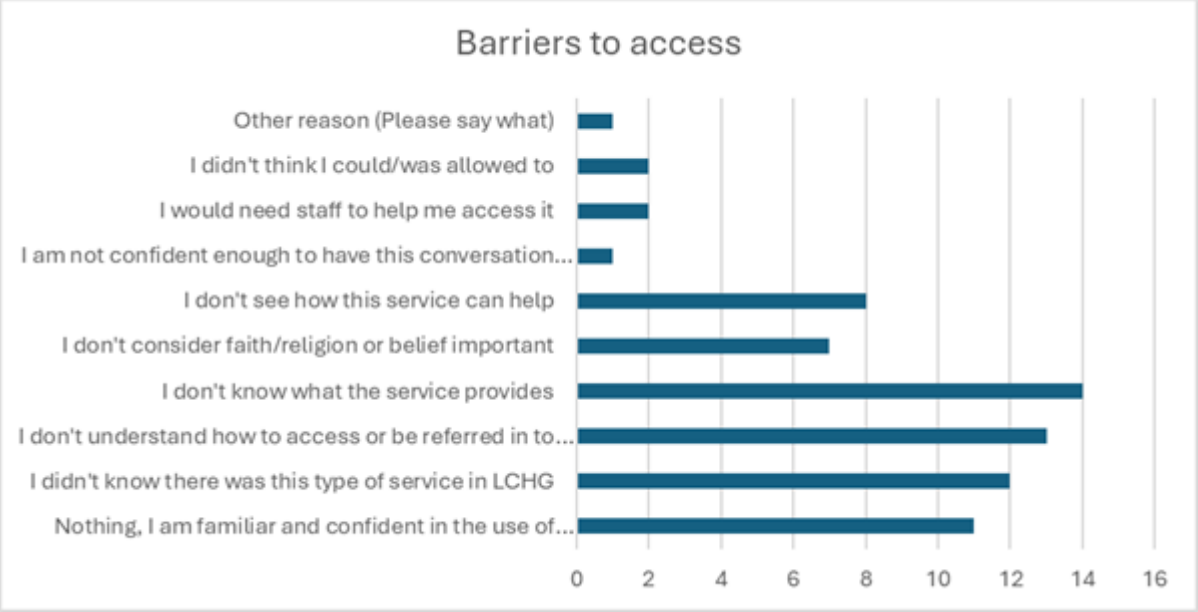
- Not knowing what the service provides
- Not understanding how to access or referred into the service
- Not knowing that this type of service existed in LCHG

Awareness & navigation dominate as barriers, indicating that visibility and clarity of offer are the primary constraints on use.

Perception-based barriers were secondary, the importance of faith being a pre – existing condition for accessing the service was not a high factor barrier for people responding to this question.

Confidence or permission concerns (needing staff help to access, feeling not allowed, or not confident to raise the topic) were cited less frequently (3–6% each), suggesting staff approachability and access rules may be less of an obstacle than awareness and perceived relevance.

Note: These percentages represent the share of total selections. Respondents could choose more than one barrier; percentages reflect selections rather than unique individuals.



Responses	Barriers to access = n	%
I don't know what the service provides	14	19.7

I don't understand how to access or be referred into the service	13	18.3
I didn't know there was this type of service in LCHG	12	16.9
Nothing, I am familiar and confident in the use of this service	11	15.5
I don't see how this service can help	8	11.3
I don't consider faith/religion or belief important	7	9.9
I would need staff to help me access it	2	2.8
I didn't think I could/was allowed to	2	2.8
I am not confident enough to have this conversation with staff	1	1.4
Other reason (Please say what)	1	1.4

For other reasons

One person wrote into the 'other' option. Here is what they said:

"We know it has impacted very destructively on our care".

This survey is confidential and as no other personal or contextual details were shared in this section it is impossible to relate this to practice or look at remedy. For safety netting, contact details of the service were provided at the end of the service, should anyone wish to pick up their experiences.

As routine, LCHG policy and practice is to provide any/all service users with alternate comments complaints and concerns routes. This type of comment prompts serious consideration within the service around governance and quality.

Overall, these responses to this question provide service leads with priority for action against barriers and improving usage and experience. These include clarify the Chaplaincy offer, simplify access, and increase visibility, with secondary emphasis on reframing Chaplaincy as inclusive support for all beliefs and none.

The service needs to ensure FFTs, complaints, concerns and PALS access routes for those who experience or perceive challenges within Chaplaincy service use.

Suggestions on how we can improve the Chaplaincy service

We are pleased that 22 people (patients, service users, public) took the time to share their views and insights, all comments were highly appreciated, and we sincerely thank those who gave them. Comments were themed; these themes should be used for action planning and shaping Chaplaincy services moving forward

Thematic analysis

Theme	Justification quotations (examples)
1) Awareness, offer & access (proactive information and asking)	• “I think it would benefit and help people, especially those who don’t have visitors. Leaflet advertising what is available would help.” • “Chaplaincy was not even mentioned to me during my recent stay in hospital… I would have appreciated being offered the chance to talk to someone.”
2) Perceived relevance for non-religious people (scope beyond ‘faith work’)	• “I appreciated being offered this type of support, but I don’t have faith and don’t consider it useful or needed. I don’t know what the service does other than faith work.” • “Let people know what is available then they can decide if they want it or not, it’s important for some. I liked listening to Songs of Praise… it is nice to hear it.”
3) Integration with clinical care & staff referral (mental health, recognition of distress)	• “… staff training to recognise and offer referrals when they notice distress… whether the patient has religion or not.” • “Chaplaincy should be offered alongside other

	therapies and medication… people, including those with mental health issues, should not ignore their spirituality but develop it."
4) Timing & readiness (patients coping, early admission, competing priorities)	• "I'm very newly admitted… haven't met chaplains yet… nice to know what chaplains can do and will think about this when they visit." • "I'm a life-long Methodist… it's a good idea, I've just got so much to cope with at the moment."
5) Practical priorities over spiritual support (discharge, rehab, care at home)	• "I don't know how this might help me… most important things are practical things about getting home safely and getting full rehabilitation." • "Nothing, I would want more practical help for my 90-year-old wife who is at home—what would chaplains do about that?"
6) Environment & space quality (multi-faith rooms, privacy, amenities)	• "The room is too small in Grantham Hospital and needs a makeover… no privacy through the fire door. Can this glass be opaque? Not enough space for multifaith users." • "Liked having Songs of Praise on but can't see the TV in here."
7) Continuity with community clergy & specific groups	• "Better contact information for clergy in parishes." • "Support for LGBTQIA patients."
8) Service features & options (prayer in person or remote, regular prompts)	• "Offer to patients the option to be prayed for, in person or remotely." • "People should be asked every Saturday if they want a service on the Sunday… give people time to think about it."
9) Positive impact & appreciation (benefit regardless of faith,	• "I don't have religious beliefs, but it helped me a lot… I am grateful for the care I had… please pass on my personal thanks."

compassion, bereavement)	• “I couldn’t have got through without their care, empathy, and them arranging a funeral for a person who passed without funds… thank you.”
10) Preference for hospital chaplain (trust, accessibility over external clergy)	• “I am having CBT… she suggested that I talk to my own vicar… however, I would be much more comfortable talking to a hospital chaplain.” • “Thank you to all who sacrificially devote themselves to others… and for your commitment even when some struggle to do the same.”

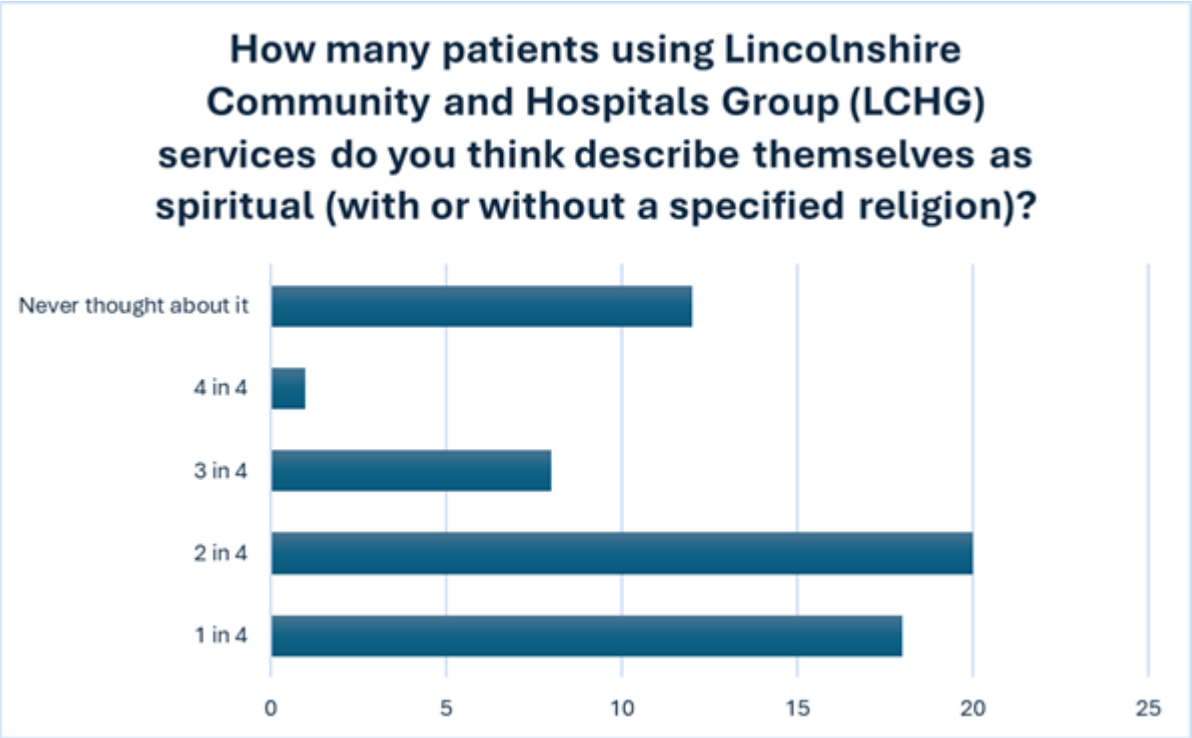
Staff

Staff roles engaged

Feedback was gathered from a diverse range of staff roles across both organisations, there was no obligation to share role, but 61 out of 99 staff did and as such we are confident that views are reflecting a broad spectrum of clinical, corporate, and specialist functions.

Respondents included frontline professionals such as nurses, advanced clinical practitioners, and healthcare support workers, alongside allied health roles like occupational therapists and therapy teams. Senior leadership and governance perspectives were represented through divisional leads, nurse directors, and clinical leads, while specialist services contributed insights from bereavement support, palliative care, and spiritual care. Administrative and communications staff added viewpoints too, the engagement outputs also extended to volunteers and NHS reservists.

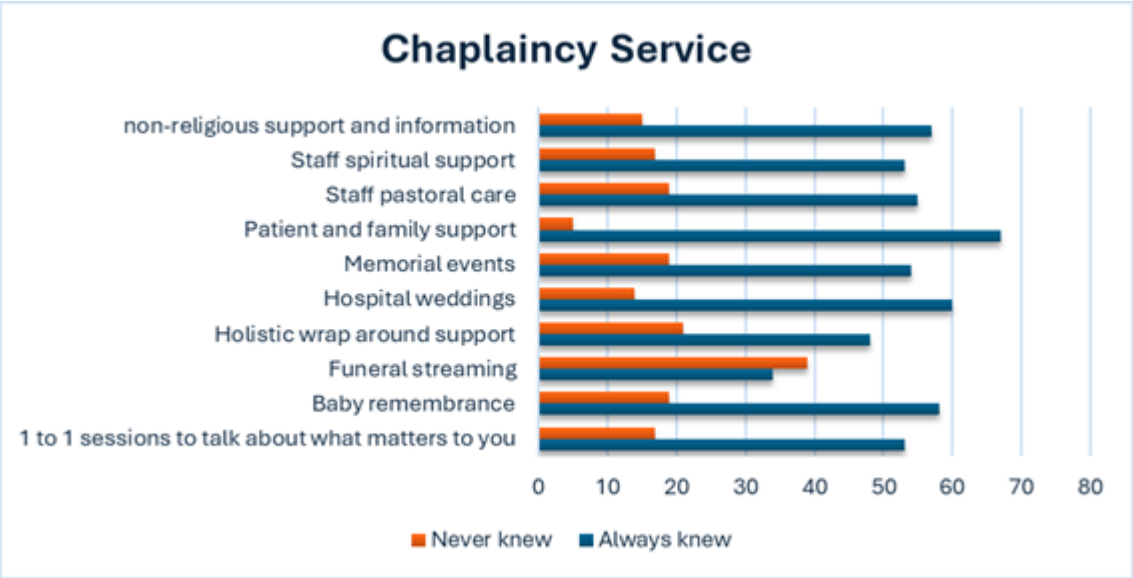
Perceptions of Spirituality



How many patients using LCHG services do you think describe themselves as spiritual (with or without a specified religion)?	(n)	%
1 in 4	18	30
2 in 4	20	34
3 in 4	8	13.5
4 in 4	1	1
Never thought about it	12	20

59 people chose to answer this question; about 1 in 5 responded to say that they have never thought about service user faith orientation. About a third of people responding to this question thought that half of our service users would identify with being spiritual, in one way or another.

Awareness of Chaplaincy services



Our respondents shared that the top three best known Chaplaincy services to them are

- Patient and family support
- Hospital weddings
- Baby remembrance

The least known three to our respondents are

- Funeral streaming
- Holistic wrap around support
- Staff pastoral care, memorial events baby remembrance

Insights:

Inferences can be suggested for all the categories, but we are well served to be able to consider just one aspect of patient impact and one for staff. If staff are unaware of key services, there are implications for both patient experience and staff wellbeing, for example

For Patients – Holistic Wrap-Around Support

Missed opportunities for whole-person care: Patients may not receive emotional, spiritual, or practical support alongside clinical treatment, which can affect recovery and satisfaction.

Increased stress and isolation: Without holistic support, patients and families may feel unsupported during critical moments, especially in end-of-life or complex care situations.

Equity concerns: Lack of awareness can lead to inconsistent access—those who know about the service benefit, while others miss out.

For Staff – Pastoral Care and Spiritual Support

- Reduced resilience and morale: Staff who don't know pastoral care exists may struggle with stress, burnout, or moral distress without appropriate support.
- Impact on retention and wellbeing: Unmet emotional needs can contribute to sickness absence and turnover, undermining workforce stability.
- Cultural gap in compassionate care: If staff aren't accessing support themselves, they may be less likely to advocate for similar support for patients.

Making a referral

Next, we asked our staff if they have ever made a referral, response was fairly evenly distributed:

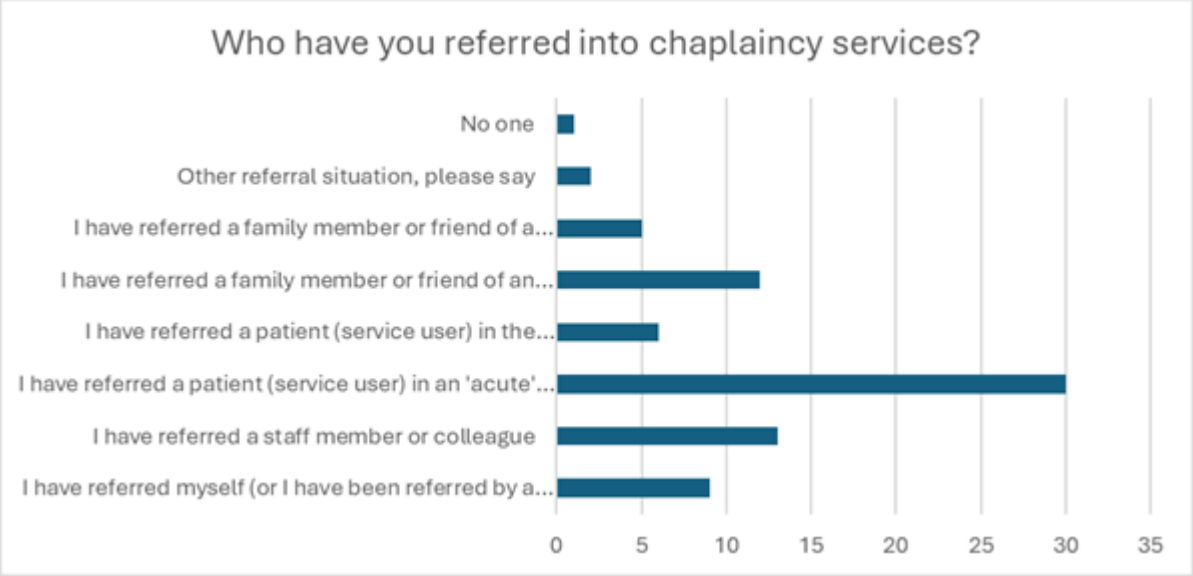
85 out of 99 staff entering the survey said:

Have you ever made a referral (including for yourself) to the Chaplaincy service?	n
Yes	41
No	44

We asked staff who have made a referral, who they have referred into Chaplaincy. Those who have referred could select as many categories as relevant to them. There were 2 individuals who write in “other”:

- I’ve also used the Chaplin to provide meaningful supervision.
- I have referred inpatients experiencing baby loss:

The bar chart shows that the most frequently referred were patients from the acute setting, with far fewer referrals declared from community. Combined higher frequency was the nature of referring oneself, or a colleague, suggesting professionals are practicing mutual compassion for themselves and people that they work with who are in distress, as long as they are aware of the services in the first place. It is also noteworthy that a staff member uses Chaplaincy for professional supervision.

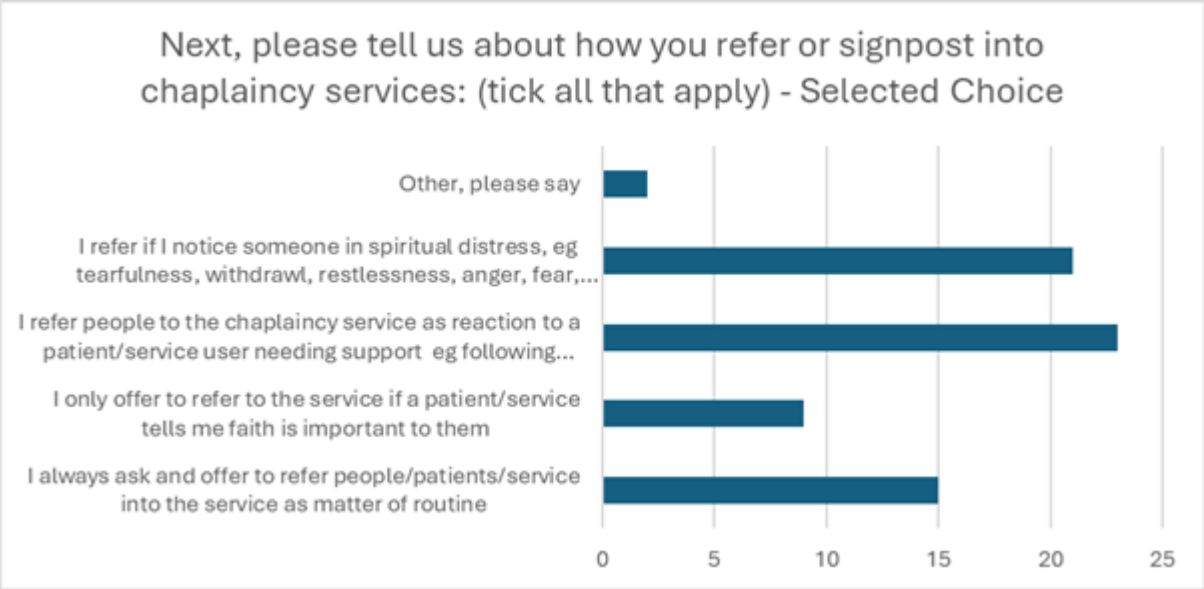


Who have you referred into Chaplaincy services?	n
I have referred myself (or I have been referred by a colleague)	9
I have referred a staff member or colleague	13
I have referred a patient (service user) in an 'acute' hospital	30
I have referred a patient (service user) in the community or from a community setting	6
I have referred a family member or friend of an acute Trust service user (patient)	12

I have referred a family member or friend of a service user (patient) in the community or from a community setting	5
Other referral situation, please say	2
No one	1

How referrals are made

We also wanted to understand how people refer in, in other words what are the most frequent triggers for activating Chaplaincy care:



Next, please tell us about how you refer or signpost into Chaplaincy services: (tick all that apply) - Selected Choice	
I always ask and offer to refer people/patients/service into the service as matter of routine	15
I only offer to refer to the service if a patient/service tells me faith is important to them	9
I refer people to the Chaplaincy service as reaction to a patient/service user needing support eg following bereavement, difficult diagnosis, difficult decisions, etc	23

I refer if I notice someone in spiritual distress, eg tearfulness, withdrawal, restlessness, anger, fear, struggling to make sense of things, losing hope, purpose or life meaning	21
Other, please say	2

“Other, please say” people wrote in:

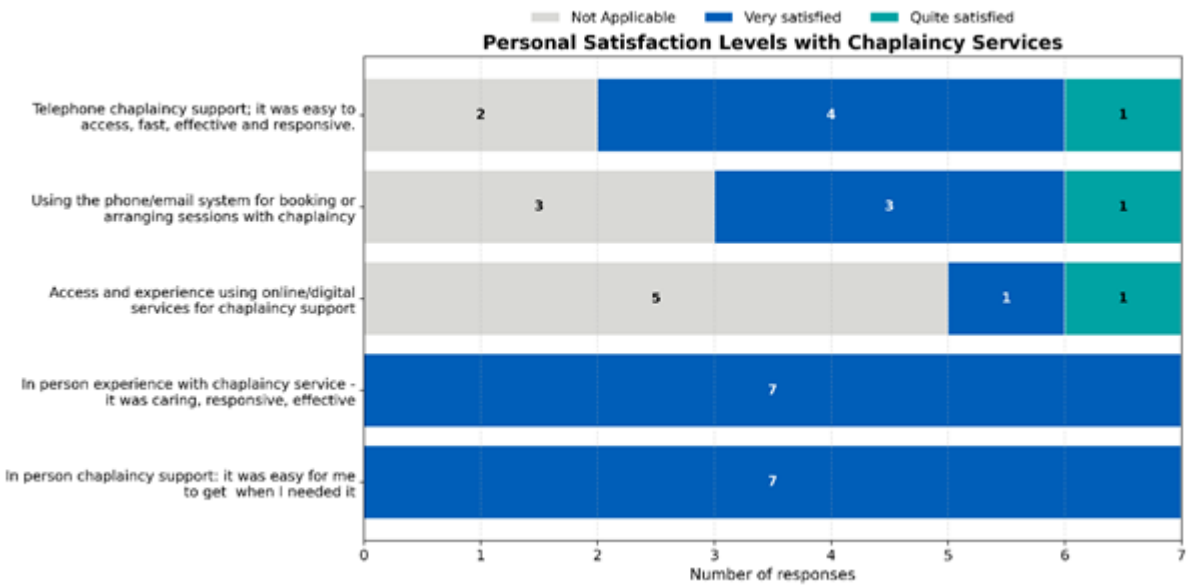
- If and when a patient asks
- If the situation arose and they asked to be referred, I would refer

The chart tells us the most common approaches to referrals are staff noticing distress or sensitivity around diagnosis, bereavement and difficult decisions. Lots of staff are also referring proactively, and some are more selective and prefer to wait until a patient tells them if faith is important to them.

Personal use of Chaplaincy

We were also interested in experiences of staff who themselves had support by Chaplaincy. Eight people shared their personal insights, seven people had support in person and one by phone. Four of these were not sure if they received a Chaplaincy needs assessment, 2 were confident that they had, one was clear that they did not get assessed.

Satisfaction ratings of staff experience of use of the Chaplaincy service



Summary of staff personal satisfaction with Chaplaincy Services

Feedback from seven staff who accessed Chaplaincy services shows consistently high satisfaction, particularly for in-person support, which achieved 100% “Very satisfied” ratings for both ease of access and quality of care. Telephone support and phone/email booking systems also performed strongly, with 75–80% of applicable users reporting they were very satisfied. Online and digital Chaplaincy services had the lowest engagement, with most respondents marking “Not Applicable,” indicating limited awareness or uptake; however, among those who used them, satisfaction remained positive.

As with patient satisfaction, these findings suggest that core face-to-face and telephone services are meeting expectations, while digital options require greater visibility and promotion to improve accessibility. Onward monitoring is required, but a theme is emerging around under use of digital and phone Chaplaincy capability.

What is working well with Chaplaincy

Here is what some of our staff said has worked well with Chaplaincy for them:

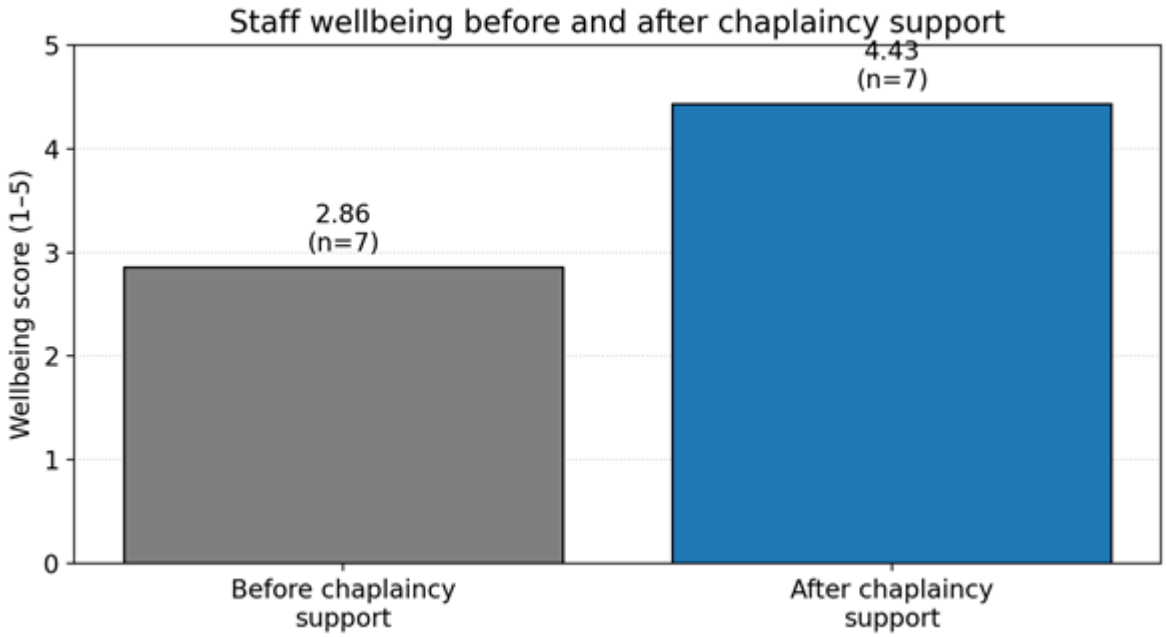
"I have & know others to have, received care and support that put us back on our feet”.
“Our Chaplaincy team are invaluable to teams after traumatic experiences & I have often signposted staff, pts & relatives "
“We had a really tough shift in A&E when I was a 3rd year student, the Chaplaincy service came down to support the staff on our next night shift, to give support and assist if any staff members needed spiritual guidance and a listening ear. Carl came down and it was lovely to have the support if needed and someone to talk to about how we were all feeling. We also had a different chaplain that came down to support the debrief for ULHT staff, ambulance crews involved and bereavement support staff.”
“Was a great comfort when I needed it”
“Staff very supportive and allowed both staff and service users to feel at ease and heard in a non-judgmental manner.”

What could be improved in Chaplaincy

We also asked what could be done to improve our Chaplaincy offer. It is important to note that there were no comments from staff who have used the service expressing any dissatisfaction in any way

Impact of Chaplaincy

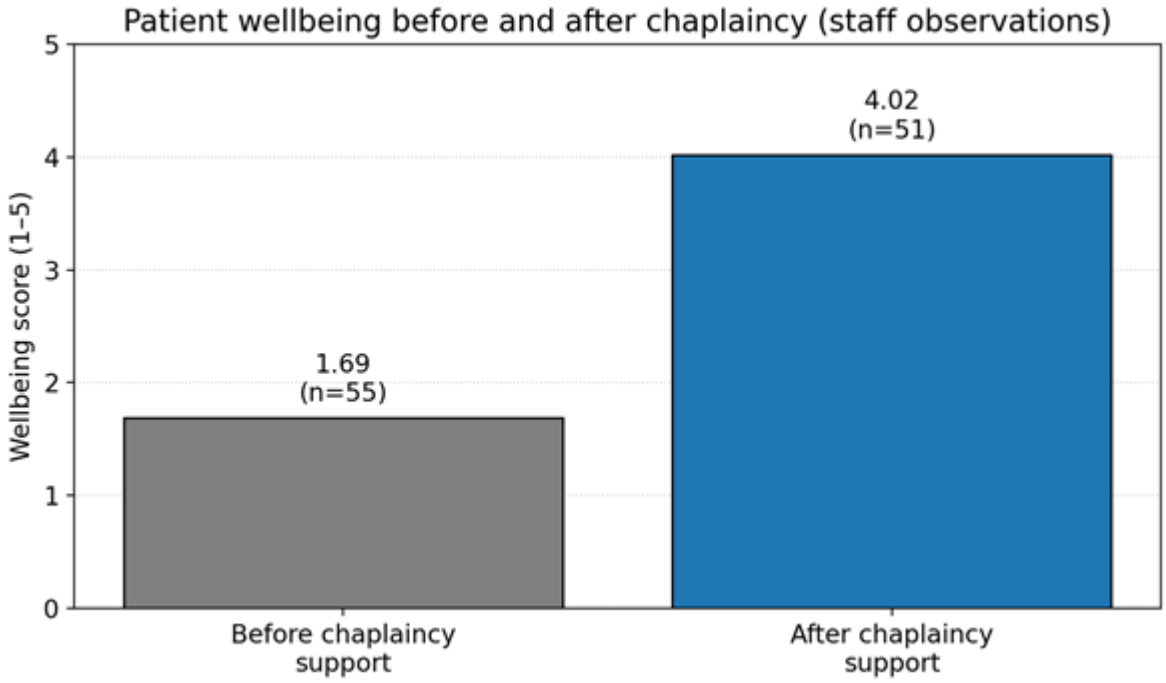
Next, we wanted some clear information about Chaplaincy impact on our staff and our patients. We asked staff who had experienced support how they felt before and after personally receiving Chaplaincy support:



Explainer: Think of wellbeing like the charge in a phone battery. Before Chaplaincy support, staff were at about 57% charge (2.86 out of 5). After support, they were at roughly 89% charge (4.43 out of 5). That's a big jump from just over half full to almost fully charged."

This same question was asked slightly differently, this time of all staff who took part in the survey, 55 out of a 99 could share an observed effect of Chaplaincy on service users. Those that had observed Chaplaincy in action

with patients gave these ratings of patient wellbeing, before and after, they have seen a chaplain:



Data source (staff observations):

- Before Chaplaincy support: Mean = 1.69, *n* = 55.
- After Chaplaincy support: Mean = 4.02, *n* = 51.

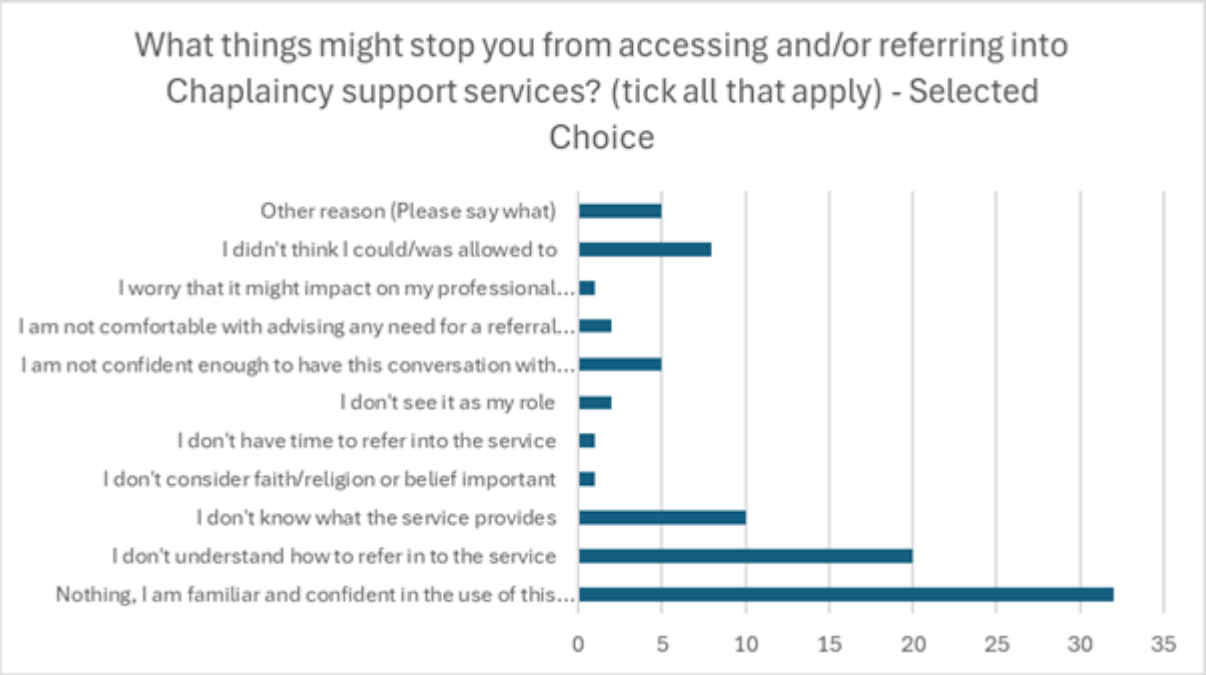
Explainer: think of patient wellbeing like phone battery charge: before Chaplaincy, staff observed patients at about *34% charge* (1.69/5). After Chaplaincy, staff observed roughly *80% charge in patients* (4.02/5). This means the 55 staff that were able to share observations indicates that Chaplaincy is very good for our service users that access it. In effect, these 55 staff had seen a jump from a low energy charge to a high charge in our patients that receive Chaplaincy attention.

Barriers to accessing the Chaplaincy services

This question was directed at all staff that took part, not just those that had experienced Chaplaincy themselves.

We were keen to understand what barriers there were to accessing Chaplaincy so that we can work at reducing them. This bar chart tells us that most frequently cited barriers to access and referrals was:

- People not understanding how to refer into the service
- They don't know what the service provides
- They didn't know they could



Barriers	n
Nothing, I am familiar and confident in the use of this service	32
I don't understand how to refer into the service	20
I don't know what the service provides	10
I don't consider faith/religion or belief important	1
I don't have time to refer into the service	1
I don't see it as my role	2
I am not confident enough to have this conversation with patients/service users	5
I am not comfortable with advising any need for a referral into this type of service	2
I worry that it might impact on my professional registration/status	1

I didn't think I could/was allowed to	8
Other reason (Please say what)	5

Free text comments:

- Time
- I will only do it if patients ask
- I don’t know what all services they are providing (only few know)
- Not needed to
- I don’t think all these services should be offered by a member of the Church of England, we are a multi faith setting and this should be met by other faiths or persons who have no relation to Religion to improve access for all to

Suggestions on how we can improve the Chaplaincy service

We asked our staff to share some ideas on how we might improve Chaplaincy uptake; the ideas have been themed and the service would do well to develop and shape the service according to these themes, individual comments are of great importance too:

Thematic analysis

Theme	Examples (staff quotes)
Visibility & presence across sites	• “Needs to be more visible in LCHS and on LCHS sites.” • “Utilising all spaces available to create an awareness of Chaplaincy services across the county/trust.” • “Be more visible.”
Referral & access process (make it easy)	• “Easier way of referral.” • “Please make the information about Chaplaincy services available to staff in Emergency Department, especially the referral process.”

	• “Automating Chaplaincy referrals… a smart prompt could be triggered automatically by staff in patient electronic records… to send a Chaplaincy referral…”
Inclusive, non-religious framing	• “I find it difficult to ‘sell’ the Chaplaincy service… Chaplaincy to many means religion… some still say no because of the name or that someone will come in religious attire.” • “See them out & about… so those without a religion also feel that this is a service they can access.” • “We should move away from the church-led model and have persons from a non-faith point lead… religious support should be secondary when people of an identified faith want a specific service.”
Out-of-hours cover & staffing	• “No actual presence of any Chaplain service, especially on a Sunday.” • “Being able to access the service 24/7… difficulties often occur out of hours.” • “An increase in Chaplains to cover day/night shifts—also to cover community for patients and staff.”
Staff support & bereavement care	• “Managing several staff who have had bereavement… it didn’t cross my mind to seek Chaplaincy support… lack of awareness the service supports staff… caring for our bereaved staff needs looking at…” • “Chaplains… offered invaluable supervision and space for reflection for myself and the wider team.” • “Having Andrew pop out at intervals for staff support was great.”
Training & education for staff	• “Raising awareness and educating staff on Chaplaincy service.” 1 • “Maybe some ESR training so we can better understand how it works, how to refer, who can refer…”

	• “I recently completed an insight day… it opened my eyes to the importance of spirituality in patient care.”
Communication & messaging (how to access)	• “Better communication with staff about what is available and how to access the service.” • “Information in easy format for all to read which could be put up on walls for staff and visitors.” • “The group bulletin wording makes it sound more spiritual/religious… a clearer list will truly highlight the support available (including non-religious).”
Community services presence	• “I do not recognise a Chaplaincy presence in community services… it has always seemed to be a hospital thing.” • “Create awareness of Chaplaincy services in the community.” • “Increase Chaplains… also to cover community for patients and staff.”
Quality concerns / adverse experiences to address	• “It’s a costly service for very little in return… the chaplain was abrupt and quite rude… patients were made to feel uncomfortable being encouraged to hold hands and pray.” • “Maybe not spending as much time in the cafes talking.”
Emergency Department awareness	• “Please make the information about Chaplaincy services available to staff in Emergency Department, especially the referral process.”

Site visits and direct engagement

As part of this engagement exercise, three LCHG site visits were carried out by the Stakeholder Engagement Manager (SEM):

- Scotter Ward at John Coupland Hospital, Gainsborough
- Archer Ward at County Hospital, Louth
- Butterfly Hospital, Boston

Scotter Ward – John Coupland Hospital

This transitional care ward focuses on rehabilitation and discharge planning. This visit was planned to gather views from patients and staff about chaplaincy services. Most patients that were approached were willing to share views, patients generally welcomed being asked for their views on Chaplaincy.

Eight patients engaged in conversation and three others were too unwell to participate. Feedback was entered into directly into the survey software system for aggregate analysis. Eleven staff were also invited to share their views, three provided verbal feedback.

There is no routine chaplaincy presence on this unit. The current model on Scotter Ward is to facilitate contact with a someone from the patient's own faith community, if they request it.

Some patients expressed that their care was excellent in the main, and they did not perceive any gaps or deficits from not having Chaplaincy involvement. However, most did not understand what the Group's chaplaincy service offers or how to access it. None recalled being asked about spiritual or faith needs on admission.

Staff feedback highlighted strong appreciation for individual chaplains known from another site (Skegness), particularly Father Aiden, who was praised for his open, inclusive approach and ability to connect with staff and patients regardless of faith. His style was described as vibrant, refreshing and

supportive, with resources such as YouTube clips about him being shared by staff.

Two staff reflected on the significant benefit chaplaincy brings to patients and expressed sadness at the loss of a long-standing unit chaplain, Bill, who had gone beyond his contracted duties and was highly valued. Since his departure, routine chaplaincy rounds have ceased. Information was not shared on why he was not replaced.

A staff member noted that ward volunteers provide consistent companionship and wellbeing support, which they thought helps to bridge gaps left by the absence of Chaplaincy.

Archer Ward – County Hospital, Louth

This transitional care ward focuses on rehabilitation and discharge planning. Most patients approached were willing to share views; seven participated, two declined, four were asleep, and three were barrier-nursed.

Patients expressed gratitude for the high quality of care that they receive overall. Some felt chaplaincy would add little value to them, while others said they were more concerned with other life priorities.

Common themes emerged: patients were not routinely asked about spiritual needs on admission, they were unaware of chaplaincy services, what they did or how to access them. Several noted that there is a weekly visit from a volunteer chaplain with a ‘therapy dog’, which they appreciated. Most people that were engaged perceived chaplaincy as faith-based and primarily for those with religious beliefs or needs. Patients here also reflected on the social benefits of Chaplaincy, such as shared activities like singing or watching church services together on the TV.

One patient without religious belief, described a significant positive experience following a chaplaincy referral, prompted by nursing staff who identified spiritual distress. This was a remedial intervention, applied after an adverse effect of primary surgical/medical treatment, Chaplaincy was reported to have helped reduce its negative impact. This patient was so grateful for nurse

observation and recognition of potential benefits, his thanks have now been directed to the Ward.

Staff feedback was positive about chaplaincy involvement but raised concerns about funding and visibility. Three staff shared some reflections:

- A robust volunteer Chaplaincy model operates locally, with a vicar visiting weekly and a Catholic priest available on request who comes when patients are known or request their services.
- Trust chaplains do not attend routinely; their involvement is ad hoc.
- Staff expressed concern that a significant budget allocation (around £30K) is deducted for 'Trust' Chaplaincy services, yet they see little direct benefit at Ward level.
- One person suggested these funds should instead support tangible improvements, such as refurbishing the chapel. The view was extended that Chaplaincy in person services should not be resourced out of NHS budget at all, instead this should be church funded.

Staff praised the Volunteer Chaplaincy model on this unit, three staff noted excellent rapport with the volunteers attending, and suggested it could be replicated elsewhere. However, there was uncertainty about who manages Chaplaincy volunteers, governance arrangements or monitoring of Chaplaincy access to patients; it was not known if ward funds are linked to these Chaplaincy visits, and what processes exist for raising practice issues or wellbeing checks for Chaplaincy themselves, if any were to arise.

One staff member on this unit is developing an introductory leaflet for patients, this will be including chaplaincy information and access details, in both digital and paper formats. Staff have now been connected to Chaplaincy services to make this leaflet accurate and best for patients and their families.

LCHS-Funded Butterfly Hospice (Lincolnshire)

Patient Engagement

- Patients present: 3. 2 were able to converse (one with a family member present), 1 too unwell to participate.

- Feedback from the two patients was entered into the survey software for collective analysis.

Key observations:

- Neither patient was aware of different chaplaincy services.
- Both reported that spiritual needs were not assessed at admission (one patient admitted late the previous night, so staff may not have had the opportunity).
- Both patients stated that faith or spiritual lineage was not important to them, though they appreciated being asked.
- Patients assumed chaplaincy support would be religion centric.

Staff Engagement

One staff member was available for discussion; previous staff views had already been captured in the survey by the nurse in charge.

- Staff emphasized that spiritual care is a core pillar of hospice care and a high priority, that they actively assess and engage patients in.
- Chaplains (Andy and Martin) attend every Tuesday for 2 hours, offering care to all patients, as part of routine visits.
- Staff acknowledged their own challenges in coping with death, dying and bereavement, particularly when caring for younger patients, which can trigger reflections on personal mortality.
- Key point: Coping with death should not be assumed as “part of the job”; emotional impact varies.
- Staff valued chaplaincy’s in-reach support, distinguishing it from Trust generic well-being services that require staff to self-initiate. This chaplaincy service is brought to them.

Chaplaincy Provision & Budget

- Current model: Inherited arrangement; unclear engagement levels with the service and/or its impact on patients.
- Financial context:

- Approx. £6k on this unit per annum spent on chaplaincy as an external contract.
- No formal budget allocation for chaplaincy – despite its hospice status. This £6k as such is currently recorded as an 'overspend'.
- Discussion with a staff member focused on value for money and whether the current model meets patient and staff needs.

Patient Impact

- No formal monitoring of chaplaincy's impact on patients.
- Comfort and benefit noted anecdotally, but faith-based support is not universally desired or tracked by this unit
- No demand for night or weekend chaplaincy callouts, as far as this staff member can recall
- Evening and weekend call outs are always an assured offer; it is just not required (as far as this staff member understands)

Operational & Cultural Considerations

- Staff uncertain about chaplains' management structure, employment status (NHS banding vs. volunteer), or escalation routes.
- Increasing presence of Roman Catholic patients, possibly linked to local migrant communities; often well supported by their own faith leaders.
- Staff will always connect with faith leaders from the patient's own community, if they express or wish it; it is also offered as part of admission assessment.
- Staff proud of proactively around spirituality for the betterment of patients' well-being.

Equality, diversity & inclusion (EDI):

- Very occasional but significant needs from Muslim, Hindu, Sikh patients (e.g., same gender washing and burial within 24 hours).
- Practical challenges arise when staff must arrange rapid funerals, as they must do the administrative and labour around this; it is unclear if chaplaincy could/should assist with this.

- This unit has only one male staff member, this has been known to create difficulties when cultural requirements, such gender preference washing, cannot be met during his absence. Is this something that Chaplaincy could help with?

Emerging Trends

Growing preference for direct cremation (no funeral) arrangements.

- Budget cremation providers may delay collection of the deceased person that commissioned them for 12+ hours.
- The hospice cannot keep the deceased in rooms beyond 4 hours (health & safety, etc). Not know if this is a Trust wide mandate.
- There is no on-site mortuary at the purpose-built hospice.
- The Pilgrim hospital mortuary is nearby (in close sight), but not accessible to hospice patients.
- Local undertakers previously offered goodwill support (ie collecting and accommodating the deceased until direct crem services can attend), but now are recognising this as a cost to them £200/day for housing/conveyance. This good will has expired, and staff at the hospice are worried about this. The view provided by staff was that the direct crem service will not pay the local undertakers to look after the deceased until they arrive (they can be delayed more than 12 hours). The direct crem provision have been advised on this but are not dealing with the problem (don't answer calls about it)
- Staff expressed concern about multi-deceased person transport practices by budget crematoria. It is not clear if when booking these types of services, people are aware/bothered about this. Some may perceive it as undignified.

Key Questions Raised

- Should chaplaincy funding be reallocated to address practical spiritual and cultural needs (e.g., funeral arrangements)?
- Should the hospice have its own defined ring-fenced chaplaincy budget?

- Is there a co-op style Chaplaincy funding model in place, so that some service budgets are expected to financially support the chaplaincy needs of other services without chaplaincy budgets?
- How can chaplaincy assist with modern end-of-life dispatch preferences
- How can chaplaincy assist with changing EDI requirements of Lincolnshire's diverse population?
- Is there scope for Group-level discussion on shared mortuary access between ULTH (hospital) and the LCHS (hospice) in Boston? Should chaplaincy monies be top sliced for this?
- Would the public understand or accept current differentiation in mortuary facilities and responsibilities within Group?

Summary

The hospice demonstrates strong commitment to spiritual care but faces budget constraints, operational challenges, and changing cultural expectations. Chaplaincy is valued for staff support and patient comfort, yet its role in addressing practical dilemmas and diverse needs requires review. Future considerations should include development of impact assessments, benefits realisation, clarity on governance, and strategic planning for resource allocation.

Site visits conclusion

Across the three sites, chaplaincy services are recognized as beneficial for both patients and staff, particularly in providing emotional and spiritual support. However, there is low awareness of what chaplaincy can do, seemingly inconsistent assessment of spiritual needs (patients overall say they aren't asked, but staff are saying that they do), and staff seem unaware of governance structures for chaplaincy and funding justification.

Funding models seem to lack transparency with the limited number of staff engaged with at site visits; there seems to be gaps in funding allocation and alignment with perceived value. It may be that this is creating tension between

resource allocation and service impact. Volunteer chaplaincy models are well-received but require more robust oversight and understanding.

There are some reported cultural and operational challenges for dealing with matters that are well within the Chaplaincy brief—such as diverse faith requirements and emerging funeral trends. Site visits highlight the need for chaplaincy to improve understanding of their remit and evolve patient staff and public perceptions beyond the traditional faith-based roles.

Direct staff well-being support through chaplaincy is a clear strength that should be preserved. With staff that shared their views, this support and relationships with Chaplaqincy were well regarded and seen as very helpful.

Recommendations

The engagement produced a rich set of insights from patients, the public, staff, and site visits which have been translated into strategic and practical actions. These cover improvements in awareness, access, inclusivity, integration with clinical care, and physical environments, as well as staff training and community links. The workbook accompanying this report provides survey analyses drive recommendations, including:

- **Engagement-specific suggestions**: Direct quotes and themed actions from public and staff feedback, ensuring recommendations are grounded in lived experience.
- **Practical steps for implementation**: Clear actions such as improving visibility through leaflets and posters, introducing proactive prompts, enhancing multifaith spaces, and piloting digital chaplaincy options.
- **Staff-focused improvements**: Training modules, communication strategies, and out-of-hours cover to strengthen resilience and wellbeing.
- **Future engagement enhancements**: Suggested questions aligned to CQC domains to capture safety, effectiveness, inclusivity, and leadership assurance in future evaluations.
- **Site visit recommendations**: Site visits highlighted the need for routine spiritual needs assessments at admission, improved awareness of

Chaplaincy and inclusive communication, clearer Chaplaincy governance and safeguarding protocols, a review of funding models, enhanced cultural competence with attention to emerging end-of-life trends, and formal impact measurement to strengthen accountability and patient experience.

Readers are encouraged to consult the **Chaplaincy Engagement Workbook** for full details, including thematic analysis tables, quick wins, and prioritisation guidance. This ensures transparency and supports evidence-based decision-making for service development.

Conclusion and next steps

This engagement confirms that Chaplaincy services are deeply valued by those who access them, offering comfort, compassion, and dignity during some of life's most challenging moments. Patients and staff alike described the positive impact of empathetic listening, presence, and practical support, reinforcing Chaplaincy's role in holistic care. However, the findings also reveal significant gaps in awareness, accessibility, and inclusivity, alongside practical challenges such as physical space limitations and inconsistent referral and assessment processes. These barriers mean that many who could benefit from Chaplaincy do not currently receive it.

An accompanying workbook, *Chaplaincy Recommendations*, provides detailed actions, quick wins, and thematic links to survey questions. It includes engagement-specific suggestions from patients, service users, and staff, as well as strategic priorities identified through analysis covering awareness, access, inclusivity, governance, and impact measurement etc. Service leads and teams should actively engage with this resource, use it to guide implementation, and report back on progress within 12 months to the Communications and Engagement team.

Intentionally blank for your own notes