

Notes of the Meeting of the N E London Chaplaincy Collaborative

24 May 2006, SHA Offices, Commercial Road, London

1. Those present were Peter Cowell, Yasar Zaman, Dave McKay, Frances Moore, Christine Hall, Tim Coleman, Janice Strachan, Sudha Lau, Susan Hollins, Mark Griffiths (for a short time)
2. Apologies were received from Mike Pritchard, Pete Martin, Duncan Dalais, Yunus Dudhwala, Nadia Pfaff, Russell Ogston, Ben Rhodes, Shafique Rahman.
3. Members had been asked to submit three top priorities.
 - a. Chaplains at ELCMHT proposed
 - i. Spiritual Needs Assessment
 - ii. Developing partnerships with faith communities
 - iii. Providing training to staff and to the community
 - b. BHR
 - i. Recruitment & training of Volunteers
 - ii. What would it look like if the Collaborative became the focus for this?
 - iii. Referral system improvement – models to use; training of nurses in spiritual care assessment (London South Bank Nurse training does not provide modules in spiritual healthcare). MG noted that the way to address this is via the SHA.
 - iv. Good practice in multi-faith working
 - c. BLT
 - i. Keeping data
 - ii. How to care for staff when staff counselling budget cut by 1/3
 - iii. Income generation
 - iv. How best to access patients
 - d. Homerton
 - i. Cutbacks
 - ii. Measurement of what chaplains do/customer satisfaction
 - iii. Vision of what spiritual care is within the hospital environment using NHS language

- iv. How chaplaincy reflects the shift to the care of patients in the community
 - v. Sharing skills across Trusts
 - vi. Making use of the SHA link
 - vii. Multi-faith work - ensuring quality
- e. Mark Griffiths noted that in terms of what the Collaborative wants from the SHA it is important to keep the global picture and to keep the SHA informed.

4. Local Issues

- a. BHR – a formal notification has been given to the chaplaincy team that one of the team will be made redundant. The service will have a new, flat structure and will be managed by the Patient Satisfaction Manager. This new arrangement will mean that BHR chaplaincy will be staffed by 2 whole-time and 2 part-time chaplains. The new service will be in place by the end of June. It is not regarded as a core service so that attendance at MDT's will be disallowed. However the chaplains have been asked to collect more data. In the Trust as a whole 500 job losses are proposed.
- b. BLT – the chaplaincy is now managed by the PPI lead, and not an Executive Director. The CEO responded to the letter sent from the Collaborative by saying that "Chaplaincy is a vocation" and that all targets will be met. Chaplaincy is facing 5% cuts which has meant that one chaplain is now seconded to Administration for 4 days /week, while another part-time chaplain has been 'sold' to a local parish for 1 day/week in order to recoup an income for the service.
- c. Whipps Cross - The Trust has to save £24 million during the next year. A Director of Turnabout has been appointed, while 4 wards and 2 theatres have been closed. 400 jobs are threatened with 50 compulsory redundancies. These will increase as NHS job availability decreases. The Turnabout team is to assess all services. There is an unprecedented level of change in the organisation. Staff are consequently very tense. The care of the Elderly ward is due to close in July. Chaplaincy has been busy collecting data.
- d. ELCMHT – The chaplaincy is staffed mostly by volunteers who are trained free at the University of E London via a very strict selection

and supervision process. There are major issues relating to the BME agenda in Newham with spirituality high on the priority list.

- e. The use and collection of data
 - i. BHR – referral sheets which contain comprehensive information on patients and the spiritual care interventions they receive. There is a MDS Annexe in use on a weekly basis. This includes 20 different categories, each with a code which now needs to include participation in MDT meetings and staff training. This is based on the system in use at Sheffield Acute hospital chaplaincy service. The BHR chaplains will send this to SH for distribution. Pete Martin is in conversation with IT to see how the programme may be developed and held centrally.
 - ii. Whipps Cross- There is a record card for each patient which contains less detail than at BHR but with space for written detail after each visit. Frances Moore is now putting this onto the computer. Referrals are collected via FM's involvement in 3 different MDT meetings. Duncan also attends MDT's and picks up referrals. The service has Caldicott clearance to access PAS although FM is the only chaplain to have and use this access, mostly for the purposes of clarification.
 - iii. Homerton – use a patient information sheet including Name, Religion, source of referral, diagnosis and space for comments. Everyone except the RC chaplain keeps this information. PAS access is denied. Referrals come in the main from Bereavement Midwives. Other work arises from involvement in trauma and cardiac teams. Funerals are recorded, but the time spent is not recorded. A general notice board indicates the wards visited and other work undertaken.
 - iv. BLT – there is no means of recording repeated admissions of patients; a returning patient will be recorded as a new entry. There are 2 call-out sheets – in hours, out of hours. All Chaplains have PAS access for accessing Religion only.
 - v. ELCMHT – no data is collected. Spiritual Needs Assessment is done by chaplains and this initiates other referrals. Ward staff should undertake the assessment but are slow to add this to their work. There are link nurses with chaplaincy on each ward. There is poor uptake of the Spiritual Needs Assessment. Each

patient receives a copy of the assessment. Chaplains are invited to participate in ward therapeutic hours.

5. Action points from the meeting

- a. Nurse Training – to identify where spiritual healthcare is omitted from the syllabus; to identify where chaplains have input into nurse training
 - b. To share information about data collection and referrals
 - c. Developing systems to ensure the quality and cost effectiveness of multi-faith work
 - d. Volunteer training – who does this and how; training programmes in current use. Members of the Collaborative to begin an email conversation about the programmes currently used.
6. Next meeting – **4 October at St Bartholomew's Hospital**. The meeting on 29 November will not be held at BHR. Offers for an alternative meeting place will be helpful.
7. Draft Agenda to include
- a. Nurse Education
 - b. Referral systems
 - c. Local Issues
 - d. Responses to the Baseline Questionnaire