

N W London Strategic Health Authority

Launch Meeting of the Chaplaincy Collaborative

SHA Offices, Boston Manor, London

March 15 2006, 1300 – 1700

Those present:

Richard Osborne	Knowledge Resources Manager, N W London SHA
Susan Hollins	Lead Chaplain (eastern area) Caring for the Spirit Strategy
Jonathan Osborne	Senior Chaplain Ealing and West Middlesex Acute Trusts
Gareth Beresford-Jones	Chaplain Ealing and West Middlesex Acute Trusts
Chris Guinness	Chaplain Hammersmith Hospitals Trust
Nigel Griffin	RC Chaplain Hammersmith Hospitals Trust
Steven Smith	Senior Chaplain Chelsea and Westminster Acute Trust
Steven Flatt	Senior Chaplain, St Mary's Trust, Paddington
Art Barron	Assistant Chaplain, St Mary's NHS Trust Paddington
Ian Hewes	Chaplain Royal Brompton & Harefield Trust Harefield Hospital
Ann Percival	Deputy Director of Therapies RBHT
Sarah Illingworth	Chief Dietician RBHT
Chris Lee	Senior Chaplain, Royal Marsden NHS Foundation Trust
Alistair McCulloch	Chaplain, Royal Marsden NHS Foundation Trust
Adama Ndongo	Muslim Chaplaincy Volunteer St Mary's Trust Paddington

Apologies were received from:

Edward Morris Senior Chaplain Hammersmith Hospitals Trust

1. Richard Osborne and Susan Hollins welcomed everyone to the launch of the chaplaincy collaborative
2. Susan Hollins gave two presentations:
 - a. A review of the Caring for the Spirit Strategy
 - b. The form and purpose of a chaplaincy collaborative
3.
 - a. **Data Protection Act:** Following the first presentation questions were asked about the ongoing difficulties in chaplaincy access to patient records given the strong emphasis upon the role of chaplaincy by the cancer networks and the Liverpool pathway for the care of the dying. Within the SHA there does not appear to be any difficulty for chaplains accessing patient records. SH said that many chaplains in other parts of the country experience difficulties in gaining access even to patient religion lists.
 - b. **Minimum Data Set:** Initial comments received about the collection and usage of data were as follows –
 - i. the amount of detail collected is time-consuming
 - ii. there is extra difficulty in data collection where a single overarching chaplaincy provision is located in several Trusts each with different protocols etc

- iii. How may like data be compared across Trusts? A Collaborative would be very helpful in facilitating this
 - iv. There is no software dedicated to this which can be used by everyone. SH response: The NHS Connecting for Health IT Programme may be able to develop such a programme. The chaplaincy service at Sheffield Teaching Hospitals and Cambridge University Hospitals NHS Foundation Trust each use data sets for which a software programme has been devised, to great benefit for individual chaplains and the service as a whole.
 - v. CL remarked that chaplains at The Mayo Clinic, USA who use data sets, have indicated a difficulty in recording time
 - vi. Where would such data be stored? A Trust's central Drive would hold this information securely.
 - vii. The worth of an MDS is not as great as it sounds. The greater benefit is to enhance the personal reflection of the individual chaplain, rather than to advance the service. (RMH)
 - viii. Activity specific to a faith group would be hard to record.
 - ix. The MDS has been helpful in assisting the chaplaincy Line Manager to understand the service and its needs.
 - x. Some chaplains are suspicious of what a Line Manager might use a MDS for, thinking that the MDS is something that is 'done unto' a chaplaincy service instead of the chaplaincy actively using a Minimum Data Set and gaining control of it.
- c. **Consultant Chaplain:** Chris Lee (RMH) asked about examples of any chaplain exercising the role of Consultant Chaplain. SH directed the him to the chaplaincy team leader at Cambridge University Hospitals NHS Foundation Trust.
 - d. **Education for Chaplains:** a discussion focussed upon the new Foundation Degree in Healthcare Chaplaincy provided by St Mary's College Twickenham (Strawberry Hill) with its emphasis upon practice alongside theory.
- 4. Chaplaincy Collaborative:**
- a. Following the second presentation a full discussion took place. The following is a summary of the comments made in the discussion.
 - i. Patient & Public Involvement: DB (NLMHT) said that the Trust pays service users/patients for their involvement in such forums, if only to cover expenses. Such payment would need to be factored into formal service user/patient involvement in a collaborative
 - ii. The Collaborative as a training Forum: The chaplaincy service at the N London MH Trust is bidding for 2 Training posts, each lasting 3 years. This Trust is well-placed as a training environment for a new chaplain given its full range of MH services. It is also planning for Foundation status which would necessitate all training funds to be found by the Trust itself. Some wondered if a newly appointed chaplain would be expected to undertake a placement in each Trust within a collaborative and expressed concern that this would be onerous. SH said that it would be possible for the trainee chaplain to be appointed on placement to selected Trusts.
 - iii. Caring for the Spirit Strategy: Chris Lee (RMH) considered that there is a lack of clarity in relation to chaplaincy at national level with some work apparently being duplicated (CPD; Data Protection). This leads to serious misgiving about the role of

the CfS strategy in relation to the work of the College of Healthcare Chaplains (CHCC). CL went on to say that chaplaincy has to prove itself, but from within Trusts rather than rely on any external support from the NHS. Money/funding should be generated for chaplaincy within each Trust. SH acknowledged that the CfS Strategy is guidance and is not mandatory therefore Trusts are free to choose not to engage with it, just as they are with other NHS guidance. Jonathan Osborn wondered how a collaborative could benefit those chaplains who meet in strong peer groups on a regular basis. In response SH emphasised the SHA link as being crucial, and distinguishing the Collaborative from other meetings of chaplains. Ann Percival (RBHT) said that she had been encouraged by the Trust Directors and the General Manager to attend the meeting. AP considered it essential that others in the team became involved. Steven Smith (Chelsea & Westminster) expressed his own misgivings, especially in relation to the tensions between CHCC and the Strategy, but also expressed his willingness to be involved on the understanding that if the Collaborative did not meet his needs/requirements then he would not remain an active member. SH stressed the ownership of the Collaborative by the chaplains in the SHA, and that it was expected that colleagues would bring to it key issues of service/practice that could be addressed collectively such as the sharing of good practice (for example in relation to the development and use of data sets).

- iv. Steven Flatt (St Mary's Paddington) considered that the Chaplaincy Collaborative to be a very exciting initiative while recognising the need for it to be relevant to spiritual healthcare. CL (RMH) emphasised that the agenda would need to be a 'chaplaincy agenda' and not a 'health agenda'. SH again emphasised the strength of the collaborative in bringing together chaplains from one area (SHA) to address the needs of the chaplaincy-spiritual healthcare workforce in a focussed manner.
 - v. Good value? CL (RMH) asked if the chaplaincy collaborative would be good value and if the chaplaincy service at RMH could gain anything from the collaborative that it could not find anywhere else. Emphasis was given once more to the critical mass afforded by a chaplaincy collaborative in order to address the current inequities of service provision and resource, as well as the benefits that may be experienced through learning from one another.
5. **Taking it forward:** The majority of those present indicated their willingness to be involved in the chaplaincy collaborative by a show of hands.
 6. **Future meetings:** SH outlined the frequency of meetings throughout the year (every 2 – 3 months). The next meeting will take place during May, with further meetings to be held in September and early December. SH will circulate members with a list of possible dates for confirmation. It was agreed that future meetings would be held at the Boston Manor offices subject to the results of SHA reconfiguration in London.
 7. **PowerPoint presentations attached.**