Notes from the Meeting of the S E London Chaplaincy Collaborative

7 June 2006 at Lambeth Hospital Room of Peace

1. Those present were Mark Sutherland, Rosemary Shaw, Qaisra Khan, Luke Marrapillil (left to attend emergency), Kes Grant, David Flagg, Amar Hegedus, Ivelaw Bowman, Susan Hollins
2. Apologies were received from Georgiana Heskins, Annie Shaw, Stuart Meyer
3. Minimum Data Set –
    a. GSTT – Chaplains have to complete activity sheets along with other members of the Therapies Department. These sheets provide 'tick boxes' and their format is inappropriate for chaplaincy usage. These sheets are given to the Line Manager each month. In addition a Referral sheet is used which sets out different kinds of spiritual care. There are also On-call sheets. Chaplains are also recording their involvement with the Evelina Children's Hospital.
    b. Oxleas – there is no PAS access. Chaplains send time sheets of activity to Qaisra Khan which detail the number of patients seen and the activity undertaken
    c. Queen Mary Sidcup – Chaplaincy Volunteers complete sheets detailing the time of their arrival, the ward visited and the departure time. 1 Volunteer collects the sheets and another Volunteer inputs the information into graphs. Referred patients are listed in a book, with a tick system for a visit with the date given alongside, and spiritual care requirements.
    d. Greenwich – A patient referral sheet (which includes Nurse referral) is used which includes the name, date and identified needs, family and a chronological pathway. This information is then filed on patient discharge and may be re-used on re-admission. There is no link between the records kept by Volunteers and those kept by Chaplains. Additionally Social/Religious visits sheets are filed by ward (these are based on 'hello' encounters). There is no staff data kept.
    e. Lewisham – Data sheets currently include the person referring a patient to chaplaincy, the reason for the referral, how many times the person is visited and by whom. The Volunteers use a separate sheet although they are now encouraged to use the main sheets. No staff

support data is kept. KG is imploring Nurses to record patients' religion accurately on the PIMS as there is much faulty data recorded at present. All failed contacts are also recorded – when requests for a chaplaincy visit are not passed on to the service.

f. SLAM – currently there is no data recording at all. Soon the service will be moved to a sophisticated computer programme designed by Amar Hegedus. The new system will produce reports and graphs automatically, with numerical codes appearing in drop down menus. The programme will record the nature, area and intensity of chaplaincy activity. The capturing of data in this way will assist in the chaplaincy's demonstration of different levels and ranges of funding with a view to developing service provision. The system won't keep confidential patient records although it has the capacity to feed into the Trust record system.

g. Orpington – the chaplaincy picks up requests for visits, Holy Communion, prayer. There are some Volunteers. There is no other faith chaplaincy input. Volunteers will visit very sick patients on the wards. Referrals are made via staff, clergy. PAS access is allowed and the RC Chaplain has the list of RC patients. Other patients not on the RC list will be discovered by the Volunteers. An analysis of where the calls originated took place some time ago. There is no means of bringing together the separate pieces of information into any report. TM is not convinced about the meta-narrative of spiritual religious care and is concerned that it is far more complex, requiring further analysis. All religious Services are recorded in the Service Register which is sent to the Diocese of Rochester. This includes all Crematorium and Ward services.

h. A shared concern is how complexity may be recorded? Would a ratings scale be appropriate for this? SH said that alongside the 'minimum' data a narrative might be supplied, especially for complex encounters in which key elements could be highlighted. It was suggested that chaplains could consider using a research protocol which everyone understood which could then be applied to grade qualitative encounters. It was agreed that evidence needs something to illustrate the quality of time used.

i. SH informed colleagues of her work with the DH in relation to the DPA issue for patient consent being provided within the PAS. Amar

Hegedus agreed to send her the list of religions which will be used in the SLAM data system.

4. Local Issues
    i. KSF- how are people getting on with this? Some have completed this, others are struggling with it. At GSTT everything has been done electronically. QK said that the KSF made more sense once Appraisal had taken place. It was recognised that more emphasis was being placed on evidence of development illustrated in the Portfolio. QK had also recognised that the language of the Healthcare Commission Standards and KSF are similar.
    ii. SH asked for details of contacts within HEI's in order to extend and develop the membership of the Collaborative. The name of some contacts were supplied. SH is following these up.
5. Next Meeting – **13 September.** Meeting to take place either at South Bank Techno Park or at the Room of Peace Lambeth Hospital.