

Devon and Cornwall SHA Chaplaincy Collaborative Launch –

30th May 2006 in Exeter Cathedral

Present:

Reverend Christine Braithwaite	Hospice Care
Reverend Jon Bush	Plymouth Teaching PCT
Reverend Peter Eastwood	Baptist Minister
Reverend Dr John Garner	South Devon Healthcare NHS Trust
Reverend Derek Hill	South Hams & West Devon PCT
Reverend David James	East Devon PCT- Sidmouth Hospital
Reverend David Luce	South Devon Healthcare NHS Trust
Reverend Ian Morter	East Devon PCT
Reverend Canon Robin Murch	Teignbridge PCT
Irvin Penberthy	Okehampton Community Hospital
Reverend Kathy Smith	Cornwall Partnership NHS Trust
Reverend Martyn Trembath	Royal Cornwall Hospitals NHS Trust
Reverend David Walford Trust	Royal Devon and Exeter NHS Foundation
Reverend Alan West	Royal Cornwall Hospitals NHS Trust
Tony Cox	RDE
Reverend Tony Kyriakides Yeldham	PHNT
Reverend Juliet Harwood	PHNT
Reverend Mandy Churcher	PHNT
Reverend Peter Ellmore	Caring for the Spirit Strategy Lead Chaplain
Chrissy Aspinall Communications	SW Peninsula SHA Head of

1) Presentation of the Strategy, Collaborative working - Some feedback:

a) Some issues for Part-time chaplains:

- i) Needs for support
- ii) Need for resource materials, chat room, and web site. *(Note that these are all available through the South Yorks SHA web pages on Caring for the Spirit and through a Smartgroup set up for chaplains. The information needs dissemination to part-time chaplains who have not been included in mailings and newsletters etc. to date)*
- iii) For Part-time chaplains'; some felt that their needs and the manner by which they could be met would be distinctively different from their whole time brothers and sisters. The time that could be afforded for development in a collaborative by part-time chaplains would be disproportionate compared with that of whole-time chaplains. Some whole time chaplains felt that there might be a need for separate grouping to fulfil their needs. *(It is noted that there are points in common, viz; the need for role development; the need for exchange of best practice; research awareness; integrating a multidisciplinary approach to the work; making their service clear and accessible; working with changes to the healthcare services etc. Part-time chaplains might learn from the whole-time*

chaplains and new insights gained for all. Some adjustment to programmes might be explored.)

b) Collaborative Working groups:

- i) The question of governance and ownership of the group was raised and posed questions of;
 - (1) Who? – who is involved in the planning processes? *(This should be a representative grouping of the membership including chaplains, SHA lead staff, management and co-workers. Room should be allowed also for public/ user representation. The agenda would be decided by the membership working to meet the objectives of the Caring for the Spirit Strategy and the priorities set both locally and nationally.*
 - (2) How? – how is the collaborative to meet and be maintained? *(It is hoped that this would be hosted by the SHA. There is the implication of a small administrative workload and the need to source suitable meeting venues. Costs though should be minor and meeting places might be found in Trust hospitals willing to host the event.*
 - (3) When?- How frequent should meetings occur? *(The ideal frequency for meetings would be about three times per year. That would allow time for work to be progressed by membership between meetings and also enable progress to be achieved.*
 - (4) Where?- Where best to meet? *(The meeting venue for the launch in Exeter cathedral was not ideal. Heating was not controllable and it was uncomfortably cold. IT facilities were lacking. A more suitable venue might be found within larger teaching hospital Trusts. Crucial to the meeting venue is the accessibility for the region. More work in needed in this area)*
- ii) Delegates to the meeting were requested to make known their willingness to be part of the governing or steering group for the collaborative. *(Champions will be approached if insufficient volunteers are forthcoming).*

c) The Professional Agenda

- i) A discussion ranged on this subject and included a number of related issues.
 - (1) In what way are chaplains professional or seeking to be professional? *(Statutory professional regulation is the 'gold standard', equivalent to other allied health professions and has been sought by chaplains for some time. The College of Healthcare Chaplains has actively pursued this agenda. There are some difficulties that have emerged and are voiced by the DH. These are to do with the need to pass legislation that would introduce standards that may conflict with those already held by faith groups and applicable to their ministers. Negotiations continue.)*
 - (2) Several drivers lie behind a desire for professional regulation and these were the subject of some discussion.
 - (a) Continuing Professional Development (CPD). There is recognition of the difference skills developed and held by those engaged in whole-time chaplaincy work compared with those whose work is in community faith groups. There is a desire to progress and develop those specialised skills. *(Much work has been done by CAAB and others to define the knowledge and skills for chaplains, different levels of expertise and practice, access and develop educational frameworks. The work continues at several levels. Local developments are desirable with local schools of healthcare and*

theological courses to ensure provision can be accessed for all at the entry level)

- (b) Position in the Healthcare Community. A desire to be included, viewed by patients and staff as an equal with other professionals in healthcare.
- (c) Involvement in the Healthcare Community. A wider acceptance and involvement of the role of the chaplain and spiritual care within the healthcare provision.
- (d) Confidentiality. A need to be offered full access to patient confidential information particularly in the area of religious and spiritual care. (The question of Data Protection and Human Rights Act implications).
- (e) Recording Patient Information. A need to be enabled to contribute to patient record information

2) Visualising the Future:

- a) Delegates were asked to choose a theme from the six main elements of the Caring for the Spirit Strategy (Evidence Based Care; Multidisciplinary Working; Multi-faith work; Professional Standing; PPI and work with community'; Leadership; Any other) and to visualise the characteristics of a future service that included that element and how it would differ from the present practice. They were asked to explain how they got to that point and also what they needed to get there. The groups were small and three points only were picked up. They were 'Evidence Based Care', 'Multi-faith Working' and 'Professional Standing'.
 - i) **Professional Standing:**
 - (1) The Future – cease to be invisible; be seen and known; equality with AHP, viz. Statutory Regulation, Professional NHS Status, Inclusion, Fully Staffed, Trusted with access to confidential patient information, meet with other professionals.
 - (2) Achieved by - registration/ recognition, creative adaptation, training, formation as a generalist first. Do away with denominational requirements, review corporate acts of worship in hospitals. Conduct ourselves professionally.
 - (3) Needs - Recognition and inclusion.
 - ii) **Evidence Base**
 - (1) The Future – Staff sensitive to the spiritual needs. A system designed to meet those needs. Spiritual needs defined as patient care needs; Evidence of intervention outcomes.
 - (2) Achieved by – an educational programme for staff and patients. Perceptions modified. (E.g. currently many see chaplains as not directly part of the NHS, but part of a church/ faith group provision.)
 - (3) Needs – Education programme.
 - iii) **Multidisciplinary Working**
 - (1) The Future – Accepted and recognised for a particular expertise within MDT groups. An accepted understanding of holistic care and spiritual needs and care as part of that, an integrated component of healthcare.
 - (2) Achieved by – Education/ Status improvements, Prayer, Champions in high places
 - (3) Needs – Resources for nursing education, champions to lead the way.

3) The Way Forward

- a) There was an expressed desire that the collaborative has 'local' ownership by which it can be guided and directed. It was explained that it was the intention to enable that in common with other collaboratives that were forming in the South. Several chaplains offered to be a part of that and further discussion is needed with the SHA to enable that to be put into operation.
- b) It was clear that a number of issues emerged in the group exercise and these could form the basis for an agenda for the next meeting.