

SOUTH WEST STRATEGIC HEALTH AUTHORITY

Minutes of the **Devon and Cornwall area Caring for the Spirit Collaborative** held at **The Royal Devon and Exeter Hospital, Exeter on 14th February 2007.**

Present:

Revd Mandy Churcher	South Devon Healthcare Trust
Rev'd Preb. Philip W. Darby	Ashburton and Buckfastleigh Hospital.
Revd P Eastwood,	Chaplain, Exeter (Devon PCT)
Simon Franklin	Chaplain Ottery St Mary Hospital
Revd John Garner	South Devon Healthcare Trust
Juliette Hall	Chaplain Royal Devon and Exeter
Rev Tony Kyriakides-Yeldham	Derriford
Rev'd Prebendary John Good,	Axminster
Revd David James,	Sidmouth
Revd David Luce	South Devon Healthcare NHS Trust
Revd Dan Papworth	Royal Devon and Exeter (hospice)
Revd Allan Sheath	Honiton Hospital
Revd David Walford	Royal Devon and Exeter

Apologies:	Revd Derek Hill,	Devon PCT
In Attendance:	Revd Peter Ellmore	Caring for the Spirit Strategy

- 1) The aims of the day were to gain some familiarity with the spiritual aspects of the DH Policy (the levers and drivers of change) and to enable opportunity for reflection on new models of practice and service.
- 2) Revd Mike Williams, CE of Musgrove Park hospital and the Taunton and Somerset NHS Trust was unable to attend due to sickness and sent his apologies. In the circumstances Peter Ellmore spoke to some slides that Mike had used at a similar presentation about nine months ago to the Dorset and Somerset Caring for the Spirit Collaborative. This addressed the driving forces behind government policy (economic) and their impact on health policy and direction (a trend to limiting and rationing costs, competition and provision of local and individual patient needs - slides are attached). [Presentation re policy drivers etc.](#)
- 3) Peter Ellmore offered some examples of NHS Policy that included aspects of spiritual healthcare. A good example is found in The Standards for Better Health (SfBH) and the Developmental Standard D2 that contains the element of spiritual care that will come into force within the next year or so. Trusts will have to demonstrate to the Health Care Commission their developmental progress and compliance with the standard using evidence from their Clinical Governance and Local Policy. Chaplains could assist the process by identifying elements of spiritual healthcare that matched the standards or could be developed within their services. (See slides attached from Susan Gooding of Wiltshire PCT– [National Standards - Chaplains](#))

- 4) Consideration of chaplaincy models of service and practice are useful when working with the Trust to devise business plans that engage with Trust aims. (see slides attached [Models of Practice and Service](#); [Business Planning](#))
- 5) The material of the presentations fed into discussion.
 - a) The following points were raised regarding the Developmental Standard :
 - i) To comply with the Developmental Standard D2b of SfBH there would need to be comprehensive assessment of the patients needs.
 - ii) Current attempts at assessment of spiritual needs are weak. Eighty per cent of the 'religion' categories of the patient records are left empty.
 - iii) Staff are not equipped to carry out spiritual assessment nor do they have sufficient awareness or knowledge of the subject.
 - iv) Assessment needs to be carried out by open questions, not 'What is your religion?'
 - v) Some developing practice of spiritual care can be found in areas using the Liverpool Care Pathway. This is still suffers resource and time limitation. Needs are not always met.
 - b) The following were raised regarding development of Trust Policy for Spiritual Care and Business Planning and engaging with Trust policy development.
 - i) Some chaplains working in community had no idea who their Line Manager might be. They were therefore unsupported by the NHS in the provision of the pastoral care that they offered. They drew their resources from their church base. 'Who is my Line-Manager?' is a question faced by all ministers!
 - ii) Examples of working policy for spiritual care would be useful to the collaborative (these had been shown last year at a meeting of the Avon Gloucester and Wiltshire Area collaborative and would be shared with the Devon and Cornwall group – see attached [Spiritual Healthcare Policy – Feb 2005 Gloucester Hospitals](#)).
 - c) Specific points discussed by the group were connected with management and supervision and the provision of spiritual care: What does a chaplain do that a volunteer cannot?
 - i) Differences of fact exist between the breadth and extent of Knowledge and Skills as well as the Time that can be offered by a chaplain and a volunteer. The Chaplain is considered able to offer more.
 - ii) Extensive training and formation of the chaplain marks a difference.
 - iii) Continuity of ministry was a significant factor. Chaplains have potential to be more regular.
 - iv) Voluntary ministry might suffer a poorer quality of overall care due to lack of continuity/ reliability (ed. note – experience in some Acute and Mental Health settings is that properly trained and supervised volunteers can be very effective and offer very high quality of care).
 - v) Volunteers may suffer excessive zeal and be treated with the status of visitor.
 - vi) Good volunteers, however, are often integrated well to the service and regarded as members of staff. The key is good management of volunteers.
 - vii) The paid chaplain can oversee a group of volunteers. That can be an efficient way of offering basic pastoral care to patients. Difficult or complex cases are then referred to the chaplain by the volunteer.
 - viii) A Chaplain is a paid professional, usually a minister of Word and Sacrament.

- ix) The role of chaplain in the hospital is divided between that of NHS Manager and that of faith community minister or priest.
 - x) A chaplain carries a statement about the ethos of the institution that recognises spirituality.
 - xi) A Chaplain reflects humanity and represents the local community.
 - xii) A Chaplain in a hospital is a statement.
 - xiii) Spirituality is what a chaplain does.
 - xiv) Conclusion is that the roles of Chaplain and Volunteer are different but complementary.
- d) Some discussion was made around Models of Service. The proposal of a model of service that could be staffed by a single chaplain maintaining a team of volunteers was questioned. It is a model that has been proposed (controversially) in Worcester.
- i) It was felt to be flawed. 80-90% of those serviced in the hospital by the chaplain are of no particular faith group, struggling with faith issues/ connections. A theology of 'lose ends' serves them. Volunteers might find dealing with the breadth of patients in this category challenging. It requires specialist knowledge.
- e) A question discussed was 'Theologically, where are we as chaplains, given where the NHS is today.'
- i) Whole-time chaplains are in danger of becoming bureaucrats, deskbound in a management role often without administrative assistance.
 - ii) Parishes and mission communities required 20 hours per week administration assistance to the minister.
 - iii) Other NHS professions required 20 hours per week patient contact time to maintain practice.
 - iv) Being with people with faith issues, taking their lead in dialogue and encounter is what marks us out as priest when functioning as chaplains.
 - v) We meet people where they are. They recognise us as Christian Ministers. They are happy not 'to belong' but are happy to 'be with us'. We address their heritage.
 - vi) 'I know where I am theologically, called as a servant to all. Even when I cannot fulfil a need, 'I know a man who can.'"
 - vii) We have an essential role in 'representation' of Christ and the Church (incarnational role).
 - viii) We are doing and living a practical theology.
- 6) Outcomes – Some possible points for action by the collaborative
- a) A local policy for spiritual healthcare could usefully be developed in every Acute Trust by working interactively with existing management structures and local healthcare policy aims.
 - b) Opportunity for inclusion and participation in patient audits should be sought in every Trust working through Clinical Governance departments.
 - c) Work is needed through the Primary Care Trusts to establish management and policy structures for community chaplains.
 - d) There is an expressed need for a support network to be established within Devon PCT for spiritual healthcare.
- i) The Next meetings of the Collaborative are proposed
 - (1) 30th May 2007
 - (2) 19th September 2007.