

DORSET AND SOMERSET STRATEGIC HEALTH AUTHORITY

NOTES FROM THE CARING FOR THE SPIRIT COLLABORATIVE CONFERENCE WHICH TOOK PLACE AT THE HOLLIES ON WEDNESDAY 18 JANUARY 2006

1. Jane Barrie opened the proceedings by welcoming everyone and stressed that spiritual healthcare is a very important part of the NHS Agenda.
2. The Reverend Peter Ellmore, who is lead Chaplain for the South of England, gave a presentation: 'Introducing the Strategy' and said that the strategy supports chaplaincy collaboratives within the NHS and emphasised the need to work closely with the carers and clinicians.
3. He said that an NHS Strategy for Chaplaincy and the Spiritual Healthcare Workforce was in place:
 - "to enable individuals and groups in a healthcare setting to respond to spiritual and emotional needs and to the experiences of life and death, illness and injury, in the context of a faith or belief system".
4. There were hidden assets with regard to certain aspects of the organisational development relating to the big difference to care being seen as part of the developing opportunities for those from different faiths working together. A problem voiced was that people were reporting to too many different managers. It came across that whether working in a community hospital or hospice with a range of chaplains from multi-faith backgrounds, chaplains needed training and educating as to how they could best contribute to spiritual healthcare. The foundation for the future is training different cultures to learn how to adjust to different faiths and make chaplaincy a crucial part of healthcare development.
5. The aim is that by 2010 all chaplains and co-workers:
 - should be delivering an evidence based system of care;
 - that chaplains should be members of the Healthcare Professional Workforce;
 - that they should support multi-faith working which respects all;
 - that they should demonstrate a professional standing through education pathways;
 - that they should contribute to the leadership of healthcare services;
 - that they should forge effective links with community groups and faith groups both local and national.
6. Patient involvement is important and helpful in identifying what is necessary for the patient to make a difference to their lives. It must not be forgotten that specialist knowledge which is gained through training and experience is needed to be a chaplain and as such chaplains have an enormous contribution to make to towards the peace of mind and well being of the patient that can aid health and healing.

7. It is important to have a record system. Chaplains need to ask themselves if they are working in the most effective way and it was also suggested that there should be a spiritual input into audits. Chaplains need to document and exchange good practice.
8. Chaplains must remember that they are part of the Healthcare and Professional workforce. The main element of their experience is working in conjunction with other healthcare professionals and it is important for the patient to know that the chaplains work as part of a multidisciplinary team for their healthcare, not just on the religious side but also from the general support they can offer.
9. We need to share information within the bounds of confidentiality, and care and work within a pluralistic network of care. Chaplains will have information fed back to them and they will be called upon. It is important to remember that other carers are also charged with spiritual care whether physical, mental, spiritual or medical.
10. There is a need to establish good relations with local faith groups, identify the needs of minority groups and remember we live in a pluralistic society which in itself identifies the need for recruiting and training spiritual health carers of all faiths and beliefs.
11. It was thought to be important for chaplains to have an annual appraisal which would tie in with the agenda and the growth of the hospital. It is also important to keep up-to-date with training and to listen to other people. 'Calling', 'vocation', 'profession' and 'training' should not be in conflict but should blend in together. It was suggested that the achievements of chaplains should be recorded and put together to build a personal portfolio.
12. There should be creative ways of dealing with pressure and chaplains should engage positively with the NHS agenda for healthcare and bring spiritual insight into the workplace. It was suggested that it might be useful to have a chaplain who could speak regularly with the board of a Trust or PCT. There are, of course, the attendant social issues of justice and equality and ethical issues and contributing to ethical committees.
13. In our pluralistic society effective links should be made with community groups in line with the recognition of the validity of all faiths and information should be shared on a 'need to know' basis. The data protection act was mentioned and the need for confidentiality was stressed plus the problems of asking the patient whether they would like the support of a chaplain.
14. It was noted that there are funding concerns and also that Primary Care Trusts are not easy to approach. Many chaplains are part-time and the question was raised as to whether or not the Government would make extra money available to ensure a 'joined up' spiritual care service.
15. It was stressed that the aim of the chaplaincy collaborative is:

- to support and secure the development of spiritual healthcare within England;
 - it should be a forum for audit and research;
 - it should be a forum for developing good practice;
 - it should enable the progress of training issues and workforce development and modernisation
 - it should develop links with educational providers and others;
 - it should provide a training environment for trainee chaplains and volunteers;
 - and provide a forum for public and patient involvement in relation to spiritual healthcare.
16. There was a group work session where those present broke away into smaller units, bounced ideas off each other and centralised their own ideas. During this time it was voiced that multi-disciplinary working was the way ahead and to achieve this chaplains should be involved and included in board level meetings possibly at non-executive director level.
17. There should be better communication between patients, clinicians, carers and chaplains and this should generate trust and confidence and confidentiality as and when the need arises.
18. The Reverend Dame Sarah Mullally gave a presentation in the afternoon with the emphasis on leadership for chaplains in the NHS. She stressed that people did not have to be at the top of their professions to be leaders, nor did they have to have power, authority and status. Their aim should be a determination to improve things for others. To this end they needed:
- encouragement from managers;
 - qualifications;
 - professional ability;
 - to be proactive;
 - have a willingness to learn;
 - to be approachable;
 - to have integrity;
 - to develop an emotional intelligence;
 - to learn to speak people's languages with regard to spiritual needs;
 - to be able to take risks in order to change things for the better.
19. There should be an investment in leadership and a drive to increase the number of people with leadership skills and, ideally, more training for potential leaders.
20. She stressed that it is necessary to focus on individualism and not individuality and to show how to make the NHS meet people's needs.
21. A future vision of healthcare chaplaincy should be:
- patient choice;

- an integrated model of care;
 - ritual equivalence (how do patients want their individual needs met);
 - ritual responsibility (understanding meaning and language);
 - generic and faith based chaplaincy;
 - community and NHS accountability recognising and working across organisational boundaries to enable patient care.
22. A future model of healthcare chaplaincy is:
- building the health care capacity in the faith community;
 - building the spiritual capacity of the NHS;
 - providing specialist spiritual advice;
 - meeting complex spiritual needs;
 - providing strategic spiritual direction in the NHS;
 - providing leadership.
23. The conference was very well attended and very successful. Feedback has been very positive. One comment was that it would be useful for members of the group to share areas of good practice and developments with the rest of the group. Someone said that they could see the direction of “Caring for the Spirit” and could identify some of the potential difficulties.
24. One of the attendees felt rather overwhelmed by the amount of issues raised/discussed. Whilst he realised a collaborative had to start somewhere, he felt there were too many issues. Also some issues need to be addressed nationally (i.e. Data Protection) and a country-wide agreement is needed which would come from collaboratives, and some of the issues need to be addressed locally.
25. Another person said that during the day she had achieved:
- a greater understanding of the varieties of chaplaincy across a wide range of hospitals/healthcare facilities;
 - affirmation was received that what she had been doing was fine;
 - a desire to build bridges between hospitals and faith communities needs to be enhanced.
26. One of the hospital managers said that he would like to see a development of the interface between spiritual care providers in acute settings and those in the community/other trusts be they mental health, community hospitals, community midwives and nurses.
27. The conference was the first of it’s kind to take place within the Strategic Health Authority . The second conference is due to take place on Thursday 11 May 2006.