DORSET AND SOMERSET STRATEGIC HEALTH AUTHORITY

NOTES FROM THE CARING FOR THE SPIRIT COLLABORATIVE CONFERENCE WHICH TOOK PLACE AT IVEL BARBARIANS ON THURSDAY 11 MAY 2006

1. The Reverend Peter Ellmore, lead Chaplain for the South of England, welcomed the members to the second Caring for the Spirit Collaborative held by the Dorset and Somerset Strategic Health Authority at Ivel Barbarians Rugby Football Club in Yeovil. He passed on Christine Whitehead's apologies for her non-attendance owing to the exigencies of the NHS.

2. Peter gave a synopsis from the feedback of the last collaborative meeting held in January.

   a. What was achieved/gained at the first meeting?

      (i) Professional:

      - insight to Managerial/Professional issues;
      - insight to Caring for the Spirit Strategy;
      - insight to Collaborative working;
      - insight to Leadership;
      - shared practice.

      (ii) Individual:

      - support/networking;
      - shared experience;
      - shared dreams and ideas.

   b. What needs do you have?

      (i) Professional:

      - management issues/standards, competencies;
      - further understanding of the Cfs Strategy;
      - application of the Cfs for my setting;
      - multidisciplinary team work;
      - access to continuing training;
      - share best practice
      - community issues;
      - develop inter-professional relationships.

      (ii) Individual:

      - contact with others/support;
      - inspirational speakers.

c. Visualising the future.

(i) What will it be like?

- different.

(ii) How did you get there?

- willingness to change practice;
- education.

(iii) What did you need to get there?

- planning;
- meeting with others;
- new standards;
- training;
- change of practice/culture/policy;
- taking risks.

3. The importance of collaborative meetings was stressed, viz: to ensure the modernisation of the Chaplaincy Department and the integration of the service with the clinicians and those dedicated to the healthcare of the patients. Peter informed the attendees that an analysis of the results of the feedback from the last meeting indicated a need for a programmed series of meeting to ensure action for change. He also stressed that the drivers for change were embedded in the NHS policy for healthcare. The next three meetings are sequenced to example how closer multidisciplinary team work might be achieved:

a. Today's meeting is aimed towards developing local strategy for spiritual healthcare and is focussed upon the policy drivers at work in the NHS and how we might consider those in our local strategy and business plans.

b. The next meeting will consider how we make our services known and transferable through simple and practical data and information recording methods.

c. The third meeting will aim at defining some new methods of working and collaborating with other healthcare professionals for patient spiritual healthcare.

4. A small representative group is proposed to ensure governance, ownership and continuity to deliver the Strategy. The Strategic Health Authority is going through a 'reformation' and there are a lot of unknowns. Until the new authority is formed we won't know who will take strategic responsibility for spiritual healthcare. We need a discussion on how we manage this collaborative and it was suggested that a small group of experts should be formed to decide on how we can go forward. The aim of the collaborative is to meet once every four months and maintain links with the Dorset and Somerset Strategic Health Authority.

5. The Chief Executive of Taunton and Somerset NHS Trust, The Revd Mike Williams, gave a presentation: 'The Impact of NHS policy' – what is happening in the NHS and how that will impact on staff and patients and what is happening in the wider NHS undergoing change. Mike's status also as an ordained minister enables a unique insight from both faith and management perspectives. He explained that there will be one regional health authority covering the south west and reiterated that there will be a huge amount of change in future provisions but he did say that from the very top of the NHS the Caring for the Spirit Strategy was considered an extremely important issue.

4. Mike said that the NHS is a producer and not a consumer orientated organisation and said that how we provide healthcare is being looked at although costs were rising faster than the funds were forthcoming. Patients want more and deserve more The Government policy is about choice, to give patients choice and part of this is being achieved by:

- payment by result – money follows the patient;
- practice based commissioning;
- independent sector treatment centres;
- national standards and inspection.

5. Financial levers are being brought to bear to reflect choice and this applies to care in an acute hospital and 80% of the income is covered by results. The impact for patients with increased choice could:

- bring about uncertainty due to service fragmentation;
- increase efficiency with a shorter stay in hospital;
- create a potential lack of continuity in care;
- give a common set of standards for health;
- motivate us to do things differently because of living with competition and risk.

6. 60% of patients are admitted to hospitals the day before surgery which is more like a 'Bed and Breakfast' approach from a cost point of view. Mike said that in the USA patients are normally operated on the day they arrive at the hospital and don't see their respective wards until they have had their operations.

7. There is a set of rules private organisations can sign up to prior to working for the NHS. The money follows the patients no matter where they go to be treated and some could argue that we are fast reaching a stage of 'conveyor belt medicine' which necessarily makes the roles of the Chaplains extremely difficult. The public sector is now being run as a commercial organisation and thus there could be unforeseen consequences.

8. There has been a huge expansion of Chaplains and volunteers in hospitals and a greater significance is being put on emotional and spiritual needs not only for the patients but also for the carers. The Chaplains have an extremely valuable part to play having the time to listen and to show understanding. When people are in hospital they are at their most vulnerable and are very often desperate to

speak to someone. Communication is important and there is anxiety in waiting. The clinicians are very often too busy to stop and talk and reassure. It is in our commercial interest to listen to the patients.

9. In response it was voiced that at Shepton Mallet, for example, which is an Independent Treatment Centre used by the NHS, there is no room for Chaplains due in no small part to the fact that the policy is to treat people as quickly as possible and ensure that as soon as they are treated they are released. It was also noted that many hospital chaplains feel redundant.

10. It should be noted that the Department of Health contractual arrangements specify that should patients require spiritual care then steps should be taken to ensure that it is provided. However, that is not the same as those services provided by a retained/employed chaplain etc.

> *'The DH policy is that the Contract for electives specifies the following for Chaplaincy services (Schedule 16 of the Service Agreement): "The Provider shall procure NHS chaplaincy services (or services equivalent to NHS chaplaincy services) for the benefit of Patients and any relatives, carers, and friends upon any reasonable request from such persons."*

11. Canon Jane LLoyd gave a very moving presentation 'Touching Lives' in which she described a service she had held of encouragement for women and men affected by gynaecological cancer. The service was secular and the combination of an approach by the Gynaecological Cancer Clinical Nurse Specialist and Canon Jane's own experience. She used non-religious readings, poetry and secular music. Canon Jane also talked about the prayer web she and some others made with balls of wool, leaves with their written prayers and candles which again has proved a huge help for everyone. The presentation Jane gave was published in the College of healthcare Chaplains Journal 2005, issue 6, volume 2, p32.

12. Reverend Father Declan McConville also gave an excellent presentation which he had used when visiting schools entitled 'Care of the Dying' in which he talked about grief and bereavement and the journey through to the recovery process. To the poignant music of Cold Play he talked us through the journey of grief.

13. Discussion groups considered the 'drivers and levers' affecting strategy and were encouraged to use these to inform their own planning in conjunction with local management.

14. Summing up it was noted that:

- there are huge financial pressures in the NHS and that where there is no funding some are still visiting hospitals to offer support to patients;

- there is also understaffing;
- the culture of our society is changing;
- Chaplains need supervision and support;
- there is a great deal of time and energy used particularly by those working from a parish base and as Chaplains in a Trust, having to see to the needs of patients and the needs of the parish.

15. Some aims could be discerned but also moderated by limitations:

    - a bigger budget was desirable;
    - could there be other streams of income;
    - however much money is poured in, it will never make money;
    - much of spiritual healthcare cannot be measured;
    - we need to spend otherwise the quality will drop;
    - patient experience is the key.

16. All were charged with 'homework'. The task set is:

    a. **Use the insights gained by the group to inform your own situation. Devise a strategy for spiritual healthcare by working in consultation with key partners in your own Trust.**

    The aim is to design a project that will change the way in which spiritual health is delivered to a sector of patients and staff in your Trust.

17. A small governing group was proposed and will meet to plan the following meetings. Peter closed the meeting and said that the next meeting will be in September although a date and venue have not as yet been decided.

Developing a local Strategy for Spiritual Healthcare

Some Basic Considerations

1) **Driver**
   - ***a) Local Trust policy directions***
     - i) What are upcoming developments?
     - ii) Where is change forecasted?
     - iii) How could spiritual healthcare be affected?
   - ***b) National NHS policy e.g.***
     - i) Standards for Better Health July 2004
     - ii) Creating a Patient Led NHS March 2005
   - **c)** ***The Evidence Base***

     (Making sense of your perceptions – Your market research)
     - i) (Inter)-National Research findings
       - (1) Peer assessed journals etc.
       - (2) CHCC journal, SACH journal
     - ii) Local Audit of Patient Services
       - (1) What do your patients need?
       - (2) e.g. SYSHA Foundation exercise of PPI June 2003
       - (3) e.g. Patient Survey – Sheffield Teaching Hospitals
     - iii) What can/ should the service provide?
       - (1) Breadth of skill
       - (2) Resource limits/ constraints

2) Definition of the Service
   - ***c) A Vision Statement***
     - (what you want to be/ what your Trust wants you to be)
   - ***d) A Clear Mission Statement***
     - (what you/ your Trust want you to achieve)
   - ***e) Defined SMART goals and objectives (for the service)***
     - Specific
     - Measurable
     - Achievable
     - Realistic
     - Time-related
   - ***f) Local Quality Standards***
     - (agreed with your management)
   - ***g) National Chaplaincy Standards***
     - (applied to your service)
     - iii) NHS Chaplains Meeting the Religious Needs of patients & staff
     - iv) NHS Caring for the Spirit Strategy
     - v) Healthcare Chaplaincy Occupational Standards
     - vi) Spiritual Healthcare Quality Standards