

SOUTH WEST STRATEGIC HEALTH AUTHORITY

Minutes of the **Dorset and Somerset Caring for the Spirit Collaborative** held at **St Margarets Hospice, Yeovil** on **18th September 2006**.

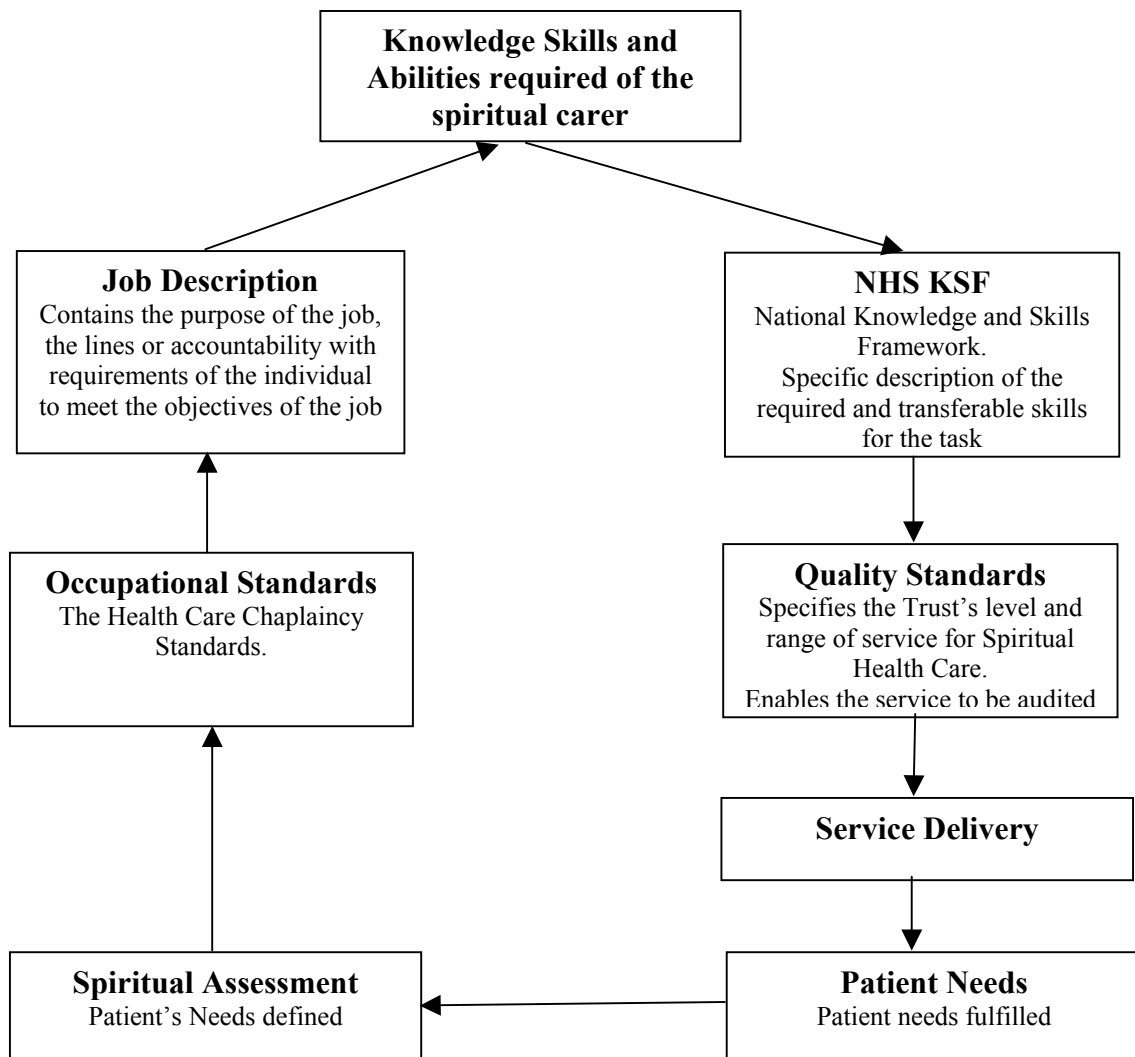
Present:

- Revd Canon Jane LLOYD Poole
- Ms Fay Wilson-Rudd Somerset Partnership
- Ms Julie Vale St Margaret's Hospice, Yeovil
- Matron Janet Wright Mendip PCT
- Matron Pauline Woodward South Dorset PCT
- Revd Alison Vercoe Somerset Partnership NHS and Social Care Trust
- Revd Declan McConville Poole NHS Trust
- Revd John Rothewell Yeovil NHS Trust
- Revd Kenneth Coles Somerset Partnership
- Revd Mary Godin Taunton and Somerset NHS Trust
- Revd Michael White Mendip Primary Care Trust
- Revd Robin Ferguson South and East Dorset PCT
- Ms Virginia Membrey Somerset Partnership NHS and Social Care Trust
- Ms Penny Fennel Dorchester NHS Trust
- Ms Judith Lawrence West Mendip PCT

In Attendance: Revd Peter Ellmore Caring for the Spirit Strategy

1. The meeting was the 3rd of the Dorset and Somerset area. The aim of the day was to enable chaplains to demonstrate the content of spiritual healthcare by means of a form of spiritual assessment and record keeping for their work. The agenda was split into three defined areas for attention, viz. assessment, standards, and recording methods.
2. The collaborative was presented with the Terms of Reference for the Steering Group and these were agreed subject to minor grammatical correction.
3. A short presentation of a research paper 'Engagement of patients in religious and spiritual practices' by Bussing et al was given by Peter Ellmore. The research was conducted in Germany and related to a Quality of Life questionnaire. It concluded that five types of spiritual practice were commonly found in the research subjects who were a range of patients. This had implications for the range of services that all that chaplains and spiritual carers could offer or facilitate as well as how such types of spiritual need could be assessed. (Powerpoint handout attached)
4. A simple form of spiritual assessment was introduced by Julie Vale of Somerset Coast PCT. This was trialled by the collaborative members in the form of a self assessment (copy attached for reference). Its form provides opportunity in a non threatening manner for anybody to reflect on the essence of their spiritual life.
5. The range of activity that may be encompassed by chaplains is described in the Healthcare Chaplaincy Standards (The can be found on the Multifaith for Healthcare Chaplaincy Group web site <http://www.mfghc.com/> or the Chaplaincy Academic

Accreditation Board web site <http://www.caabweb.org.uk/>). The relationships between the Chaplaincy Occupational Standards, Job Descriptions, KSF and Quality Standards were explained (see diagram).



6. Jane Lloyd presented the factors to be considered for the design of a Job Description (Several chaplains in the community commented that they did not have Job Descriptions). Notes for her presentation are attached.
7. In group discussion the following points were noted:
 - 7.1. Arrangements for management of Chaplains in Community settings are not well defined. They can be retained by an arrangement through the churches without selection, clear source of funding, payment of expenses, level of service agreed, a Job Description or definition of line management. (e.g. There is not a clear view of the service that is offered. Related comments were, who is the line manager, matron, local vicar or the PCT chaplain?)
 - 7.2. Training and support were an identified need for Community Chaplains

- 7.3. A specification for the provision or commissioning of spiritual healthcare by PCTs needs to be designed to ensure that appropriate services are able to be offered by the reconfigured NHS healthcare.
- 7.4. It would be desirable to determine the current arrangement and level of service that exists in PCTs. Such questions as, what is spiritual healthcare and how will it be accessed by the PCT on behalf of the patient require answers?
- 7.5. Issues for Mental Health Chaplains:
 - 7.5.1. Inconsistencies in job descriptions for chaplains employed in the same Trust.
 - 7.5.2. Personal Development Review. Not all have received or completed it.
 - 7.5.3. Uncertainty of funding source for training and associated extra sessions.
 - 7.5.4. Access to continuing training.
 - 7.5.5. Lack of equipment.
 - 7.5.6. A positive comment was that they felt well supported.
8. Recording chaplains and chaplaincy activity.
 - 8.1. Comment by member, *"If it does not appear in the patient's notes, then it has not happened"* A lot of what chaplains do is not recognised because it is not known about. Multidisciplinary work demands that information is conveyed.
 - 8.2. Evidence from report in the collaborative indicates that practice is not consistent.
 - 8.2.1. Some chaplains have word lists
 - 8.2.2. Others have their own lists on which they note patient needs
 - 8.2.3. Some compile records and retain them in a filing cabinet.
 - 8.2.4. A few have PC based Data base records
 - 8.2.5. Some summarise their records each month.
 - 8.2.6. One has an integrated electronic system that can produce reports with ease.
 - 8.3. A question of what it is for, arose. Two reasons.
 - 8.3.1. The record of activity can be used to ensure that management understand what is done with patients and staff so that judgement about the most effective use of the service can be made.
 - 8.3.2. A record will ensure that patients receive care that is timely and appropriate.
 - 8.4. Issues about Data Protection and Patient Consent arose. How and where are chaplains permitted to record anything?
 - 8.4.1. Some Trusts have solved the issue by allowing access to patient notes on a 'need to know' basis. (Cfs is working with DH to resolve the question of patient consent. Further work will be needed to ensure that spiritual health care is inbuilt to the new electronic patient record.) Local and practical arrangement must be negotiated with Caldecott Guardians and nursing leads etc.
 - 8.4.2. Chaplains should not keep their own permanent patient records. Details of factual encounters with the patient should only be recorded in their notes.
 - 8.5. N.B. *"If it does not appear in the patient's notes, then it has not happened."*
9. Spiritual Assessment – This is a subject for future exploration.
 - 9.1. Current practice is not defined
 - 9.2. A common method in use is for chaplains to attempt a pro-active 100% visitation of patients with enquiry. Spiritual needs arise in conversation or in response to direct questioning, e.g. 'Would you like holy communion? Or, would you like to come to chapel services?' This approach is not a very comprehensive assessment and is apt to be subjective or led by the chaplain.
 - 9.3. Assessment is often made by listening and responding to a patient's story (narrative).

- 9.4. Several methods of assessment are being trialled in Somerset Partnership MH Trust.
 - 9.5. Needs may be defined through a referral from another member of staff or the patient's faith community.
 - 9.6. A comment was made that chaplains in Ireland are trained using the Clinical Pastoral Education model. That model seemed to be recognised, understood and accepted by other disciplines in healthcare. As a result the chaplains were also recognised, their gifts and abilities known and valued etc.
10. Some challenges for the collaborative:
- 10.1. Develop models of spiritual assessment that are practical and effective to identify patient spiritual needs.
 - 10.2. Obtain permission and training (by negotiating with Caldecott Guardians and Nursing Leads) in every Trust to write into patient notes.
 - 10.3. Inform emerging PCTs about the needs for commissioning spiritual healthcare (this will need the help of the new NHS SW lead in spiritual healthcare – yet to be identified).

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19/09/06

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