



Chaplaincy Collaborative

Avon, Gloucestershire and Wiltshire
Strategic Health Authority



Opportunity Knocks!

Steve Henderson - Swindon

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1

I've entitled this presentation "Opportunity Knocks".

Time to change



A Cinderella Service?

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2

Suddenly something amazing happened. As Cinderella was sitting all alone, there was a burst of light and a fairy appeared. "Don't be alarmed, Cinderella," said the fairy. "I know you would love to go to the ball. And so you shall!" "How can I, dressed in rags?" Cinderella replied. "The servants will turn me away!"

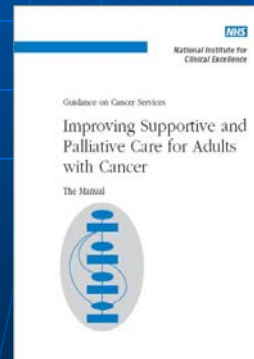
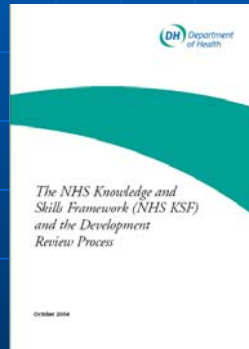
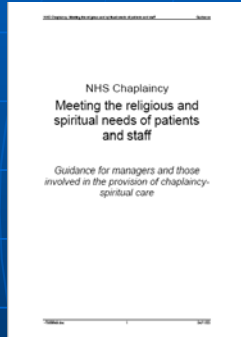
When I started in full-time chaplaincy service in 1998 I remember walking into the hospital, full of anticipation about what the days were going to hold and how, having come from the Baptist church, there was an expectation that in the hospital I would have a clear role and clear expectations put on me from my new boss. I arrived in my office only to find a small red book (from the Free Church Federal Council) With various sections to fill-in the blanks to get me acquainted with the Senior Nurse, the Locality Manager, the Catholic Chaplain, the Personnel Manager and my Line Manager. All were filled in but with no sign of my line manager. I was then to discover that he had been off sick for about a month and I never saw him.

Then, as I was to discover to be a common experience for chaplains I was eventually given a line manager, the Director of Operations, who told me that she had no idea about what I did but as long as I just got on with the job we'd get along just fine. She became a firm friend and seemed constantly surprised by what her "Vic the vicar" got up too. I recall on one occasion, when I showed her the Occupational Standards suggesting that she might want to use these in conducting my appraisal, she looked bemused and said "Oh so that's how you do your service is it?" And things have moved on from there.

HEALTH CARE CHAPLAINCY OCCUPATIONAL STANDARDS - A MAP OF THE STANDARDS



CHCC is a professional section of Amicus



Association of Hospice & Palliative Care Chaplains

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3

And moving on is what is happening with the agenda for the development of spiritual healthcare. It is clear that there is a developing framework of guidance and documentation to inform and develop best practice in the workplace.



The Japanese word on the screen pronounced “Kiki” so I’m reliably informed is made out of 2 characters, one that means “Danger” and one that means “Opportunity”.

That sums up our present situation well as we see the the NHS going through enormous change and terrific pressures being applied to its structure the powers that presently are, are forcing through the reforms and the Darwinian-like questions that face chaplaincy, need to be urgently attended to. The laid back attitude of even those few years ago has now given way to a frenetic need to evaluate and justify every last penny committed to the NHS coffers.

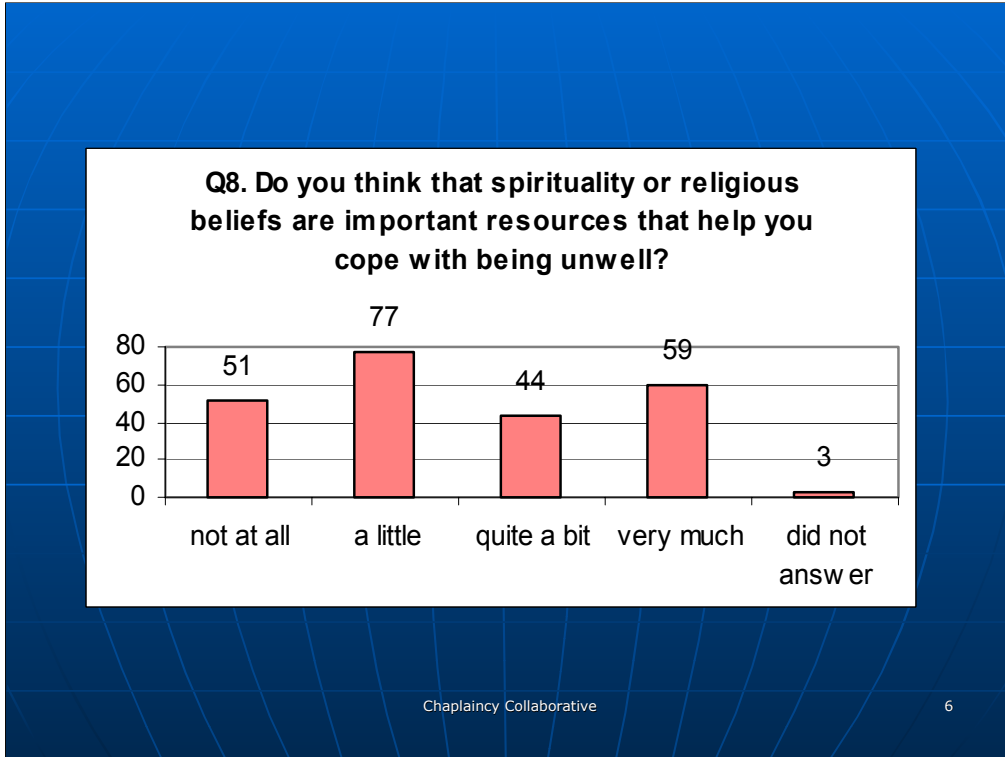
Don't re-invent the wheel



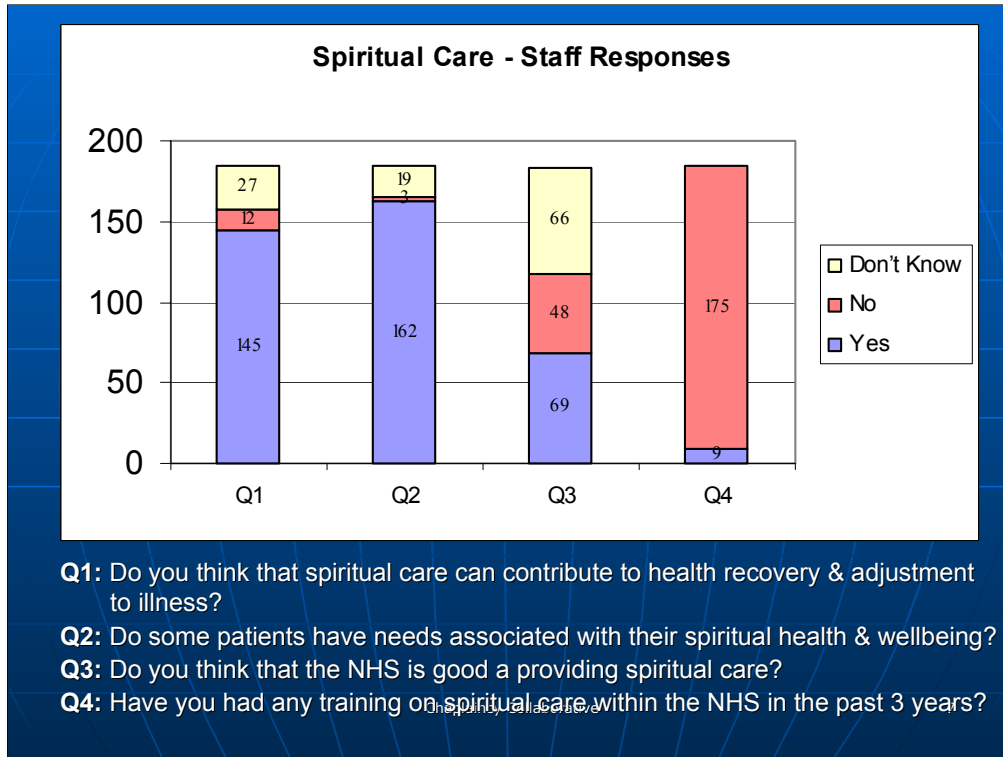
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5

Working in a chaplaincy collaborative minimises the likelihood of re-inventing the wheel in spiritual healthcare as I seek to address the questions about how a population that has less than a 7.5% religiously committed group of people can have a justifiable place in our modern NHS. The next few slides are taken from a presentation that Mark Cobb put together and these show some interesting information.



From a survey that was conducted in Sheffield last year, out of a sample of 234 people 180 of those surveyed expressed varying degrees of belief that spiritual or religious beliefs were important resources in the experience of being unwell. The second largest group - 59 in number, felt that to be very much the case.



When staff were asked the 4 questions the picture that emerges is that they feel according to Q3 a pretty evenly split opinion to the notion that the NHS is good at providing spiritual care with the minority categorically feeling we don't. What is interesting though is that only 9 of the 180+ surveyed had received any training in the past 3 years.

The inhibitions of health professionals in spiritual care:

- fear of incompetence
- uncertainty regarding personal spiritual and religious beliefs and values
- discomfort with the conditions that frequently bring spiritual needs to the surface
- lack of time, low priority
- deficiencies in communication skills
- a physical/functional focus
- environmental factors
- patient's mental and physical state

based upon Taylor, Amenta & Highfield 1995: 31

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8

Drawing on some work done in the 1990's, the staff researched displayed some lack of confidence in dealing with matters spiritual and this was exacerbated by a lack of time and a pre-occupied physical/functional focus.

“The cornerstone of the modern NHS is the ability to respond sensitively to the diverse nature of the communities it serves; all services, including spiritual ones, should be delivered appropriately to service users and NHS staff.”

“The Human Rights Act, introduced in October 2000, enshrines in law the right of the individual to religious observance. This underlines the need for NHS Trusts to provide appropriate world faith representatives and worship spaces for faith communities within the healthcare population.”

NHS Chaplaincy (2003)

It is still a core activity of the NHS that patients have their spiritual needs attended to. So there is definitely a need to urgently attend to this matter.

Religion, Spirituality, and Medicine: Application to Clinical Practice

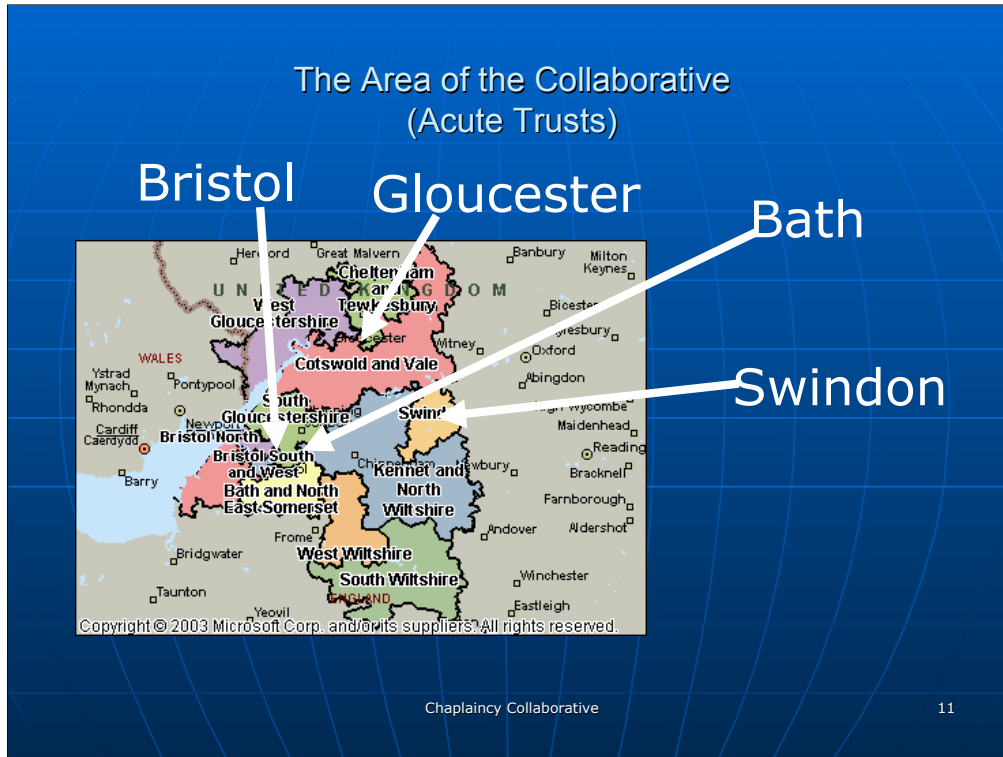
Koenig, H (2000) *Journal of the American Medical Association*

“Patients want to be treated as whole persons, not as diseases. A whole person is someone whose being has physical, emotional, and spiritual dimensions. Ignoring any of these aspects of humanity leaves the patient feeling incomplete and may even interfere with healing.”

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10

I'm sure that you can see that the conclusions of the work of Koenig across the pond further underlines the results of the Sheffield survey undertaken by Cobb. Indeed I have a strong feeling that these very sentiments have equal validity wherever you would find people struggling with the effects of being unwell.



The Chaplaincy Collaborative in the Avon Gloucestershire and Wiltshire Strategic Health Authority area is a natural development of the informal group of chaplains in the acute sector of the hospital service. The chaplains in the conurbations marked on the screen have been meeting together not often but regularly. As you can see, there are a number of areas in the Primary Care sector which avail opportunities to develop the network with chaplains who are working in them. This process is continuing and will develop as the needs or the opportunities arise.

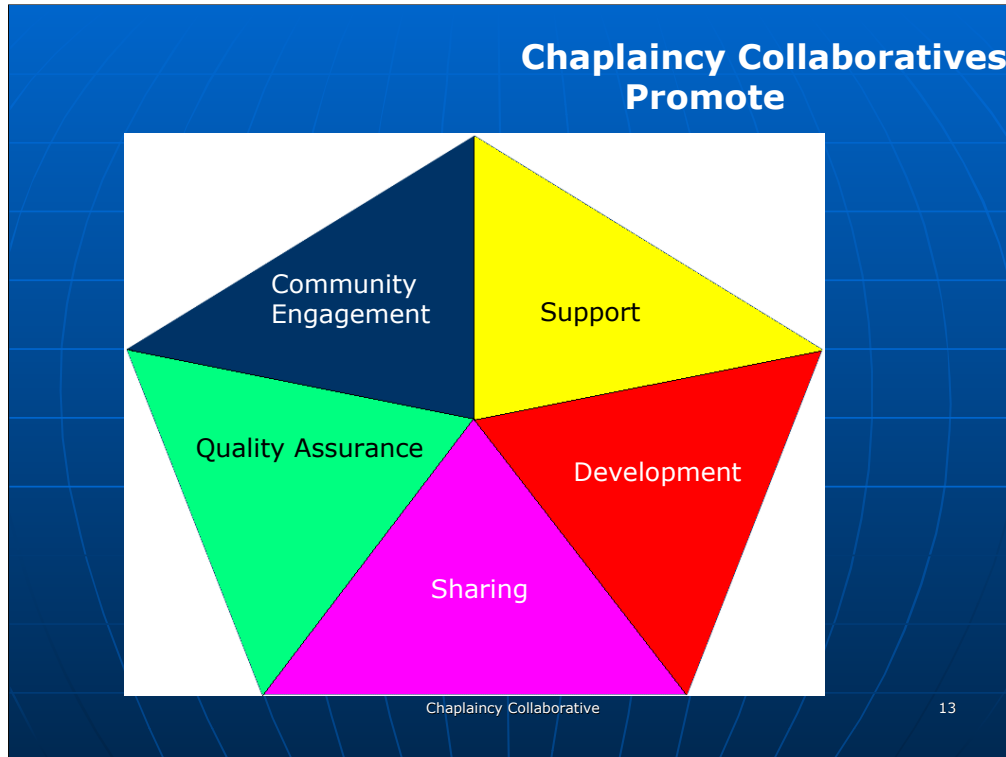
parameters of good practice in spiritual care:

- competent
- organised & resourced
- promotes the good of the patient
- ethical
- professional
- rigorous and reflective



"Many Hands Make Light Work"

Over the last years the other hospital chaplains within our SHA have been a source of challenge and support in developing my own practice in the ways shown here. Now of course, there are other fora that we can join and network with to develop practice but the advantage of networking and collaborating within an SHA means that we are to an extent (as the present financial challenge will clearly show) facing the same challenges. The collaboration will then give us a louder and more coherent voice to which we can address our commissioners (presently the SHA) to more robustly talk about these areas listed. Two or more heads are better than one or Many hands make light work.



As the screen shows, there are five ways in which
So What can be offered through working in a collaborative?

1. Provide support to secure and develop the spiritual healthcare modernisation agenda.
2. Provide a rich forum in which audit, research, education training and problem-solving can be effectively enabled.
3. Provide a forum to develop and profile raise good practice in spiritual healthcare, for all healthcare staff.
4. Address the matters of workforce development and training and promote occupational standards.
5. Provide a forum for patient and public involvement.

Levels of Expertise

- Trainee
- Practitioner
- Advanced Practitioner
- Service Manager
- Specialist Practitioner



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14

Professional Development

The richness of the relationship in being able to offer a wider degree of experience and the sharing of insight helps to replenish the energy of the approach to delivering care in specialist areas.

In my hospital I have been able to develop a chaplaincy data management system which I have been able to share with my colleagues across the SHA. In turn in a week or so I will be going to spend sometime with one of them to look at some of the work they are doing in an Emergency Care dept. we have been able to share various approaches to the development of Knowledge and Skills Framework outlines and although this is available nationally there is a cogency in all working to some agreed criteria in the same SHA.

Targets for 2010

- Deliver evidence-based healthcare.
- Work in multidisciplinary teams.
- Support multi-faith working.
- Demonstrate professional standing.
- Demonstrate effective management.
- Advocate for the marginalised.
- Network with the community.

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15

The Targets that the Caring for the Spirit strategy is flagging up for concern contribute helpfully to the development of effective business planning to provide a service that is relevant and helpful to the 21st Century NHS delivery plan.

□□ Delivering evidence-based spiritual healthcare for all users needing such care in a patient-centred fashion and to agreed standards within agreed resources;

□□ Working as members of the healthcare professional workforce in multidisciplinary teams which reflect the speciality and expertise of the chaplain in a variety of care settings;

□□ Supporting multi-faith working which respects the validity of all faiths as a pre-requisite for effective chaplaincy and acknowledges that patients and staff can expect all reasonable efforts to be made for them to receive spiritual care appropriate to their beliefs.

□□ Demonstrating professional standing through education pathways and attainments common to all chaplains and authorised appropriately by faith group mechanisms acceptable to all;

□□ Contributing to the leadership of healthcare services by effective management of spiritual healthcare and positive support to organisational and corporate objectives whilst also being able to give voice to those whose views do not accord with those of the organisation;

□□ Building effective and useful links with community groups and with faith groups locally and nationally.

Making the Connection



- Peer Support
- Service Development
- Continuing Professional Development

To close all that this is about really can be summed up easily:

A collaborative approach will help us to go on making the connection in a healthy and effective way delivering chaplaincy and bridge building between the many cultures within which we naturally live and move and have our being.



The End

Any Questions??