**NHS Education for Scotland**

**Transcript of ‘Supporting people who are bereaved in primary care’ NES Bereavement Webinar (2022) recording**

**Chair**: Dr Graham Whyte, Associate Postgraduate Dean for Grief & Bereavement, NHS Education for Scotland.

**Speakers**:

* Rebecca Adams, CCL Listening Service Coordinator, NHS Tayside
* Muriel Knox, CCL Listener, NHS Tayside
* Dr Sarah Luty, GP and Associate Advisor, NHS Education for Scotland
* Vicki Waqa, GPN National Coordinator, NHS Education for Scotland

Graham Whyte (GW): Well, good afternoon everybody. My name is Graham Whyte. I'm one of the Associate Postgraduate Deans with NHS Education for Scotland and also a Consultant in Palliative Medicine at Marie Curie Hospice in Glasgow, and I'll be Chairing this lunchtime session. So, I'd like to welcome you to the, now the 17th Bereavement webinar in, in our series. And today's session is entitled Supporting People Who Are Bereaved in Primary Care. And I'd very much like to welcome our speakers as we've got four great speakers for you this afternoon. Rebecca Adams is Coordinator for the Community Chaplaincy Listening Service in NHS Tayside. We've got Muriel Knox who's a retired healthcare chaplain living in Aberdeen. Muriel's worked mainly in mental health and now trains people for the Community Chaplaincy Listening service and also helps deliver that service. Sarah Luty, sorry, is a GP and also Associate Advisor with NHS Education for Scotland, dealing with matters of patient safety and quality improvement. And last but no means least we've got Vicki Waqa, who's a General Practice Nurse National Coordinator for NES and in former roles as an Advanced Nurse Practitioner in primary care and a Senior Charge Nurse in A&E in London. So welcome to all our speakers today.

Just to give you a bit of a, an idea as to how today's session is going to work. It's kind of split into two halves. So, we're going to have a 20-minute presentation from Rebecca and Muriel and then the second-half of the session will be handed over to Sarah and Vicki to have a kind of conversation about bereavement within, within primary care. Hopefully at the end, we'll then have an opportunity for questions and have a bit of a Q&A session at, at the end. So I think that's it from me and I'll hand you over to Rebecca, I think's going to kick us off and hope you enjoy today's session.

Rebecca Adams (RA): Thanks very much Graham, it's great to be here. And thanks also to Muriel as well who's joining us from NHS Grampian. I hope that lends itself to, as an example actually of how CCL, Community Chaplaincy Listening is a consistent practice across the whole of Scotland where it exists. And so, although I'm in Tayside and Muriel's in Grampian, there is a huge amount of mirroring and consistency across the practise as well. So thanks very much, so much for joining us Muriel.

So first of all, just to set the context of why CCL exists in the first place. So I just, let you consider a few things for a moment. You don't need to write anything down to just hold on to the thoughts for a moment. So, I guess just looking at grief from, and the experience of loss from a wider context initially than just bereavement. So I'm wondering what loss there's been over the last two years, over the last five years for you, for your family. Maybe a loss of work, loss of health, relationships, perhaps the loss of a sense of safety or security, a loss of freedom, and perhaps a loss of meaning or hope for some people. And so just to consider for a moment the various different types of losses and wonder if you felt that when a new loss occurs, it might throw open the drawers of many of the other losses or bereavements you may have experienced in the past. And I also wonder whether or not there was anything that perhaps surprised you about how you felt, not just emotionally but perhaps also physically as well when you experienced that loss. And perhaps it brought home the realisation that there are as many different ways to grieve as there are human beings on the planet. So just consider your own experience for a moment before we look at you as healthcare professionals. And what, and kind of next, I guess, consider what got you through, perhaps who got you through. What kept you going, what perhaps still keeps you going and, and what those things were and what, and maybe again some of those things might surprise you about what what, what was that that was your, your support through that time and continues to be perhaps.

And so, then, as we start to think about you as health and social care professionals, I'm wondering how you feel when you are faced with somebody else's grief through your work. Do you have maybe a strong desire to fix it and maybe you feel that you lack the tools to do so? Those of you that perhaps are able to prescribe medication, do you feel an urge to do that? Do you worry that if you open the doorway to their grief and loss that it might be difficult to close that door again? And from that, what are the pressures around you? What are the clinical pressures, the time pressures that you have around you when you're faced with somebody else's grief in that moment? And so all of these things that that that you're thinking about, all of those things in your head, this is, this is an example of the context of why CCL was set up. And so again, it's not just about bereavement, it's not even just about loss, but it's for any challenging experience that somebody is going through. This could be work related, stress, difficult relationships, chronic illness. It could be caring responsibilities.

So what Community Chaplaincy Listening does is it provides a 50 minute, 45-50 minute space to talk, and be heard by someone with buckets of empathy, plenty of training and support, and a lot of self-awareness. But it also is provided by someone who doesn't have any of the clinical or time pressures that may surround you. And so, if you've ever felt truly listened to without interruption, without advice, without judgement, you'll know how affirming and restorative that can feel. And so as well as listen, what we do is we also encourage and we help to draw out what may be a source of support for people.

So we recently collected evidence as part of a Patient Reported Outcome Measure. And the people who responded said that they felt less anxious after CCL. They felt more in control, more at peace, and for some CCL is is is a time where they have maybe the first opportunity to be really honest with themselves about how they're really feeling. Sometimes it's the first time they've talked to anybody at all about a particular subject, so being a CCL listener is honestly a privilege, and the listeners in Scotland are made-up of experienced staff and volunteers. So, you'll meet Muriel in a moment. There's also, like I said, there's a consistency across the boards that provide it. So there's a national formational training programme and no matter what somebody's background of work or life, they are all given the same task and the same boundaries. Our volunteer listeners, or staff listeners are mainly chaplains or CCL coordinators, but our volunteer listeners are made-up of a variety of might be healthcare staff, some nurses and doctors, AHPs. Some might have a counselling or a psychology background, some might have a spiritual care background. But many have just brought with them their experience of life and a willingness to donate their time and energy, and it's, it's such a privilege to work with an amazing group of people.

Unfortunately, I will say at this point in time the, the service is not provided across Scotland in every board area and it's provided slightly, by a slightly different group of people in some board areas, although everyone's trained the same, there's a, there's a kind of, there's not a continuity of, of availability of the service. So, some of you may be aware that it's present in your GP practice, either where you work or where you're a patient. Others may never have heard of this service. So I would encourage you to investigate whether or not it's available. If you'd like to know more about the status in your board area, please do get in touch with your NHS board's Department of Spiritual Care, which is where CCL's home is. The main issue is financial resources to support it, so there might be conversations around that, but I would encourage you to investigate whether or not it's available in your area. So I would like to introduce Muriel as well. I don't know if you're muted Muriel? Is, is your microphone on?

Muriel Knox (MK): I, no, I don't think, I think it's on. Is it?

RA: Good. Perfect. So first of all, if you could just say, say a little bit about your background before you became a listener with CCL, that would be good.

MK: Okay, well, I, I, I am a trained counsellor, but really I was, I came into CCL through chaplaincy because I was the Lead Chaplain at the psychiatric hospital in Aberdeen for a number of years. And then when I retired, I wanted to continue to do, to use some of the tools that I'd learned. And so that's why I'm in CCL.

RA: Perfect, that's fantastic. And what, what is your description of the formational training? What's, what's involved in the training that, that you have to go through as a listener?

MK: The training, I've just finished yesterday, a new cohort of training and the training consists of eight half day sessions usually condensed into four full days. We're not training people to listen. We kind of take that as a given that that the people who come on our training, have already listened in their line of work or have have done some sort of listening training. We're training them to listen in a specific way and training them for specific areas and, and of course bereavement is, is one of them and that I hope we spend a half day session on that and we spend some time looking at mental health. And the, the kind of listening we do is called it's spiritual listening but it's called asset, assets based listening. And when I say spiritual I should say not religious. We, we make that quite clear. We're not there as representatives of any particular religion. We're there just to listen to people. If people bring up religion, of course that's their right and we will talk to them with, about that. But that's not in the agenda. So we're looking really at at what people's resources are, helping them to identify what gets them through, what gets them up in the morning, what help, what's helped in the past and what can help now and trying to identify that with them and just journey with them really and listen to them.

RA: Perfect. And could you say a little bit about the triads as well, which is the kind of core part of, of the training?

MK: Okay. Yes, the, the training is, is very experiential. A lot of the training is spent in triads and I'm, I'm sure most of you know what that is. We have one listener, one speaker and one observer and they rotate and so everyone has a, a chance to, to listen. And that's really an important part of it, because we ask people to, to make themselves vulnerable and to, to, to really share quite deep things about themselves. So that they have the experience of, of being listened to. And then the listener obviously is practising the listening skills and the observer's watching what they're doing, writing it all down for them, which can be very daunting. But, but people get through it, get used to it. But it's a very important part of the training. Yeah, fantastic and it's such a it's a, a really good experience, even if people don't proceed on to become a listener. It's a very...

MK: Exactly.

RA: ...quite an intense and very rewarding process to go through the training. Great. Yes. So, when, when you, when you become a listener, what kind of support and do you get once you become a listener?

MK: Okay, well, we, we have supervision for all our listeners and there's a, a minimum of four sessions a year of supervision. Now I'm a trained supervisor as well. And we also have to use the jargon VBRP. If you don't know what that is, it's Values Based Reflective Practice which is really like a kind of group supervision because we have a facilitator and, and other, other listeners who are sharing their experience. So there's quite a lot of support and there are in Aberdeen, I don't know about everywhere else, but we've got a couple of coordinators in Aberdeen. So there's, there's always somebody to talk to if you're having difficulties with your listening or, or practical difficulties in the surgery where you're working and things like that, that that's not really the listener's job to sort that out. That's somebody else's job and there's always somebody on hand to help with that. But, but there is, there's a good back, there is good support and there's also not, not there haven't been for the last couple of years obviously, but there is, there is national gather-, there are national gatherings sometimes that we can all get together and share our experiences.

RA: Perfect. Thank you. And so just moving on to bereavement specifically. So you mentioned a little bit about that already but if you, if you could say a bit more about bereavement and loss as a feature of, of kind of CCL appointments that you've, you've been listening for. But also describe what your role is when somebody wants to express their grief within that context.

MK: I think the, the thing about bereavement and grief is that it can be, it can be in the present here and now, it can have happened just quite recently or it can be, have been reawakened because of some trigger and, and be something that perhaps has been hidden for a while and comes to the surface. I think one of the, the positive things about CCL is that, that there isn't usually a waiting list. So whereas with, with some of the other services, you know, you have to wait quite a long time to talk to someone, usually at CCL, you can get in quite quickly. And it's important to say what we're not, we're not therapists, we're listeners and that, that’s really quite important. And I think quite often that's a very positive thing because for people, they don't feel that they need counselling or psychiatric help or anything like that. They just want somebody to talk to. When I was young, I was brought up in the top of a tenement and some of you may know what that is like, but there was a great fellowship and community and when someone died there was somebody there for everyone. You know, we could all talk about it together. That doesn't really happen very much now. And so just the, the sheer ability to talk and go over the same kind of thing. Often you want to tell the story again and again and again until you are beginning to learn to live with it, and so I think that's a great benefit of CCL. As you've already said, loss comes in all forms, but the actual experience of losing a loved one, and death is, is a huge part of CCL. And also I'm, I'm just thinking of, of something that happened to me. I was just at the surgery one day and one of the doctors knocked on the door and said, 'Oh, can you see this man for me?' And in he came and he was in an awful state and just two days before he'd found his son had hung himself and, and he'd found his body and, but there was nothing much to do with him except just be beside him, give him space and be another companion with them to share his grief. So you know it can be instant like that as well.

RA: Yeah, thanks so much, Muriel. That's, that's really illustrative of, of what can come in the door at any point. And we don't, we, we don't have any information, so we don't read patient notes. You know before someone comes in, we just have their name occasionally their date of birth. So it really can be anything and, and often bereavement and grief and loss doesn't come in a vacuum in somebody's life. It can be surrounded by maybe financial worries, difficult relationships at home, stress at work, so often it's a, it's a single layer within other layers that are coming in for them at that time. And with us not being specifically a bereavement service, it allows the opportunity for somebody to talk about some of the other things that are also going on in the context of that grief as well as you know, instead of just purely focusing in on the bereavement. And also a lot of what we do, I think you found this as well, Muriel, is that kind of sense of reassuring people that what they're experiencing is understandable and a very natural process that they're going through. I don't like the word normal. I prefer to use the word understandable or natural because normal, it's not normal for them. They're not feeling okay. They're not feeling normal for them, so understandable or natural, I think it's, it's just a bit of reassurance I think as well that they're not doing it wrong or incorrectly or they're not going mad.

MK: Yes, and we, we've got some illustrations that we can use with people. Some of you may have seen the whirlpool of grief or things like that that that that help to to to show people that a lot of people go through the same kind of experiences. As you say 'normal' is a funny sort of word, but it's, it's yeah it's, it's a common experience to feel guilt, to feel, sometimes to feel relief even, because that that's something that people are almost afraid to express, but nevertheless it can be there. So, there are all sorts of things can be told in that...

RA: Thank you, yeah...

MK: …confidential space.

RA: …yeah, absolutely. And that safety when you're not a friend or family member to be able to express some of those things as well. Thank you so much, Muriel. That's our time. And yeah, there will be a Q&A after this. But also I think there'll be other further questions being able to be emailed round to us as well, so any, any other questions anyone has about CCL then happy to, I'm happy to answer them. Thanks so much.

MK: Thank you.

GW: No, thank you very much Rebecca and Muriel, that was really insightful. I had some understanding of CCL, but that certainly crystallised things a lot better for me. And so I very much had the focus of it on more on bereavement, so it was interesting to hear how certainly it's, it's much, much wider than that. So that, that's really helpful to know. So, and as I say I'd encourage you to post some questions in the chat and we'll get an opportunity to answer them later on. So, thanks again and, and so we'll now move on to the, the second-half of the, the session. So, I'll welcome Vicki and Sarah to have a conversation about supporting people who are bereaved in primary care. So thank you.

Sarah Luty (SL): Thank you.

Vicki Waqa (VW): Thank you. So that, that was great. Actually I was writing some things down and the one thing that stuck in my head Muriel was journey with people, I just thought how powerful a, a statement that is because that is really what you, you do for people. So thanks for sharing that. Sarah, I've got some, just a few questions for, for you. So I suppose as a GP, in probably in quite a small practice, you're in, you work in a nice community practice maybe is a better word to, to, to say how, how do you support people in primary care who are bereaved or grieving?

SL: I'm going to echo that. I wrote down journey with people as well and I think, I think to me that's what being a GP is. That, that's my primary role is that, that journey with people through all, all, all that they, they share with us and the, the sort of the traditional model or the viewpoint of, of what primary care is, it's comprehensive care, first point of contact, continuous care and coordinated care. So that is journeying with somebody throughout their, their whole life. So when I was asked to this webinar a few months ago now, I started to pay attention to my consultations and I started to just keep a wee five bar gate of how many bereavement or grief showed itself in our, in our consultations. And it is remarkably common. It is remarkably common how often it comes up. And it comes up just as Rebecca was saying about new losses opening the drawer, the drawer on old losses. And just as Muriel was saying about grief can be here in the here and now or it can be, be awakened at other times. And I think an example of that, I'm going to tell a story, if that's okay. About the day or so after I was asked to do this webinar I was on triage and I took a phone call for somebody that had diarrhoea and had, had vomited a few times and I phoned her and I had to make the decision if she had a GI bleed, so that, a very acute general practice type of consultation. And I looked through her notes and she had the, the, the notes that you can imagine the tone of this. 'She had denied excessive drinking'. She had denied drinking at numerous occasions and, 'fit to drive'. These sorts of sentences were in the notes and I, I didn't think anything of it because I was doing an acute piece of work. So she was brought up for me to do a pulse and a blood pressure and have a feel of her tum. And when she came in from the waiting room I recognised her, I recognised her face, didn't recognise her name. She wasn't known to me at all but I recognised her face. So when she came in I did this sort of opening of and, and how are you? And her sentence was, 'Oh, that's been six years, doctor'. So she's in for an assessment of, has she had a stomach bleed or not? And her opening sentence with me was ‘that's been six years’. And I had looked after her husband who had died, and this was our first, our first contact since that acute grief and bereavement. So she sat down and started talking about the days being long and there not being much focus to them. And she was drinking a little bit more than, than normal. She hadn't told her family. She was a wee bit ashamed about that. And she had to go into hospital for a GI bleed. And in the notes they wrote, this woman who has struggled since the death of her husband has, drinking excessively and now has health consequences of that. And in the hospital she was treated with utter compassion, from having had previous in and out hospital admissions with, with the same thing. She was treated with compassion, and she met the alcohol link worker and she came home on a slightly different path. And I think, I think I would have always had that consultation but I probably wouldn't have framed it quite as much in the, this was unresolved grief, and this was a, a bereavement reaction that that that showed itself in, in our normal general practice setting. And I think that when I count the number of times that people will, will hearken back to loss and it will be said, just as Murial was saying, they don't want it fixed, they don't want it taken away. But they just bring it. They just bring it into the space of the consultation. And, and that's a privilege because that, that's part of, of what we do.

VW: Thanks, Sarah. I think a lot of that goes back to us as well, wanting to be fixers, isn't it? We think we're not doing anything by listening and it's the most powerful thing that we can do. And I've learned that as well. And I've got a thing, as you know, about language. So that, that's amazing by reframing that, just that the empathy and the compassion, that's really powerful, really powerful, sharing that. So thank you.

SL: Yeah, I think, I think you're right about that language. The, the difference of, you know, 'hasn't, hasn't done what she's told' to 'I understand that she's lost, that she feels lost'. It's a very different, a very different sentence.

VW: Very. And what, what about kind of like, if we're thinking of sudden or unexpected deaths, is, is that different maybe in how we go about dealing with that or approaching that?

SL: Absolutely. There's the sort of phrase of 'good death, good grief'. And when you're involved in the end-of-life care with a patient that you've known for a long time, you know the family, you know, I don't really get involved in grief work at all because a lot of that is, it's been dealt within the anticipatory period. A sudden death is, is a very different ball game. And part of that is your role as a doctor comes into question there. 'Why did this person die?' was 'Oh my goodness, who saw them last?' is that's, you know, that's there in your thoughts. And also, you know, Rebecca was talking there about the pressures that you feel as a health professional. And that strikes a chord. If you arrive in your work at eight o'clock in the morning and the police are there because somebody's been found or your junior doctor was the last person to see them and they didn't think that this was a path that they were, that they were on, that, that wasn't the trajectory of their disease. Or the receptionists have taken the call and the patient has said they didn't need a home visit. 'I don't want to bother them. I know they're really busy. It'll be fine tomorrow when I can get a lift down' or, and, and we underestimate that. We underestimate that is, that's a big deal, that's a big thing for for for us as not just healthcare clinicians but the whole staff deals with, with that in different ways. And Muriel mentioned suicide there. That's a, a burden. It's a, it's a burden of guilt. You you you want to make sure that you, you had done everything that you could and if, if you'd seen them. So sudden deaths have a very different feel in primary care, and, and I think it's, it's in, I don't think it's to do with being in a small practice. I think it's to do with all practices - who takes the phone calls, who's, who's, who's dealt with that and you just feel the energy in the the the room and the, the tension being slightly higher.

VW: Yeah. Just before you even said the police being in the, the building at eight in the morning, that was exactly the thought I had. And I haven't asked you these questions before, but that was the exact feeling I had. And it's that relief that you weren't the last clinician to see them. But then how do you support the, the last person to see them or speak to them? And yeah it's really...

SL: Yeah…

VW: …different.

SL: …it is, it's, we had one recently that just, it just grew arms and legs because it was a, person had been found by a, their teenage neighbour.

VW: Oh gosh.

SL: And the teenage neighbour had called the ambulance and the police and, and all of those things. And the, the police came to us to sort of identify next of kin and those sorts of things and you, you start to go, okay what am I dealing with here? Who who's the teenage neighbour? Is he one of ours? Is he okay? What age is, what age is the teenager? Is this an expected or unexpected event? And who's in that person's life? And are any of our staff in that person's life? And you'll remember this from A&E days, if, if a person, an incoming patient was known to one of the staff, you were able to sweep them away and, and protect them a little bit. In primary care, you can't really predict who's coming in on the phone or what's going to happen. So if this is somebody that is, is known or or or is going to have an impact on one of your team it's, it's important that we, that we get right who's, who's in this person's life. What's their sort of circle of support around them? Who else might be coming into the practice today for a routine blood pressure check and they find out that there's, there's police here and there's, there's chat about somebody that's died. So it's, it's trying to get who that person is or was in their life and, and who, who, who's all involved in that.

VW: How do you go about doing that?

SL: So when it's, when it's one of us and it's the 'who was the last person to see them alive?' and it's an unexpected death, as, as a partnership we don't do that ourselves. So, we have, you have the look to go, who was it? And then I would look on behalf of my partner and say let's have a look, you saw them yesterday. What was your assessment blah blah blah? Because when you, when you look through your own records with the hindsight bias of what has happened, you look and you appraise yourself very, very critically.

VW: Yeah.

SL: So as a, as a partnership we do that for each other and for our junior doctors, their supervisor would do that. They'd go, okay this is an unexpected thing let's, let's have a look. And there's quite a lot of tea involved, and quite a lot of tea, and quite a lot of, sort of, make space for this. Because you're going to have to answer a phone call in a very short time saying 'Are you going to issue the death certificate?' 'Is there any suspicious circumstances?' And, and you have to know what you're thinking. You have to have clear logical thoughts about it. When it's something like a, a patient that the, the receptionists might have be involved in or, or somebody that's well known to our team and, and, and they're obviously not family but well liked, you know, part of that it's that the, the old uncle that comes for... we we we will make sure that we know who, who needs to be told so that they don't find out and that you know, the idea of that person's relative coming in a couple of days or weeks later and one of your staff not knowing. So we, we have a board that we write deaths on and we have, we actually physically draw a circle around that, who's involved, who knows, who's, who's yet to find out? You know, we'll have to make sure Fiona finds out before she comes back from her district nurse conference, or so-and-so's on holiday, we'll have to make sure... because they are likely to meet people. And just because, there's nothing worse than getting caught out and being, being kind of suddenly caught unawares or, or distressed by something. And a bit like Rebecca was saying about new losses and old losses, if one of our staff has had a particularly traumatic event in life, so if, if it was one of our staff that had experienced the loss of a loved one with suicide or something, I wouldn't want, I would want them to know and in a careful and planned way if something had happened in the practice, so that they didn't find out, you know, 'oh that's you know, so-and-so', that something happened, that they would, they would have the space to deal with that as opposed to finding out from a patient. So…

VW: Sorry.

SL: ...so there's lots, lots to think about.

VW: Just the, yeah, just how you, so thinking of that full team and the impact on the team, the family, the community, that real relational compassionate care, isn't it. So my, my question kind of, was about, like, do you think it is different with being in smaller kind of, community and environment? But you've maybe answered.

SL: I don't think it is. I think, I think what we have to think as health professionals and especially in in general practice and primary care is that when we're wobbling when, when, when we are not fit because of our own grief or our own shock and despair of something, we're not fit to be good at our jobs. And so, and that's all of us. Somebody on, on my front desk answering the phone that's had a bit of a 'Oh my goodness, you know that was me. I didn't put that home visit in' or, or 'That's, that's a suicide, and that reminds me of...' They're, they're, they have to deal with whatever happens next. So if that's an angry patient or a distressed patient or, they've got to be fit for that and they've got to be in the right space. And in order to do that we have to have, how, how they are in this moment in time discussed and, and it doesn't take long, it just takes the, the awareness that that might be needed. Then it, you know, it might just be a 'Are you okay? Do you need time off the desk? Do you want me to put the kettle on?' And that might be all it takes or it might be this has, this situation has made me, is opened up that loss again and I'm not fit. Could you see that patient for me I'm, I'm not going to be able to do that well. That's, that's my job, that's, that's what we should be able to do, so that our patients get the best of us.

VW: It's back to that enabling that conversation though, it's that language isn't it, because I'm thinking, is that a big formal process? And do you need to sit down with your full team? And how do you do this? But you're, you're just saying it's just, 'Are you alright? Do you need time away from the, the desk?'. It's just being thoughtful and kind isn't it.

SL: And also, knowing, knowing your team, so that, so that if having a, a kind of culture in the organisation that, that they're allowed to say, 'I'm not so good'. You know, and you know we, we experienced a, a terrible event many years ago where one of our staff lost their son and it, it if we'd had the Community Listening service really if we, if we could have accessed that, that would have been great because none of us really knew what to do. And we had a... I went to her house with, and you can imagine, anybody that works in primary care can imagine this, I went to her house with the collection of mugs because I thought she's going to have lots of visitors and we took tea bags and we took you know, all these things that, that she might need. Because when I arrived, the staff had put all this stuff together and still makes us all laugh that she had, you know, HRT branded mugs that she's giving out in her home and, and she just saw that as being, we're all in, we're, the team is all in. This is terrible and we don't know what to do but, but we're here. But it's, it's how do you, how do you make that organisational culture fit for, you know, how, how do you get people... people don't want to talk about their, their problems that their work and, and often we get into that 'fix it' mode. 'I'm fine, I'm fine'. 'No, it's okay. I need to be at my work'. 'I'll be, I'll be alright, I'm better here. I need to keep busy'. And that's fine, that's absolutely fine, if you are okay.

VW: Yeah.

SL: But, the next person coming in through that door needs your full attention. You have to be able to do it. I'm going to write that line down as well, the next person coming in your door. That's really powerful too. I'm aware of time and I know how you and I both like to talk. So I don't know if there's anything else that you wanted to, you wanted to say Sarah?

SL: No, I think it, I, I think it's just such a privilege. It's such a privilege to, to do that journey with people, you know to, to journey along with them and, and loss is such a huge part of it for many, many people. And I see it as being the core business of the primary care team.

VW: Thank you, Sarah. Thank you.

GW: No, thank you very much Sarah and Vicki, that was really nice to, to listen to and, and certainly pick up a few, a few tips there. I mean, I think we've been talking recently just about, the kind of bereavement-friendly workplace almost and how do you create that culture? So, certainly listening to how you've done that within your practice and yeah, as you say that ripple effect almost of grief and how it can affect all those number of different, different people. And, and just how you have that awareness and, and you need to start in a place and talk about it, don't you to, to actually enable that. So that was really interesting and powerful to, to hear some of your thoughts on that. So thank you very much.

So, I think I'd like to invite Muriel and Rebecca back as well I think and, and we can maybe open the, open the floor to, to questions if anyone... please, wants any questions, post them in the, in the question box on the right-hand side of your screen. And I think just while we're starting I suppose it was just when listening to Rebecca and Muriel, I suppose it was more, I was thinking in terms of, how do people go about I suppose, referring to the service, so if they think somebody might benefit from... how do you find out if it is available in your area, or how do you... and if you wanted to, to refer somebody how, how do you actually do that I suppose? I don't know if you're able to answer that but...?

RA: Yes. So, the vast majority of our referrals are GPs picking up on somebody's need to talk. And the GPs will either, depending on their system, will either book them directly into their appointment system within the practice or it might be that on the, the way out, the person will book in at reception. But we're increasingly getting referrals from elsewhere now in Tayside. So in Tayside we accept self-referrals. We have a central phone number where people can, can book in with us and have a phone appointment if there's not a, a face-to-face listener available in their practice. And also we're, we're getting increasing referrals from other areas of, of the organisation as well. So from, from acute as well, people are being discharged from acute pain clinic referrals. We have worked quite closely with the AHP team in supporting people with long COVID as well. So there's, it's, it's not, it doesn't just need to be a primary care model. It can fit with all kinds of different sections of, of the NHS's work and with, with referrals from other clinicians. So, in, in short anyone can refer themselves in to CCL but still a lot of people will not self-identify themselves as needing the service. It often will take a clinician to suggest it to them and say, look, we have the service available. It sounds like it might be helpful for you to have a chat with someone. Here's the service and then that, that really can give somebody the confidence and the boost that they need to make an appointment as opposed to them seeing a leaflet and then thinking that that's something that would work for them. We do get a few people like that, but it's, it's, it's less common.

GW: No, thank you for that. We do have one question here related to the CCL and someone possibly interested in terms of how, how you would actually go about applying to be a trainer then or sorry to, to be trained. So, if you're interested in volunteering, who would you get in touch with I suppose?

MK: I guess you would get in touch with the, the, the chaplaincy department of your, your health board and they would be able to tell you that. We certainly have just, we've just been recruiting in, in NHS Grampian and I've got another cohort coming up in July and August. We've still got open places there if anybody's interested in that, but that would depend where you live.

GW: Okay. No, thank you for that. And sticking with a CCL theme I think, can, can anybody refer, it says can practice nurses refer or is it just only, only GPs? This is somebody based up in the Highlands. Andbody can refer?

RA: Yeah no, any anyone, yeah anyone can refer in. The most, the most common source of referrals is GPs. But yeah, anyone can refer in.

MK: Yeah, or self-refer. Certainly, I think most places would take self-referrals as well.

GW: Okay, that's good to know. And in terms of, for patients who perhaps English isn't their first language is there a, do you use interpreters or the translation service available or...?

RA: Yep. So what we've found has worked best actually is having the desk phone in the, in the practice room on speakerphone and having the, the language line interpretation services. And it takes, I've, I've done about a dozen appointments now with, in various different languages and it's, it's quite off putting the first time but you do get used to it with, with a 50 minute listening appointment and it's, you do get into the swing of, of there only being two people in the room and having a third person, extremely professional, and completely blown away by the interpretation service's skills. But it does, it does take a wee while to get into the swing of it but yeah absolutely it's, it's absolutely there for people who need it. Yeah.

MK: Yeah.

GW: Yeah, okay that's helpful. Thank you. And, and another question here for somebody potentially interested in almost setting up some services and they maybe don't have them at the moment but they're saying if we were wanting to establish some listening services what would be the key selling points for a GP practice and how would we best identify which areas would benefit most from, from this?

RA: So...

MK: It's a big question.

RA: ...so, I, I don't know, I'd love to know who that question is from and whether or not that's from someone who works for a spiritual care department or, or not. But I would definitely encourage somebody to have a conversation first with the department of spiritual care, because this is a core part of spiritual care kind of, strategy, is the community, the community listening part of it. So, have a chat with them. Come and have a chat with us as well. So we've, there's between various different people in Scotland there's a huge amount of experience of setting up CCL services from scratch in practices that have never had it before, and the types of conversations that you might have with, with GP practices in order to set that service up. But to be honest in Tayside, I mean it doesn't cost the practices anything to have this service in their practice. It is in Tayside, I'm funded and a colleague are full-time permanently funded by the Health and Social Care Partnerships across Tayside jointly. So it doesn't cost the practices anything, so in all honesty we get our hands bitten off by GP practices wanting the service in their practice so there shouldn't be it, that's, the main issue is not selling it to the practices, the main issue is finding that core support to be able to support the team of listeners and to develop the service as it needs to develop and to, to make sure all that support and training is in place for people. So yeah, there's various different ways of, of accessing that type of, that type of resource. So yeah, any, any other conversations around that happy to have one-to-ones or, or point you in the direction of the local department.

GW: No, that's helpful Rebecca.

MK: I think one of the, the problems that we have certainly in Grampian with the GP practices in particular is space. They really do want the service, but they haven't got a room for us. So that, that's our, our challenge for us to be looking at how we can get around that one.

GW: Okay. And is there a limit to the number of sessions that are offered, or is there a fixed programme initially someone was asking?

RA: Yeah, so, it's interesting. A lot of it is, is entirely decided by the person who uses the service. So a lot of people will only need or only feel that they need one or two appointments. They might come into the service expecting to have to need weekly appointments that go on for weeks or months. But actually that 50-minute space just to, to offload, to explain, to describe is enough for what they're looking for. And then they, the security to know that they can come back and make further appointments is always there. If we do, on the occasion that we do, get up to, in Tayside this is the way we work, if they do get up to about five or six appointments, there might be a little bit of a review with the person to see how they're feeling, how things are going. It might be that there's more specific forms of support out there, more specialist forms of support in the community for example. It might be Women's Aid. It might be you know, welfare rights support. It could be anything that might be a bit more specialist around what it is that they're bringing to a CCL session. But what we do say to people is that we're not intended to be a long-term source of support. And the other thing is if, if somebody's main challenge that they're having is social isolation, so they're really looking for solid social support over a long period of time, that's not what we're able to offer. There are fantastic befriending services out there in the community. And also the other thing to highlight is actually social prescribing, and the loneliness that can be generated by bereavement can be overwhelming for people. And so don't forget that you're, you should all have local social prescribing services and link workers who, when the time is right for that person can help them to access other kind of more sustainable forms of community support. So don't forget your social prescribers either. They're also brilliant listeners, but they have a huge range of services and tools at the, their fingertips as well.

MK: Yeah, I think we, we do encourage people when they're doing their training to, to build up their own resources. The link workers are great and they're a great source of referral, but there can be a very informal kind of bank of stuff. I mean, I've got loads of things that I can refer people to like lunch clubs and book groups and websites and, and things like that. I think we, we all build up our own resources for that.

GW: And I suppose there's a question here, kind of linked to, to delivering the service there, but in terms of if, if someone's asking if space is an issue, has there been experience of delivering the services online either sort of over, even over the telephone or on a kind of virtual online delivery? Does that happen?

RA: Yeah. So, it's actually, it's really interesting. When, so I, I started my job here in Tayside in February 2020 and within eight weeks we had switched everything over to the phone. I was, you know, fully expecting it to be, oh, it'll just be a few weeks, it'll be fine. And then we'll be back into the practices and two years later we still have an amazing kind of team of people who do central phone appointments, because a lot of people actually might prefer using the phone to turning up to GP practice. Interestingly, I was speaking to a colleague and we were saying how it's interesting that some men seem to prefer using the phone because there maybe isn't that sense of, of that feeling of judgement of sitting in front of somebody while you're telling, you know, you're telling your story. But having that sense of anonymity that, that the phone kind of provides has been beneficial to people as well. So yeah, absolutely, it's provided over the phone. We considered providing it via Teams or Zoom or, or Near Me or Attend Anywhere, but we carefully looked at the setting of that up because a lot of our listeners are volunteers and so they don't have access to IT systems. But also, I've looked at similar services and what the, the take up of face-to... of video conferencing appointments was and it was a very, very low take up in comparison to, to phone. So we just decided not to go down that route in Tayside. I know others have tried to do the, the Near Me service in some places, but yeah, we decided against that.

MK: Yeah, I, I used the Near Me service. It was very dependent on the surgeries and whether they suggested that or not. But it was interesting because although a lot of people were offered the Near Me service, the take up wasn't great. It was mostly phone. So yeah we do, we do deliver by phone but I think most of us would say we prefer not to. And that's in Aberdeen.

GW: Yeah.

MK: We prefer the face-to-face.

GW: Yeah. And, and Sarah, I don't know if there's maybe anything you wanted to add about that in terms of maybe providing bereavement support either through kind of virtually Near Me type services or telephones during the pandemic from a GP perspective, or...?

SL: I think it's, I think there's so much lost in the subtleness and the, you know we're, we're now very experienced with telephone consulting in a way that we weren't before but the, are they going to say something else? Is there that there's, there's we, we lose a lot. We were exactly the same with Near Me. We went to Near Me video consulting and we had very, very limited uptake. Still do two consultations a day with Near Me but they're very planned kind of medicine reviews sort of, quite straightforward Medicine. And it just feels a little bit less human, a little bit less connected to, to do it in that way and certainly not opportunistically, you know, we're, we're faster to see somebody face-to... face-to-face in primary care. You can do a consultation within your 10-minute slot face-to-face. On average our telephone consultations are a little bit longer and our video consultations are shorter. So it's, that's with my quality improvement hat on. We've, we've timed, timed all these things, and I think, I think we're fastest and most connected face-to-face and for something like this you can get away with a lot and with a, a touch of the arm and a, a nod and a, a reassurance that you could never do on, on video, so.

MK: Yup.

GW: No, thank you for that. I'm just checking any final questions, I think again just about the availability of CCL, someone's asked is it available within Edinburgh and the Lothian area? I don't know if you're able to answer that one?

RA: It's, it's very limited in Lothian at the moment, but definitely I would contact the local spiritual care department and they'll be able to give you an update on whether or not they're going to be expanding and training more, more people.

GW: Okay, no, thanks for that. Looking... it doesn't look like there's any, any further questions - we're sort of coming up towards the end of our time. I mean, I suppose one thing that stuck with me is, I suppose there's been lots of useful advice I suppose in here in terms of how we can support people, and, and when Sarah was talking about the that referral that you made to the, the acute admissions unit and, and the different approach that had just from that little bit extra in their referral. I suppose it's how... is there ways we can, kind of, try and embrace this culture and, and train people that are coming through in terms of how they should do that? I don't know if there's any comments on how we raise that awareness of the importance of the bereavement, or create those bereavement-friendly workplaces that people feel able to sort of, sort of deliver care this way? I don't know anything, final comments from any of you?

SL: I certainly feel like I've aged into this, and I think that's probably my own life and my own lived experience. I think as a junior doctor and a new partner I was, it was just so much more efficient but maybe a little bit less compassionate. I think, I think mentoring and mirroring people, seeing it as they come through, is, is probably beneficial. But it's the experience too.

GW: Yeah. Okay.

RA: I would, I would say don't lose confidence in your own abilities to, to be able to provide that care. And it can be daunting, but do trust, trust your own abilities to provide that kind of listening support to people at any point. And it doesn't even need to be about bereavement. It can be at any point. If you feel as though you've run out of tools in your... clinical tools in your box, there's always, always listening in that box. So, and it does, it does work, it really does work. So do trust, trust your own abilities to do that.

VW: I think my, my one thing as well Graham is being a bit vulnerable yourself, and being a bit open and honest and transparent and just saying 'I'm really struggling this week. I've have had some, a family bereavement' and to just grow in that culture, breeding that culture. Because 10 years ago I would have went into work and not told someone that a close family member had died or something. Whereas now I'm telling people, like probably just because I've experienced so much grief during COVID and so much death. I'm just like, no, I'm going to talk about this, I'm going to talk about this and the more I am, I can see people mirroring as Sarah's saying, my behaviour as well.

GW: Yeah. No, absolutely. We produced a little film during the, at the beginning of the pandemic, just around 'TALK'. 'Tell' people how you're feeling, 'Ask' them and 'Listen' and, and just be 'Kind' I suppose was the, the, the, the basis of that. But, no, that's us just coming up to, to half past one, so just, just want to say a huge thanks to all, all four of you. I think there's lots of nice comments in the, in the box about the very compassionate stories and it's been lovely to, to hear your experiences. So thank you very much for your contributions today and, and we'll say, as I say, we'll, we'll... if people can fill in the feedback when they're available, we've put a wee list up there of some of the, the previous webinars that that are available, and we've also got our Bereavement Conference coming up at the end of this year on the 24th of November. So that's a date for people's diaries. But further webinar will be, information, will be available on the, on the website as, as we deliver them. So, thanks again and I wish everybody a nice afternoon. Bye, bye.

The film was produced in October 2022 and can be found at [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or <https://vimeo.com/722870991>

For more information visit [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or contact [supportarounddeath@nes.scot.nhs.uk](mailto:supportarounddeath@nes.scot.nhs.uk)

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