EMBARGOED UNTIL DATE OF MEETING

Greater Glasgow NHS Board

Board Meeting
Tuesday, 20 January, 2004 **Board Paper No. 04/3**

Director of Nursing, South Glasgow Acute Trust
Head of Board Administration, GGNHSB

Spiritual Care Policy

Recommendation:

The NHS Board is asked:

(i) to note the outcome of consultation on developing a Spiritual Care Policy for NHS Greater Glasgow.

(ii) To approve the attached Spiritual Care Policy for NHS Greater Glasgow.

(iii) To approve the setting-up of a Spiritual Care Committee as a Sub-Committee of the Health and Clinical Governance Committee, under the Chairmanship of Mrs R K Nijjar, Non-Executive Director.

Background

A National Working Group on Spiritual Care in the NHS in Scotland was formed in 2000/01 and it issued a report for consultation in the summer of 2001. The finalised report was used to produce the guidance contained in the Scottish Executive Health Department's letter of 28th October, 2002 to NHS Board (NHS HDL(2002)76). This guidance required NHS Boards to develop and implement a Spiritual Care Policy for their areas.

NHS Boards were therefore required to develop and implement a Spiritual Care Policy that complied with the national guidance and Chief Executives of NHS Trusts/Operating Divisions would, thereafter, be required to develop and implement local plans for a Spiritual Care Service that complied with the overarching NHS Board Policy.

Short-Life Working Group

A Short-Life Working Group was formed on behalf of the NHS Board, under the Chairmanship of Miss Maureen Henderson, OBE, Director of Nursing, South Glasgow University Hospitals NHS Trust, to develop a draft Spiritual Care Policy for the provision of chaplaincy, religious and spiritual care services across NHS Greater Glasgow, and consult upon same and make recommendations to the NHS Board.

The Working Group membership (Appendix E of the Policy) was drawn from the Faith Communities, the Humanist Society of Scotland, Healthcare Chaplains, Health Council, Area Partnership Forum (representing staff interests), Managers from the NHS Board and the four NHS Trusts. Sir John Arbuthnott, Chairman, and Mrs R K Nijjar, Non-Executive Director, both attended a meeting of the Working Group. There were 6 meetings of the Working Group, 5 from February to June, 2003 in which a draft Spiritual Care Policy was developed for consultation and a further meeting was held in December, to consider the outcome of consultation and make recommendations to the NHS Board.

Miss Maureen Henderson and Rev. Blair Robertson, Chaplaincy Co-ordinator, South Glasgow Acute Trust, will be present at the NHS Board meeting to discuss the Spiritual Care Policy and answer Members' questions.

Draft Spiritual Care Policy for Consultation

A draft Spiritual Care Policy was drawn up by the Working Group for consultation. A 4-month period of consultation took place from 25th June to 24th October, 2003; the draft policy was sent to the Board's standard consultation list (together with additional groups identified for this consultation); made available on the NHS Board's website, and the Involving People's Group's comments were sought on any further consultative activities necessary.

The Involving People Group recommended setting up two particular focus groups to look at the draft policy in detail; one comprising representatives from the Glasgow Churches Together and the second one comprising representatives of faith communities from the Scottish Inter-Faith Council. Both groups were provided with external facilitation and their report and key findings were submitted to the Working Group for consideration.

26 responses to the consultation were received and the summary of the consultees' comments is attached as Annex B (Part 1 summarises the two focus group responses and Part II summarises the individual responses received). The summaries provide a "Comment and Action Taken Where Required" column, which shows the Working Group's response to each individual comment received. The individual line numbers quoted on the Policy are for ease of reference to allow NHS Board Members to see the changes to the Policy as a result of comments received during consultation. The shaded areas also highlight the changes as a result of consultation.

Each respondee will receive a letter setting out the outcome of consultation and the NHS Board's consideration of the Spiritual Care Policy.

Main Themes from Consultation

The vast majority of responses were supportive of the underlying values of the Spiritual Care Policy and the need for such a Policy within NHS Greater Glasgow. This was seen as a valuable step forward and had significant potential to contribute positively to the delivery of spiritual care amongst patients and therefore health care, and staff.

The two focus groups – representatives of Glasgow Churches Together and representatives of the Scottish Inter-Faith Council summed up the positive aspects and strengths of the Policy as:-

- recognised that spiritual care represents significant need;
- the recognition of the diversity of needs of spiritual care – which are functions of the diversity of the beliefs and requirements of the range of faith groups within NHS Greater Glasgow;
- the commitments and comprehensive nature of the Policy;
- the Policy was sufficiently prescriptive, whilst allowing local freedom to reflect local circumstances.

In addition to a number of issues raised by the two focus groups, there was also a range of issues raised by consultees which the Working Group has tried to address in the amendments to the Policy. The main themes, taking them in the order of the main headings of the Policy were as follows:-

<u>Underlying Values</u>

A number of respondees asked that the Policy should include a definition of spiritual care. However, it was also recognised that from a multi-faith perspective and non-faith perspective, such a definition would be difficult. Appendix B to the Policy sets out definitions of spiritual care and spiritual need.

The two focus groups were keen to see a clearer clarification/definition between 'religious' and 'spiritual care', with greater emphasis given to the religious element of spiritual care. The Working Group, in understanding this desire, believed that religion was a critical element of spiritual care, but not the only element and the Policy had to be seen in a wider context.

There was concern that staff should not deliver spiritual care from their own particular spiritual or religious standpoint. The Working Group amended the Policy to recognise that concern, making it explicit that staff should not impose upon another person in the workplace their own religious beliefs, faiths or values. This issue would also be picked up in staff training.

Structures

Representatives of the Roman Catholic faith were concerned about the management responsibility of Priests within a department/directorate, this role being the responsibility of their Bishop. This issue and the development of, and signing up to, a Code of Conduct of Healthcare Chaplaincy Professional Organisations will be discussed with the Glasgow Archdiocese in a meeting being arranged to take place in the next few weeks.

Practices

The major issue of concern in this section related to trying to ensure that Healthcare Chaplains deliver their care in accordance with the professional standards/Code of Conduct of Healthcare Chaplaincy Professional Organisations.

There was acceptance that there needed to be reference to adherence to standards and Codes of Conduct and this was necessary within the Policy. The Scottish Inter-Faith Council believed, however, that this should not apply to those providing religious care and support. The Roman Catholic faith representatives were concerned that this would breach the Code of Canon Law.

These concerns will be discussed further with those who have expressed concern; the Working Group was, however, encouraged that there was a general consensus that where a number of Healthcare Chaplaincy Professional Organisations had a role to play, these should have a range of minimum standards.

People

The training implications for NHS Greater Glasgow was raised; particularly, to what extent would the NHS Board/NHS Trusts be willing and able to provide the necessary training to staff who, as part of their broader responsibilities, will require to provide spiritual care.

The Policy recognises this as a priority area for local implementation plans if the Policy is to be successfully implemented across NHS Greater Glasgow.

Place

A desire to see an ongoing review of facilities and that all faith communities should be fully consulted in the design of facilities in order to ensure that no elements of design offended or compromised any particular faith.

Washing facilities for Muslims in the North Trust were raised by two respondees and this will be a matter for the North Trust to address.

Resources

There were concerns that resources would not be made available to support and implement the Policy at the local level. The Working Group understood the financial constrains on the NHS and recognised that, while much was currently being done in hospitals etc., any new developments would need to compete with other local priorities and the NHS had to be delivered within its available resources.

Accountability/Monitoring – Spiritual Care Committee

A few responses highlighted the need to ensure that the composition of the Spiritual Care Committee represented and took account of the range of faith communities which would be involved in the delivery of spiritual care within NHS Greater Glasgow. This was supported by the Working Group and every effort would be made to achieve that aim, together with the recognition of the need to represent those with no faith.

A number of comments supported the Spiritual Care Committee having a role in monitoring and evaluating the implementation of the Policy at local level and this will be incorporated in the remit for the Committee.

General

These are the main themes raised – Annex B provides a point by point response to each issue raised by the two focus groups and respondees.

Spiritual Care Policy

The NHS Board is asked to approve the attached Spiritual Care Policy for NHS Greater Glasgow (Annex A) and ask the NHS Trusts to develop and implement local plans, within available resources, for a Spiritual Care Service that complies with the overarching NHS Board Policy and national guidance. As stated above the shaded areas show the additional comments which have been added as a result of the comments received during consultation – in addition, attached to the Policy, are the following Appendices:-

- Appendix A Summary of local demography
- Appendix B Definitions of Spiritual Care
- Appendix C Baseline survey of Chaplaincy and Spiritual Care Services, December 2003
- Appendix D Scottish Executive Health Department's guidance on setting up a Spiritual Care Committee
- Appendix E Working Group Membership

Spiritual Care Committee

The NHS Board is asked to set up a Spiritual Care Committee as a Sub-Committee of the Health and Clinical Governance Committee.

It is recommended that Mrs R K Nijjar, Non-Executive Director, Chair this Sub-Committee and that she and the Head of Board Administration, draw together a membership for the Sub-Committee from the suggestions in Appendix D of the Spiritual Care Policy, together with a representative from the Area Partnership Forum, the Humanist Society, and each Trust/Operating Divisions being represented on the Sub-Committee.

It is also suggested that the Sub-Committee draw up its own remit, taking account of the approved Policy, Scottish Executive Health Department's guidance and also the need to monitor and evaluate local practice in the context of the Performance Assessment Framework. The draft membership and remit would then be submitted to the Health and Clinical Governance Committee for approval.

J C Hamilton
Head of Board Administration
0141-201-4608

ANNEX A

NHS GREATER GLASGOW

Spiritual Care Policy

Introduction: Definition, Vision and Values.

We are committed to providing holistic health care that is responsive to the physical, psychological, emotional and spiritual needs of our patients.

The Scottish Executive Health Department issued NHS HDL (2002) 76 'Spiritual care in NHS Scotland' in October 2002. This laid a responsibility upon NHS Boards to develop a Spiritual Care Policy for the populations they serve and to give direction to NHS Trusts and local service providers in their delivery of spiritual care.

This policy was prepared by a Short-Life Working Group drawn from the NHS Board, NHS Trusts, Health Care Chaplains, the Faith Communities, the Humanist Society of Scotland, the Health Council and the Partnership Forum. The draft policy was consulted upon following advice from the Involving People Group, and the list of consultees included those groups representing minority faiths and beliefs. This pattern of consultation will be continued in the implementation of the policy at NHS Trust/Divisional level.

This policy does not repeat the guidance contained in NHS HDL (2002) 76 nor does it anticipate the detailed work required from the Operating Divisions of NHS Greater Glasgow (NHSGG). Rather, this policy seeks to direct the delivery of spiritual care and Chaplaincy services within the NHSGG area.

The NHS Greater Glasgow area has a population of 868,000 and includes areas of great social need, deprivation and also an increasing diversity of ethnic minority groups. (For a summary of local demographics see Appendix A). Fair For All (HDL (2002) 51) commits the NHS to design its services so that persons of all faiths and beliefs, cultural and ethnic backgrounds, have equal access to its services. The NHSGG Race Equality Policy demonstrates a commitment to the provision of spiritual and religious care which is appropriate to the ethnic minority communities.

Underlying this Spiritual Care policy are these values:

- That spiritual care is addressing the fundamental human need to have a sense of peace, security and hope particularly in the context of injury, illness or loss. (For further definitions of spiritual care and need see Appendix B.)
- That spiritual care is offered and usually given "in a one-to-one relationship, is person centered and makes no assumptions about personal conviction or life orientation." (HDL (2002) 76, paragraph 3)
- That religious care is an aspect of spiritual care and is "given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community." (HDL (2002) 76, paragraph 3)

- That it is inappropriate for any member of staff to impose upon another person in the workplace their own religious beliefs, faith or values.
- That the delivery of spiritual care to patients and their carers is a responsibility of NHS staff working in partnership with those employed with specific responsibility, training and skills in spiritual and religious care.
- That spiritual care must be accessible to all who use the services NHSGG provides, as in-patients or out-patients, visitors or staff, in acute hospitals or community based services.
- That access to Spiritual Care is grounded in an ethos of respect, support and compassion and includes the availability of information and staff trained in spiritual care
- That Health Care Chaplains are key providers and enablers of spiritual care to patients and their carers and all NHS staff.

Local service providers are required, in accordance with the Guidelines and the above vision and values, to prepare a local Spiritual Care Implementation Plan. (Paragraph 15 of NHS HDL (2002) 76 offers a framework for this plan.)

Structures

Health Care Chaplaincy, as a publicly funded service within the NHS, will be regarded as an integral component, among many, working for the well-being of patients, their carers and staff. Health Care Chaplains are bound by the same policies and codes of conduct (e.g. patient confidentiality) as all NHS employees and volunteers.

Local service providers will ensure that their Chaplaincy/Spiritual care service is integrated into their structures by:

- Establishing a Department of Spiritual and Religious Care, which may be known by that title or some other decided upon locally.
- Designating a Director with managerial responsibility for Chaplaincy/Spiritual Care Services; appointing a Head of Department and putting in place appropriate systems of communication.
- Reviewing and where necessary making provision for the Chaplaincy/Spiritual Care of patients from the smaller faith communities, either by the appointment of a Chaplain to that Community or the establishing of a resource of contact persons who are able to offer such care.
- In consultation with chaplains/spiritual care givers ensure that policies and procedures incorporate, where appropriate, their role (for example, Major Incident Procedures, Bereavement, Race Equality etc.)
- Putting in place appropriate systems of referral so that patients, visitors and staff may access the religious and spiritual care for which they have been assessed or that they request.

Practices

It has been the practice, since the formation of the NHS in 1948, for Health Care Chaplains to be employed and paid to deliver religious and spiritual care. In that time, the understanding of spiritual and religious care has evolved due to increased recognition of the religious needs of

ethnic minorities and the spiritual needs of those who do not identify themselves with any particular belief or faith.

This entails:

- Impartiality, accessibility and availability.
- Sensitivity, compassion and the ability to make and maintain attentive, helping and supportive relationships.
- Respect for the diversity of faiths, beliefs, lifestyles and cultural backgrounds within the population.
- The sensitive addressing of pastoral needs through worship, liturgies, ceremonies and rituals that have religious and spiritual integrity.
- Good working relationships with other health care professionals, leaders of local faith communities, voluntary groups, trade unions and professional organisations.

Local service providers will ensure that Health Care Chaplains deliver their care in accordance with these principles and the Professional Standards/Code of Conduct of the Health Care Chaplaincy Professional Organisations.

People

People are the key to the delivery of spiritual care.

Local Service Providers will therefore ensure that:

- Training in spiritual needs and spiritual care will be included in staff training programmes, including induction programmes, and training will be available to all staff.
- Training will include awareness of the religious traditions and needs of faith communities.
- Health Care Chaplains will have access to training provided by local service providers and budget provision for attendance at relevant Health Care Chaplaincy training courses.
- Health Care Chaplains receive an appropriate form of supervision for their own emotional, psychological, pastoral and spiritual support.
- Chaplaincy Volunteers, where used, will be integrated into the Volunteering Policy and will receive appropriate training. The valuable role of volunteers in assisting the delivery of spiritual care is recognised and affirmed.
- The role of Health Care Chaplains in supporting staff and providing a confidential service of pastoral care is affirmed.

Place

Local service providers are required to review the provision of facilities for their Departments of Spiritual and Religious Care.

Facilities must include places appropriate for use by people of all faiths or no faith for the purposes of:

- Prayer, meditation and quiet reflection;
- Spiritual and religious ceremonies;
- Meetings and pastoral counselling.

All such facilities will be available for use by patients, visitors and staff. The above might comprise a Chaplaincy Centre but, where reasonably possible, additional rooms must be provided in easily accessible locations for use by patients and visitors for quietness, prayer and pastoral counselling.

Where the NHS body is commissioning new buildings the provision of accommodation for spiritual and religious care services must be included as part of the specification. Consultation with local faith communities will be undertaken with reference to the design, decoration and furnishings of any new facility for spiritual and religious care. Whilst a space for prayer and quiet is necessary so also is attention to the physical surroundings of a building. The architecture, design and decoration of health care facilities, the level of noise, the outlook from windows, can all contribute to the spiritual well-being of patients and so to their total health.

Resources

Local Service Providers are required to review their current financial provision for Chaplaincy services and in particular:

- The number of Chaplaincy sessions budgeted for.
- To assess the composition of Departments with reference to whole-time and part-time appointments and the needs of the smaller faith communities.
- Ensure that all related costs are budgeted for (travel, phone-line rental, training, etc.)
- Ensure that a 24-hour on-call service is adequately resourced.
- Involve the appropriate faith community and/or employing body in any discussions concerning the above where necessary.
- The administrative support for delivering a spiritual care service includes appropriate IT and secretarial assistance.

NHSGG will ensure that where NHS funds are used to secure services from non-NHS bodies that these services will include provision of spiritual care.

Current Chaplaincy provision within Glasgow is outlined in Appendix C.

Accountability and monitoring/evaluation

To facilitate communication between service providers, faith communities, chaplains and managers, NHSGG will establish a Spiritual Care Committee which follows the remit and membership suggested in NHS HDL(2002)76 (see Appendix D.)

It is recommended that the Spiritual Care Committee be a sub-committee of NHS Greater Glasgow Health and Clinical Governance Committee. It will report to that Committee through the submission of its minutes and submit reports to that Committee on issues of strategic policy which may have resource implications.

The provision of spiritual care is an essential part of the services provided by NHSGG and the implementation of this Policy will be monitored by the Healthcare Chaplaincy Training and Development Unit on behalf of the Scottish Executive Health Department as part of the annual Performance Assessment Framework.

APPENDIX A

Data from the 2001 Census – Religion

Greater Glasgow NHS Board

Greater Glasgow

Religious upbringing:

Church of Scotland	340,837
Roman Catholic	255,281
None	110,394
Not answered	84,680
Other Christian	42,281
Muslim	20,736
Jewish	4,502
Sikh	3,815
Hindu	2,107
Buddhist	1,122
Another Religion	1,395

APPENDIX B

NHSGG – Chaplaincy & Spiritual Care

Baseline Assessment as at February 2002

1 Number of Chaplains financed by Trusts

	Whole-time	Part-time
North Glasgow	3 (2 at GRI; 1 at Gartnavel/WI)	15 (see note 1)
South Glasgow	3 (2 at SGH; 1 at VI)	8 (see note 2)
Yorkhill	2	0
Primary Care	3 (1 in each sector)	5

2 Provision of Facilities

	Office	Chapel	Quiet Room	Meeting/ Counselling Room	Computer	Secretarial help	Washing facilities for Muslim prayer
North Glasgow	4	5	1	0	2	0	0
South Glasgow	3	0	2	1	3	0	2
Yorkhill	1	1	1	0	2	0	0
Primary Care	3	0	0	0	3	0	0

3 Use of Volunteers

North Glasgow	GRI: ward visitors, eucharistic ministers, Sunday escorts, printing of literature/documents, flowers, music. Stobhill: ward visitors; Western/ Gartnvael: sunday escorts
South Glasgow	Staffing centre; administrative help; ward visiting; assistance with services; eucharistic ministers
Yorkhill	Priest who gives on-call cover for catholic community One nun, part-time, visitation of certain wards Two trainees, 2 hours per week in one ward
Primary Care	Playing for services and visiting

4 Line Manager & Directorate

	Line Manager	Directorate
North Glasgow	Hospital Manager	Facilities
South Glasgow	Director of Nursing	Nursing
Yorkhill	Director of Nursing	Nursing and Patient Services
Primary Care	The Appropriate Sector General Manager	

5 Provision of Funding for Training

North Glasgow	In theory – yes.
South Glasgow	Yes
Yorkhill	Yes
Primary Care	Yes

6 On-Call: Participation and Frequency (this excludes Roman Catholic on-call)

	Participation	Frequency: call-outs/month
North Glasgow	W/t and some p/t	9
South Glasgow	W/t and some p/t	6
Yorkhill	W/t	2
Primary Care	W/t	8

Note 1
Part-Time Chaplaincy in North Glasgow

Glasgow Royal: 1 @ 5.5 sessions
1 @ 2 sessions (Care for the Elderly, including Lightburn Hospital and Greenfield Park Nursing Home)
1 RC @ 3 sessions
Canniesburn Hospital 1 @ 1 session
Stobhill Hospital 2 @ 2 sessions each
2 @ 1 session each
2 @ 1 session vacant and unfunded
1 RC @ 2 sessions
Fourhills Nursing Home 1 @ 2 sessions
Western/Gartnavel 1 @ 2.5 sessions
1 @ 2 sessions
2 RC @ 6 sessions in total
1 Episcopal @ 1 session
Blawarthill 1@ 2 sessions
Drumchapel 1@ 2.5 sessions

Note 2
Part-time Chaplaincy in South Glasgow

SGH: RC p/t chaplain
1 session Episcopal
1 session Muslim
2 non-denominational sessions
VI : 3 sessions RC p/t chaplain
1 session Episcopal
1 session Muslim (? 2)
2 sessions non-denominational
Also partnership beds at Darnley Court (1 session) Rutherglen Takare

This assessment was completed from the results of a questionnaire which was sent to the Chaplaincy in each Trust in January 2002.

APPENDIX C

NHS HDL (2002) 76 - Spiritual Care in NHS Scotland

A Spiritual Care Committee

10

NHS Boards are required, in consultation with its service providers, to establish a Spiritual Care Committee to support the integrated planning and delivery of spiritual care services across the area they serve. The Committee should normally meet at least twice a year. Its membership should reflect the size and nature of the NHS organisations and faith communities in the area served. As a minimum it should consist of:

- An NHS Board nominee to act as convenor;
- Representatives of the main faith communities in the area served, nominated by the appropriate presbytery, bishop, faith community governing body or inter faith council;
- Two lay persons nominated by the local Health Council, or other appropriate patient representative organisation, such as a Patients' Council;
- Representatives of NHS staff with an interest in spiritual and religious care;
- Representatives of the area's spiritual care staff and volunteers; and
- The Head of the Department of Religious and Spiritual Care and the Spiritual Care Manager of each local service provider.

11

The remit of a committee should include:

- Providing advice on, and a forum for developing the NHS Board's spiritual care policy and overseeing its local implementation;
- Maintaining partnership between the local healthcare system, its spiritual care staff and local faith communities;
- Providing an advisory function to spiritual caregivers; and
- Overseeing the process of appointment of spiritual care staff.

12

Each local service provider may wish to establish a local sub-committee to oversee the delivery of the local spiritual care service. Membership of the sub-committee should reflect the size and nature of the organisation and faith communities in the area it serves.

APPENDIX D

NHS HDL (2002) 76 - Spiritual Care in NHS Scotland

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Appendix E

NHS GREATER GLASGOW
SPIRITUAL CARE SHORT-LIFE WORKING GROUP

Membership

Chair	-	Maureen Henderson, Director of Nursing, South Glasgow Trust
NHS Board Rep	-	Jim M Hamilton
North Trust Rep	-	Ian Crawford
Yorkhill Trust Rep	-	Rev. Alister Bull
Primary Care Trust Rep	-	John McLelland/John Crighton
Faith Reps:		
- Glasgow Presbytery (Church of Scotland)	-	Rev. Valerie Duff
- Judaism	-	Ephraim Borowski
- Glasgow Archdiocese (Roman Catholic Church)	-	-
- Muslim	-	Mr H A Sadiq/Mr Shah
- Buddhist	-	-
- Hindu	-	-
- Sikh	-	Mrs Ravinder Kaur Nijjar
Healthcare Chaplaincy Training and Development Unit	-	Rev. Chris Levison
	-	Andrew Moore
Humanist	-	John Kelsall
Hospital Chaplain Rep	-	Rev. Cameron Langlands
Partnership Forum Rep	-	Donald Sime
Local Health Council Reps	-	Mrs Pat Bryson Mrs Moira Ravey
Health Promotion (Advising on Fair For All)	-	John Crawford
Chaplaincy Co-ordinator, South Glasgow Trust	-	Rev. Blair Robertson
Head of Board Administration	-	John C Hamilton

JCH
April 2003

ANNEX B

NHS GREATER GLASGOW

Draft Spiritual Care Policy

Part I – Summary of Focus Group Responses:

Glasgow Churches Together & Scottish Inter Faith Council

Summary of points and concerns raised	Comments and action taken where required
1. Whilst recognising the difficulty of defining 'spiritual care' in a multi faith context suggest further definition would be helpful	Action: New Appendix B with further definitions included.
2. Concern over whether GGNHSB would take ownership of the values of the policy and back them with resources and support	The NHS Board wholly supports the Policy and its values and will look to the NHS Trusts/Divisions to implement local plans within available resources.
3. More emphasis needed on 'religious care' as opposed to 'spiritual care.'	Line 49: religious care is defined as an aspect of spiritual care on the assumption that while all people are spiritual people not all are religious.
4. Concern about confidentiality and the separation of the spiritual from the health related issues/	Access to patient health records is denied to health care chaplains under the Data Protection Act: this is under discussion both at Scottish and UK levels. It should be noted that in order to deliver appropriate religious and spiritual care Chaplains, as part of the health care team, are given information about a patient's medical care by clinical staff.
5. Roman Catholic representatives see the Bishop as having responsibility for the delivery of spiritual care (ref. line 54)	Partnership in working for the well-being of ill patients is crucial. Discussion with Glasgow Archdiocese of The Roman Catholic Church will be helpful to clarify this matter and a meeting is being arranged for the next few weeks.
6. "mechanisms to ensure that staff do not deliver spiritual care from their own particular spiritual or religious standpoint"	Action: Values section, line 52, now has the following: *That it is inappropriate for any member of staff to impose upon another person in the workplace their own religious beliefs, faith or values.* Staff training would include this aspect of care: see line 128.
7. Concern about word 'chaplain' and its applicability to all faith groups	UK wide moves towards professional registration of Chaplains will entail retention of title. Muslim chaplains, for example, are generally content to use the title as it gives an identity and a role which is understood by many people.
8. Concerns about training	Training needs and programmes will be the responsibility of local service providers. Chaplains have access to national training, including an MA in HealthCare Chaplaincy at Leeds University.

9. Need for a glossary to define the different sorts of chaplaincy	Considered but not felt necessary by the Working Group.
10. Ref. line 74: clearer definition of confidentiality required and insertion of 'patient' suggested	Action: 'patient' inserted before confidentiality at line 74.
11. The policy should suggest a size for Departments	This is the responsibility of local service providers (see Resources section at line 167).
12. Concerns about line management of priests	No change to policy but, as with Point No. 5, seeking discussions with Roman Catholic Archdiocese to try and resolve these concerns.
13. Concerns about Codes of Conduct, who they will apply to and who sets them	Chaplaincy Codes of Conduct have been produced by The College of Health care Chaplains, The Scottish Association of Health Care Chaplains and The Association of Hospice & Palliative Care Chaplains. They are presently not binding upon Chaplains but in due course, if Health Care Chaplaincy is admitted to the Health Professions Council, a Code of Conduct will be mandatory for all who are appointed as Chaplains.
14. "the draft policy should make reference to initial training, induction training and ongoing training."	Action: at line 129 the addition of "induction programmes for staff."
15. Ref section on 'Place' at line 142: 'the terms 'ought' and 'should' should be replaced with the term 'must.'	Action: amendments made to lines 147 and 154.
16. Consultation with faith communities in the provision of facilities must happen.	Action: at line 159 a line added to this effect.
17. Spiritual Care Committee must be representative	Agreed. This is covered by HDL (2002) 76.
18. Mechanisms to measure the impact of spiritual care so that it can be maximised	This will be one of the main tasks of the Sub-Committee. Also the Performance Assessment Framework and the monitoring work of the Health Care Chaplaincy Training and Development Unit will assist in this; also Patient Focus – Public Involvement agenda gives opportunities to assess effectiveness of service.
19. Suggest inclusion of 'religious' at line 13	It was intended that Spiritual Care included religious care much of which remains, quite correctly, the responsibility of faith groups.
20. "Chaplains can play a role in providing direction to individuals, should they desire it" and this should be stated at line 46.	This is contained within the bullet point: person centred means that if the person desires some direction that this will be explored with them.
21. Ref. line 50: include 'sacramental'	The word 'liturgies' is used to include the ceremonies/services of all faith groups; the inclusion of 'sacraments' may be considered inappropriate as they are specifically Christian.
22. Ref. line 73: suggested deletion of 'among many.'	This is included and retained because Chaplaincy is one of many components of the NHS working for the well-being of patients etc.

23. Ref. line 90: clarification of 'where appropriate.'	There are many policies and procedures where it is neither appropriate nor necessary to refer to the role of Chaplains (e.g. policy on anaesthetic consent). Action: However, for clarification this bullet point now reads*: In consultation with chaplains/spiritual care givers ensure that policies and procedures incorporate, where appropriate, their role (for example, Major Incident Procedures, Bereavement, Race Equality etc.*
24. Ref. line 93: suggest end of sentence to read*: 'or that they/their family request.'*	This is included already in what is said and the word 'visitor' allows for the inclusion of, for example, next of kin who are not relatives.
25. Ref. line 112: suggested inclusion of 'sacrament' after ''ceremonies.'	As at Point No. 21.
26. Ref. line 147: suggest amend to read: 'all faiths or no declared faith.'	The amendment implies that everyone has a faith, whether they state it or not, which is not the case. The amendment does not allow for the recognition of the spiritual needs of those who have no faith.
27. Ref. line 147: suggested inclusion of 'staff, visitors and patients' after 'people.'	Action: new sentence at line 153: *All such facilities will be available for use by patients, visitors and staff.* New European legislation makes mandatory the provision of space for religious observance by employees.
28. Ref. line 169: suggested amendment to 'Local service providers are required to regularly review …'	HDL (2002) 76 makes mention of having systems in place to monitor and review the service and this ought to be part of implementation plans. At this stage the policy is asking for a review of provision with the recognition that it may be the first ever review.
29. Ref. line 182: Suggested change to 'NHS Greater Glasgow will ensure that, where NHS funds are used to procure services from non NHS bodies, that these services will operate within the provision of spiritual care.'	The Working Group felt that the original text conveyed the strength of the message they were trying to get over.

NHS GREATER GLASGOW

Draft Spiritual Care Policy

Part II - Summary of Consultees Responses

Consultee	Summary of points and concerns raised	Comments and suggested action
A Professional Advisory/Consultative Committees		
A1 Area Medical Committee	1. 'some clarity about where chaplains would be able to turn for their own emotional, psychological, pastoral and spiritual support' 2. encourage connection of spiritual and psychological care by services 3. spiritual care most relevant in palliative care and links ought to be made 4. support of patients' 'spiritual advisors' is important	1. The supervision of chaplains is referred to in HDL (2002) 76 and ought to be part of the local implementation plans. Action: addition at line 133 to this effect.. 2. Action at local level. 3. Agreed. Action at local level in addition to current arrangements. 4. Agreed.
A2 Area Nursing & Midwifery Committee	1. Will the policy be available in other languages? 2. Nurses need to be reminded of their responsibility to be aware of spiritual needs 3. Need for Chaplaincy service to have a higher profile 4. Spiritual Care Committee members should have not only an interest but a practising faith	1. Once final Policy has been approved by the Board it will be translated into the 3 most commonly used community languages in our area. 2. Ref. line 128 covers training. 3. Agreed and much of the rationale of the Policy. 4. The Working Group believes that the composition of the Sub-Committee should cover a wider membership.
B NHS Trusts		
B1 Yorkhill NHS Trust Spiritual Care Group	1. clarify spiritual care and avoid confusion with religious care 2. provide a glossary to include HDL definitions? 3. Refer to spiritual needs of children and young people 4. Review on-call commitments and look at a pan-Glasgow service 5. Move administrative support to section on resources from place	1. Action: new Appendix B. 2. Considered but not felt necessary by Working Group. 3. Children and young people are included; concern that reference to any one particular group in the Policy would mean needing to refer to all groups. 4. Chaplaincy is to be division based but this could be reviewed if required by the Spiritual Care Committee. 5. Action: administrative etc. moved from line 155 to 179.

C **Local Health Council**		
C1 Greater Glasgow Health Council	1. Refer to policy as Spiritual and Religious Care Policy 2. Query name 'Chaplaincy Centre' as being biased against non-Christian religions 3. 'a service specifically for bereavement, which is not purely a Chaplaincy service, should be established' by GGNHSB 4. Church/chapel is inappropriate in a multi-faith society 5. Facilities for spiritual and religious care must be an integral part of the provision of new buildings and not an 'add-on.' 6. Ought to be lay representatives on Chaplaincy Training & Development Unit which is the monitoring body.	1. HDL (2002) 76 requires a 'Spiritual Care Policy' and the Working Group believes that 'spiritual' includes 'religious'. 2. The name for offices/centre etc would be a matter for decision at a local level. 3. The Working Group believed that such a service would be beneficial and would ask the Spiritual Care Committee to consider further. 4. As at 2 above. 5. Agreed – see lines 158/159. 6. There is Health Council Representation on the Unit's Management Group.
D **Local Authorities**		
D1 East Dunbartonshire Council (Social Work Comments)	1. Unclear as to the role of Health Care Chaplaincy in context of Primary Care 2. Unclear as to Chaplains having access to training and budget provision 3. Absence of washing facilities for Muslims in North sector is unacceptable	1. It is hoped that implementation of the policy will result in a higher profile of chaplaincy and the spiritual needs of patients in the primary care setting. 2. Ref. line 131: this means that chaplains, as with other staff, are able to attend all training courses offered by a Training Dept. This already happens in most cases. 3. Noted. Action will be required in line with implementing this policy at a local level.
E **MSPs**		
E1 Mr Bill Aitken MSP	1. 'if it ain't broke don't fix it' 2. no complaints therefore service is adequate 3. 'existing provision is adequate … difficulty in supporting transfer of funds'	1. Noted. 2. Noted. 3. Policy implementation will be in line with local competing priorities and within available resources.
F **Universities**		
F1 Dr Philip Cotton	1. query use of 'Department' – too compartmentalised: suggests 'Hospital Spiritual and Religious Care.' Decisions on a title should be regional not local 2. spirituality is a right as much as confidentiality 3. suggests spiritual and religious care has a group of 'trustees' drawn from all grades of staff 4. need for ethicists	1. Working Group discussed this and felt that no action was required – local matter. 2. Noted. 3. Spiritual Care Committee will have similar functions to those suggested. 4. Area for future discussion by Spiritual Care Group.

F2 Caledonian University Nursing Dept.	1. need for further definition of spiritual care 2. provide a framework for an implementation plan 3. reservations about term 'chaplaincy' – prefer 'spiritual care givers' 4. importance of a place 5. Role of a lay preacher 6. Importance of multi-disciplinary training in spiritual care 7. Who leads the training? 8. Crucial role of nurses in assessment needs highlighted 9. Evaluation of the service – how?	1. Action: new Appendix B. 2. Action: Reference at line 66. Para 15 of HDL suggested a possible framework. 3. UK wide moves towards professional registration of Chaplains will entail retention of title but some individual departments may adopt other titles as their needs require. 4. Agreed – see Lines 147 - 164. 5. Volunteers are used within Chaplaincy/Spiritual care services. 6. Training will often be at local level but ought to be multidisciplinary. 7. Training will be by a number of specialists including chaplains. 8. Agreed and will be a training issue. 9. Spiritual Care Committee role, Performance Assessment Framework and Health Care Chaplaincy Dept. Unit responsibility for monitoring and evaluation.
G **Social Inclusion Partnerships**		
G1 North Glasgow SIP Board Building People's Capacity Sub Group	1. Lack of facilities for ethnic minority groups, especially washing facilities for Muslim prayer which are 'non-existent in North Glasgow.'	1. Noted. Action will be required in line with implementing this Policy at a local level.
H **Faith Organisations**		
H1 Glasgow Quakers	1. develop the following: 'provision and design of worshipful spaces, provision and content of worshipful occasions, ensure that those who claim no traditional religious affiliation are aware of chaplains and the services they can receive from them and volunteers.	1. These are supportive and welcome comments which are in keeping with the thrust of the Policy.
H2 Jehovah's Witnesses	1. Welcome Policy and no significant issues.	1. Comments welcomed.
I **Community Councils**		
I1 Cambuslang	1. Another burden on the health service; is more management required? 2. Current arrangements are satisfactory and should not be changed.	1. HDL (2002) 76 arose from the feeling that Chaplaincy required greater ownership and management by the NHS so that there was proper oversight of the use of resources. 2. Noted.
I2 North Monitoring Group Comm. Council Rep.	1. 'I feel there is not enough spiritual needs and emotional care in the hospitals mentioned in the policy.'	1. This highlights the need for work on spiritual care and the development of a Policy to bring consistency and a framework to local plans.

I3 Kinning Park Comm. Council	1. Committee structure must be representative of population.	1. Noted – Appendix D sets out national guidance and all efforts will be made to get as many of the faiths involved as possible.
I4 Mearns Comm. Council	1. 'In today's multi-faith society the traditional format of hospital Chaplaincy is becoming untenable, for reasons touched on but not developed' 2. How can one chaplain be employed when there are so many groups, cults etc? 3. don't stretch NHS resources with a new department 4. no need for IT, secretarial assistance etc 5. 'this Draft is a set of well-intentioned but vague instructions.' 6. All that is required is a list of available ministers/priests of relevant faith (not on the pay-roll) and a quiet room 7. 'man cannot live by regulations alone.'	1. HDL (2002) and the Spiritual Care Policy attempts to address these concerns. 2. One of the tasks of the whole time chaplain is to refer patients as necessary to the appropriate spiritual/religious carers. 3. Policy implementation will be in line with local competing priorities and within available resources. 4. Noted. 5. The Policy provides a framework for local plans. 6. Noted. 7. Noted.
J **Community Forums**		
J1 Gorbals Comm. Forum	1. Are representatives of other faiths available? 2. Need for equality and anti-racist training 3. Are necessary finances and resources available?	1. At a minimum, contact persons can always be arranged and such a list should be in place in each site (Ref. lines 85-88). 2. Agreed. Also forms part of the Board's Race Equality Strategy and local training initiatives. 3. In addition to current provision (see line 72) the implementation of the Policy will be in line with the local competing priorities and within available resources .
J2 Health Service Forum South East	1. Pressure upon resources: 'to add the responsibility of spiritual care is a step too far.' 2. Provide a suitable room 3. Employment of religious/spiritual carers is remit of religions or groups	1. Ref. line 72: funding has long been a part of the NHS budget (see J1.3 – answer above). 2. This already happens in most sites. 3. The employment of chaplains/spiritual care givers is currently by faith groups and NHS Trusts. Payment is from the NHS and has been since its inception.
J3 PAIH (by e-mail)	1. Concerned about needs of Black, Minority and Ethnic patients.	1. Issue relevant to Race Equality Scheme.
K **GP's etc**		
K1 Dr Gary MacFarlane, GP	1. Who are local service providers? 2. implications for LHCC's and GPs?	1. 'Operating Divisions' rather than Local Service Providers (which has been used throughout the Policy). 2. These comments have been passed to the Primary Care Trust chaplains.

K2 Mr Bernie Pugh, Social Worker	1. Do only Church of Scotland Chaplains receive remuneration? 2. More community chaplains required	1. No. All Chaplains appointed to a post receive remuneration, including 2 part-time Muslim chaplains. 2. Welcome comment. Ref. line 169: Operating Divisions will be required to review provision.
K3 Dr Kishwar Sultana, GP	1. Offers assistance in assessing needs of Muslim patients.	1. Welcomed statement which will be followed up.
L **Staff**		
L1 Mr Mohammed Ishaq, Muslim Chaplain, VI	1. Comments relating to the implementation of the policy with particular reference to needs of the Muslim community.	1. Welcomed and issues of relevance to local implementation plans.
L2 Ms Tracy McFall, Planning Manager, CHD/Stroke, GGNHSB	1. Importance of training across all disciplines 2. 'the group should include representatives of academic institutions in Glasgow to ensure support of health professionals'	1. Wording at line 128/129 changed to include all staff 2. Spiritual Care Committee to consider when considering membership. .
L3 Niall McGrogan, Head of Community Engagement, GGNHSB	1. Good work of volunteers (eg the 400 at VI) should be noted and encouraged 2. commissioning of new buildings affords opportunity to engage with all faith communities – reiterate the Board's commitment	1. Agreed: new sentence on value of volunteers in 'people' section at line 136/137. 2. Agreed. For more emphasis new lines 159/161 added to this effect.
L4 Nurses Christian Fellowship	1. 'would there be sufficient financial support for the service and … enough chaplains and volunteers' 2. 'As nurses take a major role in caring for patients, could they not take a role in the spiritual care service as part of the team.'	1. The Working Group recognises the financial position of the Board and the difficulty in increasing expenditure. 2. This is affirmed: ref. lines 54-56 and 128.
L5 Dr Chris Williams, Gartnavel Royal	1. clarify definition of spiritual care 2. emphasise staff training needs 3. dangers of inappropriate spiritual abuse by staff 4. child safety issues	1. Action: new Appendix B. 2. Agreed – training is a cornerstone of the Policy. See lines 128/129 and addition to line 175. 3. Acknowledged at line 52, the following is included: "*That it is inappropriate for any member of staff to impose upon another person in the workplace their own religious beliefs, faith or values"*. 4. All employed chaplains are checked by Disclosure Scotland.