

SPIRITUAL CARE IN NHSSCOTLAND

SCOTLAND REPRESENTATIVE ON THE COUNCIL OF THE COLLEGE OF HEALTH CARE CHAPLAINS

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Abstract: On behalf of CHCC Scotland, the author welcomes 'Spiritual Care in NHSScotland,' while recognising that much depends on its local implementation. Its clarification of the nature of spiritual care, the role of the care giver and the sharing of patient information is timely. Reservation is however expressed about the role of the proposed Spiritual Care Committee.

The Scotland Branch of the College of Health Care Chaplains has welcomed the publication of the NHS Guidelines, and this has been echoed by the Council of the College at their meeting in November 2002. Indeed, College members in the rest of the UK have been jealous of the speed with which the matter has been pursued in Scotland, and of the detail of some sections of our Guidelines. The process of the Multi-faith Working Group in England has been considerably slower, and the final document from the Department of Health is still awaited!

The College has been deeply involved with the development of these Guidelines from the start when it was College members who urged the initial approach to the Scottish Executive Health Department for funding for the Training Officer post. It was from that point that the Executive's interest and involvement was stirred, and so much else has flowed. The College has been ably represented in all the discussions by Blair Robertson, Chaplain at the Southern General Hospital in Glasgow.

There has been a great deal written about spiritual care in the past decade – much of it in nursing journals. The majority of these articles start with a bold attempt to separate “spiritual” from “religious” care – and then proceed to get bogged down in confusion between the two. One of the major contributions of the Guidelines is their very clear differentiation: *“Religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyles of a faith community: Spiritual care is usually given in a one-to-one-relationship, is completely person cen-*

tered and makes no assumptions about personal conviction or life orientation.”

The way the Guidelines describe what the majority of patients look for in a chaplain, is also helpful in clarifying the role of the spiritual care giver in a way which many of us have argued for, but never before had formally laid down:

“a skilled and sensitive listener who has time to be with them. A person who will acknowledge the deep desires and stirrings of their spirit, recognise the significance of their relationships, value them and take them seriously. A person who can help them to find within themselves the resources to cope with their difficulties and the capacity to make positive use of their experience of illness and injury.

The College has been persuaded for several years of the need to develop the place of healthcare chaplaincy as a fully recognised healthcare profession, and it is for this reason that the College is working to establish Chaplaincy as a registered profession. The Guidelines clearly establish spiritual care as a central theme of healthcare in Scotland, and equally recognise chaplaincy as having a central place within that theme.

For the past four years, the Scotland branch of the College has been upholding the right of chaplains to be directly employed by their NHS boards or trusts, believing that this is the right way forward for a healthcare profession, rather than have chaplains seen as “outsiders” who are employed by the church and come into healthcare as visitors. The Guidelines

re-enforce that option, and have kindled a wider interest in this transfer of employment, with many people previously opposed to the idea now reviewing their stance.

One of the major concerns of the College throughout the UK in the past few years has been the whole question of data protection and confidentiality. In many places in England, even whole-time chaplains working in established departments are being denied information on the religious affiliation of patients. This matter has been the subject of lengthy discussions between the Scotland Branch of the College and the Scottish Executive, and we are pleased that the Guidelines have made clear that the sharing of information with chaplaincy/spiritual care departments is to be seen as the norm. The wording of this section has formed the basis of discussions at ministerial level in England with a view to improving the situation for our colleagues in the south.

Against this clear move to professional status for chaplaincy, can be placed the section of the Guidelines on the role of the Spiritual Care Committee. While the idea of local involvement is to be applauded, mirroring as it does the idea of local Health Councils which monitor the service and encourage accountability, the suggestion that spiritual care requires a separate body from all other sections of healthcare seems to run counter to the main thrust of the Guidelines. Why cannot spiritual care be monitored by the Health Council, like all other aspects of care? And why should the Spiritual Care Committee be empowered to oversee appointments? It is to be hoped that in the working out of this locally, some common sense will prevail, before we find local Nursing Care Committees responsible for the appointment of nurses!

The section on the employment of chaplains is, of course, misleading where it talks of the Board of National Mission of the Church of Scotland employing whole time and part time chaplains. The Church has resolutely refused in the past to grant part-time employment status to “sessional” chaplains. Pressure is currently being brought to bear by the College through our Amicus/MSF colleagues to have this anomaly corrected, so that all chaplains are employed on a whole-time equivalent basis, with all the rights afforded to them by the Part Time Workers (Prevention of Less Favourable Treatment) Regulations 2000. These rights include pro-rata payment, and the right to incremental increases in pay and things like holidays, pensions etc.

There is much to be welcomed in these Guidelines – but they are guidelines, and the important thing is how they are applied locally. The requirement on all NHS Boards to produce a local policy by the end of May is a tight timetable, but one which hopefully reflects the importance with which the Executive’s Health Department views the matter. It is in these local policies that the realities will be faced, and the cost of developing Spiritual Care will become a reality. The College hopes that boards will not flinch from providing well resourced departments to carry forward the policies, and, through our Amicus/MSF representatives on local partnership forums, we will be supporting all efforts to establish spiritual care in its proper place in the health service, and to ensure that Chaplains receive their full status and reward as NHS employees.

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