

## SPIRITUAL CARE IN NHSSCOTLAND

### THE ASSOCIATION OF HOSPICE AND PALLIATIVE CARE CHAPLAINS (SCOTTISH BRANCH)

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*Abstract: 'Spiritual Care in NHS Scotland' emphasises spiritual care as broader than religious care, and makes clear the importance of well resourced spiritual and religious care within healthcare. In response, chaplaincy must become more accountable and professional. There are implications for ongoing training and registration of chaplains, and this may well create difficulties for part time and volunteer chaplains, as well as for church authorities. However, the Guidelines are to be welcomed as a means to improving practice in healthcare settings.*

This document might at first be a little daunting to anyone coming to it without a familiarity with Government papers. It is useful, therefore to have seen the resume prepared by the (Scottish Executive funded) Healthcare Chaplaincy Training and Development Unit.

It is recognised that spiritual care is not necessarily religious and that religious care, at its best, should always be spiritual. It is also stated in the 'Guidelines' that people who may be confronting serious or life-threatening illness or injury, have spiritual needs and welcome spiritual care. The 'Guidelines' then go on to detail the kinds of questions which arise for people caught up in such situations, recognising that a Chaplain or Spiritual Care Giver will be concerned for the patients and for their relatives, carers and friends, but also for the staff of the place where they work.

There is a good deal of information on how NHS Boards and Trusts should organise themselves to make sure that spiritual and religious care are resourced and given in those institutions and communities for which they are responsible. This is important for Chaplaincy, as it makes clear that NHSScotland accept that good, well resourced spiritual and religious care is part of what patients, carers and staff ought to be able to expect in healthcare settings in institutions and the community.

Some of the decisions on how best to deliver spiritual and religious care are to be made by Boards (and Trusts where the Board decides that this is necessary), based on local assessed need. With figures on which to base such decisions, people may be appointed as spiritual and religious caregivers, and their expressed needs and religious affiliation (if any) will be documented, with a system put in place for referrals.

It is also made clear that individual spiritual caregivers must have 'clear and recognisable lines of accountability for their professional conduct', and that any volunteers are selected and appropriately trained.

All this means a more accountable and a more professional service will be expected in return for better recognition of the job done by Chaplains. This is a big step in a positive direction, but with this greater exposure of what 'Chaplaincy' is about comes the responsibility on the part of chaplains to make sure that the service we offer is adequate to do the tasks expected of us. This seems to me to mean that training of chaplains will have to be on-going and documented and that to remain a chaplain we will have to register with our professional body. Which organisation that will be, CHCC, SACH or AHPCC will become clearer in the future, but no one should be able to practice as a spiritual and religious caregiver without such registration.

While none of what has been said will (I hope) be news to whole-time chaplains, it may be more difficult for part-time chaplains, or volunteer chaplains, to see the necessity of conforming to more rigorous requirements (qualifications, documentation etc). It may be even more difficult for a bishop or a presbytery, faced with a request for a chaplain in a healthcare setting, to understand that the 'very person' who happens to be available, may not be acceptable. And with the very real shortage of ministers and priests of all denominations, the vocations of lay people may at last become more recognised.

But I work in a hospice, and hospices do not come directly within the net of NHSScotland, although some of the money which hospices receive does come from the Health Service. This does not mean that these 'Guidelines' say nothing to hospices. Palliative care units exist within NHS Hospitals as

well as hospices and good practice is good practice where ever it occurs.

It is my belief that good and improving practice in NHS healthcare chaplaincy will not just have a beneficial effect on chaplaincy in hospices via osmosis, but that hospice managers and their chaplains must continue to have an influence on the thinking and analysis behind what is planned for development of pastoral spiritual and religious care in healthcare settings, and indeed can be at the forefront of such thinking and planning for the future, because it is the welfare and benefit of patients carers and staff for whom we are all, together, concerned.

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