

trative burden outlined above and would eliminate employer's on-costs and employer's pension contributions thereby making a substantial overall contribution to cost reduction.

The current system is cumbersome and inefficient. While there would be some cost savings for the church, these are not the main reason for the proposed changes.

What might be the drawbacks of such a move? Some chaplains might be concerned that direct employment would compromise their independence within the institution. Our experience from other forms of chaplaincy suggests that this is not likely to be the case. Other chaplains might feel that the church is trying to detach itself from them; nothing could be further from the truth. It might also be felt that "religious" care was being downgraded to pro-

mote "spiritual" care, but the "Fair for All" agenda will ensure that appropriate religious care continues to be provided.

Healthcare chaplaincy is growing and developing and becoming better understood and recognised. It is important that it should not be regarded as a service for the 'religious' people in the institution. The church will continue to be partners in the provision of spiritual and religious care of patients, but for chaplaincy to develop its full potential it should not be seen as belonging to the church, but to the health service, meeting the spiritual and religious needs of patients and staff.

As the spiritual well being of patients is increasingly recognised in improving outcomes for care, spiritual care will be seen as vital in any patient focussed healthcare.

Who employs the chaplain in NHS Tayside?

Gillian Munro

Head of Department of Spiritual Care
NHS Tayside

When I came to Tayside just over a year ago, I was appointed to a directly employed post. We already had two such posts, one part time chaplain and the chaplain working in the specialist palliative care unit. The rest of the team were employed by the Church of Scotland, the whole timers directly through the Board of National Mission, the part timers through the four presbyteries in the area, and the denominational chaplains nominated by their bishops. So we had one team employed in a number of ways, answerable to various people and with different conditions of employment.

Part of that first year was spent working with the Board of National Mission to have our part time chaplains paid the pro rata rate for the valuable work they do. Fortunately the work of our whole time chaplains had always been acknowledged appropriately and recognition made of any pay increase or

increments. But as with a number of health boards there was no one to monitor what was happening with the part time chaplains, and so they often lagged behind. I am pleased to say this has now been resolved. Yet it seems that while one group is responsible for financing the service and another for appointing the chaplains, this may be a yearly debate, and seems to me to devalue the work done by our part time chaplains.

Then there is the question of the **appointment** of part time chaplains. I should point out here that we do not differentiate between part time chaplains and sessional chaplains as there is no place in employment legislation for such a category. However, so long as part time chaplains are **appointed** by the church, they do not have appropriate conditions of employment such as entitlement to holiday cover, sick pay, maternity leave, etc. in the past when most

part time chaplains were parish ministers perhaps these things were not such an issue. Now we have a number of very able part time chaplains whose chaplaincy is their only work, therefore these issues are necessarily of importance. Furthermore, is it not simply wrong to have people doing work for which they do not receive appropriate entitlements? There is an established mechanism within the NHS for the employment of all of these people, so to transfer to direct employment seems to me the most appropriate way to go.

Perhaps the most important reason for transferring all chaplains to direct employment is to encourage them all to recognise themselves and to be recognised by other staff members as part of the integrated health care team. One concern of whole time

chaplains has been that they might lose their valued independence of being employed by the church. But they are still financed by the NHS, so how strong is this argument? Personally I have found my professionalism respected in my directly employed role whether I am speaking as an advocate for patients or for the team delivering spiritual care.

While valuing the work done by the staff of the Board of National Mission for many years in employing, appointing and supporting healthcare chaplains, it seems that with the highlighting of the importance of spiritual care in the NHS the time has come to recognise chaplains as an essential part of the healthcare team, by employing them in the same way as all other members of staff.

Playing Cards with the Octopus.

Ken Coulter

Chaplain
Stobhill Hospital, Glasgow

Time for cards on the table. Firstly, I am not a Presbyterian; though I have some very good friends who are. I come from a different authentic Christian tradition. Secondly, my political leanings are left of centre. The first comment may explain what follows, and the second... well I've always wanted to write this but churches don't always want to know. Underneath is a world-view of co-operation – "from each according to his ability, to each according to his need"

In 1998 at Stobhill we prepared a paper for management on ways forward for chaplaincy and meeting the then Scottish Home and Health Department (SHHD) recommendations. One option was called 'privatisation'. This politically loaded term, which we weren't happy with, described the then contemporary shift of responsibility for provision of services from direct employment to contractors in areas such as catering and domestic services.

Then as now, Stobhill chaplaincy was provided by a part-time team under three Denominational banners: Church of Scotland, Roman Catholic and Episcopalian. At times, this institutional trinity proved cumbersome and not always responsive to local needs for us or for management. On the horizon in 1998 was the Ambulatory Care and Diagnostic Centre (ACAD), the beds were becoming fewer and the stays in hospital shorter. We desired to be responsive to these developments.

The vision was to create a chaplaincy co-operative that would contract with the hospital to provide Chaplaincy services. In our budgeting of this we allowed for one full time chaplain and eight part time chaplains and included a figure for training and administration. The total cost of this was similar to the hospital fully implementing the SHHD recommendations

We argued that the advantage to the hospital was a more accountable and professional group to deal