

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

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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

with. This was significant for management who perceived that the chaplains were being paid for but could not be effectively managed.

For the chaplains there would result greater control over resources, and the provision of a more flexible and locally responsive service to the hospital would be enabled. Such an arrangement would impose business like disciplines, remove the almost voluntary set of relationships team members had with each other and increase accountability. This last comment betrays an underlying weakness of a part time team who are moonlighting in the hospital.

Removed from denominational constrictions, based on an outdated formula of religious affiliation in an area, focus could be on the abilities of different members of the team to address specific needs within the hospital. In vision it appeared as a way of creating a closer ecumenical and spiritual community. We also saw ourselves as having a greater stake in the hospital and not having to relate to some distant denominational body.

The perceived disadvantage was more administrative work.

The paper was well received, encouragement was given, and in yet another re-organisation, those with whom we had built understanding moved on elsewhere. The only negative comment was regarding chaplaincy as being about spirituality not business plans. This was not a dichotomy we saw, as our desire was to provide an improved service for the hospital, but the warning was there.

Six years on, the seascape is different. The ACAD is closer. HDL (2002)76 has happened, but is not omnipresent. Privatisation has been reversed. The wards are fewer, the stays shorter and the budget redder. Some of us have seen the advantages of a denominational body in negotiating on behalf of small fish with a Trust that resembles a blue whale crossed with an octopus. Yet still, if anyone wants to play cards with us ... the table is open.

A Roman Catholic Perspective on Direct Employment

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Within a few months of its publication, I and my colleagues seemed to be eating, sleeping, breathing and even dreaming NHS HDL (2002) 76. As Argyll & Clyde developed its spiritual care policy so meeting followed meeting and tension built on tension. On more than a few occasions the gathered body of religious and spiritual care providers would have benefited from some of the peace and tranquillity they strive to bring others.

Why the tension? Several areas of difficulty contributed to it, concerning, for example, analysis given of today's society, the training and registration of chaplains, the implications of the data protection act, and the employment of chaplains, about which I will say more in a moment.

Significantly, it seemed to some of us that, in HDL (2002)76 and the draft policy which flowed from it, the death of religion was a given, and that "spirituality" had taken its place.

"Chaplains in healthcare settings who once offered a purely religious ministry to members and adherents of their own denomination now devote most of their working time to patients, carers and staff who have no link with any faith community..." (NHS HDL(2002)76)

Is that really the case? In my experience of the Royal Alexandra Hospital in Paisley most of the people with whom I came into contact were people of faith who did have a link with a faith community. Most of them declared themselves to be religious people, linked with a particular religion. Perhaps the