



NHS England Chaplaincy Guidelines 2015:

Promoting Excellence in Pastoral,
Spiritual & Religious Care

Equality Analysis

OFFICIAL

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Target Audience	Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of Nursing, NHS Trust Board Chairs, NHS Trust CEs
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Additional Circulation List	Chaplaincy Associations, Community and Voluntary Sector partners and organisations, Trade Unions, Royal Colleges, Universities UK, Higher Education Institutions, Regulators.
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Description	The Equality Analysis of the NHS Chaplaincy Guidelines ensures compliance with the Equality Act 2010 and the Public Sector Equality Duty; ensuring due regard to advancing equality for people on the basis of certain protected characteristics, including religion or belief. The document responds to changes in the NHS, society and the widening understanding of pastoral, spiritual, and religious and care.
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Cross Reference	NHS Constitution, NHS England 'Putting Patients First', The NHS England Business Plan for 2013/14 - 2015/16, Equality Act 2010
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Superseded Docs (if applicable)	Replace the 2003 NHS Chaplaincy Guidelines
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Action Required	NA
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Timing / Deadlines (if applicable)	NA
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NHS England Chaplaincy Guidelines 2015: Equality Analysis

Promoting Excellence in Pastoral, Spiritual & Religious Care

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Prepared by: Scott Durairaj on behalf and in partnership with the National Equality and Health Inequality Team, NHS England

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The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

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1 Equality Analysis

Title: NHS England Chaplaincy Guidelines 2015

What are the intended outcomes of this work? Include outline of objectives and function aims

From 1st April 2013, The NHS Chaplaincy programme moved from the Department of Health to NHS England. The NHS Chaplaincy programme and budget of £159,000 is project managed by the Free Churches Group on behalf of NHS England and assurance is monitored through a Service Level Agreement.

The NHS Chaplaincy programme is part of NHS England's drive to ensure good patient care and compliance with policy and legislative drivers:

- Equality Act 2010 and the Public Sector Equality Duty – ensuring due regard to advancing equality for people on the basis of certain protected characteristics, including religion or belief
- Compliance with the NHS Constitution principle 1 of ensuring comprehensive service for all irrespective of gender, race, disability, age, sexual orientation, gender identity, religion or belief.
- The Human Rights Act 1998 incorporates the Council of Europe's Convention on Human Rights (ECHR) into UK law, including its guarantee of freedom of religion or belief:

The revision of the 2003 NHS Chaplaincy Guidelines was a key deliverable for the NHS Chaplaincy programme for 2013/14. These guidelines replace those published in 2003 and provide a comprehensive description of good practice in chaplaincy care for the NHS in England.

The document responds to changes in the NHS, society and the widening understanding of spiritual and religious care. It has been updated to reflect the wider religion and belief groups supported across the NHS.

Who will be affected by this work? E.g. staff, patients, service users, families and carers, partner organisations, wider community etc.

The guidelines will affect those working in chaplaincy, spiritual and pastoral care across different NHS care settings or responsible for commissioning and designing those services locally. Their aim is to provide better spiritual and pastoral care for patients, service users, carers and staff accessing this service.

2 Evidence

What evidence have you considered? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section on page 9 of this template.

The following sources of evidence were used to support the development of the Equality Analysis:

- Engagement with key stakeholders during the development of the guidance
- 2011 ONS Census Data
- British Social Attitudes Survey, 2013
- Review of existing Equality Analyses for similar policies and procedures
- Research on religious and non-religious identification

2.1 Age

Consider and detail age related evidence. This can include safeguarding, consent and welfare issues.

The 2011 census data shows that the age profiles of those belonging to each religion are very different, with Christians having the highest median age (45) and Muslims the lowest (25).(Table 1)

	Population in thousands	Median age in years
All categories: Religion	56,076	39
Christian	33,243	45
Buddhist	248	37
Hindu	817	32
Jewish	263	41
Muslim	2,706	25
Sikh	423	32
Other religion	241	42
No religion	14,097	30
Religion not stated	4,038	40

Table 1: Total population and median age of religious groups (England & Wales 2011)- all usual residents

Source: Office for National Statistics, 2011

The age groups from 0-49 have a greater percentage of people identifying as having no-religion compared to the average for England (24.7%) (Table 2).

Religion	0-17	18-34	35-49	50-64	65+	England
Christian	50.8%	46.5%	57.4%	69.2%	80.5%	59.4%
Buddhist	0.3%	0.6%	0.6%	0.5%	0.2%	0.5%
Hindu	1.5%	2.3%	1.5%	1.3%	0.8%	1.5%
Jewish	0.5%	0.4%	0.4%	0.5%	0.6%	0.5%
Muslim	8.5%	7.0%	4.6%	2.3%	1.2%	5.0%
Sikh	0.9%	1.1%	0.8%	0.7%	0.4%	0.8%
Other religion	0.2%	0.5%	0.6%	0.6%	0.2%	0.4%
No religion	29.5%	35.1%	27.4%	17.5%	8.4%	24.7%
Religion not stated	7.8%	6.5%	6.5%	7.5%	7.7%	7.2%

Table 2: Breakdown of religious belief by age group (England 2011) - all usual residents

Source: Office for National Statistics, 2011

There is no strong evidence to suggest that people from different ages would suffer any adverse impact because of the implementation of these guidelines, although it is unclear that with a higher proportion of younger people identifying as having no-religion whether the current and future service offer will be appropriate.

It is also of note the significant increase in Muslim 0.17 age range. This will impact on both chaplaincy and in particular chaplaincy maternity and paediatric services.

The NHS chaplaincy guideline positively considers the needs of people of different ages through the development of spiritual and pastoral support in a range of specialities including Specialist Paediatrics and Palliative care.

The guideline states 'Chaplains have a unique potential to support approaches which view the patient or service-user holistically'. The service could meet the particular needs of people transitioning between services for young people and services for adults by supporting the continuity of the spiritual care needs of that person during transition and also their family members. It is recommended that this chaplaincy function be considered for inclusion in the guideline review.

The guideline also includes 'Implementation of the guidance will improve support for patients, carers and staff across the health service' and further highlights the importance of safeguarding. Together these could have a positive impact upon ensuring the specific spiritual and pastoral needs of young carers are met. It is also recommended that this chaplaincy function be considered for inclusion in the guideline review.

The role of chaplaincy to help NHS England deliver their priority policy area for frail older people: 'Safe, compassionate care for frail older people using an integrated care pathway' (<http://www.england.nhs.uk/ourwork/pe/safe-care/>) is not referenced. Recommend at the review the guidance is harmonized.

The role of chaplains and the impact upon staffing ratios during times of winter

pressures is not mentioned. Recommend it is factored in at the review.

2.2 Disability

Consider and detail disability related evidence. This can include attitudinal, physical and social barriers as well as mental health/ learning disabilities.

According to the 2011 census, it does not appear to be any substantial difference in terms of religion or belief between disabled people and the general population (Table 3)

Religion	Long term sick or disabled	England
Christian	60.1%	59.4%
Buddhist	0.4%	0.5%
Hindu	1.0%	1.5%
Jewish	0.3%	0.5%
Muslim	5.6%	5.0%
Sikh	0.8%	0.8%
Other religion	1.0%	0.4%
No religion	22.9%	24.7%
Religion not stated	7.8%	7.2%
	100.0%	100.0%

Table 3: Breakdown of religious belief by disability (England 2011)

Source: Office for National Statistics, 2011

There is no strong evidence to suggest that disabled people would suffer any adverse impact because of the implementation of these guidelines, although a number of recommendations to improve positive impact are included below.

Reasonable adjustments

The chaplaincy guidelines require that patients and service users are given access to the most suitable chaplain to meet their spiritual needs. Access would include chaplains ensuring that reasonable adjustments were made for disabled people to overcome any disadvantage.

There is not a definitive set of requirements for reasonable adjustments within NHS chaplaincy services. The guideline (p10) gives an example of assistance in transporting patients to collective acts of worship. On pg 5 of the guideline, the Equality Act 2010 is mentioned as a key driver and as such the statutory code of practice for services issued by the Equality and Human Rights Commission (2011) has effect, including guidance on making reasonable adjustments.

Other examples (i.e.pg.14) of reasonable adjustments may include allowing extra time to support a disabled individual to avoid them facing a disadvantage, or ensuring that multi-faith and belief spaces are physically accessible or that loop systems used by some people who are hard of hearing are used by chaplaincy staff.

Accessible information

Page 19 of the guideline cites 'Poor communication skills' of chaplains create potentially serious risks for the patient and the organisation. The duty to make

reasonable adjustments under the Equality Act 2010 always – and specifically – includes the provision of accessible information for disabled people.

As well as ensuring that NHS chaplaincy services communicate accessibly, chaplains' holistic view of people's needs (p20) and their duty to safeguard vulnerable adults and children (p8) mean that the guideline could positively support services that meet people's communication needs, e.g. in arranging for an interpreter to be brought in or for information to be provided in Easy Read format suitable for someone with a learning disability.

There is an entire section (p18) on information governance, which concerns the effective sharing of information to ensure that people can access spiritual and pastoral support services. It is recommended during the review that this be updated to include reference to the Accessible Information Standard (NHS England 2015) so that disabled people with specific communication needs can access the service and experience continuity of communication support across different care providers.

Mental Health

The benefits of pastoral and spiritual support to promote spirituality are positive for some individuals' recovery (Gilbert 2008)¹ and promote resilience (Davydov et al. 2010)². The guideline require NHS chaplains (p14) be skilled at working with people to ensure that spiritual concerns are addressed in ways that enhance resilience and support healthy living.

The guidance does not address the increasing number of out-of-area placements that dislocate adults and children and young people in mental health inpatient units from their familial and local spiritual support networks. This potentially misses a vital role the chaplain could play in providing and coordinating pastoral support across areas and sometimes-long distances.

More significantly the chaplaincy staffing ratios for mental health care (p14) indicate they must take into careful consideration the composition and needs of the user population by religion or belief. However the impact of moving a person with a minority faith or belief out-of-area and into a locality with very little or no local appropriate chaplaincy provision could be detrimental to their spiritual needs, and it is unclear how planning of chaplaincy based on composition could be achieved when the user population is not static. It is recommended that this must be updated during the review.

The guidance does not address (or cross-reference) chaplaincy staffing-ratios for the three high-secure mental health hospitals. It is recommended that the current strategy for providing spiritual and pastoral support in these care settings be reflected within this guideline during the review.

¹ Gilbert, P. "Guidelines on Spirituality for Staff in Acute Care Service: Recognising a person's spiritual dimension is one of the most vital aspects of care and recovery in mental health" (2008) Staffordshire University.

² Davydov, Dmitry M., et al. "Resilience and mental health." *Clinical Psychology Review* 30.5 (2010): 479-495.

2.3 Gender reassignment (including transgender)

Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment.

There is no nationally standard for monitoring Gender Reassignment within the NHS to inform this analysis. There is limited available UK evidence on the religious attitudes of Trans* people, although The Trans Mental Health Study 2012 found:

Most people who took part stated that they had no religious beliefs (62%). Of those who did, the majority were Christians (20%), with Pagans (6%) and Buddhists (3%) being the next highest groups represented. Jews, Muslims and Sikhs accounted for less than 1% of the sample each, whereas Hindus were not represented at all. Again this is not representative of the UK population as a whole and religious inclusion is an on-going difficulty for UK trans and LGBT support groups and research studies. (McNeil et al. 2012)³

The guideline recognises (p.6) that 'the need for chaplaincy departments to advise providers about equality and access has increased'. It is implicit that trans* people will require pastoral or spiritual care within any of the specialities that chaplaincy services support as set out within the guideline.

The guideline specifies (p7) that chaplains must abide by all requirements of NHS/ NICE standards. This includes the generic Quality Standard for patient experience in adult NHS services (NICE 2010) that includes the requirement that care 'should be culturally appropriate' and will include the Department of Health and NHS co-branded guidance 'Bereavement: A guide for Transsexual, Transgender people and their loved ones' (2007)⁴.

The absence of Trans* data suggests that as part of the review it is recommended that NHS England engage with religious and belief organisations that have a special Trans* interest to ascertain experiences and awareness of spiritual and pastoral support services. For example, the Metropolitan Community Church, or the Imaan LGBTQI Muslim Support Group or the Gay and Lesbian Humanist Association (GALHA)

2.4 Marriage and civil partnership

Consider and detail evidence on marriage and civil partnership. This can include working arrangements, part-time working, caring responsibilities.

There is no available quantitative data relating to religious affiliation by marriage and civil partnership within NHS services. There is no strong evidence to suggest that married or civil partnered people would suffer any adverse impact because of the implementation of these guidelines.

Whilst the duty to promote equality of opportunity does not include the protected characteristic of 'marriage or civil partnership', this assessment includes the positive

³ McNeil, Jay, et al. "Trans mental health study 2012." *Retrieved from Scottish Transgender Alliance* (2012).

⁴ Whittle, Stephen, and Lewis Turner. "Bereavement: A guide for Transsexual, Transgender people and their loved ones." (2007).

impacts for people who are married or civil partnered. The guideline ensures that 'Chaplaincy provides highly skilled and compassionate spiritual support for... carers'. This will for many carers include a caring relationship by virtue of their marriage or civil partnership to a patient or service user, so they will potentially benefit from implementation of the guidance locally.

Services have traditionally arranged for bedside marriages within inpatient units, thus promoting family life (Article 8 of the European Convention on Human Rights). The guidance also provides clearer standards for multi-faith and belief working within chaplaincy. Although too detailed for this guidance, this in effect may include determining local arrangements (p6) for sign-posting people who are using NHS services who require support for religious, civil or humanist bedside marriages, unions or civil partnerships or for providing naming ceremonies and funeral guidance etc. It is recommended during the review that this function of chaplaincy is made clearer.

2.5 Pregnancy and maternity

Consider and detail evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities.

There is no available quantitative data relating to religious affiliation by pregnancy and maternity within the NHS. There is no strong evidence to suggest this group would suffer any adverse impact because of the implementation of these guidelines.

The guideline states 'Chaplains have a unique potential to support approaches which view the patient or service-user holistically'.

Chaplaincy services could positively meet the particular spiritual care needs of pregnant women (including those suffering illnesses or complications connected with pregnancy), or those women who have had a stillbirth or women in their maternity period. This also extends to her family members, including her child (ren), for example through helping with baptismal and baby-naming ceremony arrangements. This is not specifically covered in the guidelines and should be considered as an extension as part of a review of the guidelines.

The guidelines does include the value of spiritual support for people facing various 'harrowing situations', including sudden infant death (p7), which can occur in the 26-week period of maternity covered by the protections of the Equality Act 2010.

2.6 Race

Consider and detail race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers.

There is potentially a link between race and religion, as some religions have a bigger concentration in some ethnic groups. Religious affiliation can be seen as part of a national / cultural identity which would explain such a concentration.

According to the 2011 Census, in England and Wales, of the 59.4% of the population who identified as Christian, 93 per cent were White and 89 per cent were born in the UK, though the numbers have fallen since 2001.

Nearly four in ten Muslims (38 per cent) reported their ethnicity as Pakistani, a 371,000 increase (from 658,000 to over a million) since 2001. Nearly half of all Muslims were born in the UK.

The majority of people with no religion were White (93 per cent) and born in the UK (93 per cent) and these groups have increased since 2001.

Religion	All Ethnic groups	White	Other white	Mixed	Asian	Black: Total	Other ethnic group: Total
Christian	59.4%	64.0%	67.6%	46.3%	10.7%	69.2%	19.9%
Buddhist	0.5%	0.2%	0.4%	0.8%	3.5%	0.2%	0.6%
Hindu	1.5%	0.0%	0.2%	0.8%	18.6%	0.3%	1.5%
Jewish	0.5%	0.5%	1.3%	0.4%	0.1%	0.1%	2.1%
Muslim	5.0%	0.2%	4.4%	8.4%	43.6%	14.5%	51.1%
Sikh	0.8%	0.0%	0.1%	0.4%	8.8%	0.1%	7.4%
Other religion	0.4%	0.4%	0.5%	0.6%	1.0%	0.4%	0.6%
No religion	24.7%	27.6%	17.4%	32.2%	8.2%	7.4%	9.2%
Religion not stated	7.2%	7.1%	8.1%	10.1%	5.6%	8.0%	7.6%

Table 4 : Breakdown of religious belief by ethnic group (England 2011)

Source: Office for National Statistics, 2011

There is no strong evidence to suggest that people from different racial groups would suffer any adverse impact because of the implementation of these guidelines.

The guideline addresses the provision of multi-faith or belief chaplaincy, which may positively impact access to services for people from particular ethnic groups, with the caveats around mental health noted in the disability analysis section earlier in the EIA.

Page 20 of the guideline cites 'Poor communication skills' of chaplains create potentially serious risks for the patient and the organisation. The guideline also specifies (p7) that chaplains must abide by all requirements of NHS / NICE standards. This includes the generic Quality Standard for patient experience in adult NHS services (NICE 2010)⁵ that includes the requirement that care 'should be culturally appropriate' and that it should:

'...Be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Patients

⁵ NICE (2012) Quality standard for patient experience in adult NHS services. NICE quality standard 15. Available at www.nice.org.uk/qs15

should have access to an interpreter or advocate if needed'

It is recommended that as part of the review the role of the chaplaincy service in arranging for and providing interpreters and communication support for people who have little or no English is made clearer.

2.7 Religion or belief

Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.

People who identified as Christians were the largest religion or belief group (59.4% or 31.5 million people) in England in the 2011 national census. People who identified as having no religion were the next biggest identified group (24.7% or 13.1 million) with those identified as Muslim the third largest group (5% or 2.7 million).

- The religion question was the only voluntary question on the 2011 census and 7.2 per cent of people (3.8 million) did not answer the question.
- In 2011, London was the most diverse region in terms of religion and belief with the highest proportion of people identifying themselves as Muslim, Buddhist, Hindu and Jewish. The North East and North West had the highest proportion of Christians.

Religion		Percentage
Christian	31,479,876	59.4%
Buddhist	238,626	0.5%
Hindu	806,199	1.5%
Jewish	261,282	0.5%
Muslim	2,660,116	5.0%
Sikh	420,196	0.8%
Other religion	227,825	0.4%
No religion	13,114,232	24.7%
Religion not stated	3,804,104	7.2%
	53,012,456	

Table 5 : Religious affiliation in England 2011

Source: Office for National Statistics, 2011

The British Social Attitudes (BSA) survey has been published annually by the National Centre for Social Research since 1983, and contains around three thousand interviews each year conducted with a representative sample of the British population.

The BSA reveals a slightly difference picture with a higher percentage of people indicating that they do not identify with any religion (table 6). The increase in this group appears to be linked to a decline in numbers of people reporting an affiliation with the Church of England

	1986	1993	1996	2000	2006	2012
1 Church of England / Anglican	37	32	29	30	22	20
2 Roman Catholic	10	11	9	9	9	9
3 Other Christian	16	16	15	16	16	17
4 Non-Christian	3	3	4	5	6	6
5 No religion	34	37	43	40	46	48
8 Refused/Not answered/DK	0	0	1	1	1	0

Table 6 : Religious affiliation in England 1986-2012

Source: BSA, 2012

The BSA also show that when people were asked how often they attended services or meetings connected with their religion in Great Britain (apart from special occasions such as weddings, funerals and baptisms) 55 per cent stated that they never or practically never attended.

The BSA survey⁶ also highlighted some differences in attitudes between religious and non-religious people which might have an impact on the level of demand for a chaplaincy service:

- 71% of religious people and 92% non-religious (82% in total) believed that a doctor should be allowed to end the life of a patient with an incurable disease 29% of religious people believed pre-marital sex is wrong, compared to 3% of non-religious people
- 50% of religious people believed homosexuality is always or almost always wrong

The guidelines set out a framework for the provision of multi-faith and belief spiritual and pastoral support that is expected to have a positive impact on the wellbeing and recovery for people with either religious or non-religious beliefs using NHS services.

The guideline also sets basic requirements for *the provision of suitable areas for worship, prayer and contemplation for spiritual and pastoral needs to be supported. Further more specific guidance on this matter produced by Manchester University is made requisite for services (p.21) in the management of such facilities.*

There has been engagement throughout the development of the guidelines with the Healthcare Chaplaincy Faith and Belief Group (HCFBG), which includes members from major religious and belief organisations.

Separately there has been disagreement about the use of the word 'chaplaincy' with concern expressed by the British Humanist Association (BHA). Whilst the words:

⁶ McAndrew S. (2009) 'Religious faith and contemporary attitudes', in Park, A., Curtice, J., Thomson, K., Phillips., Clery E., and Butt, S. British Social Attitudes: the 26th Report, London: Sage

'chaplaincy' to describe the service, and 'chaplain' to describe the role, both have a religious association according to the Oxford English Dictionary⁷, the word will be retained for the purpose of these guidelines with the recommendation that the issue of naming conventions be addressed within a future review.

Differences in opinion on role titles within the NHS are not without precedent, for example the decision of the Department of Health to reintroduce the role of 'Matron' as part of the modern matron programme generated a lot of feedback of 'sexist bias' as reported in the final report from the RCN to the Department of Health (Read et al. 2004)⁸. This example potentially points out a helpful way forward and it is recommended from this impact assessment that further research be carried out to determine whether the titles of chaplain and chaplaincy are perceived to exclude people who do not associate with a religion from accessing spiritual and pastoral support.

Page 7 of the guideline states that 'where an instance of safeguarding arises during the course of spiritual care the chaplain must alert the patient or member of staff to the reporting obligations of the chaplain. The policies of the chaplain's NHS organisation must be followed in all circumstances'. This is a generic requirement and it is recommended that the government's strategy to safeguard people vulnerable to radicalisation be given specific consideration within the review.

No data has been provided on numbers of chaplains by religion or belief. This data should be collected and made available in the revised guidelines as part of the review. This will ensure that the needs of patients by religion or faith are aligned to the available workforce.

2.8 Sex

Consider and detail evidence on men and women. This could include access to services and employment.

According to the ONS 2011 Census, it appears that there is a difference between men and women in terms of their reported religion or belief. 62.8% of women compared to 55.8% of men report themselves as Christian. Males are more likely to report no religion (27.7%) compared to females (21.9%)

	Males		Females	
Christian	14,556,687	55.8%	16,923,189	62.8%
Buddhist	112,300	0.4%	126,326	0.5%
Hindu	415,076	1.6%	391,123	1.5%
Jewish	127,267	0.5%	134,015	0.5%
Muslim	1,383,834	5.3%	1,276,282	4.7%
Sikh	212,467	0.8%	207,729	0.8%
Other religion	100,895	0.4%	126,930	0.5%
No religion	7,214,991	27.7%	5,899,241	21.9%
Religion not stated	1,945,631	7.5%	1,858,473	6.9%

⁷ Oxford Dictionaries. Oxford University Press, n.d. Web. 13 February 2015. <<http://www.oxforddictionaries.com/definition/english/chaplain>>.

⁸ Read, Susan, et al. "Evaluation of the modern matron role in a sample of NHS trusts." RCN Institute/School of Nursing and Midwifery, University of Sheffield, Sheffield (2004). RCN 2004 https://www.rcn.org.uk/__data/assets/pdf_file/0007/78640/002493.pdf

Table 7: Breakdown of religious affiliation by gender

Source: 2011 Census

The guidelines set out a framework for the provision of multi-faith and belief spiritual and pastoral support that is expected to have a positive impact on the wellbeing of women and men in general NHS-funded services.

It is unclear what the impact is of staffing ratios by gender on access to or experiences of spiritual and pastoral care. The guidance could also be updated during the review to include by reference to supporting women receiving care in gender specific services, such as sexual assault referral centres (SARC) or maternity services or for sex specific conditions (e.g. ovarian or cervical cancer).

Page 7 of the guideline states that 'where an instance of safeguarding arises during the course of spiritual care the chaplain must alert the patient or member of staff to the reporting obligations of the chaplain. The policies of the chaplain's NHS organisation must be followed in all circumstances'. This is a generic requirement and it is recommended that the cross-government policy to safeguard women and girls who have been subject to (or are at risk of) Female Genital Mutilation (FGM) be given specific consideration within the review.

Despite FGM not being 'mandated by religious scriptures, the belief that it is a religious requirement contributes to the continuation of the practice' (UNICEF 2013)⁹. Healthcare chaplains could play a leading role in supporting staff, patients and service users and it is recommended that their leadership role be included within the review.

Operationally it is unclear from the guidance what the pathway would be from NHS111 directly into chaplaincy services (<http://www.england.nhs.uk/ourwork/pe/nhs-111/>). For example a carer phones wanting support over a spiritual linked decision around end of life care for their loved one at their home, and there is no regular member of their care team who can support them. The access to a chaplaincy service in many community and home settings is unclear. It is recommended that at the review a generic model of spiritual care is mapped to include typical patient pathways and primary access points within the guideline. It is also recommended that the guidance encourages commissioners and providers to tailor localized more specific spiritual care models integrated across localities that draw together primary, community and acute chaplaincy services. Use of telemedicine and the internet could be actively considered here.

The role of chaplaincy to help implement NHS England's Patient-led assessments of the care environment (PLACE; 2013) is not cross-referenced, particularly in coordinating the Organizational assessment of facilities relating to provision of "multi-faith/prayer rooms" (<http://www.england.nhs.uk/ourwork/qual-clin-lead/place/>). Recommend at the review the guidance is harmonized.

⁹ United Nations Children's Fund, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, UNICEF, New York, 2013.

2.9 Sexual orientation

Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.

There is no available UK quantitative data on the religious attitudes of this community. There have been examples of studies of how sexual orientation is integrated with spirituality ¹⁰

There is no strong evidence to suggest that lesbian, gay or bisexual people would suffer any adverse impact because of the implementation of these guidelines, although it is possible that the teachings of some organisations against same-sex or bisexual relations may impact how chaplains affiliated to that organisation are perceived.

The absence of data suggests that as part of the review it is strongly recommended that NHS England engage with religious and belief organisations that have a special lesbian, gay or bisexual focus to ascertain experiences and awareness of spiritual and pastoral support services. For example, the Metropolitan Community Church, or the Imaan LGBTQI Muslim Support Group or the Gay and Lesbian Humanist Association (GALHA)

2.10 Carers

Consider and detail evidence on part-time working, shift-patterns, general caring responsibilities.

As part of the economic activity data, the Census reports on people who look after home or family. We used this as a proxy for people with caring responsibilities. There appears to be an over-representation of Muslim people in this group.

Religion	Looking after home or family	England average
Christian	50.0%	59.4%
Buddhist	0.8%	0.5%
Hindu	2.1%	1.5%
Jewish	0.5%	0.5%
Muslim	14.3%	5.0%
Sikh	0.9%	0.8%
Other religion	0.5%	0.4%
No religion	25.7%	24.7%
Religion not stated	5.2%	7.2%

Table 7: Breakdown of religious affiliation by caring responsibilities

Source: 2011 Census

¹⁰ Foster K, Bowland B & Vosler AN: *All the Pain Along with All the Joy: Spiritual Resilience in Lesbian and Gay Christians*, American Journal of Community Psychology, March 2015, Volume 55, Issue 1-2, pp 191-201

The guideline (p5) includes that ‘Implementation of the guidance will improve support for patients, carers and staff across the health service’. The specific spiritual and pastoral needs of carers could potentially be strengthened through implementing the guidance throughout the NHS.

The role of chaplaincy to help implement NHS England's Commitment to Carers (2014) (<http://www.england.nhs.uk/ourwork/pe/commitment-to-carers/>) is not aligned. There are missed opportunities here to ensure carers have access to services and support. Recommend at the review the guidance is harmonized.

2.11 Other identified groups

Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality, income, resident status (migrants, asylum seekers).

The Census provides us with a breakdown of religion or belief by National Statistics Socio-economic classification (NS-Sec). People from higher managerial, administrative and professional occupations are slightly more likely to report no religion (26% compared to 24% of national average). There is a higher probability of someone from lower supervisory or routine occupation to report as a Christian (65% compared to a national average of 60%). It is also worthwhile noting that Muslim people are over-represented in the group of people who haven't worked or are long term unemployed.

Religion	Higher managerial, administrative & professional occupations	Intermediate occupations	Small employers and own account workers	Lower supervisory and technical occupations	Semi-routine and routine occupations	Never worked and long-term unemployed	England average
Christian	59.7%	67.1%	61.7%	65.0%	66.6%	47.0%	59.4%
Buddhist	0.5%	0.3%	0.5%	0.5%	0.4%	0.7%	0.5%
Hindu	1.9%	1.3%	1.3%	0.9%	1.2%	2.4%	1.5%
Jewish	0.8%	0.5%	0.7%	0.2%	0.2%	0.4%	0.5%
Muslim	2.3%	2.3%	4.3%	2.8%	3.2%	16.8%	5.0%
Sikh	0.7%	0.6%	0.9%	0.6%	0.8%	1.3%	0.8%
Other religion	0.6%	0.5%	0.5%	0.4%	0.4%	0.5%	0.4%
No religion	26.6%	20.6%	22.8%	23.0%	20.6%	22.5%	24.7%
Religion not stated	7.0%	6.8%	7.4%	6.7%	6.7%	8.3%	7.2%

Table 8: Breakdown of religious affiliation by NS-Sec
Source: 2011 Census

The guideline addresses the provision of spiritual and emotional support within healthcare settings. Some NHS healthcare settings are co-located with other services that are particularly relevant to other groups that typically experience certain

negative health outcomes. For example, prisons, armed forces hospital facilities and also schools. Some of these settings have their own chaplaincy arrangements or multi-faith or belief facilities and it is recommended that this guideline be updated during the review to include the development of local partnership and joint-working arrangements (e.g. information sharing) to ensure consistency and high quality spiritual care provision.

3 Engagement and involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

To achieve effectiveness of engagement; the Chaplaincy Leaders Forum (CLF) was developed in September 2013 as an effective mechanism for dialogue between NHS England, and the wider chaplaincy associations listed below:

- College of Health Care Chaplains (CHCC) - professional group within Unite Union, with a membership of almost 1000 members.
- Association of Hospice and Palliative Care Chaplains (AHPCC) - professional group supporting and working with people in end of life care.
- UK Board of Healthcare Chaplains (UKBHC) a professional group which holds a professional register for chaplains.
- Health Care Chaplaincy Appointment Advisers is a partnership with the leading chaplaincy bodies and the NHS England. The advisers themselves are experienced practitioners covering a range of health care chaplaincy contexts. They have no role in validating the faith or belief position of applicants or candidates for interview but advice employers about their professional suitability. This includes an assessment of applicants against published standards, job evaluations and other documentation relevant to the advertised post.
- Healthcare Chaplaincy Faith and Belief Group (HCFBG) which includes all 8 Faith groups, Roman Catholic Church and British Humanist Association.

The CLF meets monthly with quarterly meetings with the wider forum, and the consultation of the revised NHS Chaplaincy Guidelines has been the key priority for discussion and continued engagement.

The National Secular Society is not part of the Chaplaincy Leaders Forum.

How have you engaged stakeholders in testing the policy or programme proposals?

Phase 1 - The draft Guidelines were drafted through a series of design workshops in November 2013 in London and Doncaster, with 50 people attending each event.

The attendees were from a range of organisations – Provider Trusts, Churches,

CCGs, Chaplaincy Organisations, BHA, HCFBG, Catholic Church, UKBHC, AHPCC, CHCC.

A dedicated email address and on-line survey to review relevance of the 2003 guidance received in total 143 responses to e-questionnaire; with most feedback from Chaplaincy leads working in the NHS, and limited responses from 'external' bodies and individuals.

There was wider engagement with key individuals & organizations into the design specific sections of the Guidance. For Example:

Mental Health Network – part of the College of Healthcare Chaplaincy

Paediatric Chaplaincy Network – Chair Paul Nash

GP lead – Dr Ross Bryson and Dr Fiona Collins from Sandwell and West Birmingham CCG

Phase 2 - Formal NHS Gateway and Consultation process March 2014 – 30th September 2014

- Submit for formal NHS Gateway process : March 2014 – June 2014
- Formal consultation launched 7th July – 30th September 2014 with Draft Guidelines
- Draft Guidelines consultation and email address promoted on various websites – College of Health care chaplaincy, CLF association's websites; alongside wider promotion in E-bulletins to Chaplains and wider networks. The information was also promoted through the NHS England Public and Patient Voice Team and wider to the Health and social care Strategic partners* (see Appendix 1 for List)
- Two hosted face to face events in Wigan on the 7th July and 11th July in London with over 60 people present at both events.
- Formal public consultation event held on 24th September in Birmingham with 30 people attending from a range of organisations attending – see Appendix 2 Key issues requested for input – strengthen commissioning focus in the document, ensure an Equality Impact assessment of the document is completed.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Throughout the engagement phases 1 and 2 highlighted above, this section aims to focus on some of the findings and key feedback from formal consultation process:

In total 104 e-mail submissions were made to the dedicated consultation email address

Each email was responded to promptly by the project lead

All consultation feedback by email was discussed in weekly teleconference meetings, to discuss any potential risks and challenges.

Twenty of the email responses were single issue responses regarding the input of the catholic faith, concerns regarding the generic model being advocated; the concerns of the Guidelines on the College of Health care chaplaincy website as opposed to NHS England, as the college was seen as a union.

Comprehensive email feedback was received from the following organisations :

- Roman Catholic Church; and Church of England
- National Secular Society; British Humanist Association
- CHCC; AHPCC; Mental Health chaplains
- Public Health Wales; Northern Ireland Chaplains
- Major Teaching Hospital response re. Information Governance

Phase 4 – Post Consultation process

Two formal meetings were set up with the Roman Catholic Church and the British Humanist Association to discuss the content of the submission, clarify any concerns and issues and ensure ownership / endorsement of the revised guidelines.

Post – Consultation feedback to Chaplaincy Leaders Forum

On the 20th October 15 people from various organisations including the BHA and Roman Catholic Church attended the meeting of the CLF. The draft guidelines were circulated to all the CLF a week prior to the meeting, and the purpose of the meeting was to ensure the endorsement of the revised guidelines prior to going back to NHS England. The CLF agreed the guidelines should be seen as an umbrella covering the standard approach for spiritual care, which needs to be determined locally.

4 Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will mitigate any negative impacts? How you will include certain protected groups in services or expand their participation in public life?

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

The public sector equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.

- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Equality Analysis demonstrates that we live in a society with an ever changing and diverse mix of religions and beliefs, which NHS organisations need to be considering when developing services.

Even within established religions there are various branches and regional variants with different traditions of interpretation, rituals and practices, moral guidelines and laws. There are also levels of personal compliance ranging from nominal to strict observance. Additionally, many people hold strong views about not having personal religious beliefs.

The limitations of using the census data as a way of measuring religion or belief has been raised by researchers. The way academics use and interpret such instruments has ethical and normative dimensions: numbers are not neutral but shape and are shaped by perceptions and identities.¹¹

We have drawn on census data to try to predict which people from protected characteristics might be affected disproportionately by these guidelines. Self-identification on the census is not always linked to a certain type of behaviour. More local intelligence would be necessary in terms of demand for a spiritual and pastoral support service.

The importance of language is also recognised. The language is not static, and it evolves over time. The term “chaplaincy” has been traditionally linked to a Christian clergy member working in an institution. Stakeholder consensus is necessary as to how we can describe chaplaincy service in a more inclusive way, a service that needs to cater for all communities- multi faith communities and non-religious people who might require support at a time of emotional and spiritual distress.

5 Evidence based decision-making

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to eliminate discrimination issues, partnership working with stakeholders and data gaps that need to be addressed through further consultation or research.

- Engagement with stakeholders to seek feedback for this Equality Analysis
- Update the guidelines further in light of this Equality Analysis
- Publish it on the NHS England website
- Commit to a review to examine further recommendation

¹¹ Abby Day & Lois Lee (2014) Making sense of surveys and censuses: Issues in religious self-identification, Religion, 44:3, 345-356

5.1 Recommendations

During development and consultation there has been disagreement about the use of the word 'chaplaincy' with concern expressed by the British Humanist Association (BHA). Whilst the words: 'chaplaincy' to describe the service, and 'chaplain' to describe the role, both have a religious association according to the Oxford English Dictionary¹², the word will be retained for the purpose of these guidelines with the recommendation that the issue of naming conventions be addressed within the review, it is recommended from this impact assessment that further research be carried out to determine whether the titles of chaplain and chaplaincy are perceived to exclude people who are not religious from accessing spiritual and pastoral support.

It is recommended during the review that the section on information governance (p18) be updated to include reference to the Accessible Information Standard (NHS England 2015) so that disabled people with specific communication needs can access the service and experience continuity of communication support across different care providers.

The chaplaincy staffing ratios for mental health care (p14) indicate they must take into careful consideration the composition and needs of the user population by religion or belief. However the impact of moving a person with a minority faith or belief out-of-area and into a locality with very little or no local appropriate chaplaincy provision as in out of area mental health placements, could be detrimental to their spiritual needs, and it is unclear how planning of chaplaincy based on composition could be achieved when the user population is not static. It is recommended that this must be explored during the review.

The guidance does not address (or cross-reference) chaplaincy staffing-ratios for the three high-secure mental health hospitals. It is recommended that the current strategy for providing spiritual and pastoral support in these care settings be reflected within this guideline during the review

The absence of Trans* data suggests that as part of the review it is recommended that NHS England engage with religious and belief organisations that have a special Trans* interest to ascertain experiences and awareness of spiritual and pastoral support services. For example, the Metropolitan Community Church, or the Imaan LGBTQI Muslim Support Group or the Gay and Lesbian Humanist Association (GALHA)

It is recommended that as part of the review the role of the chaplaincy service in arranging for and providing interpreters and communication support for people who have little or no English is made clearer.

The guideline states that 'where an instance of safeguarding arises during the course of spiritual care the chaplain must alert the patient or member of staff to the reporting obligations of the chaplain. The policies of the chaplain's NHS

¹² Oxford Dictionaries. Oxford University Press, n.d. Web. 13 February 2015. <<http://www.oxforddictionaries.com/definition/english/chaplain>>.

organisation must be followed in all circumstances'. This is a generic requirement and it is recommended that the government's strategy to safeguard people vulnerable to radicalisation be given specific consideration within the review.

It is unclear what the impact is of staffing ratios by gender on access to or experiences of spiritual and pastoral care. The guidance could also be updated during the review to include by reference to supporting women receiving care in gender specific services, such as sexual assault referral centres (SARC) or maternity services or for sex specific conditions (e.g. prostate or cervical cancer).

The guideline states that 'where an instance of safeguarding arises during the course of spiritual care the chaplain must alert the patient or member of staff to the reporting obligations of the chaplain. The policies of the chaplain's NHS organisation must be followed in all circumstances'. This is a generic requirement and it is recommended that the cross-government policy to safeguard women and girls who have been subject to (or are at risk of) Female Genital Mutilation (FGM) be given specific consideration within the review.

Despite FGM not being 'mandated by religious scriptures, the belief that it is a religious requirement contributes to the continuation of the practice' (UNICEF 2013)¹³. Healthcare chaplains could play a leading role in supporting staff, patients and service users and it is recommended that their leadership role be included within the review.

The absence of data suggests that as part of the review it is strongly recommended that NHS England engage with religious and belief organisations that have a special lesbian, gay or bisexual focus to ascertain experiences and awareness of spiritual and pastoral support services. For example, the Metropolitan Community Church, or the Imaan LGBTQI Muslim Support Group or the Gay and Lesbian Humanist Association (GALHA)

Some NHS healthcare settings are co-located with other services that are particularly relevant to other groups that typically experience certain negative health outcomes. For example, prisons, armed forces hospital facilities and also schools. Some of these settings have their own chaplaincy arrangements or multi-faith or belief facilities and it is recommended that this guideline be updated during the review to include the development of local partnership and joint-working arrangements (e.g. information sharing) to ensure consistency and high quality spiritual care provision.

The role of chaplaincy to help NHS England deliver their priority policy area for frail older people: 'Safe, compassionate care for frail older people using an integrated care pathway' (<http://www.england.nhs.uk/ourwork/pe/safe-care/>) is not referenced. Recommend at the review the guidance is harmonized.

¹³ United Nations Children's Fund, Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change, UNICEF, New York, 2013.

The role of chaplains and the impact upon staffing ratios during times of winter pressures is not mentioned. Recommend it is factored in at the review.

The role of chaplaincy to help implement NHS England's Commitment to Carers (2014) (<http://www.england.nhs.uk/ourwork/pe/commitment-to-carers/>) is not aligned. Recommend at the review the guidance is harmonized.

Operationally it is unclear from the guidance what the pathway would be from NHS111 directly into chaplaincy services (<http://www.england.nhs.uk/ourwork/pe/nhs-111/>). For example a carer rings up wanting support over a spiritual linked decision around end of life care for their loved one at their home, and there is no regular member of their care team who can support them. The access to a chaplaincy service in many community and home settings is unclear. It is recommended that at the review a generic model of spiritual care is mapped to include typical patient pathways and primary access points within the guideline. It is also recommended that the guidance encourages commissioners and providers to tailor localized more specific spiritual care models integrated across localities that draw together primary, community and acute chaplaincy services.

The role of chaplaincy to help implement NHS England's Patient-led assessments of the care environment (PLACE; 2013) is not cross-referenced, particularly in coordinating the Organisational assessment of facilities relating to provision of "multi-faith/prayer rooms" (<http://www.england.nhs.uk/ourwork/qual-clin-lead/place/>). Recommend at the review the guidance is harmonized.

5.2 Governance and monitoring of the recommendations

The Equality Impact Analysis of the NHS Chaplaincy Guidelines analysis and recommendations will be monitored through the sponsoring Director lead for the NHS Chaplaincy programme within NHS England, in partnership with Chaplaincy Leaders Forum.

The EIA action plan of the analysis and recommendations will be reviewed and updated annually by the sponsoring Director for chaplaincy and the Chaplaincy Leaders Forum. The next review of the EIA action plan is 27th February 2016.

The EIA analysis will be delivered and reviewed over two year review period in line with the policy.

6 How will you share the findings of the Equality analysis?

This can include corporate governance, other directorates, partner organisations and the public.

The EIA will be shared with all partners and those who took part in consultation and engagement and published on the NHS England website alongside the guidance.

OFFICIAL

For your records

Name of person(s) who carried out these analyses: Scott Durairaj and Michail Sanidas.

Name of Sponsor Director: John Holden, Director of Policy, Partnerships and Innovation

Date analyses were completed: 17th February 2015

Review date: 27th February 2016

7 Appendices

7.1 Appendix 1 – Engagement with Stakeholders on Guidelines in May 2014

Health and Social Care Strategic Partners

- Health watch England
- National Trust Development Agency (NTDA),
- Foundation Trust (FT) Network,
- Royal Colleges, BMA, RCN, RCPsych
- Miscarriage Association,
- Aids UK
- Patient Association
- Faith Action
- Universities

7.2 Appendix 2 – Public Consultation on 24th September 2014

- CCGs
- Providers Trust
- Royal colleges
- Universities - Staffordshire
- Faith Action
- Multi-Faith based groups.
- Chaplaincy Organisations and bodies