

Religion or belief

A practical guide for the NHS



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Foreword



This guide is part of a suite of guidance that seeks to equip NHS staff at all levels – whether as employers, employees, service planners, commissioners or providers – to understand the needs of all people.

Research suggests that attention to the religious and cultural needs of patients and service users can contribute to their wellbeing and, for instance, reduce their length of stay in hospital. Religion and belief are therefore important considerations for all patients and staff. This guide, whilst summarising our legal obligations in this regard, also sets out how equality issues in religion or belief relate to the principles that underpin our health objectives.

Other existing public sector equality duties, ongoing reform towards personalised services and the commissioning agenda present a real opportunity for NHS organisations to reconsider the design of services to take full account of the equalities agenda. By developing expertise and implementing the lessons learnt, we can embed equality at the heart of all functions and structures and contribute to a better understanding of

our staff and more informed, personalised patient care.

As an employer and provider of healthcare services, the NHS should not only comply with the law, but should also aspire to be an exemplar of good practice in ensuring that its services and employment practices respond to the needs of the whole of our society. This means that it is essential that we strive to take account of everyone's needs in the design and delivery of services – including people of different religions or beliefs and those with none. It is also essential that we strengthen our role as an inclusive employer – removing barriers that might prevent us from attracting, recruiting, developing and retaining people with the best skills and aptitude to make careers in the NHS.

A handwritten signature in black ink, which reads 'Surinder Sharma'. The signature is fluid and cursive, with a large initial 'S'.

Surinder Sharma

National Director for Equality and Human Rights, Department of Health

Executive summary

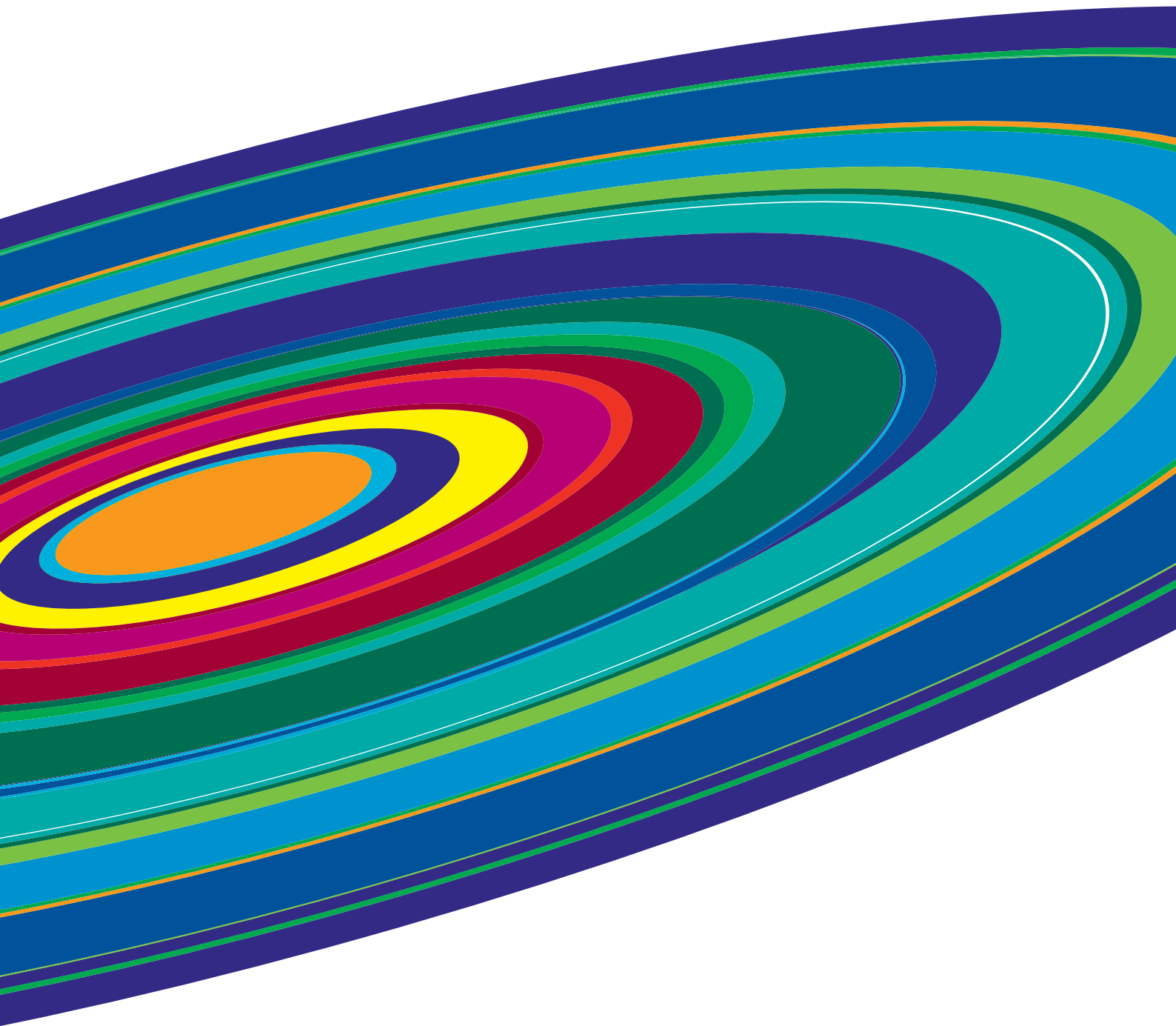
This guidance document is part of a suite of equality guides produced by the Department of Health (DH) for the NHS. It gives practical advice to NHS organisations to help them comply with recent equality legislation, understand the role of religion or belief in the context of healthcare, and integrate this knowledge into single equality schemes (SESs). Other guides in the series include those for disability, gender, sexual orientation, learning disability and trans people. The Race for Health programme provides extensive guidance and support for the NHS on issues of race. The Department of Health is also sponsoring a guide on age issues to be produced by Age Concern.

Many NHS organisations will already be working towards developing a SES. A single equality approach helps to bring together parallel strands of key systems, e.g. equality impact assessment, data collection etc, needed to respond to the specific duties of the different equality laws. This helps to utilise expertise and scarce resources more effectively. It also contributes to a better understanding of staff and workforce issues and encourages a personalised approach to patient care, treating patients as individuals. A combined approach will help to minimise 'information request overload' through frequent consultation and ensure that key personnel, such as public health analysts, service managers and administrative and frontline staff, are encouraged to work together to ensure a co-ordinated approach to achieving equality of outcomes.

However, in developing a SES it is important to understand that there are significant differences between the legal requirements for the different equality strands that must be understood in order that they are complied with. This guidance is designed to assist NHS organisations to implement and comply with the requirements of legislation on religion or belief enacted recently, and also provides general practical guidance around the issues that fall out of that for the NHS.

The guidance will provide a workbook and a one-stop shop for information about the legislation, its impact and examples of best practice. It will take you through the steps necessary to equality impact assess and plan for the integration of issues of religion or belief during the development of your overall equality schemes. Many of the processes, such as equality impact assessment and consultation, are similar to those described for the other equality strands, but the guidance will highlight any areas that need special attention for religion or belief and will also provide a handy reference for best practice and cohesive and collaborative working.

Section One: Context



Legal requirements

Over recent years in the UK, levels of awareness of different religions and beliefs have grown – and, in the main, equitable treatment of individuals and inter-faith relations have improved. But, in spite of this, discrimination on the grounds of religion or belief, religious intolerance and prejudice still exist in certain areas.

Until December 2003, legal protection against discrimination on grounds of religion or belief was confined to those from particular faiths who were covered by virtue of their ethnicity, as in the case of Sikhism and Judaism. A certain degree of protection was afforded to other religious and non-religious communities by Article 9 of the European Convention on Human Rights, as given effect by the Human Rights Act 1998, but this was very limited.

The European Council Directive of 2000 establishing a general framework for equal treatment in employment and occupation came into force in the UK in December 2003 through the **Employment Equality (Religion or Belief) Regulations**. These regulations make it unlawful to discriminate against people on the grounds of their religion or belief. The regulations apply to vocational training and all aspects of employment including recruitment, terms and conditions, promotions, transfers, dismissals and training.

The forms of discrimination that are unlawful under the regulations are:

- **Direct discrimination:** treating workers or job applicants less favourably than others because they follow, or are perceived to follow, a particular religion or belief. The regulations also extend to cover discrimination based on a person's association with someone of a particular religion or belief.
- **Indirect discrimination:** applying policies or practices that – although applied to all employees – could disadvantage people of a particular religion or belief. These policies or practices are unlawful unless the organisation can justify implementing them because of a legitimate business need.
- **Harassment:** behaviour that is offensive, frightening or in any way distressing related to a person's religion or belief. It also includes comments or behaviour aimed at the religion or belief of those with whom the person associates. Harassment can include violation of a person's dignity, or creating an intimidating, hostile, degrading or offensive environment. It can also include preventing someone from declaring their religion or their lack of belief in religion.
- **Victimisation:** treating someone less favourably because they have made or intend to make a complaint or allegation, or have given or intend to give evidence in relation to a complaint of discrimination on the grounds of religion or belief.
- **Instructing or causing discrimination:** instructing or otherwise causing another person to discriminate in a way that is unlawful.

Exceptions may be made in very limited circumstances if there is a genuine occupational requirement for the worker to be of a particular religion or belief in order to do the job or to comply with the religious or belief ethos of the organisation.

Religion or belief is defined as being any religion, religious belief or similar philosophical belief. This does not include any philosophical or political belief unless it is similar to religious belief. It will be for employment tribunals and courts to decide whether particular circumstances are covered by the regulations.

Since 2003, two more pieces of legislation have been introduced, as outlined below:

Part 2 of The Equality Act 2006

(Discrimination on the Grounds of Religion or Belief) came into force on 30 April 2007. The Act defines 'religion' as "any religion", and 'belief' as "any religion or religious or philosophical belief" as opposed to "any religion, religious belief or *similar* philosophical belief" as defined in the original Act. Reference to 'religion' or 'belief' in this context also refers to lack of religion or lack of belief.

Part 2 also makes it unlawful to discriminate in the area of goods, facilities and services on the grounds of religion or belief. The exercise of any public function by a public authority must be free from discrimination on grounds of religion or belief. This includes the provision of goods, facilities and services by a person exercising a public function.

The Racial and Religious Hatred Act 2006

came into force on 1 October 2007 as an amendment to the Public Order Act 1986. It gives protection to people against hatred because of their religious beliefs or lack of religious beliefs, and prohibits the stirring

up of hatred against persons on racial or religious grounds.

Whilst the legislation aims to protect people against discrimination on the grounds of their religion or belief (or lack of religion or belief), it should be remembered that, conversely, the law does not entitle people to apply such beliefs in a way which impinges upon other people – even if they claim that their religion or belief requires them to act in this way. The legislation is not intended to hinder people in the expression of their own religion or belief, but everyone has the right to be treated with respect whatever their views or beliefs and nobody should try to harass others because they do not agree with certain religious convictions.

Article 9 of the European Convention on Human Rights (Freedom of thought, conscience and religion) as given effect by the Human Rights Act 1998 states that:

- "Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
- "Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others."

Annex B explains the circumstances in which an interference with Article 9 rights can be justified, and the possible ramifications for NHS service delivery and workforce.

(www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_3#sch1)

The role of religion or belief in healthcare

We live in a society with an ever widening and diverse mix of religions and beliefs, which NHS organisations need to take into account when developing both services to the public and employment policies. Even within established religions there are various

branches and regional and sectional 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 belief.

The following table from the 1996 and 2006 British Social Attitude Surveys (published in *Social Trends 38*, available at www.statistics.gov.uk/statbase/Product.asp?urlnk=13675) shows respondents' answers to the question 'Do you regard yourself as belonging to any particular religion?'

Belonging to a religion in Great Britain

	1996 (%)	2006 (%)
Christian		
Church of England/Anglican	29.3	22.2
Christian – no denomination	4.7	9.6
Roman Catholic	8.9	9.0
Presbyterian/Free Presbyterian/Church of Scotland	3.8	2.5
Baptist/Methodist	3.0	2.4
United Reformed Church (URC)/Congregational	0.8	0.1
Brethren	0.1	–
Other Protestant/other Christian	2.2	1.7
Non-Christian		
Islam/Muslim	1.8	3.3
Hindu	0.6	1.4
Jewish	0.3	0.5
Sikh	0.2	0.2
Buddhist	0.5	0.2
Other non-Christian	0.4	0.4
No religion	42.6	45.8
Refusal/not answered/didn't know	0.8	0.6

Further, research has highlighted differences in the health and wellbeing of different religious communities – a finding that provides an opportunity to target services. The British Muslim community, for example, has the poorest reported health, followed by the Sikh population. For both groups, as well as for Hindus, females are more likely to report ill health, whereas for Christians and Jews there is only minimal gender difference. It should be borne in mind that this is not necessarily a case of cause and effect, but more likely is compounded with other factors such as housing and economic and social status.

Employers should be aware that the regulations on religion or belief extend beyond the more well known religions and faiths to include beliefs such as Paganism, humanism, atheism, Shamanism etc. The regulations also cover those without religious or similar beliefs (see point 1.1 in the ACAS guidelines: www.acas.org.uk/CHttpHandler.ashx?id=107&p=0).

With the exception of atheism, most religions have in common the teaching of a particular way of life in relation to power(s) or being(s) that are taken to remain outside the laws of nature – even where they exist within nature, as some religions hold. ‘Way of life’ includes the teaching of what is considered the right attitude towards life and human relationships. Often such attitudes are expressed in rites, social and cultural customs and liturgical traditions, which can therefore play an important role in the life of the individual believer. Such recommended or prescribed attitudes towards all aspects of life from beginning to end, and the afterlife, obviously have ramifications for the delivery and design of healthcare as an area that deals with life, and sometimes death, in the most immediate way.

Policy implications

Religious and cultural views on the beginning of life can influence attitudes towards reproductive medicine, abortion, contraception and neonatal care. Views on dying, death and the afterlife can influence attitudes towards pain relief for terminally ill people, means of determining the moment of death, brain death, organ donations and care for the corpse. (For a more detailed explanation, please refer to ‘End of life concerns’ in Section Three.)

Palliative care is the prevention of and relief from suffering by means of early identification and treatment of pain and other problems (physical, psychosocial and spiritual). It aims to enhance the quality of life for terminally ill patients as well as for their relatives or family. It seeks to integrate both physical and spiritual aspects, and leaves room for religious communities’ interpretations of the relationship of body/mind/soul/spirit. (A more detailed explanation is in ‘Palliative care’ in Section Three.)

The inclusion of relatives/family is particularly relevant in religious communities, where high emphasis is often placed on familial bonds and responsibilities. With due attention to confidentiality and the patient’s wishes, where the family and relatives are included in care, it is vital that staff involved are aware on some level of the patient’s religious attitudes towards disease, suffering, dying, death, religious practices and rites, as well as their views on familial responsibilities and traditions, in order to ensure sensitivity and respect when administering care to the patient. Staff should also be aware that an individual’s level of compliance with their religious belief may well vary according to their perception of their illness, and that relatives and/or next of kin may have differing views on religion, practice and observance.

Religious and other beliefs can also impact on the types of treatment and drugs used: for instance, the prohibition of eating pork in Judaism and Islam means that porcine- or alcohol-based drugs might be forbidden in these communities. Similarly, the use of bovine-based drugs or cattle-derived cartilage transplants would have belief implications for Hindu communities and for some vegans and vegetarians.

Many religions recognise a power or powers that exist outside the laws of nature yet are in relationship with, and have an influence on, natural reality. This power or powers can be either good or bad. Such recognition of 'the supernatural' can have implications for religious attitudes towards scientific explanations of illness and medical therapies. For instance, it can lead to the view that scientific explanations of illness alone are insufficient.

Diseases are increasingly acknowledged to have a variety of causes (including psychosocial factors, for instance), yet some religious groups would say that supernatural forces can also have an influence on the body – they can make it ill but also well – which requires altogether different forms of therapy, such as prayer or the driving out of demons. For example, some evangelical Christian doctors argue, with reference to the New Testament's account of demonic possession, that perhaps mental illnesses such as depression might be caused by demonic interference in people's lives. A truly holistic view of the human condition, they argue, should involve spiritual as well as psychological, social and physical dimensions (see www.cmf.org.uk/literature/content.asp?context=article&id=619). (See also 'Mental health issues' in Section Three.)

Other issues to be considered include gender issues (same-sex wards and treatment by members of the opposite sex), sexuality

and reproduction, spiritual practices such as prayer and ablution facilities, the impact of fasting on those with long-term conditions or breastfeeding, and clothes as a religious sign of modesty or respect for the deity or place of worship.

Conversely, it is also vital to ensure that the personal beliefs of healthcare staff do not adversely affect the care given to patients or their relationships with colleagues, and, where possible, that the jobs they are required to carry out do not offend their own religious or other beliefs. An example of this would be a person whose beliefs prohibit abortion being in attendance at a planned termination. These are things that should be discussed from the first days of training and again at induction. The nursing or clinical lead will need to decide what is clinically necessary and what can be determined locally.

Religious attitudes towards different forms of healthcare, such as in-vitro fertilisation (IVF), organ donation and palliative care, can often be the result of a lack of understanding amongst client and patient groups about the processes and the benefits to be derived from them. Raising awareness in communities and sensitively explaining some of these processes could lead to greater flexibility in attitudes towards some medical procedures. However, there is a need to be very aware of religious stereotyping and to be mindful that there can be individual differences within groups.

It is critically important to raise awareness amongst health staff of the need to take religion or belief into account when dealing with patients and colleagues, and this guidance document should aid NHS professionals in understanding the importance of religious identity or belief and in appreciating how this has the potential to interact with and impact on health and healthcare delivery.



Section Two: Key areas to consider in employment

Overview

Employment issues and service delivery issues go hand in hand, because they impact on each other. A workforce that is respected and valued will in turn be more likely to show respect and understanding in the provision of services to the public. The NHS could not operate without the dedication, knowledge and skills of its workforce, and 70% of NHS finance and resources is invested in areas such as salaries, recruitment, workplace development, training and retention.

Employment policies can often impact on religious and other beliefs and practices, and therefore policies should be reviewed to take account of this. Flexibilities around time allowed and facilities provided for prayers and ablutions are also important, as are religious observances such as observance of the Sabbath in Judaism, and sensitivity and understanding during fasting. It is, of course, also important to ensure that these flexibilities are not at the expense or disadvantage of those with different or no religious beliefs. Prior communication and discussion is vital to continued good relations.

The Improving Working Lives Standard in the NHS makes it clear that every member of NHS staff is entitled to work in an organisation which can demonstrate its commitment to more flexible working conditions and gives staff more control over their own time. This is especially relevant to taking religion or belief into account.

Other issues include an awareness of different religions or beliefs when arranging meetings – for instance, not meeting in a place where alcohol is served, or not holding Friday-afternoon events or Saturday awaydays, which persons from certain religious communities may not be able to attend. In the same way, dietary

considerations should be taken into account when arranging catering, and attendees should always be asked for their requirements or preferences.

As mentioned previously, sensitivity should be shown by healthcare staff from various religious persuasions to ensure that their religious beliefs do not adversely affect the care given to patients. Likewise, flexibility should be shown, if feasible, around the types of procedures they will be expected to attend. These issues will have to have been addressed as part of the curriculum, as well as at the personal choice for any training for a clinical or professional role – or indeed any job – in the NHS.

At the same time, the views or religious or non-religious convictions of patients should not be allowed to adversely affect NHS staff carrying out their duties. An example of this would be a patient refusing to be treated by someone from a different religious persuasion, or by a lesbian, gay, bisexual or trans person.

Recruitment

It is vital that religion or belief is taken into account from the very first stages of recruitment, whether as a medical student, other clinical professional, student nurse or any other form of employee. Issues such as dress code should be taken into account at the outset, so that students are aware before they go into NHS training that there may be health and safety issues connected with traditional religious clothing or religious symbols whilst working in a hospital or out in the community; suitable arrangements can then be reached.

When advertising posts, the organisation should ensure that it advertises in media that will attract the widest range of applicants.

Some groups may not subscribe to certain publications for reasons of religion or belief, so this should be borne in mind. If advertising on local radio, it would be good practice to also advertise on any community radio stations available. Some Asian community radio stations may attract listeners from several religious communities.

NHS organisations should ensure that any standards or selection criteria set for a post do not prevent people from applying because of their religion or belief. At the same time, they should make sure that the job description gives a clear idea of what the post actually entails, so that potential applicants can make an informed decision as to whether the job may conflict with their religious convictions.

Consideration should be given to the timing of interviews so that suitable applicants from different religious communities can attend – for example, avoiding Friday afternoons or dates that coincide with religious festivals. Similarly, where a recruitment process involves a lunch or social gathering, applicants should be asked for their dietary requirements, and consideration should be given to the venue; for instance, a gathering in a place where alcohol is served may conflict with certain religious beliefs.

It would be good practice for NHS organisations to ask whether there are any specific needs or requirements when inviting applicants to the selection process. This could be done by adjusting the usual equal opportunities form. Whilst it is important for NHS organisations to be sensitive to the religious or belief needs of applicants, those invited to interview should also make their needs known to the organisation in plenty of time so that these can be considered when arrangements are being made. Human Resources professionals and interviewers

should be aware that standards of modesty often vary depending on the audience; therefore what might be acceptable for the candidate in the interview situation might not be in the working environment. It is important that a full picture of the job and its environment is conveyed to all applicants.

When interviewing job applicants, questions should be confined to those directly relevant to the selection criteria. Personal questions such as marital status or childcare arrangements should be avoided, as should those regarding religious observance (i.e. times and places of worship). The only consideration that should be made during the selection process is whether the applicant has the skills and competencies necessary to do the job. Any information required for Human Resources, such as equal opportunities forms, should be taken in confidence and kept apart from the application and those involved in selection.

Religious observance in the workplace

Most religions or beliefs have special spiritual observance or holy days when some staff may wish to request time off in order to attend the associated ceremonies or festivals. A practical step for NHS organisations to take is to display a multi-faith event calendar and year planner so that, where appropriate, preparation and cover can be organised in advance. Employees should make requests for such leave well in advance, to allow managers to support their requests where it is reasonable and practical to do so. Where several requests are made for leave on the same day, managers should hold discussions with staff to seek mutually acceptable compromises and solutions. Employers may want to be proactive in reminding managers and those responsible for rotas of upcoming

significant dates that may impact on staffing and/or attendance of patients.

It should be noted that the dates of some religious festivals are not known until quite close to the day, because the dates depend on lunar phases and change from year to year. Again, discussion and flexibility on both sides can hopefully lead to a satisfactory outcome. At the same time, consideration should be given to those who do not hold any specific religion or belief, so that they are not unduly disadvantaged by any arrangements made. Managers may wish to keep a record of who has been granted leave in these cases, and how decisions have been reached.

Many religions also require time during the day for prayer or meditation. It is good practice to provide a room for this purpose, designated for use by all members of staff for the specific purpose of prayer or quiet contemplation. Consideration should also be given to providing separate storage for the different ceremonial objects.

Flexibility around time allowed for prayer and ablutions can be best achieved by discussion with the person concerned, as individual needs can vary. Being flexible with the times of normal break periods can often lead to acceptable solutions. It is important to remember that most individuals have had a great deal of experience at fitting such needs around the ordinary call of work and study. It is essential that all such arrangements conform to the organisational policy and are seen as transparent and fair to all employees.

Some religions prohibit working on certain days – for instance, from Friday sunset until Saturday sunset in Judaism, and on Sundays in some Christian religious groups – although there are often exceptions made for those involved in caring for others. Shift patterns

and any necessity for weekend working should be discussed from the first day of training or employment so that suitable compromises can be reached. Flexible working hours can often accommodate such requirements. Where it is impossible to do so for reasons of staffing or other business necessities, it is important to show that every effort has been made to find suitable solutions, particularly where the employee has previously indicated working preferences because of religious belief.

Many religions or beliefs have specific dietary requirements. For this reason, those bringing food into work may need to store and heat it separately from other food. For instance, some Jewish people cannot store meat products alongside dairy products, and Muslims will not wish their food to be in contact with pork or with anything that may have been in contact with pork. Those who are vegetarian for reasons of religion or belief may not wish their food to be stored near meat. These are all very real issues for those concerned, and employers should be ready to discuss and reach acceptable solutions.

In some religions, it is a requirement to fast for a certain period of time. Consideration should be given to ways of supporting staff during these periods, but employers should also be careful to ensure that excessive extra duties are not placed on other staff which could cause conflict or claims of discrimination.

Cultural dress codes based on religion or belief should be considered sympathetically unless there are justifiable reasons, such as health and safety issues, for not permitting certain items of clothing. As mentioned previously, issues on wearing traditional religious clothing whilst working in any healthcare setting should be taken into account at the very first stages of training

so that students are aware of any health and safety issues, and so that suitable arrangements can be put into place. Culturally appropriate uniforms are already available in many NHS organisations; the first of these (see Annex A) were devised as part of the Healthcare Apprenticeship Scheme.

NHS organisations that have policies regarding the wearing of jewellery or other symbolic items should factor in due consideration for items that are traditional within some religions or beliefs, unless the rules are for health and safety or other justifiable reasons. Some items of jewellery can be highly symbolic in certain religions and cultures, so any rules against the wearing of these must be justifiable so as not to constitute indirect discrimination. However, health and safety and the duty of care to patients are paramount. See case study, right.

Case study: 'bare below the elbow'

Recently, there has been some controversy over new health guidelines introduced in January 2008 to stop the spread of infections such as MRSA and *Clostridium difficile*. One of the stipulations in the guidelines is a 'bare below the elbow' dress code policy, which specifies that arms should be bare below the elbows, with no wrist watches, jewellery, nail varnish or false nails, in clinical areas to ensure good hand and wrist washing. Muslim doctors and students at Liverpool's Alder Hey Trust and elsewhere strongly objected to this, because it is regarded as immodest in Islam to expose any part of the body except the face and hands. Dr Steve Ryan, medical director at Alder Hey, underlined that 'bare below the elbow' needed to be implemented as a matter of patient safety; exceptions could not be allowed, but the trust would work with Muslim students to find a solution. For instance, he said: "A number of female Muslim students approached the University of Liverpool to ask if we would provide facilities for them to change their outerwear and hijab for theatre scrubs. We were pleased to accommodate this request and these facilities have now been incorporated."

Undressing or showering in the company of other people is forbidden in some religions. NHS organisations that require staff for reasons of health and safety to change their clothing and/or shower should consider how these needs can be met without indirectly discriminating against individuals by virtue of their religious beliefs.

In some religions, a long period of mourning is required when a person dies – for instance, in Hinduism the period of mourning is 13 days, and in Judaism there are seven days of mourning or ‘Shiva’. In Hinduism a male relative is sometimes required to carry the ashes to the Ganges. In Islam some widows observe an extended mourning period of four months and 10 days; during this period the widow is not permitted to move from her home. Where the policy for leave on the death of a close relative is three days, extra time given for religious reasons could be seen as discriminatory to non-religious and other staff. Each case should therefore be dealt with on an individual basis, and consideration may be given to using annual or other leave to cover the period of leave required.

The tradition in some religions is to wear white or in some cases black clothing during the period of mourning, and it should be remembered that during the mourning period close relatives of the deceased, and especially widows, may not be permitted to attend social functions.

Retaining staff

A diverse workforce with staff from a range of religions or beliefs should be highly valued for the personal knowledge, expertise and sensitivity they can bring to the planning and delivery of services to our multi-cultural and multi-faith society. Staff who are respected and recognised for the contribution they make will be highly motivated, conscientious and more likely to stay within the organisation.

An organisation that has robust and transparent equality policies, with appropriate grievance and disciplinary procedures for those who breach the policies, will be more likely to retain a confident workforce who are secure in the knowledge that they will

not suffer discrimination without challenge or redress. All staff should be made aware of these policies, and of the consequences of not following them, as soon as possible after they start work. The message should be reinforced throughout the working life cycle, for example at yearly reviews and on training days/seminars. All staff should be made aware of what constitutes harassment and of the penalties, i.e. that they could be held personally liable and may have to pay compensation in addition to anything the organisation may have to pay if the issue goes to tribunal or other legal action.

All staff should also be made aware of the procedures to be followed if they feel that they have been discriminated against, harassed or victimised. They should feel confident that their complaint will be dealt with in confidence, treated seriously and, importantly, acted upon.

Training

NHS organisations as commissioners of education may consider working in partnership with universities and other providers to ensure that issues of diversity in religion or belief are embedded into all processes, from the recruitment and selection of students to the design and delivery of the curriculum. It is standard good practice to require an equality impact assessment report on any new or reviewed purchase or commission. This ensures the development of a future workforce equipped with the right skills, knowledge and competencies to deliver services to all sections of the population. This process should be carried on into workplace development and training to eventually mainstream awareness and develop capability and capacity throughout the NHS.

Consideration of religion or belief issues should be taken into account when organising training. Apart from the more obvious issues which have already been mentioned, such as dietary requirements and religious festivals, other training arrangements may need to be adapted so as not to cause disadvantage to individuals because of their religion or belief:

- If training takes place outside working hours or in a residential environment, is compulsory and is the only provision available, it could have the effect of excluding some people whose religion or belief would make it unacceptable for them to attend.
- Some training activities may use language or physical contact which would be inappropriate for some religions or beliefs. It would be good practice to ask whether the techniques used could be problematic when sending out pre-training material or in training needs assessment material.
- Exercises that require the exchange of personal information may not be appropriate.
- Social and other team-building activities related to the training event may exclude some people.

Whilst training departments should take all of these things into consideration, staff themselves also have a responsibility to ensure that they notify managers and trainers of their needs at an early stage in order for these to be factored in.

Healthcare chaplains

Healthcare chaplains are an invaluable source of support for NHS managers and staff in providing advice, education and training

on multi-faith issues. The Department of Health guidance document *NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff* provides information on the roles and responsibilities of healthcare chaplains. The extract below is taken from this document to illustrate the way in which, for example, healthcare chaplains can work together with NHS trusts in cases of bereavement or for major incidents. This guidance can be found at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4073108

Bereavement services

The Kennedy Report (Recommendation 12) (Bristol Royal Infirmary, 2001) states that "all NHS trusts should provide support and advice to families at the time of bereavement".

Chaplaincy/spiritual care is central to providing support and assistance to the bereaved. All NHS trusts should ensure that the dying and recently bereaved are able to access chaplaincy services at the appropriate time.

The chaplaincy team [which can include spiritual care givers from several faiths] should play a valuable role in educating staff in some of the issues surrounding bereavement. Chaplains should maintain and develop close links with all those involved in bereavement care, for example, emergency services, critical care units, maternity services, and providers of post-mortem services. Chaplains can also offer support to staff who suffer personal bereavement.

Example in practice: bereavement

As a member of the Trust Bereavement Team, the chaplain is heavily involved in their project to review communication between all users of the bereavement service. With support from the Modernisation Team on training issues, [the Chaplaincy Department is] reviewing and revising all the service's literature in order to improve access for all community groups.

Central Manchester and Manchester Children's University Hospitals NHS Trust
Contact: 0161 276 1234

Key points

- All clinical areas have access to reliable guidance on the care of patients of differing faith communities at and after death, and of the needs of the bereaved.
- The trust-wide bereavement policy committee includes a member of the chaplaincy-spiritual care team.
- Chaplains/spiritual care givers are the trust experts on arranging and providing liturgies and ceremonies to meet the needs of the bereaved, especially in the case of neonatal and child death and in annual services of remembrance.

Emergency and major incident planning

Chaplains/spiritual care givers have an important role to play in disaster and emergency planning, as their range of skills and services may be needed by a wide variety of users at short notice. Chaplaincy teams should be fully involved in preparing NHS trusts' emergency plans, and their roles should be clearly defined with major incident plans, so that their contribution can be readily accessed.

Chaplaincy teams can also be a valuable resource for major or critical incident support and debriefing. Chaplains/spiritual care givers involved in any such incident may also be in need of support.

Example in practice: traumatic incidents

[The Chaplaincy] department offers a debriefing service to all areas of the hospital trust. Any time a critical or traumatic incident occurs, which would warrant such support, [an identified] facilitator sets a number of dates to allow maximum access and [ensures that] notices are posted to advertise the session and advise of venue. The debriefing service [with input from the Chaplaincy department] was used for a number of staff groups following the Potters Bar train derailment incident and is increasingly being seen as a resource by a variety of groups throughout the trust. Feedback from the debriefing sessions has been very positive and is reflected in the increased use of the service.

Barnet General Hospital, Middlesex
Contact: 020 8216 4000

Key points

- Key members of the chaplaincy and spiritual care team are known in the trust for their skills, so they can be useful contributors to the variety of debriefs that occur both during and after a major incident.
- The spiritual care team contribute to the trust's major incident plan and are aware of their role in the plan.
- Chaplaincy team members have the necessary skills for visiting people who are inpatients as a result of a major incident.

The Multi-Faith Group for Healthcare Chaplaincy is a Department of Health advisory group which seeks to advance multi-faith healthcare chaplaincy in England and Wales. Its website is at www.mfghc.com

Gathering information on staff

It is good practice for any NHS organisation to collect information on the make-up of staff from different religions or beliefs. This enables the organisation to monitor and equality impact assess policies to make sure that they are working, and to ensure that recruitment and training policies are reflecting the make-up of the local community and the workforce. Analysis of harassment and disciplinary and grievance records can identify whether staff from a particular religion or belief are being affected disproportionately, and can measure usage of the procedures. The information can also be used to monitor whether there are disproportionate numbers of staff from specific religions or beliefs leaving the organisation; if so, steps can be taken to understand why, ensuring that where this

is due to discriminatory practices or barriers the necessary steps are taken to remedy the situation. Information on the religion or belief of staff can also help managers and team leaders to plan for when staff may need time off for major religious festivals or other religious purposes.

As with all equality monitoring, staff should be made aware of why the information is required and how it will be used. Staff should also be assured of confidentiality and anonymity, and told that they are not obliged to give such information if they do not wish to do so. Explaining that the information will be used to benefit those from different religions or beliefs may help to reassure staff and encourage them to participate. Staff surveys and network groups can also provide vital information as to whether there are issues in respect of religion or belief that need to be addressed. **The Data Protection Act 1998** covers information gathered on religion or belief. Details can be found at www.ico.gov.uk/what_we_cover/data_protection.aspx

Sexual orientation

In some religions, same-sex relationships are prohibited; whilst in the majority of cases colleagues work effectively together despite different views and beliefs, there are a very small number of people who may seek to justify homophobic behaviour by virtue of their religious convictions. Any NHS employer faced with an employee who by virtue of religion or belief refuses to work with or treat a lesbian, gay or bisexual person, or who makes homophobic comments or preaches against being lesbian, gay or bisexual, should refer to its anti-discrimination and bullying and harassment policies and procedures, which should already be in place. Whilst everyone is entitled to their personal beliefs, colleagues and patients should be treated

with respect at all times, and should not be subjected to discrimination or harassment on any grounds whatsoever. It should be made clear that such behaviour is unlawful and could result in legal proceedings being brought.

Trans people

Although some religions embrace trans people, others do not, so NHS organisations may be faced with a situation where a member of staff objects to working with or treating a trans person on the grounds of their religious beliefs. As stated above, anti-discrimination and bullying and harassment policies should be equally applied.

Staff should be reminded of equality policies on a regular basis and during annual assessments. It would also be sound practice to speak to trade union representatives, religious staff networks, and local and national lesbian, gay, bisexual and trans (LGBT) representatives on these issues, and to agree a policy on how to proceed in such situations, so that consistency in dealing with them can be ensured before they arise. Discriminatory behaviour towards LGBT people (or indeed against anyone for whatever reason) should never be tolerated under any circumstances.

The Department of Health's guides to trans and sexual orientation give more detailed briefings on these subjects – see www.dh.gov.uk/equalityandhumanrights for details of how you can order or download these publications.

Good practice example: trans

“A bishop gave his blessing yesterday to a vicar who is to have a sex change operation before resuming his ministry as a woman. The Rev Peter Stone, 46, who will be known as Carol, is the first serving priest in the Church of England to have ‘gender redesignation’ treatment.

“The Bishop of Bristol, Rt Rev Barry Rogerson, said there were ‘no ethical or ecclesiastical legal reasons why the Rev Carol Stone should not continue in ministry in the Church of England’. He said he had researched the issue of trans and consulted Lambeth Palace before approving Mr Stone’s continued ministry.

“Mr Stone has ‘the overwhelming support’ of his congregation at St Philip’s Church, Upper Stratton, Swindon, where he has been vicar since 1996.”

Daily Telegraph, 20 June 2000

Gambling and interest-bearing accounts

Another issue that should be considered in the workplace is the fact that some religions prohibit gambling. Those organising such activities as lottery pools, sweepstakes and so on should therefore be aware that people from certain religions (for instance, Muslims) may not wish to take part, and should be mindful of this when collecting and distributing monies connected to such activities.

NHS organisations should also be aware when arranging payment of salaries that certain religious beliefs prohibit the earning of interest.

Proselytising

Members of some religions, including Mormons, Jehovah's Witnesses, evangelical Christians and Muslims, are expected to preach and to try to convert other people. In a workplace environment this can cause many problems, as non-religious people and those from other religions or beliefs could feel harassed and intimidated by this behaviour. This is especially the case when particular views on matters such as sexual orientation, gender and single parents are aired in a workplace environment, potentially causing great offence to other workers or indeed patients or visitors who are within hearing. To avoid misunderstandings and complaints on this issue, it should be made clear to everyone from the first day of training and/or employment, and regularly restated, that such behaviour, notwithstanding religious beliefs, could be construed as harassment under the disciplinary and grievance procedures. Where one or more people from the same religion are working in the same environment, an individual could be pressured to conform to certain religious practices, which is again a form of harassment. There may also be differences of opinion on conformity within groups, for example between orthodox and reformed branches of certain religions, which could cause tensions and make an individual feel under pressure because of his or her religious beliefs.

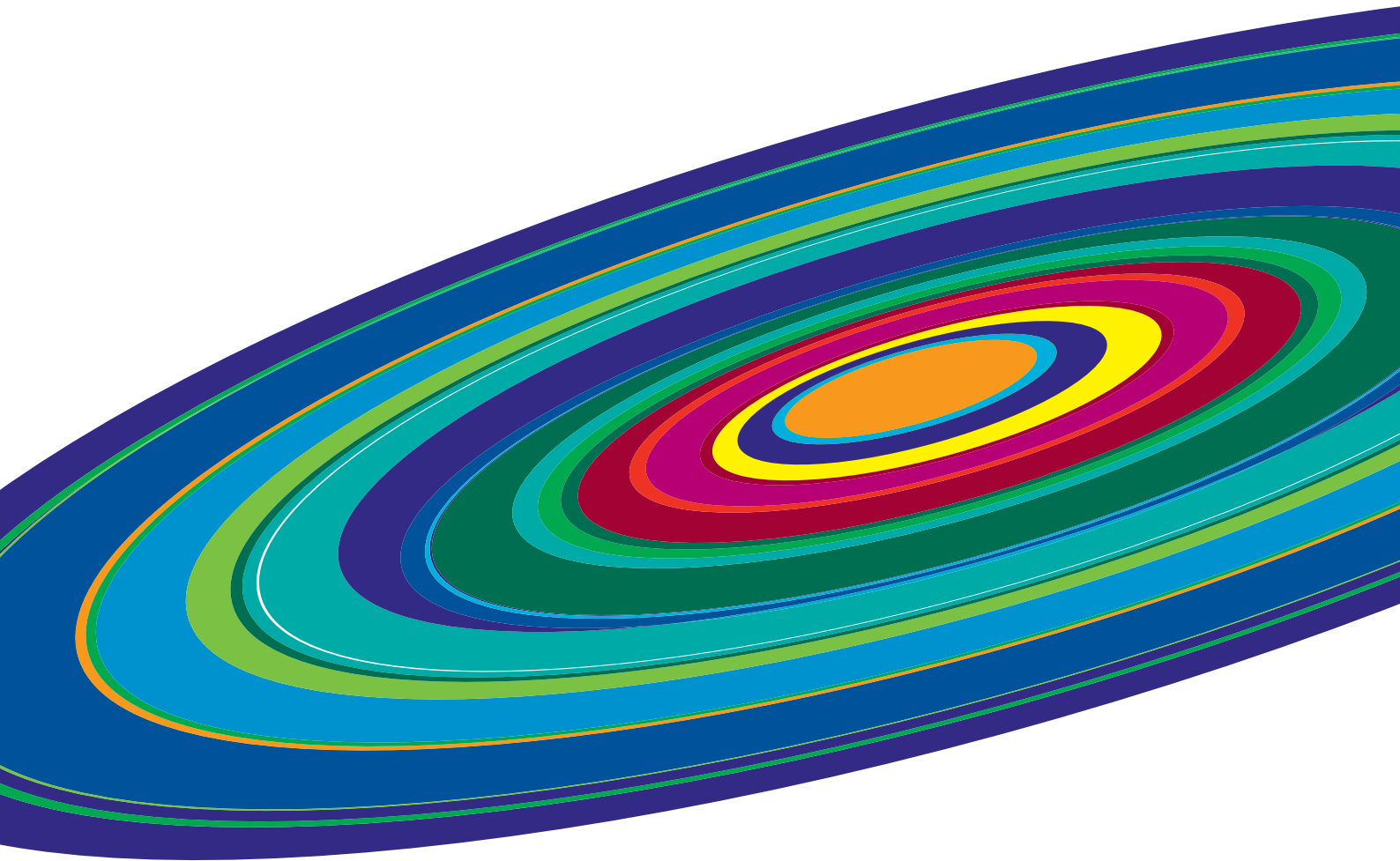
Case study: tribunal ruling

"The claimant in *Apelogun-Gabriels v London Borough of Lambeth (ET case 2301976/05)* was an evangelical Christian who distributed material to work colleagues which contained biblical extracts including passages denouncing homosexuality. Circulation was wider than the membership of the prayer group whose activities were fostered by Lambeth's provision of a prayer room available for use by Christians and others, and a number of formal complaints were made. Following suspension and investigation, [the man] was dismissed for gross misconduct and harassment in breaching the council's equal opportunities policies.

"Because of the source of the material, he claimed that he was subject to direct discrimination on grounds of religion or belief. The tribunal decided that, notwithstanding their origins, the texts were 'hostile and offensive towards homosexuals and homophobic'. Secondary claims of indirect discrimination were also rejected, the council's general support for religious groups through providing prayer facilities being noted. His claim of unfair dismissal was rejected too on the basis that employers have a positive duty to take steps to prevent harassment."

www.efrb.org.uk/legal/keycase6.html

Section Three: Key areas to consider in providing services



Overview

The wide range of religions and beliefs in the UK today, and how these impact on and influence attitudes to planning, giving and receiving healthcare from pre-conception right through to dying and even after death, require NHS staff and clinicians to be aware of and sensitive to the many perspectives that patients bring to ethical decision making.

It should never be assumed, however, that an individual belonging to a specific religious group will necessarily be compliant with or completely observant of all the views and practices of that group. Individual patients' reactions to a particular clinical situation can be influenced by a number of factors, including what branch of a particular religion or belief they belong to, and how strong their religious beliefs are (for example, orthodox or reformed, moderate or fundamentalist). For this reason, each person should be treated as an individual, and those treating them should try to ascertain their views and preferences before treatment begins.

An example of this involves patients who are Jehovah's Witnesses. It is a matter of personal choice with Jehovah's Witnesses whether they wish to accept certain blood products; for instance, some Witnesses are willing to accept plasma protein fraction (PPF) or components such as albumin, immunoglobulins and haemophilic preparations, whereas others may refuse blood products totally. Organ transplantation is also a matter of personal choice for Witnesses. It is important to highlight that a competent patient has an absolute right to accept or refuse treatment, and such patients' opinions on these matters should override their families'. There are many other issues related to treatment of Jehovah's Witnesses, such as the procedures to be followed when parents are refusing

blood products for a child. Two very useful publications give guidance on all issues related to treatment of Jehovah's Witnesses: *Code of Practice for the Surgical Management of Jehovah's Witnesses* and *Management of Anaesthesia for Jehovah's Witnesses*. Both can be found at www.gmc-uk.org/publications/valuing_diversity/beliefs_religion.asp

Diet, modesty and other matters

Patients should always be asked to state their dietary needs; nutrition is an essential element in the treatment and recovery of patients, and patients could refuse food if it does not meet the requirements of their religion or belief. This is especially relevant in older patients, who may not indicate their needs unless they are asked, or in those who fear they are likely to die and are therefore even more observant in their religious practice at the time. There is a risk that the refusal of food may be attributed to a loss of appetite, leading to poor nutrition if the real reason for refusing food is not established. An example of this could be offering a chicken sandwich with butter to a Jewish person, whose religion forbids the mixing of meat and dairy or milk-based products.

Consideration should also be given to making clear contractual arrangements with suppliers of food for hospitals, nursing homes and so on to ensure that food for people from different religions or beliefs meets their religious requirements wherever possible and is clearly labelled. Catering suppliers should be advised of the NHS organisation's policy relating to these requirements, for example for halal, kosher, vegetarian or vegan food. An example of poor practice in this context would be placing meat and vegetarian foods on the same serving platter, or using alcohol in the cooking or preparation of food without clear labelling of such. It may

be useful to source catering from suppliers within the religious or cultural groups under consideration, who may have many of these arrangements already in place.

Modesty in dress and a requirement to be treated by a doctor/nurse of the same sex is also important in some religions. NHS staff should consider these requirements in order to preserve the dignity of the patient. However, it is not always possible or feasible to provide same-sex attendance, particularly without adequate notice that this might be an issue, and this should be made clear at the time of making appointments.

Case study: Inter-Faith Gown

“Muslim hospital patients are to be offered new burqa-style head-to-toe hospital gowns to protect their religious beliefs, it has been revealed.

“The ‘Inter-Faith Gown’ has been introduced in Lancashire to allow Muslim women booking into hospitals to cover themselves completely, in line with their religious teachings.

“The blue gown, the first of its type in the UK, has already been tested on wards and will now be offered to all female Muslim patients at hospitals in Lancashire from next month.”

Daily Telegraph, 5 September 2006

For more information visit www.trustech.org.uk/case-studies/inter-faith-gown.htm

It should also be remembered that some people, such as atheists, do not have religious beliefs. Visits by the hospital chaplain on their normal rounds may be inappropriate in these cases.

Consideration should also be given to the signing of consent forms. For instance, an orthodox Jewish person would not wish to sign forms on a Sabbath or major festival. It would be preferable if a non-Jewish member of staff could sign that they have witnessed the patient or relative’s verbal agreement to the operation taking place, with the signing of consent forms taking place after the Sabbath is over.

As mentioned at the beginning of this guidance, most religions have in common the teaching of a particular ‘way of life’. In terms of healthcare, religious beliefs can influence the way in which patients wish to be treated from the beginning of life until the end. We have summarised below the most common religion- and belief-driven attitudes to these subjects.

Beginning of life

Contraception

Contraception is a consideration not only in the personal context of sexual relationships, marriage and the planning of families, but also for policy reasons (i.e. population management and public health issues such as HIV/AIDS and other sexually transmitted diseases). These are of special importance in the context of NHS organisations as public health bodies. Religions, however, tend to look at contraception largely from the perspective of sexual ethics/marriage/ family life.

The main principles at work in this regard are:

- sanctity of life and openness to children
- prohibition of killing and the taking of life
- prohibition of semen waste in Judaism.

It is therefore important that clinicians, counsellors and others giving advice on contraception are aware of the issues related to different religions or beliefs and are sensitive to the individual needs and beliefs of those they are treating and advising.

Abortion/termination

Most of the six major religions in the UK – Buddhism, Christianity, Hinduism, Islam, Judaism and Sikhism – either condemn abortion or allow it only under very limited circumstances, such as when the mother's life is at risk and/or the baby is likely to be born with a genetic disease or severe disability which is so severe that the baby has no chance of survival outside the womb. Where abortion is allowed, it is normally only in the very early stages of pregnancy. There is much controversy over the limit at which termination of a foetus should be allowed, especially now with the increase in survival rates of very premature babies.

NHS organisations will therefore need to be aware of sensitivities around this issue, both in the workforce and for patients. Members of the workforce with certain religious beliefs may not wish to be in attendance at terminations or involved in the process in any way. At the same time, those offering advice should be supported with the correct information and guidance to ensure that they deal sensitively and appropriately with patients. See page 11 for more guidance on this.

The personal religious or other beliefs of staff should not be allowed to influence any advice given to a patient. Advice should be based solely on the medical facts of each individual case.

Prenatal medicine: artificial reproductive technologies (ARTs), prenatal diagnosis (PND), prenatal genetic diagnosis (PGD)

Religious attitudes towards reproductive technologies such as IVF, PND and PGD can have implications for NHS organisations. Beliefs regarding the embryo are of relevance where patients (and their partners/extended families) and staff are involved in decision making in the context of reproduction or prenatal (genetic) diagnostic procedures.

Questions might include, for instance: Is PGD something that patients or staff want to go ahead with, considering the potential consequences such as abortion? How many embryos is it morally acceptable to transfer during IVF treatment? How should supernumerous embryos be treated? And what are the views on generational responsibility, lineage and so on in the context of sperm or egg donation?

The answers to these and many other questions may depend on the individual's religion or belief, and indeed on the strength of their convictions; those from orthodox and non-orthodox religious communities may have different, although just as strongly held, views and beliefs on certain subjects. It is essential that the clinicians providing care are able to give sensitive and contextual advice and support.

Practices at childbirth

Many religions have different practices that have to be performed during labour and on the birth of a child. Midwives and maternity

ward staff should ask pregnant women from the first appointment whether there are any religious requirements or ceremonies that need to be considered during the birth, so that planning can take place in advance. It is also good practice for NHS trusts to supply provision in maternity services to cater for different religious requirements and ceremonies.

Circumcision

In some religions (including Judaism and Islam) and for some non-religious individuals, it has been a tradition to circumcise male infants shortly after birth (usually at seven days old). In recent years, however, views have changed, and some Jewish and Muslim parents prefer to carry out the traditional ceremonies without the actual circumcision taking place. It should therefore be remembered that there could sometimes be different views on the same subject.

Currently, non-therapeutic circumcision is not *routinely* carried out by the NHS, and circumcision is normally performed for medical reasons only. There are now some exceptions to this, as indicated in the following case studies.

Good practice example: male circumcision in Tower Hamlets

[In 2007], an NHS male circumcision service [was] established for Muslim families in Tower Hamlets, London. Boys in the area have usually been circumcised when aged between five and 11, by unregulated private practitioners. The new service is offered to boys aged under five months. A charge is made. An evaluation (involving 20 semi-structured interviews with parents and five with staff) found that it was the expectation of a safe and high-quality service that had mostly influenced parents to use the service. Nearly all thought that circumcision was best carried out at an early stage, because of reduced pain and greater safety. Almost all service users commented on how helpful, reassuring and informative staff were. Most said that they would use the service again, and over half had already recommended the service to others. This small study highlights how a public sector organisation can be responsive to its community.

See www.ingentaconnect.com/content/cp/cp/2007/00000080/00000003/art00007

Good practice example: developing a private male circumcision service in Bristol

Bristol has a large and growing Muslim community (estimated at 10,000). There is currently no affordable, safe male circumcision service in the area; consequently, families are paying unregulated practitioners to perform the procedure. There have been several serious cases of severe genital damage as a result. A community engagement exercise revealed both the extent and the risks of the unregulated practice. Male circumcision is considered a religious duty by the majority of Muslims. In the absence of an alternative, boys as old as 12 were reported to have undergone the procedure in community halls and private homes, with no after-care advice given by the unregulated practitioners.

Bristol Primary Care Trust used local consultation to identify the issue, along with incident data of substandard procedures and lack of follow-up care leading to adverse events. Feedback from the consultation highlighted the lack of confidence that the Muslim community had in public services generally, and the confusion they felt about the fact that there was no safe male circumcision service. It was clear that this mistrust influenced reception to health promoting messages and participation in health improvement programmes.

In response, the Trust, in partnership with the Department of Health's Pacesetters programme, worked with the local Muslim community to develop an affordable, safe, private male circumcision service for parents who wish to have their child circumcised for social, cultural or religious reasons. This was part of a wider community engagement strategy that supports and enables all communities to meaningfully participate in shaping the services they use.

*Contact: Bristol Primary Care Trust
Tel: 0117 900 2489*

Female circumcision, or female genital mutilation (FGM), is also practiced in some cultures although universally condemned by organisations such as the World Health Organization (WHO). It is illegal in this country under the Female Genital Mutilation Act 2003, which repealed and re-enacted the Prohibition of Female Circumcision Act 1985. The Act makes it an offence for UK nationals or permanent residents to carry out or to aid, abet, counsel or procure the carrying out of FGM in the UK or abroad – even in countries where it is openly practised. Where cases of FGM are presented, they should be treated as a child protection matter.

Palliative care

Some religions believe that suffering is part of life and leads to a better state of existence – for them, cutting suffering short means interfering with progress towards liberation/salvation/atonement (for example, in the afterlife in Christianity and Islam; and in Nirvana, the end of all suffering, in Buddhism).

Palliative care aims at the enhancement of the quality of life for terminally ill patients as well as their relatives/family. Both the physical and the spiritual aspects of individual patients are considered, allowing for individual religious views on the relationship between body, mind, soul and spirit. The inclusion of family is particularly relevant in religious communities where large emphasis is placed on familial bonds.

Where palliative care includes families and relatives in the care of patients, it is particularly important that the staff involved are aware of religious attitudes towards disease, suffering, dying and death and religious practices (such as anointing of the sick in Christianity, and prayer in Islam), as well as views on familial responsibilities and traditions. They will be facing these attitudes when administering care. In Islam, for instance, prayer is key to the life of the believer and maintaining a level of consciousness close to normal is of great importance to allow for observance of worship rites for the longest period possible before death. For this reason, some patients might prefer to endure pain for the sake of greater consciousness. In these cases, families should also be involved in decision making, and alternative methods of pain relief that do not interfere with consciousness should be explored.

Palliative care is often welcomed by religious communities as a way of alleviating suffering without destroying the opportunity of using it for the purpose of spiritual growth. Painkilling drugs may permit the best use of the patient's remaining energies and consciousness and are not illicit in most religious communities. In Islam, for instance, where the use of opioids and other drugs that affect the senses is strictly prohibited, medically prescribed opioids are generally

considered permissible, but it is always advisable to ask.

It would be useful to have a readily available list of religious leaders/priests/ministers who can be contacted on request to attend terminally ill or dying patients. In most cases the hospital healthcare chaplain will hold such a list, and will have good links with local religious/faith groups. However, it is important to note that many patients would prefer their usual spiritual care giver to be present. It would be good practice to ask in the first instance.

It is equally important to be aware of those people who not hold any religion or belief and therefore would not want to be attended by a religious person at such a vulnerable time. Individual views and requirements in these cases should be ascertained as early as possible.

Good practice example: spiritual needs at time of death

The Liverpool Integrated Care Pathway for the dying patient is being used as a model in several NHS trusts. The goals are to ensure that the patient has a dignified death, and that family and carers are given an appropriate level of support. Part of the patient assessment that has to be completed includes a section on religious/spiritual support. The religious and spiritual needs of the patient at present, at time of death and after death are discussed with the patient, or with an appointed relative or carer.

See www.endoflifecareforadults.nhs.uk/eolc/files/F2091-LCP_pathway_for_dying_patient_Sep2007.pdf

End of life concerns

Many religions and beliefs include in their teachings views on dying, death and the afterlife. Increasingly, with medical progress and life-extending technologies such as respirators, antibiotics and feeding tubes, the process of dying has moved into the medical domain, where the event of death takes place.

For many religions, life does not end with death. Often the process of dying is seen as an opportunity for spiritual insight. In Buddhism, Hinduism and Sikhism, for example, the way in which one dies may influence one's rebirth. Where death is seen not as the end, and where dying is viewed as an opportunity for moving closer to the holy power(s) that for the believer rule(s) life and the afterlife, decisions about continuing treatment or allowing death to take place by forgoing or terminating such treatment have an immediate impact on the spiritual wellbeing of the dying person.

Against this background it is of paramount importance for the NHS to be aware of its employees' and patients' views of dying and death, particularly in the context of intensive care, persistent vegetative state (PVS), palliative care and dealing with terminally ill people.

The knowledge of religious practices and practical procedures after death is also crucial when it comes to the handling of the corpse and funeral rites. The time when the deceased has to be buried, for instance, might clash with requirements for autopsy. In Buddhism it is believed that the death process is not over when breathing ceases, so the patient should be disturbed as little as possible in the period from shortly before death until as long as possible after breathing stops. However, views are never uniform

within one religion, and personal and cultural differences of interpretation always need to be taken into account when addressing these issues with Buddhist, Christian, Muslim or other patients.

Particular practices that are adhered to by one tradition within one religion may not be universally adhered to by all members of the religion. All religions and cultures have different ways of expressing grief and mourning the dead, and awareness around these issues will help NHS staff when dealing with grieving relatives. For instance, in Buddhism the viewing of the body is seen as a reminder of the impermanence of life, so relatives may wish to gather for some time after the death. In Hinduism the body is normally cremated within 24 hours of death, and immediately after the death an oil lamp is lit near the deceased. The dying Muslim patient may wish to sit or lie with his/her face towards Mecca. Another Muslim, usually a relative, may whisper the declaration of faith into the ear of the dying person. A dying Jewish patient may wish to hear or recite special psalms, particularly Psalm 23, and the special prayer (the Shema). A Catholic patient may wish to receive the last sacrament of anointing by a priest, and to receive Holy Communion.

In the event of a death, NHS staff should consult the patient's relatives to determine their preferences with regard to preparation of the body and other religious requirements. It is important to remember that early burial is a requirement in some religions.

Concerns with certain drugs and treatments

As mentioned above, some religions prohibit the ingestion of certain foods and of alcohol. Consideration should therefore be given to the patient's religious beliefs before

prescribing drugs or treatment. For example, porcine-based drugs would be forbidden in both Jewish and Muslim communities, bovine-based drugs or cattle-derived cartilage transplants would have implications for Hindus, and many religions would also prohibit alcohol-based drugs. The use of gelatine is only acceptable in Islam if derived from a halal source, and where medication is available in another form (i.e. not gelatine-based capsules), this would be preferable. In Judaism there is a distinction between medication taken orally and non-orally. If the porcine-derived or non-kosher medication were to be taken orally, then an alternative that was as effective but did not contain non-kosher derivatives would be preferable. There would also be questions asked as to how seriously ill the patient was before non-kosher medicine was refused, because there are dispensations where a person's life is at risk.

Work carried out by a UK-based expert group on this topic resulted in the publication, in April 2004, of a booklet for health professionals on drugs of porcine origin and their clinical alternatives. The booklet not only provides a directory of such drugs and their alternatives, but also provides guidance on the religious and cultural aspects of porcine-derived products and explains why and how patients of all faiths should be involved in decisions about their medicines if the pitfalls of cultural misunderstanding are to be avoided. The booklet is available at www.npc.co.uk/med_partnership/assets/drugs-of-porcine-origin (Adapted from the *British Medical Journal* website at www.bmj.com/cgi/eletters/329/7469/778)

Mental health issues

The National Service Framework for Mental Health sets national standards and defines service models for promoting mental health

and treating mental illness in five areas: mental health promotion; primary care and access to services; effective services for people with severe mental illness; caring about carers; and preventing suicide. The Framework also clarifies expectations about the future configuration of mental health services; sets out arrangements for local implementation; puts in place national underpinning programmes to support local delivery; and establishes milestones and a specific group of high-level performance indicators against which progress within agreed timescales will be measured. The Framework is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598

Spiritual interpretations of mental disease can play a crucial part in therapeutic success. An awareness of 'demonic' and other religious interpretations or models of mental diseases, and the fact that there is often stigma attached to mental health conditions in some cultures, is very important. There is also a need to be aware of cultural differences in attitudes to therapy. For instance, the treatment of mental illness by counselling (i.e. 'talking cures'), which is an essentially Western model, cannot be assumed to work equally well in other cultures.

A holistic approach to the patient, which takes account of their physical, cultural, social, mental and spiritual needs, would seem to have a particular significance within mental health services. Spirituality and an individual's religion or beliefs are increasingly acknowledged as playing an important role in the overall healing process. Stressful life events can lead to mental illness, and it is during these events that religion or specific beliefs can play a large part in the way that an individual copes. Most religions have developed symbols and analogies as a way of interpreting and coping with life events,

and these are seen as tools that might be integrated into the medical healing process.

For instance, the Royal College of Psychiatrists stated in its 2006 booklet *Help is at hand – Spirituality and Mental Health*: “Spirituality involves a dimension of human experiences that psychiatrists are increasingly interested in, because of its potential benefits to mental health... Evidence for the benefits for mental health of belonging to a faith community, holding religious or spiritual beliefs, and engaging in associated practices, is now substantial.”

As mentioned above, some religious interpretations of mental health conditions are different from medical interpretations. What might be seen by psychiatrists as a schizophrenic attack, which can be described in terms of biological and brain functions, might be interpreted spiritually by religious communities; it might be taken as a spiritual event caused by a holy power leading to greater enlightenment. Others might interpret mental illnesses as a spiritual reality caused by, for instance, a demonic attack to which the appropriate response is religious, not medical, intervention. Another great concern can be the question of responsibility for mental disease and its relationship to sin. This might lead to questions such as: Did I get ill because of my behaviour? Am I to be held morally responsible for my disease? It is crucial to find out how a patient would answer these questions, as it may have a direct effect on their response to treatment.

Against this context, staff awareness of a patient's religion and/or spirituality as well as his or her interpretations of mental events is a key component of, if not a platform for, mental health therapies.

The Royal College of Psychiatrists recommends that patients in mental health institutions – and, indeed, all healthcare settings – should be given a private place for worship and prayer as well as the opportunity for exploring the spiritual meaning of their illness, if desired under the guidance of a religious leader or chaplain. Staff need to be informed of available spiritual services.

Staff also need to be offered advice on issues such as demonic possession, the concept of sin, and the ministry of deliverance (exorcism) as it might affect some Christian, Shamanic and Pagan beliefs.

Psychotropic drugs

Most religions do not reject psychotropic drugs (which act primarily upon the nervous system to alter brain function) when given for therapeutic reasons, although in Buddhism and Hinduism the importance of ‘awake consciousness’ is stressed, and some teachers recommend the combination of traditional and Western medicine.

Case study: a spiritual needs assessment tool developed by the Surrey and Borders Partnership Trust

Spirituality – religious and non-religious – plays a key role in the mental wellbeing of an individual and is increasingly recognised as being important in effective mental health assessment and treatment. The Surrey and Borders Partnership Trust is committed to ensuring that the quality of patient assessment, treatment and care is excellent, so it needs to ensure that patients’ care plans address all their needs – an individual's spiritual needs are a key part of this process.

A spiritual needs assessment tool was developed with the involvement of individuals who used the trust's inpatient services from minority ethnic communities and representatives of the faith communities. It was then piloted in some inpatient settings in the east of the trust. The tool helps staff to ensure that the spiritual needs of people who use services are assessed and addressed appropriately, regardless of their beliefs.

Working in partnership with the Department of Health's Pacesetters programme, the trust has ensured that this spiritual needs assessment tool is available to all those who use its inpatient services across North-West Surrey, whatever their religion or belief and regardless of whether these beliefs are religious or non-religious. Guidance notes on the key religions have been prepared, and staff in inpatient services have been trained in spiritual needs assessment.

The project aims to integrate spiritual needs assessments into the Care Programme Approach. Care co-ordinators undertake a spiritual needs assessment as soon as an individual is referred to the service. Over time, use of this tool will ensure that the quality of care and outcomes are improved.

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Suicide

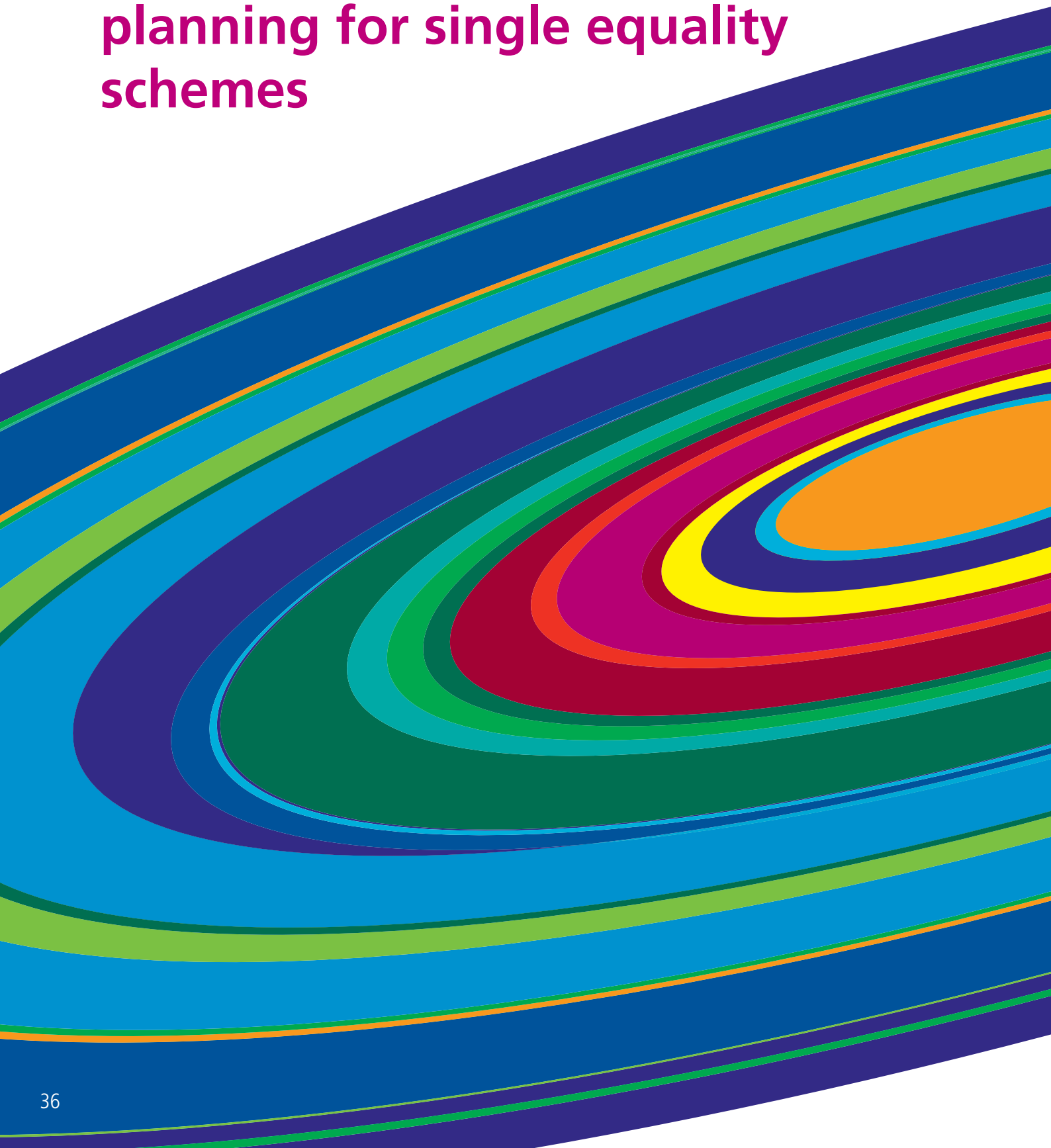
The decision to take their own life and the failure to do so are both enormous issues for the individual. Failed suiciders may worry that they will be punished in this life or the afterlife for having attempted to kill themselves.

All the major world religions condemn suicide unequivocally. The act of suicide or failed suicide can cause great anxiety and spiritual distress, particularly to the relatives and friends of the victim. Relatives may worry that the person will be punished for the act, and may also blame themselves for not having prevented it.

All of these issues can have implications for the future mental health of those concerned, and it is important that staff are ready to address these worries and are aware of the availability of faith-based counselling services. A useful resource giving statistics and viewpoints on this subject can be found on the Suicide and Mental Health Association website at www.suicideandmentalhealthassociationinternational.org

A national project exploring spirituality and mental health is currently being run jointly by the Care Services Improvement Partnership (CSIP) and the National Institute for Mental Health in England (NIMHE). Further details can be found at www.nimhe.csip.org.uk/our-work/spirituality-in-mental-health.html

Section Four: Process – how to integrate issues on religion or belief into action planning for single equality schemes



Gathering information

See also 'Gathering information on staff' in Section Two.

Unlike the legislation on race, disability and gender, there is no legislative requirement at present to produce a separate equality scheme on religion or belief. It is, however, good practice for organisations to integrate actions to address issues on religion or belief into their single equality schemes and action plans. Before NHS organisations can do this, it will be necessary for them to understand any issues that may arise on the grounds of religion or belief that relate specifically to their organisation, and to determine the make-up based on religion and belief of their workforce and patients.

Most NHS organisations can ask patients for their religion at first contact. This information can be used when analysing customer complaints and customer surveys to see whether there is a disproportionate number of people from a certain religion or belief who are dissatisfied with the service they receive. More importantly, it should be used to see whether treatments or a hospital stay need to take account of a religion or belief.

If this is found to be the case, the information can be further disaggregated to determine any common issues that may appear, which would in turn inform what action can be taken to resolve these issues.

Where people are asked for information on their religion or belief, it should always be explained why the information is needed, and how it will be used. It should also be made clear that giving this information is voluntary.

In order to collect data from staff and patients effectively, it is advisable to use the 2001 ONS census categories as outlined below:

- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Sikh
- Any other religion
- None
- Not stated.

The above ONS codes can be disaggregated further to better reflect the religions within local populations. For example, it may be helpful to distinguish between the different Muslim sects. Useful breakdowns of different religions are given in the *Health Survey for England 1999* (Department of Health) and in *Count Me In*, the national census conducted by the Mental Health Act Commission. It is imperative that any breakdown of the ONS codes is 'built' back up to the original ONS categories to allow for local and national comparisons.

For additional guidance, see *A practical guide to ethnic monitoring in the NHS and social care*, available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4116927

Consultation

It is very important that NHS organisations consult with patients and employees when deciding on priority actions to take forward, as these are the people who will be affected by the outcomes. The involvement of staff and patients will also facilitate transparency and awareness of intended actions.

NHS organisations are already involving and consulting their local communities on delivery of services, so some mechanisms such as patient forums are already in place and can potentially be used to consult on religion or belief issues. Staff opinions can be sought via network groups, trade unions and staff surveys.

In order to get a truly representative range of opinions, NHS organisations may consider breaking down the consultation process to include the following groups from all of the main religions and beliefs and from those with no religion or belief:

- men and women from different racial and ethnic backgrounds
- disabled men and women
- men and women across all age groups
- gay, lesbian and bisexual people
- trans people.

The Department of Health has produced *A Dialogue of Equals: The Pacesetters programme Community Engagement Guide*, which has been written to support NHS organisations participating in the Pacesetters programme to better engage with seldom-heard communities and groups. It is a useful reference for all trusts, and is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082382

The public participation organisation Involve has released *Healthy Democracy: The future of involvement in health and social care* in partnership with the NHS Centre for Involvement. It is an anthology on Patient and Public Involvement (PPI) in Health and was launched on 28 November 2007. *Healthy Democracy* highlights current trends and the diversity within patient and public involvement, and seeks to encourage debate around current practice and what the future may hold. The publication comes at a key point in time with recent proposals for new Local Involvement Networks (LINks) to replace existing Patient and Public Involvement Forums in England. For further information, see www.involve.org.uk/health

Assessing policies and functions

There is no legislative requirement at present for NHS organisations to conduct equality impact assessments specifically on their policies and practices in relation to religion or belief. However, again it is agreed best practice to equality impact assess on the grounds of religion or belief, and it would make sound business sense to incorporate this into a broader equality impact assessment which included all the equality strands as part of a single equality scheme approach.

Not to do so may result in a failure to identify the need to incorporate specific actions relating to religion or belief when introducing changes in processes and/or clinical practice or procedures, which could have unexpected negative impacts on planned outcomes and take-up elsewhere in the organisation. These impacts could include some staff being unable to attend development weekends, some women feeling unable to use or access a particular service that is predominantly staffed by men, or even Islamic men not taking up services provided on Friday afternoons.

Gathering information, consulting and assessing the results as described can give a good indication of how policies are affecting and are likely to affect the main beneficiaries for whom their different religions or beliefs may be significant. Therefore, when developing new policies it is important to consider how to include religion or belief (where it is practical to do so) in existing equality impact assessment procedures used for the other equality strands.

Action planning

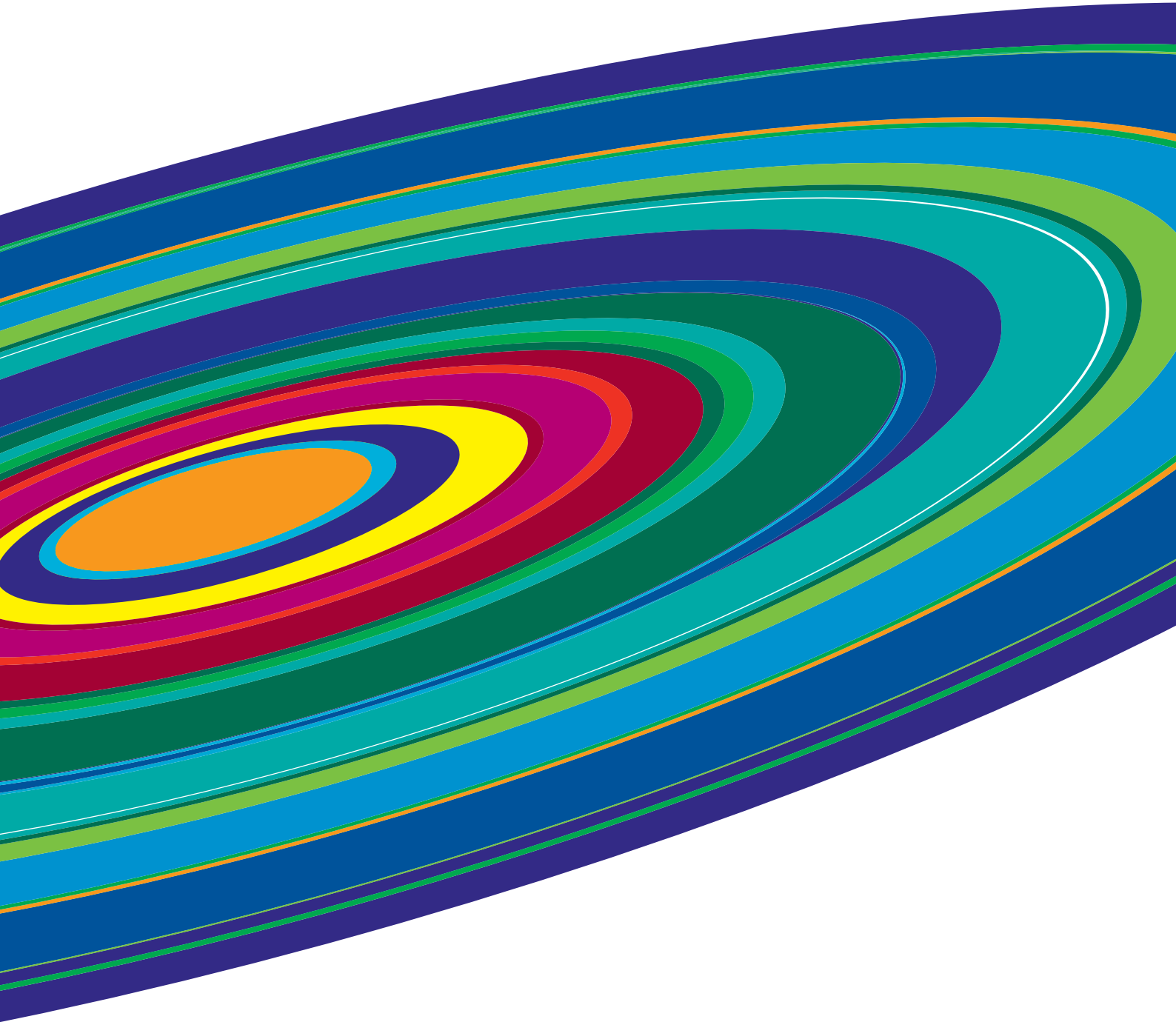
Issues regarding religion or belief that need to be addressed can be integrated into existing action plans for single equality schemes. Objectives, outcomes and timescales should be clearly indicated to make it easier to track progress. Worksheets 1 and 2 in Section Five contain an action planning framework and a sample action plan.

Monitoring actions

Although there is no legislative requirement as yet to monitor on the basis of religion or belief, it is considered good practice for NHS organisations when monitoring existing equality scheme action plans to also monitor for impact on religion or belief. Existing auditing processes, such as disciplinary and grievance management policies for staff, can be used to monitor key religion or belief issues in the workforce. Similarly, mechanisms set up for monitoring actions on race, disability and gender can also be used or modified for religion or belief.

The Department of Health has produced *10 Steps to your SES*, a web-based practical guide to help NHS organisations develop their single equality schemes. The guide includes examples of best practice and learning outcomes from the Single Equality Scheme Learning Sites project, comprised of 18 trusts across the country working together to develop single equality schemes for their organisations. It can be found at www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Browsable/DH_066006

Section Five: Resources



Annex A – Healthcare Apprenticeship Scheme



Some of the first healthcare apprentices in their specially designed uniforms. These were produced in 1996/7 and were amongst the first culturally appropriate workwear for the NHS. See 'Religious observance in the workplace' in Section Two for more information.

Annex B – Human rights and religion or belief

According to Article 9 (Freedom of thought, conscience and religion) of the European Convention on Human Rights (ECHR) as given effect by the Human Rights Act 1998, a person is free to hold a broad range of views, beliefs and thoughts, and to follow a religious faith. The right to manifest one's religion or beliefs may be limited in specified circumstances.

Article 9 falls within the group of ECHR rights known as 'qualified rights'. These are rights that require a balance between the rights of the individual and the needs of the wider community or state interest.

Interference with Article 9 is allowed if there is a clear legal basis for the interference with the qualified right, i.e. if the interference has a legitimate aim as necessary in a democratic society. This means that the action or interference must be in response to "a pressing social need" and must be no greater than that necessary to address the social need.

Key points

The principle of proportionality applies such that any interference must be proportionate to the aim being pursued.

Legitimate aims may be in aid of:

- public safety
- the protection of public order, health or morals
- the protection of the rights and freedom of others.

For example, possible areas for challenge could include:

- abortion advice
- access to religious leaders as part of the care of terminally ill or dying patients
- anaesthesia and Jehovah's Witnesses
- blood transfusion
- circumcision
- contraception advice
- cutting hair
- examination of members of the opposite sex
- facilities for worship or culturally appropriate food
- female genital mutilation

- fertilisation (same-sex/non-married couples)
- consultation with terminally ill patients and, in the event of death, with the patient's relatives or carers regarding their preferences in relation to the preparation of the body and other religious requirements
- medicines and drugs
- provision in maternity services for staff to cater for religious requirements and ceremonies relating to childbirth
- privacy and space for patients and families to spend time together or to perform religious ceremonies
- religious items, including religious and wedding jewellery, removed without the consent of the patient or their next of kin
- transplants, organ donation and tissue donation
- the insistence on using mixed-sex wards for those to whom they are not acceptable for religious reasons.

Worksheet 1 – Action planning framework

Below is a sample action planning framework which organisations may have already set up for existing equality schemes or single equality schemes. The work on religion or belief can be inserted into this framework and carried out alongside the work on other diversity strands.

Religion or belief actions are set out in bold.

Task	How to	Outcomes sought	Evaluation	Responsibility
1. Establish steering group	This will already be set up for other equality schemes	Group established with membership and terms of reference agreed	NHS trust board responsibility established with regular feedback/ reports being received	Identify trust board member who will be responsible for religion or belief issues
2. Establish working group	As above	Group established with membership and terms of reference agreed	Regular reports on progress against action plan being given to steering group	As above
3. Identify outcomes required for action plan	See Section Four	Key actions on employment and service provision identified and included in action plan	Progress against action plan and performance monitoring	

Task	How to	Outcomes sought	Evaluation	Responsibility
4. Identify who to involve – internal and external to the organisation	See Section Four, 'Consultation'	Issues identified; priorities set; priorities used to inform/ assist planning activities; priorities for future action plans identified	Active involvement of internal and external religious groups, staff networks and trade unions	
5. Identify what information is available and/or how to obtain information in the future	Refer to Section Four, 'Gathering Information'	Data sources identified; gaps in data collection identified and remedies included in action plan	Data gathered, analysed and used to inform priorities	
6. Identify measures for gathering information	As above	Data collected and analysed; information used to inform priorities for action plan; future arrangements included in action planning process	Quality of information gathered and how it is used to inform actions	

Task	How to	Outcomes sought	Evaluation	Responsibility
7. Establish arrangements for equality impact assessing new policies/ functions	This should already be in place for existing equality schemes. Include religion or belief where practical	Arrangements for screening and full equality impact assessments agreed and in place	Outcomes of equality impact assessment and inclusion of results/gaps identified in future action plans	
8. Identify arrangements for assessing the impact of present policies and function	Use information gained from consultation and data gathering	Arrangements in place with realistic timetables; priorities assigned to existing policies	Outcomes of assessments and how they influence decision making within the organisation. Inclusion of outcomes within future action plans	
9. Develop action plan based on sample provided	Actions can be integrated into existing action plans	Action plan in place agreed by trust board	Progress identified against action plan	

Task	How to	Outcomes sought	Evaluation	Responsibility
<p>11. Agree monitoring arrangements</p>	<p>Refer to Section Four, 'Monitoring actions'; monitoring for religion or belief is not a legal requirement but its inclusion in existing monitoring arrangements is sensible</p>	<p>Transparent monitoring arrangements in place. Monitoring being followed up:</p> <ul style="list-style-type: none"> ● at board level ● by the steering group ● by directorates ● within services 	<p>Identifiable improvements made</p>	

Worksheet 2 – Sample action plan

Please note that this is only an example. Your own findings from information gathering and consultation will determine what you need to action.

Name of directorate

Employment actions

Objective	Steps to achieve	Outcomes required	Timescales	Resources required	Responsible Team/ Person
Arrange religion or belief awareness training for all staff	<p>Training sessions (work with chaplaincy services)</p> <p>Guidance on intranet</p> <p>Evaluation of effectiveness of training</p>	All staff are aware of the issues and consider them in their dealings with colleagues and customers			Human Resources teams
Review all employment policies to ensure that they do not directly or indirectly discriminate against those from different religions or beliefs	Use screening tool/framework already in place for other equality strands (work with staff networks and unions)	All employment policies are non-discriminatory			Human Resources teams

Objective	Steps to achieve	Outcomes required	Timescales	Resources required	Responsible Team/ Person
Distribute religious calendars/ year planners to all sections	Link into existing distribution plans for stationery etc Communication of key dates to managers	There is awareness of key dates to aid planning and cover for major religious festivals			Human Resources teams
Set up dedicated prayer room where appropriate	Look for appropriate empty rooms/ spaces that can be utilised	Staff from all religious or non-religious backgrounds can have quiet time			Estates department

Service delivery actions

Objective	Steps to achieve	Outcomes required	Timescales	Resources required	Responsible Team/ Person
Order culturally appropriate hospital gowns	As part of normal linen ordering processes	There is respect for religious beliefs of patients			
Make sure that contracted food suppliers are aware of religiously correct food ingredients and preparation	Specifications sent to all suppliers and ongoing communication to ensure compliance	All patients can be confident that the food they eat will not offend their religious beliefs			Procurement teams
Determine potential issues for patients with regard to religion or belief	Targeted customer surveys, patient forums, mystery shoppers	Patients can feel confident when accessing NHS services that their religious or non-religious beliefs will be considered			

Objective	Steps to achieve	Outcomes required	Timescales	Resources required	Responsible Team/ Person
Provision in maternity services for staff to cater for religious requirements and practices relating to childbirth	Research the needs of different religious communities in this respect	Those accessing maternity services and their families have confidence in the services provided			

Worksheet 3 – Multi-faith event calendar

It should be remembered that many religious festivals are based on the lunar and/or solar calendars, or are on fixed dates which change with the common calendar year. It is good practice for NHS organisations to have, or arrange access to, an up-to-date multi-faith event calendar available for planning purposes.

Race for Health produces a combined multi-faith calendar and recipe book, *Recipes for Success*. The calendar combines 12 recipes celebrating food and culture from black and minority ethnic communities with 12 case studies of good practice from the Race for Health primary care trusts, alongside useful facts about race, health and inequality. To obtain a copy, simply email enquiries@raceforhealth.org. *Recipes for Success* is also now available in a monthly downloadable and printable format. You can link to the calendar from your own organisation's website or give your staff access to it via your in-house newsletters/email bulletins. www.raceforhealth.org/resources/publications/recipes_for_success

For a comprehensive list of holy days and festivals for each of the major religions, broken down by month and year, visit the BBC website at www.bbc.co.uk/religion/tools/calendar/

Bradford District NHS Trust has also developed a religious calendar, which can be accessed at www.bradford.gov.uk/NR/rdonlyres/10B58609-8770-494E-B872-EDEF9090ED94/0/CulturalCalendar2008.pdf

Useful organisations and links

Faith Requirements Resource Pack – A Guide for Hospital Staff to Improve Patient Care is a very useful, comprehensive guide to the requirements of patients from different faiths: www.mfghc.com/resources/resource_74.pdf

Check Up! is a guide to the special healthcare needs of ethnic religious minority communities, produced by Diversiton in partnership with the Northern Ireland Inter-Faith Forum: www.diversiton.com/downloads/checkUp.pdf

ACAS has developed *Religion or Belief and the Workplace*, a useful guide for employers and employees: www.acas.org.uk/media/pdf/f/l/religion_1.pdf

For useful information and guidance on the treatment of Jehovah's Witnesses, please refer to the publications below at www.gmc-uk.org/publications/valuing_diversity/beliefs_religion.asp

Code of Practice for the Surgical Management of Jehovah's Witnesses.
Management of Anaesthesia for Jehovah's Witnesses.

The Employers Forum on Belief has a very useful website with interesting real-life case studies and good practice examples from its members: www.efrb.org.uk

The **Changesurfer** website contains the essay *Buddhism and Medical Ethics: A Bibliographic Introduction*: www.changesurfer.com/Bud/BudBioEth.html

The General Medical Council page on religion or belief gives valuable information and other links to useful material:
www.gmc-uk.org/publications/valuing_diversity/beliefs_religion.asp

The Inter-Faith Network for the UK: www.interfaith.org.uk

BBC page on religion and ethics: www.bbc.co.uk/religion/

BBC site which gives information on religious customs and festival dates:
www.bbc.co.uk/schools/religion/

National Institute for Health and Clinical Excellence: www.nice.org.uk/

Race for Health: www.raceforhealth.org

Religious support groups for LGBT people:
www.nooutsiders.sunderland.ac.uk/events/religious-support-for-lgbt-people
www.eastendeye.org.uk/LGBT/LGBT_Religion.php

Gay and Lesbian Humanist Association – a non-religious LGB support group:
www.galha.org/

Below is a list of trusts on the Department of Health Pacesetters programme which are working on specific religion or belief equality interventions:

East Midlands Ambulance Service NHS Trust

Objective: To raise awareness of religious and cultural practice, so that ambulance crews can provide a more sensitive and effective service to people of different religions, especially those close to death.

East London and the City Mental Health NHS Trust

Objective: To engage with Christian faith communities to promote understanding of mental health services, reduce stigma and break down barriers that may prevent early access to mental health services.

Hastings and Rother Primary Care Trust

Objective: To improve the planning and delivery of local health services to particular faith groups through better establishing and evidencing of the relationship between religion, the inability to appropriately access services, and inequalities in health outcomes.

Surrey and Borders Partnership NHS Foundation Trust

Objective: To extend the current spiritual needs assessment throughout the Trust by embedding it within the Trust's Care Programme Approach.

Bristol Primary Care Trust

Objective: To work with Muslim communities to develop a local, affordable and safe male circumcision service.

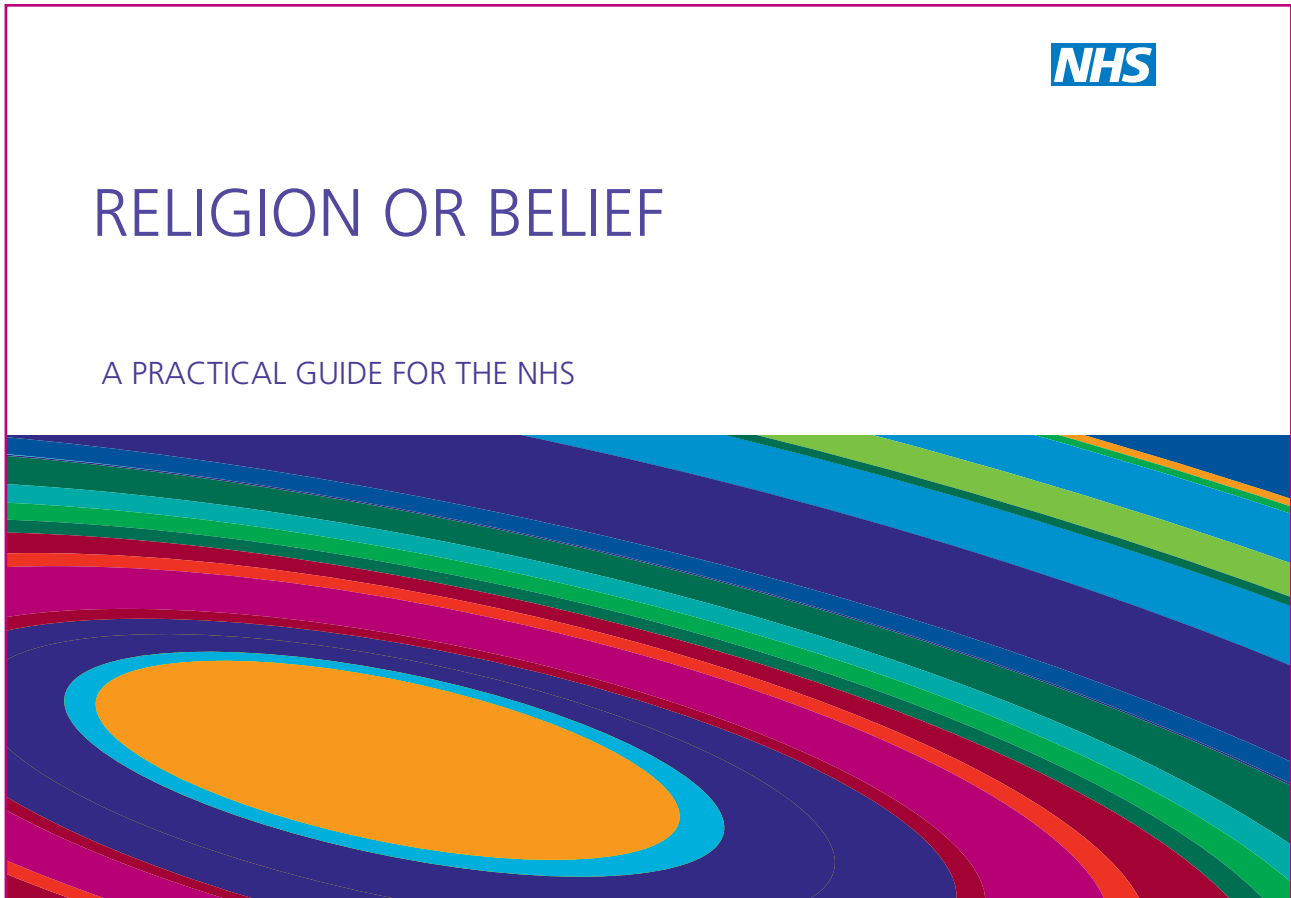
Yorkshire Ambulance Service NHS Trust

Objective: To provide basic life support training for members of the local Muslim community.

www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Pacesettersprogramme/index.htm

Appendix A – Sample presentation

This is a sample presentation which can be used for local purposes. Care should, however, be taken to customise the presentation to fit with the organisation, where possible using the local context, data and examples of good practice.



Background statistics

- The UK now has a more diverse mix of religions and beliefs than ever before, and NHS organisations need to take this into account when developing services to public and employment policies
- Christianity is the main religion in the UK – 48% of total population
- Islam is the second-largest religion – 3% of the total population
- Hinduism covers 1% of the total population
- 46% of the British population say they don't belong to any religion

Further...

Membership of particular religious communities appears to have some bearing on health and wellbeing, although this is not necessarily cause and effect – it is more likely compounded with other factors such as housing and economic and social status:

- The British Muslim community has the worst reported health
- The Sikh population is the next worst
- Muslim, Sikh and Hindu females are more likely to report ill health than males from those religions
- In Christian and Jewish communities, the gender difference is minimal

The legal requirements

- **Employment Equality (Religion or Belief) Regulations:** Came into force in December 2003 and make it unlawful to discriminate on grounds of religion or belief in all aspects of employment, including vocational training
- **Part 2 of The Equality Act 2006 (Discrimination on Grounds of Religion or Belief):** Came into force in April 2007 and makes it unlawful to discriminate in the area of goods, facilities and services on grounds of religion or belief or lack of religion or belief
- **The Racial and Religious Hatred Act 2006:** Came into force in October 2007 as an amendment to the Public Order Act 1986 and gives protection to people against harm because of their religious beliefs or lack of religious beliefs, and prohibits the stirring up of hatred against people on religious grounds
- Regulations extend to beliefs such as Paganism, humanism, atheism, Shamanism etc, and also those without religious or similar beliefs

Key issues: Employment

Recruitment

Consider religion or belief from the first stages of recruitment so that issues can be taken into account at the outset:

- Selection criteria should not prevent people applying on grounds of religion or belief
- Avoid times, dates and locations that would stop people attending interviews for religious reasons – ask if they have any special or dietary requirements when inviting people for interview
- Job description should give a clear idea of the duties of the post so that potential applicants can decide whether the job may conflict with their religious convictions
- Make students aware that there could be health and safety issues with the wearing of religious clothing or jewellery
- If a person's religion prohibits them from working on certain days, this should be discussed at the outset so that suitable solutions can be reached

Personal beliefs in a healthcare setting

- It is vital that the personal religious beliefs of healthcare or other staff do not impact on the care given to patients
- It is good practice to determine if there are issues that should ideally be addressed at the beginning of employment or on induction

Religious observances in the workplace

The Improving Working Lives Standard in the NHS makes it clear that:

“every member of staff in the NHS is entitled to work in an organisation which can demonstrate its commitment to more flexible working conditions and gives staff more control over their own time”

This is especially relevant to taking religion or belief into account

Religious observances in the workplace

- Most religions/beliefs have special holy days or festivals when staff will require time off
- It is good practice to have a multi-faith calendar and year planner available to prepare cover in advance
- Some dates are not known until close to the day; in these cases, discussion and flexibility on both sides should enable solutions to be reached
- Make sure that arrangements made do not disadvantage other staff or those with no religion or belief

Religious observances in the workplace

- Many religions require time during the day for prayer or meditation – flexibility around normal break times can be a solution, but arrangements must conform to organisational policy so that others are not disadvantaged
- Prayer rooms for all staff, which can hold up to at least 20 people, should be provided – with separate storage for ceremonial objects
- It is good practice to provide separate vegetarian and non-vegetarian refrigeration and microwave facilities
- In some religions a long mourning period is required when someone dies. Deal with each case individually and consider using annual and other leave to cover the period required
- Be flexible with dress codes unless for health and safety or other justifiable reasons. **Duty of care to patients is always paramount**

Training

- NHS organisations should ensure that diversity in religion or belief is embedded into all processes, from recruitment and selection of students to the design and delivery of the curriculum
- Consideration should be given to religion/belief issues when organising training:
 - If outside working hours or in a residential environment, those from certain religions may not be able to attend
 - Many religious groups have strict Sabbath day observances
 - Some training activities may use language or physical contact which would be inappropriate for some religious groups
 - Exercises that require the exchange of personal information may be inappropriate
 - Social and other team-building activities related to the training event may exclude some people

Healthcare chaplains

- Healthcare chaplains can provide staff with advice, education and training on multi-faith issues
- Chaplains can provide support at times of bereavement to relatives of patients and also to staff who suffer bereavement
- Chaplains can also be a valuable source of support in emergency and major incident planning
- Be aware when arranging routine visits by chaplains that some patients do not have religious beliefs
- Refer to the Department of Health guidance document *NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff*

Conflict with other equality issues

- Some religions prohibit same-sex relationships
- Although many religions embrace trans people, others do not
- Managers may be faced with situations where staff refuse to work with or treat gay or trans people on grounds of their religion or belief
- Anti-discrimination and disciplinary policies apply in these cases; staff and service users should be treated with respect at all times and not be subjected to discrimination or harassment on any grounds
- Staff should be reminded of equality policies on a regular basis, and advised that discrimination or harassment is unlawful

Proselytising

- Some religions expect their members to preach and try to convert other people
- In a workplace environment this can cause non-religious people and those from other religions to feel harassed and intimidated
- Opinions aired in the workplace can cause offence to staff or service users within hearing distance
- Make it clear from the first day of training or employment that such behaviour, notwithstanding religious beliefs, can be construed as harassment and will be dealt with under disciplinary/grievance procedures
- The same applies when one or more people from the same religion work together and pressure is applied to one of them to conform

Key issues: providing services

The religious lifecycle

- **Religious and cultural views on beginning of life can influence attitudes towards:**
 - contraception – religions tend to look at this from the perspective of sexual ethics/marriage/family life rather than as a public health issue
 - reproductive medicine – religious beliefs regarding the embryo can influence views on IVF, PND, PGD
 - abortion – most religions either condemn this or only allow it under very limited circumstances
 - neonatal care – many religions have rituals that have to be performed during labour and at birth
 - circumcision – some religions circumcise male infants at seven days, but this is not generally available on the NHS. Female circumcision or female genital mutilation is illegal in this country

Therefore...

It is essential that clinicians, counsellors and others giving advice are aware of the issues related to different religions or beliefs and are able to give sensitive and contextual advice and support

Palliative care and end of life concerns

The religious lifecycle

- In many religions the process of dying is seen as opportunity for spiritual insight
- Palliative care allows for both the physical and the spiritual aspects of the patient to be considered
- It is vital that the staff involved are aware of religious attitudes towards disease, suffering, dying, death, religious practices and rites
- It is necessary to have an available list of religious ministers who can be contacted on request to attend dying patients
- On the death of a patient, relatives should be consulted to determine their preferences for the preparation of the body and other religious requirements. Early burial is required in some religions

Other considerations

Religious belief and types of treatment and drugs used

- Porcine- or alcohol-based drugs may be forbidden in Judaism and Islam
- Gelatine-based medication may be forbidden in Islam
- Non-kosher medication taken orally could have implications in Judaism
- Bovine-based drugs or cattle-derived cartilage may have religious implications for Hindu communities and some vegans and vegetarians
- Use of blood products may be forbidden for Jehovah's Witnesses

Other considerations continued...

- Gender issues – same-sex wards and treatment by members of the opposite sex
- Modesty issues – clothes as a religious sign of modesty, culturally appropriate gowns, etc
- Spiritual practices – provision of prayer and ablution facilities
- Fasting – impact on those with long-term conditions or breastfeeding
- Dietary considerations – provision of food to meet religious requirements
- Spiritual interpretations of diseases – for example in mental health

But... do not make assumptions

- Never assume that because someone belongs to a specific religion they will necessarily be observant of all the practices of that religion – treat every person as an individual and ascertain their preferences before treatment begins
- Even within established religions there can be orthodox and non-orthodox views on certain issues
- In some religions, relatives and next of kin are involved in care and decision making, but their views may not necessarily be the views of the patient; always ask the patient first

Mental health issues

- Spiritual interpretations of mental illness can play a crucial part in therapeutic success
- There is a stigma attached to mental health conditions in some cultures
- Stressful life events can lead to mental illness, and religion can play a large part in the way that a person copes
- A holistic approach taking account of the physical, cultural, social, mental and spiritual needs of the patient is important
- Staff awareness of the patient's religion and/or spirituality and his/her interpretations of mental illness are a key component of mental health therapies

Religion or belief and single equality schemes

- Actions on religion or belief can be integrated into single equality schemes
- Processes already in place for other diversity strands can be utilised for religion or belief:
 - Gathering information – most NHS organisations will have this information from first patient contact
 - Consultation – use patient fora, staff network groups, trade unions
 - Assessing policies – use existing equality impact assessment mechanisms
 - Action planning – integrate issues of religion or belief into existing action plans for single equality schemes
 - Monitoring – use existing auditing processes already set up for other diversity strands

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