Fit for the Twenty-First Century?

The State of Inclusion for Acute NHS Chaplaincy Pastoral, Spiritual and Religious Care Services in England
The Network for Pastoral, Spiritual, and Religious Care in Health (NPSRCH)

The Network for Pastoral, Spiritual, and Religious Care in Health (NPSRCH) aims to promote and support high-quality, person-centred pastoral, spiritual and religious care in health care settings. The group is chaired by Simon O’Donoghue of the Non-Religious Pastoral Support Network and comprises appointed representatives from the major religion and belief groups: Anglican, Baha’i, Buddhist, Catholic, Free Church, Hindu, Jain, Jewish, Muslim, Sikh, and non-religious.

More details on the group can be found at [www.network-health.org.uk](http://www.network-health.org.uk)

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Message from our Chair,
Simon O’Donoghue

The Network for Pastoral, Spiritual, and Religious Care in Health has one mission, which is to support the development of high-quality, person-centred pastoral, spiritual, and religious care services across the NHS in England.

Our group is composed of appointed representatives from the major world religious and non-religious communities. In spite of our broad range of beliefs, we are united by our desire to ensure the development of services that meet the needs of an increasingly diverse society.

We believe that all patients, staff, families, and carers should be able to access high-quality care on an equal basis and that, where possible, this should be in the form of like-minded care from highly trained individuals who can offer understanding and empathy required at some of the most challenging times in our lives. Despite this, we know that significant imbalances currently exist in the way in which services operate and are delivered. Some of this inequality is borne out of a rapidly changing external context, with chaplaincy services having been originally developed at a time when the nature of our society was very different. However, as society has become increasingly plural and non-religious, it is important that services evolve to reflect such changes.

I was delighted to be commissioned as the Lead Project Planner for this report, and be given the opportunity to objectively draw together the growing number of data sources that highlight the inequalities for those of different religions and beliefs in accessing this sort of care. It is not acceptable that while the value of pastoral, spiritual, and religious services are increasingly recognised in promoting good health outcomes, they are not being provided on an equal basis to all. Based on the data presented here, we have also sought to provide practical recommendations to NHS managers, NHS England, and other stakeholders about the most effective ways of addressing the significant gaps in provision – and creating a service that is fit for the twenty-first century.
Towards the end of 2017, NHS Employers was asked to lead a piece of work commissioned by NHS England to look at the experiences of people from under-represented and marginalised groups in respect of religion, belief, and non-belief in the workplace.

We were genuinely excited at the opportunity to do this because we were acutely aware that – in the context of the Equality Act 2010 (the main focus of our overall work programme) – the protected characteristic of religion and belief was not one that had been given a great deal of attention or consideration. Therefore, we saw this as a golden opportunity to open that particular metaphorical box and see what the appetite was for exploring its contents.

We could not have predicted the level of interest and engagement that followed! No sooner had we publicised the fact that we were embarking on this work we had people knocking on our door. We very quickly realised that there was a not an insignificantly sized group of organisations/people who either were not being heard or were not being given the opportunity to be heard. The challenge that we faced was managing the expectations of these emerging voices – making them realise that our remit was very much around the employment and training aspects of this area – and exploring how our member organisations (as employers) could improve their approach to pastoral, spiritual, and religious service provision from that perspective.

In this regard, the Network for Pastoral, Spiritual, and Religious Care in Health was, and continues to be, a great source of support for us – giving us a clear steer and a guiding hand as we attempted to plot a path through this new terrain. The Network also embraced the opportunity to develop new alliances and new relationships with those who stepped forward, offering a voice, who had never done so before – and for this we thank them.

This report is an excellent synopsis of many of the issues that were raised during this time. The way that the report has been structured – offering thoughts and recommendations to the different interest groups and parties involved in this area is particularly useful.
The recommendations for NHS managers are a timely reminder for those responsible for commissioning and providing pastoral, spiritual, and religious services within their organisations to step back and review how this is being done and whether the current situation is the best it can be. The NHS is just about to embark on a new long-term plan, which includes thinking about how we can create an NHS that is the employer of choice for people, and a place where all staff feel welcome, valued, and respected. This has to include a consideration of these services and how well they reflect the communities that we recruit from, along with the needs of those communities when receiving health care from us, whether that be as patients or as staff.

- The recommendations for chaplains working within the system is similarly a very helpful checklist for them to reimagine and refresh their approach. The recommendations are a request for chaplaincy managers to ask themselves the ‘why, who and what’ questions. Why do they do what they do? Who is it they are trying to serve? What is it that the chaplaincy service is trying to be? Answering these three questions – in conjunction with the specific recommendations, will hopefully lead to an improved pastoral, spiritual, and religious service within their organisation that serves the needs of everyone.

- The recommendations for the chaplaincy bodies are very much focused on the training and development of people looking to pursue a career in the area of pastoral, spiritual, and religious care. This is an extremely important area, one which also needs to be more inclusive in terms of how it attracts, trains, and retains people.

- The recommendations for NHS England are a call to action for further investment and attention to this whole area of pastoral, spiritual and religious care across the health and social care system. The involvement of NHS Employers in this work was at the initiation of NHS England, and so I hope that any future commitments from them will allow us to be involved in some way.

In terms of the final set of recommendations, we would strongly support the call for more research to be carried out. This is an area that still has so many unknown aspects, and we have only really started to scratch the surface. More in-depth and focused research will allow us to better understand what the specific challenges facing those who are under-represented or marginalised are – and how we can work with them to overcome those challenges.

NHS Employers has been privileged to be involved with this piece of work and to be a small part of the unfolding revolution associated with pastoral, spiritual and religious services across the health care system. If the NHS is genuinely aiming to be the best place to work, then we can no longer ignore the fact that a significant number of our staff and patients carry with them deeply held views and beliefs that are an integral part of them. If we are to both be a better employer and provide better services to patients, then we need to recognise, acknowledge, and embrace this.
Executive Summary

Acute Pastoral, Spiritual, and Religious (PSR) care services in England have changed dramatically since their inception when the NHS was created. What was traditionally a service whose delivery sat entirely with the Anglican church has broadened significantly to reflect the changing needs and beliefs of society. As society has become more plural and less religious, so too have chaplaincy services, by first incorporating providers of other faiths and then more recently the non-religious.

In a small number of trusts, there have been serious attempts to diversify chaplaincy teams, with ongoing consideration given to the evolving remit of the service. However, every aspect of this report highlights the need for an immediate reality check. While there is undoubtedly excellent practice, and the non-exclusive approach of many staff and volunteers should be commended, NHS chaplaincy services today are, for the most part, provided by and to those with Christian beliefs. The current system seemingly does little to try and address this issue but instead serves to reinforce it through the way in which it communicates to potential users of the service, in its recruitment of staff and volunteers, and in its apparent lack of oversight by NHS management. This is often in the face of numerous research studies over the past twenty years that have highlighted issues related to inclusion, in addition to being, at times, in conflict with equality legislation, best practice guidance, and basic moral principles about the provision of care.

This report clearly indicates that the first principle of the NHS Constitution – that ‘The NHS provides a comprehensive service, available to all irrespective... of religion or belief’ – may, for the most part, not be achieved or adhered to in PSR services. It is not enough to claim that a service is there for ‘all faiths and none’ when representatives of just one religious tradition have an overwhelming role in determining the nature of the service and recruitment into it. It is, however, important to remember that bringing about systemic changes to a service that has deep roots in tradition does not happen overnight. However, this report points to the fact that there is clear and ongoing resistance to change, which is being bolstered by a lack of oversight and challenges from within the NHS.

Each chapter of this report highlights specific areas where inequalities may impact on patients, staff, families, and carers of different religions and beliefs. The opening literature demonstrates how the exclusion of minority faith and non-religious groups in the development of, and participation in, research has resulted in conclusions that lack validity for many current and potential service users. Where research has been inclusive and has uncovered chasms in provision between religion and belief groups, it is hard to understand why attempts to address such damning conclusions about inequality have not been taken forward more effectively. Simple freedom of information (FOI) requests to NHS acute trusts about the demographic scope of their PSR services, the findings of which are included in this report, echo much of the research conclusions: that the vast

majority of paid and volunteer staff remain Christian and so too are the majority of PSR service users. Both of these realities are at odds with the demographic make-up of the UK as a whole and of the local areas in which NHS trusts operate. In some ways, this disparity is to be expected, as there is a higher number of Christian patients (up to 67%); however, the huge disparity between care for Christians and non-Christians requires immediate, further examination. If chaplaincy teams are to be the key providers of the ‘spiritual’ aspect of the holistic model of healthcare, can it be satisfactory that 94% of all chaplaincy interactions are with those who have Christian beliefs? As the research in this report demonstrates, people of all religions and beliefs, including the non-religious, want this type of care. However, it transpires that they may not want to receive it from someone with such a different worldview to their own. This barrier must be removed.

These questions are important for a service that is adapting to long term societal changes. There are also aspects of this report that NHS managers must look to address quickly, which are related to potential legal challenges to current practices. Recruitment of new chaplaincy team members, although improved in recent years, is still discriminatory in many places. It is highly likely that much of this discrimination is unlawful and open to legal challenge. The rationale for continuing to restrict posts to Christians often lacks any real validity and is frequently in conflict with best practice guidance and equality legislation. It is ironic that most chaplaincy teams should champion the nature of the service as one that is broad and neutral in content, with the vast majority of their work being about the provision of pastoral and spiritual care and only a small part of the work being about dedicated religious care. However, it is this relatively limited amount of religious care that is cited as justification for the restriction of vacancies, and the evidence base often used is unlikely to satisfy the requirements of the public sector equality duty.

This report also demonstrates that health inequalities are not only borne out of poor recruitment practices, but as a result of many contributing and interacting factors. Even if the issue of recruitment was addressed, there remains little in the way of clear pathways into and through PSR services for those with non-Christian beliefs. Moreover, there are short-term minor changes that could be enacted to enhance inclusion; for example, a reconsideration of the way in which departments communicate their services to patients. However, there seems to be little impetus to evaluate and reconfigure PSR services by seeking out the views and opinions of users and adapting to the needs of a changing population.

2 https://med.unr.edu/psychiatry/education/resources/bio-psycho-social-spiritual-model
Recommendations

NHS Managers

1. Urgent intervention is required to ensure that NHS managers are proactive in taking responsibility for advancing the equality of opportunity of underrepresented groups in PSR services.

2. PSR services should be reprioritised to reflect the division of workload more accurately in recruitment, delivery model, and training. Specifically, services should be based on the needs expressed by service users, not just service providers.

3. Equality and Diversity staff must facilitate and support PSR managers and staff to communicate the breadth and potential impact of PSR services in ways that encourage uptake by everyone, using language that is readily understood by both patients and staff.

4. Staffing ratios in PSR teams should be brought in line with NHS England 2015 Guidelines, and an appropriate level of funding provided to advance equality of opportunity for under-represented groups.

5. Patients from a diverse range of backgrounds should be included in drawing up local policy and provision of PSR services.

6. A review should be conducted into how under-represented groups can acquire responsibilities on committees (outside of/as well as on Equality and Diversity Boards) in the trust (e.g. teaching, bereavement, etc.).

7. Equality and Diversity and HR staff must ensure that recruitment of new PSR staff is carried out in line with equality legislation.

Managing Chaplains

1. Increase the depth and breadth of information collected about staff and patients from under-represented groups, including their needs, priorities and use of PSR services in order to inform more effective service development.

2. Develop more effective communication to patients, staff, families, and carers to encourage the take-up of PSR services by those with non-religious and minority religious beliefs.

3. Be more proactive in incorporating minority and non-religious communities into PSR teams. Utilise their knowledge and understanding to develop operational-level guidance and policy.
4. Meet with minority faith and non-religious staff and volunteers to better understand their career aspirations, how well they feel they have been integrated, and their professional development support requirements.

5. Conduct a review of physical multi-faith/belief spaces in consultation with under-represented groups.

6. Carry out a full equality analysis (EA) to better understand the impact of PSR services on under-represented groups.

7. Increase opportunities for volunteers from under-represented groups to obtain additional training and continuing professional development (CPD), particularly where training is being made available to paid staff.

8. Work to ensure that, where possible, contract funerals are provided by someone of the appropriate belief system.

9. Carry out a full review of the way in which the department communicates with patients, staff, families, and carers and whether this is done inclusively of all religions and beliefs. Particular attention should be paid to first contact points, e.g. websites, leaflets, etc.

Chaplaincy Bodies

1. Formally recognise the inequality that currently exists in both provision and service delivery and publish meaningful plans to address it.

2. Move to increase their understanding of the pastoral, spiritual and religious care needs and priorities of patients/staff with non-religious and minority religious beliefs.

3. Work towards encouraging consistent PSR training models for staff and volunteers based on competency and capability to provide excellent person-centred PSR care.

4. Encourage members who participate in the recruitment of new PSR staff to seek out guidance on conducting an EA, writing job descriptions and person specifications.

5. Work together to establish postgraduate UK Board of Healthcare Chaplaincy (UKBHC) accredited courses, which are not founded upon any particular ethos, curriculum or staffing perspective, but on the development of PSR skills in line with individual beliefs. Funding for places on such courses must be considered, with financial support being extended to those from minority faith groups, if possible.

6. Develop guidance on a clear career progression pathway for volunteers into paid and professional PSR roles.
NHS England

1. Publicly recognise the inequality that exists and the organisation’s wish for a pastoral, spiritual, and religious care service that meets everyone’s needs irrespective of their religious or non-religious beliefs.

2. Provide additional training for NHS PSR recruitment managers in equality legislation related to recruitment.

3. Consider funding ‘Starting Out in Health Care Chaplaincy’ as a means towards reducing health inequalities for under-represented groups.

4. Fund the rewriting of the NHS England 2015 Guidelines to ensure that guidance is fully inclusive, in line with equality legislation, and meets the needs of our twenty-first century service users.

Researchers

1. Those with minority faith and non-religious beliefs need to be incorporated into the design and analysis of PSR research so as to ensure the development of best practice standards that are appropriate to all religions and beliefs.

2. Funding for research should be sought to support minority faith communities in developing their own unique paradigms of pastoral, spiritual and religious care, which sit outside of the traditional Christian theology model.

3. Address the need gap in patient-led research, with particular focus on under-represented groups that both use and do not use PSR services.

Care Quality Commission

1. Reconsider the way in which it assesses pastoral, spiritual and religious care services to take into account the impact of those with different religions and beliefs.
Glossary

**BAME** – ‘Black, Asian and minority ethnic’; also, ‘BME’ stands for ‘Black and minority ethnic’. These terms are widely used by government departments, public bodies, the media and others when referring to ethnic minority groups.

**Care Quality Commission (CQC)** – An executive non-departmental public body of the Department of Health and Social Care that regulates and inspects health and social care services in England.

**Census** – Every ten years, a check is made by the government on the population in order to understand demographics. This is usually done via a survey, with all members of a household included. The results can also be used to plan public services.

**Chaplaincy or Chaplain** – Originally, a priest or minister who had charge of a chapel; now, an ordained member of the clergy who is assigned to a special ministry. Within the NHS, the term is often used to describe the department or person offering pastoral support, who may not necessarily be Christian. However, the link to the Christian tradition is made by many.

**Freedom of information (FOI)** – A general term used to describe access to information, sometimes linked to transparency and right of expression. In the UK, it is often used as shorthand to discuss specific legislation (Freedom of Information Act 2000), which allows access to information held by public bodies.

**Fusers** – Pesut et al. (2012) define a category of ‘fusers’, who are people that draw from multiple religious and spiritual traditions.

**LGBTQ+** – LGBT is an initialism that stands for lesbian, gay, bisexual, and transgender. In recent years, the community has expanded to include other terms and groups. Q relates to queer, and the plus sign is used to encompass all others who may relate to other areas of sexuality and gender identity.

**National Council of Hindu Temples (NCHT)** – A resource centre, and one of the main consultative and advisory bodies on all matters relating to the British Hindu community, culture, and religion. NCHT UK also advises and consults on matters relating to interfaith dialogue, community consultations and capacity building in temples, and advises and challenges legislation and policies that may affect the Hindu community in the UK.

**Network for Pastoral, Spiritual, and Religious Care in Health (NPSRCH)** – A body that promotes high-quality, person-centred pastoral, spiritual and religious care. The goal is to ensure equal access for all, regardless of religion of belief.
Non-Religious Pastoral Support Network (NRPSN) – A body that provides and promotes a highly effective network of pastoral carers to support people who need help. The overall objective is to ensure equal access to pastoral, emotional, moral and spiritual support regardless of religion or beliefs.

PSR – Pastoral, spiritual, and religious (chaplaincy).

UK Board of Healthcare Chaplaincy (UKBHC) – This is the register of health care chaplains in the UK. The organisation is primarily concerned with the safety and well-being of the public, which it achieves by setting high standards for the professional practice of health care chaplains who are on the register.

World Health Organization (WHO) – A specialised agency of the United Nations that is concerned with international public health.
Chapter 1: 

1.1 Introduction

NHS Pastoral, Spiritual and Religious (PSR) care services have evolved from what was traditionally an Anglican undertaking, when the NHS was created in 1948, into what is now a predominantly Christian tree that grows in a very different landscape. This review seeks to discover what evidence and discourse exists about the experience of under-represented groups in PSR provision in the NHS today. The focus is on the protected characteristics of religion and belief in the context of data from the 2011 Census (ONS 2012) and surveys (Woodhead YouGov, 2015; Humanists UK YouGov, 2016; NatCen, 2019) revealing significant shifts in demographics indicating that although some religion and belief groups have relatively static numbers (e.g. Jewish, Catholic), others show significant declines (Anglicans are an ageing and rapidly declining group, which has halved since 1983) or strong growth (‘non-religious’ now polls at 52%, according to NatCen, 2019). Differences also emerge between young and old, with generational replacement indicating a further decline in religious affiliation over time; Bryant (2018) suggests that these demographic trends are key in the future planning of PSR services. Percentages may vary and be interpreted differently, but the trends are indisputable and more fully discussed by Nye and Weller (2012) as well as by Humanists UK (2017). Nolan (2019) describes PSR care as being in a ‘period of dynamic transformation’ in which its value and relevance is being questioned in an increasingly secular society.

1.2 Who are the under-represented groups?

For the purpose of this report, the term ‘under-represented groups’ refers to:

- **Minority faith groups** – such as Judaism, Sikhism, Islam, Hinduism, Buddhism, Jainism, Zoroastrianism, Baha’i and Paganism. Together, these groups make up about 6% of the UK population, although they are often concentrated in communities where locally they make up a bigger percentage (e.g. Muslims in Bradford, Jews in Stamford Hill, Sikhs in Southall, Hindus in Leicester). This group is not restricted to the main nine world religions as, inevitably, some faiths are left out and some faiths assume greater (implied) worth than others.

- **Non-religious groups** – such as atheists, agnostics, apostates, humanists, sceptics, rationalists, ‘fusers’, and indeed those who do believe in a god but describe themselves as not religious. Woodhead (2016) calls these people the ‘cultural majority’; they make up the largest percentage of the UK population and, importantly, they are people with non-religious beliefs and values, not merely people without religious beliefs (Day, 2013; Savage, 2019). Thus, they too may have specific rituals or dietary requirements based on their beliefs and feel affiliated to each other through shared beliefs and lifestyles.

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• **Minority groups within faiths** who are often hard to reach (such as Ethiopian Jews or Coptic Christians), who may experience discrimination or exclusion from services or communities and who may not necessarily identify with mainstream representatives of their faith. Bryant (2018) notes the ability of larger denominations to determine whether smaller denominations are valued in PSR health care.

• **Groups that experience discrimination or disadvantage** within society more generally. This may include those who are LGBTQ+, people with disabilities, BAME people, and women. These characteristics may overlap with a faith or belief, but are not necessarily synonymous. It may also be the case that within their faith or belief group, these groups experience discrimination that may result in acting as a barrier to accessing PSR services.

Although these under-represented groups may have vastly different worldviews, what they do share is their experience of being ‘outside’ current NHS PSR provision. This experience as an outsider is shared whether they are patients, family members, staff, or members of PSR teams. Woodhead (2016) points out that the ‘nones’ are not at loggerheads with the ‘somes’; indeed, there is scope for these groups to work together to establish more inclusive services, careers, and a common approach to spiritual care that values and draws on all faiths and beliefs. The methodological approach taken for this review can be found in Appendix 1.

### 1.3

**Who are the people doing research and publishing, leading the discourse? How representative are they?**

The literature on PSR care is dominated by white, Christian, ordained men. This impacts on the narrative, driving the discourse and validating particular perspectives and paradigms. As an example, in Swift’s 2016 A Handbook of Chaplaincy Studies, the three editors are all white, Christian, and ordained men; and of the 31 contributors, only four are from minority faiths or beliefs and only five are female. This creates a construction that is based on the experience and point of view of a narrow group within the UK population. We need to be wary of buying into one version of intellectual and practical struggle, and we need to make way for multi-belief PSR care. Galashan (2015) notes that ‘one of the major problems of having the future of PSR care debated only by the current stakeholders is the risk that the interests of minorities are not being represented’. Care needs to be taken not to restrict minority faith and alternative belief literature to a case study approach, which, although offering insights, could confine the discourse to stories rather than the meta narratives. Multiple perspectives need to be sought to understand the discourse and to help ensure that minority voices are not lost.
Although a limited number of research studies have been executed, Bryant (2018) has provided a comprehensive and timely analysis of the current state of affairs on the integration of minority faith groups in PSR care in acute health care settings. Using data from five acute hospitals, she identifies a significant gap between ‘understandings of chaplaincy promoted nationally through chaplaincy bodies and publications, and chaplains on the ground’ (Bryant, 2018). Her findings consequently highlight how strategic-level national intentions are not in line with operational work on the ground.

It is heartening to find growing research literature by and about Muslim researchers and PSR practitioners who are defining and observing the evolution of Muslim PSR care. This includes a core text by Gilliat-Ray et al. (2013), which draws on research into the practice, training, discourse and politics of PSR care for Muslims. Hafiz (2015) builds on this in exploring the evolving roles of imams and chaplains in the reality of the lives of British Muslims. The Markfield course in Muslim Chaplaincy, it can be argued, follows a Christian model (Hafiz, 2015). Siddiqui (2007) suggests that Muslims need to develop their own theology about their PSR care rather than continuing to follow a Christian-centric model. While there is a growth in Muslim PSR support, it is still based on a Christian model and needs further development to ensure that it is fit for the community needs it is designed to meet. Gilliat-Ray et al. (2013) herald the ‘gradual incorporation of Muslims into chaplaincy roles around the world [which] has contributed to an evolving perception that chaplaincy is no longer a distinctively Christian activity’.

Savage (2019) offers a useful recent publication on non-religious PSR care looking at emerging changes in society, beliefs, rituals, and institutions. The discourse on Buddhist PSR care is predominantly delivered in the USA (Giles and Miller, 2012; Watts and Tomatsu, 2012; Ellison and Weingast, 2016; Michon and Fisher, 2016). There are two publications on Hindu PSR care (Sutton, Chander and Das, 2015; Mosher et al., 2019), and one self-published guide about Sikh PSR care (Rait, 2013). The absence of literature on other minority faith/alternative belief provision of pastoral care does not mean that this cannot be articulated and is not valid; indeed, it would be a welcome addition. It also highlights the lack of current research and narrative emerging from minority faith groups. This lack of understanding means further exploration is needed to ensure that PSR offerings in the NHS are considering the entire community they are designed to meet.
1.4

How far do current models/systems of PSR provision include under-represented groups?

The way that PSR provision is organised between trusts varies, with some operating in more inclusive ways than others. This section aims to locate literature that makes specific links between the organisation of PSR provision and under-represented groups.

Given the changing user demographic, a key strategy in many PSR care departments must be about the transformation from current models to new models of inclusive PSR care. There is not enough evidence in the literature about how far this imperative is grasped across the NHS or about any strategizing for new models at a local level. Todd (2011) calls for collaborative working practices that are firmly grounded in diversity, and that are open and responsive to different expressions of belief. Swift (2017) acknowledges that changes in views on spirituality will require PSR carers to respond in new ways to personal expressions of belief but acknowledges that PSR carers remain ‘resiliently religious’. Nolan (2019) suggests three crucial questions:

1. What are the appropriate theological models in this new reality?

2. Can religiously affiliated chaplains ethically continue to claim to meet the needs of the non-religious?

3. What meaning does PSR care have in the new reality?

Savage (2019) maintains that inclusive services can only be developed if senior NHS management takes responsibility, rather than assuming they can be developed by incumbent PSR carers or religious bodies themselves. This notion further links with concerns that national policies and local implementation on the ground are not always in sync. Senior NHS management need to be responsible for national decisions, as well as ensuring that operational implementation is in line with strategic objectives.

Bryant (2018) highlights that the way departments are organised assumes that other religion and belief groups provide spiritual care in the same way as Christians, citing Gilliat-Ray (2001), Ballard (2010) and Welford (2011). Pastoral care is usually included in religious offices, often with responsibility for sacraments or rites. Pastoral care is therefore directly aligned and placed within administrative systems that are Christian, or based on Christian practices. Gilliat-Ray (2001) had suggested that alternative models for the delivery of PSR care by under-represented groups currently need to fit in with these prevailing norms. However, there has been some recent development beyond Christian norms, and Muslim PSR carers have increasingly started to define their approach to PSR caring. Faith Matters (2010) has produced guidance and standards for Muslim PSR carers. Hafiz (2015) notes how Muslim PSR carers have organised themselves into professional organisations and become proactive in terms of social problems in their
communities, suggesting that new models are emerging for contemporary PSR care. However, further work needs to be done to ensure that minority faiths have the opportunity to implement PSR systems that are right for their community, and that Christian systems are not assumed to be the starting point for PSR systems.

Bryant (2018) offers three models of multi-faith/belief PSR provision that emerge from her fieldwork:

1. **Generic** (Todd, 2011; Welford, 2011; Cadge and Sigalow, 2013; all cited in Bryant, 2018), which assumes that all PSR carers are equally able to assess spiritual need and to respond or refer appropriately. If, however, this model is operationalised by one faith, there is an implicit reinforcement of a constructed norm (Bryant, 2018). Todd (2011) notes that richness of faiths can be lost in this model and Gatrad (2003) suggested that this model can limit faith-based ritual and sacrament. Minority faiths can therefore suffer if Christianity is assumed to be the basis of PSR systems, and operational ways of working. While Gatrad et al. (2004) believed it to be ‘widely recognised’ that British PSR carers need a broader training programme to be ‘generic’, Bryant (2018) found that minority faith volunteers, especially Muslim and Sikh volunteers, have easily taken to generic visiting. This suggests that there is opportunity for shared understanding, and so an agreed system that considers the practicalities of all faiths may be possible.

2. **Multi-belief** where PSR carers predominantly see people of their own faith or belief. Gatrad (2003) notes the challenge in covering all faiths and beliefs in an institution. Todd (2011) points out that this can lead to competition for resources between faiths or beliefs. Moreover, matching funding to communities can be a challenge when populations are not equally represented, or have different community size. Jhutti-Johal (2013) suggests that faith communities should fund specific religious observances themselves, perhaps reducing some challenges to this model of PSR provision.

3. **Mixed mode** where visiting is by patient list, geared to specific faiths or beliefs, but also generic in nature.

Beyond Bryant’s (2018) fieldwork, there is limited analysis or evaluation of which models are used where, and to what effect, or which are most inclusive for under-represented groups. The model that is adopted locally will determine how services are designed and staffed. Savage (2019) points out that some key (Christian) activities take up a small proportion of workload (e.g. emergency call-outs, funerals, religious services) but may be prioritised rather than being organised in a different way through service-level agreements. Ryan (2015) cautions against a multi-faith/belief claim where teams marginalise or limit minority faith or alternative belief groups. Marie Curie (2018) suggest a different delivery model, brokered by neutral spiritual care coordinators with links to faith and belief representatives/communities so that patients have the choice to receive spiritual care from someone who shares their worldview.

The organisation of admissions data and record keeping was noted as problematic by Bryant (2018), and Ryan (2015) found inconsistencies and inaccuracies and, therefore, unreliable data about demand for, and use of, services. Such concerns
about data that are available may suggest that the true experience of PSR is not fully known. Moreover, one must be dubious about the extent to which spiritual assessment on admission (NAHAT, 1996; SYWDC, 2003) is being addressed. There does not appear to be a defined system to ensure that end users are receiving the pastoral support or observance of the religious practices they desire. Bryant (2018) noted how Christian PSR carers assume the role of being a ‘clearing house’ for religion, and went on to caution Muslim PSR carers against becoming a ‘clearing house’ for minority (Asian) cultures, practices, and beliefs. This point further highlights the dominance of Christianity in current PSR practices.

1.5 How successful is the PSR brand in conveying inclusive provision for all patients, families and staff?

Branding of PSR care conveys its role and meaning through language, spaces, visual cues, websites, literature, and behaviours. It was difficult to find any broad analysis of how inclusive and diverse PSR brands appear to under-represented groups. However, there has been much written (Mayet, 2001; Gilliat-Ray, 2001; Cadge and Sigalow, 2013 cited by Bryant, 2018) about the language of PSR care, specifically the suggestion that it is often rooted in a Christian tradition. A YouGov survey (Humanists UK, 2017) sought opinion about the religious specificity of the term ‘chaplain’, with 83% of respondents recognising this as a Christian role but only 5% thinking that a chaplain could be from another faith or be non-religious. It is therefore not surprising that three quarters of non-religious people surveyed were unlikely or very unlikely to use a chaplain. Savage (2019) explores further the implications of these assumptions regarding uptake of PSR services and suggests that ‘chaplain’ is neither inclusive or neutral; that religious symbolism and titles can convey a sense that a service is for religious people by religious people. The use of language, and specifically the use of the word ‘chaplain’, emphasises the Christian traditions, often to the detriment of other religions or those who are non-religious.

Gilliat-Ray (2016) reports that some minority faith PSR carers, such as imams, adopt terms that fit with their faith in order to convey their agency, suggesting that some flexibility in brand and language might also be considered. Job titles are only one aspect of brand: uniforms, religious insignia, colours, department literature and advertising, PSR spaces and online presence are also conveyors of brand and no specific literature (other than the small UHL survey of 2015) was found that evaluates the perceptions of under-represented groups about how the PSR brand makes them feel. Language and imagery are therefore relevant when considering PSR roles, and may inadvertently be linked to certain faiths.

Savage (2015) reports on how the rebranding of a PSR team and publicity about a Muslim joining the team tripled demand for its services and increased Hindu and Buddhist visits tenfold. This suggests that a more obviously multi-faith/belief team has a positive impact on uptake by all minority faiths and alternative beliefs. From his exploration of different case study research, Nolan (2019) argues for PSR care to be rebranded as ‘care of the human spirit’.
How equal is access to, and use of, PSR provision by under-represented groups (staff and patients)?

The Equality Act 2010 requires public bodies to advance equality of opportunity to those with the protected characteristic of ‘religion and belief’, ensuring that they are represented in services and equally able to access provision. Data about how much this is enacted in PSR provision is difficult to locate for either patients or staff. Sheikh et al. (2004) indicated that the diversity of staff in the NHS was set to increase and Bryant (2018), in her fieldwork, met a Hindu PSR carer who supported staff in combining their religious practice with their work commitments. However, very little other literature could be found on PSR provision for staff from under-represented groups. This lack of data may suggest a disregarding of the issue.

Data is key to assessing equality here and although Swift (2017) seems to consider such data important to defend the NHS from accusations of discrimination, it would be more proactive to consider monitoring data as a tool in service improvement. For example, knowing that three quarters of ‘nones’ were unlikely to access PSR care from a chaplain (Humanists UK, 2017) suggests a target group needing more equal provision.

Research conducted by Welford (2011) concluded that ‘equal access to religious care is patchy at best’, but the data is incomplete. Demand for services is mediated by partisan brokers (noted by Bryant, 2018) and an absence of requests or referrals does not necessarily indicate an absence of demand. Savage’s (2015) audit of PSR care in one institution revealed that in 2008, 93% of patient visits were to Christians; 98% of the PSR team (paid and unpaid) were themselves Christian and the bias in these ratios only started to shift through a rebranding exercise. Savage (2019) also noted that although 22% of patients described themselves as non-religious, they only received 4% of visits. He acknowledges that this could be attributed to PSR systems or to a choice made by the patient not to seek ‘religious’ services. A small-scale study at Leicester (UHL, 2015) found that 81% of people interviewed thought there should be a non-religious pastoral provision, with 79% of these people saying they would use it. The 2015 guidance suggests that staffing ratios would reflect local demographics but Ryan (2015) indicates that in Luton the demographics and representation do not match up – 25% of the local population is served by 7% of chaplains and 47% of the local Christian population is served by 87% of chaplains.

One factor that might have impacted equality of provision for minority faith groups is the way that families have traditionally attended to pastoral and spiritual needs through visiting. This meant that their needs were not necessarily attended to by PSR care. However, Gatrad et al. (2014) point to the erosion of traditional support systems, resulting in gaps opening up that might impact on health outcomes. Bryant – citing Gilliat-Ray (2001), Abu-Ras and Laird (2011), Welford (2011), Jhutti-Johal (2013) and Eccles (2014) – recognises the same phenomena and suggests that these groups are now looking to PSR carers for support. As communities change, PSR care needs to reflect these changes and ensure that all religions and beliefs are able to access appropriate support.
How far does PSR provision take an equally person-centred approach that meets the needs of under-represented groups?

This section seeks to evaluate the literature examining the quality and specificity of PSR care for under-represented groups in the context of person-centred care. Savage (2019) cautions against categorising patients into boxes as they may have fused or individual beliefs; indeed, they may not necessarily want to see a person from their designated belief group. Marie Curie (2018) identified that the biggest barriers to accessing PSR care from minority faith and alternative belief groups was a lack of awareness about services and scepticism that their specific religious or belief needs would be met (or that Christianity would intrude on them at a time of great vulnerability).

Kevern and McSherry (2016) highlight the dearth of research on the patient experience and perspective in the PSR care field, or of care being patient-led. They point to surveys done with service users but question whether there is implicit bias towards those who are religious and only accessing current PSR care provision; this suggests that a fuller understanding of patients must play a role in future evolution of the service. Pointing out that the 2015 Guidelines do not offer guidance on using surveys to gauge patient and staff preferences for PSR care, Savage (2019) advocates for patient involvement in drawing up local policy and provision. There is no range of literature about how under-represented groups experience PSR care services. Savage (2019) further points out that although the views of chaplains and institutions are important, it is the view of those who receive the provision that is fundamental to the design of services. Raffay et al. (2016) take a firmly patient-centred approach to determine what service users thought of the quality of PSR services and gathered their suggestions for changes. This confirmed that mental health service users perceive their spirituality and religion as essential to their healing process and offers a model for other patient evaluations.

The individualised nature of person-centred care should impact directly on PSR care. Abu-Ras (2010) and Gilliat-Ray et al. (2013) offer commentary on specific needs of Muslim patients (this may include Friday prayer, Halal food, observance of Ramadan and Eid, prayer and the recitation of the Qur’an, but also specific religious guidance on ethics). Jhutti-Johal (2013) comments on the specific challenges of providing pastoral and spiritual care to Sikhs in the NHS, including the dangers of a superficial or simplistic knowledge of a faith. Another emerging phenomenon is that of the mixed-belief families who call for innovations in rituals, particularly at baby funerals and at the end of life (Eccles, 2014).

Sheikh et al. (2004) reported that 22% of PSR care departments have written policies on chaplains getting training in cultural diversity and while manuals of multi-faith/belief information may be present in every PSR department, these cannot be a substitute for expertise on the team. Gilliat-Ray (2003) found these guidelines to be stereotyped and inaccurate; it would be interesting to see if today’s resources are more nuanced and authentic. Minority groups are diverse
within themselves and Woodhead (2016) provides useful, broad characteristics on the (non-religious) alternative belief group, with great emphasis on the individuality of its members.

Bryant (2018) – citing Laird et al. (2007) and Karlsen and Nazroo (2009) – notes an absence of discourse and research on the links between PSR provision and health inequalities, for example, in Caribbean, Muslim and Sikh communities, suggesting that the PSR carer is in a unique position to advocate for the relevance of faith- or belief-specific approaches to care.

1.8

What is the distribution and integration of under-represented groups in PSR teams (paid and unpaid)? How is this impacted by recruitment, training, retention and progression practices?

Bryant (2018) found that where there were minority faith members of PSR care teams, there was not necessarily cohesion, and some expressed an underlying ‘us and them’ culture. There were differences in understanding about teamworking, accountability (to the team or to the community), exclusive own-faith visiting and different priorities, but at the same time factors such as part-time or unremunerated work impacted on these practices.

1.8.1

Distribution data: paid and unpaid roles

The make-up of PSR care teams is relatively static due to high retention rates, with Bryant (2018) suggesting ten years or more. A formula was suggested in the 2015 Guidelines (Swift, 2015), which related appointments, on-call, and sessional allocations to inpatient demographics, but it appears that, particularly for non-religious belief groups, this has not been fully enacted, with only ten paid posts and a volunteer presence in only 40% of NHS trusts (NRPSN, 2019). Durairaj (2015) recommends greater analysis of current staffing ratios in the review of the 2015 Guidelines.

Sheikh et al. (2004) conducted the first national survey of NHS hospital PSR care provision and found that 93% of full-time chaplains were Christian and 6.7% were Muslim; of part-time chaplains, 91% were Christian and 9% were from minority faiths. Catto et al. (2015) tried to track down data on paid, unpaid, full- and part-time chaplains in the UK across sectors without much success. The Church of England (2010) found that of 425 full-time PSR care chaplains in the NHS only eight were not Christian (all of these being Muslim). The College of Health Care Chaplains (2016) reported that 94% of paid chaplains are Christian, 4.6% are Muslim, and 1.4% are non-Christian.
Bryant (2018) found that under-represented groups were usually unpaid (difficult to quantify) and that if paid, were only paid part-time. She found that decisions to recruit, remunerate or confer honorary status on under-represented groups relied on the lead chaplain’s perception of their contribution and was open to discrimination (e.g. paying men but not women for similar contributions). Ryan (2015) indicates that limiting under-represented groups to these lesser roles reduces their impact and influence.

1.8.2 Recruitment

For the unpaid PSR workforce, Bryant (2018) observed that recruitment often takes place through places of worship, leading to likely replication of existing provision, while Qureshi (2013) and Beckford (2015) also note that recruitment through religious leaders can play to power inequalities and local politics. Consequently, at the recruitment stage for unpaid roles, recruitment systems and practices are focused on religious networks, further limiting the opportunity to meet the requirements of diverse communities.

Recruitment can hinge on a religious qualification and Bryant (2018) found that while most Christians were ordained, and therefore ‘suitably’ qualified, and many minority faith leaders had formal religious training, there were also many PSR carers who drew on community and counselling roles rather than theological qualifications. Gilliat-Ray et al. (2013) noted the gender bias here that predisposes qualified men to take up paid roles. Bryant (2018) emphasises that the Hindu and Sikh traditions do not have a comparable qualification route, but rather adopt different approaches to the development of appropriate knowledge and skills for PSR roles. A requirement for a PSR qualification could therefore exclude under-represented groups at the shortlisting stage, and is a significant hurdle for applicants. Ryan (2015) suggests that religious groups may be misjudging the need for equivalence in qualifications, rather than seeking chaplaincy-specific training and thereby missing out on appropriate candidates. He applauds the development of PSR qualification routes for other faiths and beliefs, but cautions against following a default Christian model of pastoral care.

There is no data on failed applications by under-represented groups or the incentives or disincentives to applying for paid or unpaid work. Savage (2019) offered good advice on re-evaluating recruitment practices with a view to making them more inclusive and compliant with the legislation. His focus is on non-religious beliefs but applies just as much to those from minority faiths who may also be excluded because of requirements for rituals, sacraments, theology degree, etc. He calls for recruitment to be based on evidence of need.

Savage (2019) points to significant shortfalls in expanding recruitment to include the minority faiths and non-religious belief group, and suggests that this may be due to a number of factors, including flawed understanding of PSR care amongst institutional managers and how this conflicts with policy on equality and inclusivity; misperceptions that non-religious people do not have beliefs or values; lack of understanding of demand; lack of pressure to change; and lack of applicants.
1.8.3

CPD and progression

Bryant (2018) interviewed 37 minority faith PSR carers and found that six had done chaplaincy courses (Muslims at Markfield 4 and Hindus at NCHT 5) but that funding was an issue to continue to Master’s level (echoed by Gilliat-Ray et al., 2013), especially for unpaid PSR carers. Bryant notes a ‘strongly demarcated boundary between professional and volunteer’ and suggests that this can exclude under-represented volunteers from ever being designated as a ‘chaplain’.

Bryant (2018) also reported a level of peer criticism of the performance and commitment of under-represented colleagues on PSR teams, with only some colleagues recognising valid reasons for this and little or no expression of commitment to supporting under-represented colleagues in their professional development.

For Muslim PSR volunteers, it appears that the transition into paid work can happen (Gilliat-Ray et al., 2013). Bryant (2018) also found that five of 12 minority faith (Muslim, Jewish and Hindu) chaplains in her fieldwork had started in unpaid roles and had progressed to paid positions without formal qualifications. However, Bryant (2018) also found that Christian chaplains still enjoy unfair advantages compared to their minority faith colleagues, especially in relation to career progression.

Bryant (2018) presents a comprehensive analysis of the challenges facing under-represented groups in gaining access to professional bodies, especially since community activism and counselling roles are not considered valid. The Muslim Chaplains’ Network and the Non-Religious Pastoral Support Network provide alternative space to organisations like the CHCC, and Bryant (2018) points out how these networks allow PSR carers to develop symbolic capital. CHCC, in its Faith Coordinators (2018) report, acknowledges room for improvement and sets out objectives to engage more meaningfully with under-represented groups in order to develop aspiration, resources and support systems.

For those from under-represented groups who get paid roles, Bryant (2018) concludes that career stagnation affects a significant proportion of minority faith chaplains, although some Muslim chaplains are an exception. Opportunities to build professional profiles through membership of committees, multi-disciplinary teams and teaching do not appear to be evenly shared. Gilliat-Ray et al. (2013) identify how institutional roles not only build status and recognition, but also increase influence. Bryant (2018) found that Christian chaplains ‘occupied committee roles by default’ and that minority faith PSR carers were most likely to be allocated to Equality and Diversity committees or as spokespersons for their own communities. Christian PSR carers also assumed the teaching roles but Bryant (2018) found some Muslim PSR carers training others in cultural competence and bereavement.

4 Markfield Institute of Higher Education
5 The National Council of Hindu Temples
1.9
How inclusive and flexible are PSR physical spaces and how are they used?

Provision and care of PSR spaces reflects on chaplaincy values and priorities in relation to under-represented groups. Bryant (2018) notes how the CQC intervened on an occasion where it was felt that the spaces for Muslim worship were not adequate. Todd (2011) sees two challenges: 1) how to provide for different practices; and 2) how to make the space comfortable for all. He points to how the differing needs of regular and occasional users, gender sensitivities, artefacts and storage facilities all impact on the design of spaces. There is very little literature or research about the physical PSR care spaces in health care, as noted by Collins et al. (2007). This was further explored by Eccles (2014), who highlights the competition between faiths for sacred and worship space in the context of a legacy of traditional chapel spaces, and the constraints on NHS resources to make adaptations. In such cases, different faiths may find themselves competing for space and resources for their community, rather than offering a multi-faith combined service, which is more likely to meet the needs of the wider community. Eccles (2014) further highlights that decisions about the use of space are likely to be made on the basis of power rather than need. Bryant (2018) notes how a space can easily be appropriated for one faith group due to regular use and Nolan (2008) questions the legitimacy of the chapel space as a ‘master-signifier’ because it explicitly excludes others. Sheikh et al. (2004) found that PSR spaces favoured Christians, with 70% of departments having a Christian place of worship and only 13% having multi-faith rooms, although this figure is likely to have risen in the subsequent 15 years.

Hewson and Crompton (2016) note that the management of multi-faith spaces is frequently the responsibility of Christian chaplains but judge this to be well done from their perspectives. They note that ‘retrofitted chapels’ are not nearly as effective as those spaces explicitly designed for more inclusive use and how the location of PSR space in marginal areas marginalises their use.

1.10
Conclusion

Much work on PSR care is dominated by white, Christian, ordained men. This impacts on the narrative, and on services offered. Non-Christian communities wishing to access PSR services may find it difficult to access support from those who have a different faith or worldview. Moreover, much of the literature on PSR support focuses on the same viewpoint, resulting in the potential to lose the voice of minority religious and non-religious communities. A barrier to meeting the diverse needs of communities is the organisation of pastoral care. Often, it is directly aligned and placed within administrative systems that are Christian or based on Christian practices. Further work by managers and trusts needs to be done to ensure minority faiths can implement PSR systems that meet the needs of a diverse community, and Christian systems should not be assumed to be the starting point.
for PSR systems. When implementing a diverse PSR system, there is limited analysis or evaluation of which models are used where, and to what effect, or which are the most inclusive for under-represented groups. Moreover, there is a lack of data gathered, with poor record keeping making it problematic to confidently highlight demand in services, and specify where gaps in services exist.

There is limited evidence that patients’ needs were considered by managers and, as such, PSR services are not patient-led. Provision and care of PSR spaces reflects on chaplaincy values and priorities in relation to under-represented groups. In such cases, different faiths may find themselves competing for space and resources for their community, rather than offering a multi-faith or combined service more likely to meet the needs of the wider community. While the views of chaplains and institutions are important, the views of those who receive PSR care are fundamental to the design of appropriate services. More patient-led involvement could encourage greater diversity among service users and provide insight for managers about current barriers to access of PSR services.

Branding of PSR care conveys its role and meaning through language, spaces, visual cues, websites, literature, and behaviours; for example, the use of the word ‘chaplain’ emphasises the Christian traditions, often to the detriment of other religions, and the non-religious. Uniforms, religious insignia, colours, department literature and advertising, PSR spaces, and online presence are also conveyors of brand, which may impact in the matter of who uses PSR services. Language and imagery are therefore relevant when considering PSR roles, and may inadvertently be linked to certain faiths, and thus discourage others from using services. Recruitment of PSR staff is also relevant when considering barriers. Staff turnover is low, with many in post for ten years or more, making it a slow process to become more inclusive via natural attrition. This is further compounded by using religious systems to recruit new staff. This acts as a barrier to the increasing of diversity, as those outside of Christian worship may not even be aware of roles becoming available.

Differences between trusts’ organisation of PSR care results in variance in both service model and inclusivity. This is compounded by evidence that suggests that strategic-level national intentions are not in line with operational work on the ground. Senior NHS management need to take responsibility for national decisions, as well as ensuring operational implementation is in line with strategic objectives. Inclusive services can only be consistently developed if senior NHS management takes responsibility for creating and implementing inclusive PSR services across all trusts.
Chapter 2:
PSR Service Demographics in Acute NHS Trusts
In October 2018, there were 889 permanent or fixed-term employees in England with a job role of ‘chaplain’. This represents a full-time equivalent of 503 (NHS Digital, 2018). To put this figure in context, in March 2017 the NHS employed nearly 1,064,589 staff (full-time equivalent) across hospital and community health care services. Hence, only about 0.05% are employed specifically to provide PSR care. This makes chaplains one of the smallest professional groups working within the NHS, despite the growing diversity and complexity of religions and beliefs in the UK and the growing recognition that many, if not most, people coming into contact with the NHS are likely to benefit from some sort of pastoral, spiritual, or religious intervention.

The UK Board of Healthcare Chaplaincy sets out the bands, qualifications and duties of chaplains employed by the NHS, starting at Band 5 (£24,214 in 2019) for inexperienced chaplains working under supervision and progressing through to Band 8 (£44,606 in 2019) for lead chaplains with management responsibility across an NHS trust.

Official NHS data on the chaplaincy workforce (shown in Table 1) are rather unsatisfactory. Of the 889 records, nearly 200 are of those who ‘do not wish to disclose my religion or belief’ or are ‘blank/null’. This is difficult to understand for a service with religion and belief at its core. The only response available to those with non-religious beliefs is ‘atheism’, and this provides evidence of the poor framing of questions, or a lack of understanding of diversity in a person’s religion or belief. The figures are of headcount; hence, a Buddhist employed for half a day a week is counted the same as a Muslim working full-time. When, as shown below, employment patterns are such that most substantial posts are of one religion, headcount figures give a false impression of inclusivity. Figures quoted below, based on FOI, responses may give further information.
### TABLE 1: Breakdown of chaplains by religious belief

<table>
<thead>
<tr>
<th>Religious Belief</th>
<th>Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atheism</td>
<td>3</td>
</tr>
<tr>
<td>Buddhism</td>
<td>6</td>
</tr>
<tr>
<td>Christianity</td>
<td>571</td>
</tr>
<tr>
<td>Hinduism</td>
<td>10</td>
</tr>
<tr>
<td>I do not wish to disclose my religion/belief</td>
<td>105</td>
</tr>
<tr>
<td>Islam</td>
<td>75</td>
</tr>
<tr>
<td>Judaism</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
</tr>
<tr>
<td>Sikhism</td>
<td>9</td>
</tr>
<tr>
<td>Blank/NULL</td>
<td>91</td>
</tr>
</tbody>
</table>

The NHS England 2015 Chaplaincy Guidelines[^6] recommend that NHS organisations ensure that PSR care can be provided to people of all religions and belief on an equal basis and that chaplaincy staffing levels should take this into account, while also recognising the need to comply with the occupational requirement provisions of the Equality Act 2010. The guidance goes on to recommend appropriate staffing levels to match patients with a religious or belief system and those without a religion or belief. In other words, PSR staff should reflect the religious and non-religious composition of the organisation and the surrounding community.

2.1 Chaplaincy changes in demographics over time

The number of (full-time equivalent) paid substantive chaplains increased significantly when the NHS took responsibility for their employment. A further significant expansion occurred in the 1960s following the ‘Patients’ Charter’. Since then, growth has been slower, as can be seen in Table 2.7

TABLE 2: Increase in the number of paid NHS chaplains

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1944</td>
<td>28</td>
</tr>
<tr>
<td>1990</td>
<td>266</td>
</tr>
<tr>
<td>1996</td>
<td>350</td>
</tr>
<tr>
<td>1998</td>
<td>354</td>
</tr>
<tr>
<td>2009</td>
<td>390</td>
</tr>
<tr>
<td>2015</td>
<td>385</td>
</tr>
<tr>
<td>2018</td>
<td>503</td>
</tr>
</tbody>
</table>

It is worth noting that numbers have remained broadly level for the last 20 years (although the 2018 figure from NHS Digital seems to suggest significant growth and is likely to be anomalous), despite a reduction in the number of beds, much shorter stays in hospital, a decline in religious belief, the economic crash, and cost pressures due to an ageing population. While overall numbers have been reasonably consistent there have been significant changes in the demographics of the cohort, as shown in Table 3.8

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7 Note: there is no consistent basis for collecting these numbers so they should be regarded only as a guide. Sources are: 1948, Swift; 1990–1998, Orchard; 2009, 2015, CHCC.
8 1999 figures are from Orchard and 2015 from the CHC. The note above is relevant.
The number of Free Church and Catholic chaplains has increased substantially, with a significant offsetting decline in the number of Anglicans. The major demographic changes have been between Christian denominations. The number of Muslim ‘chaplains’ has increased but, in part, this may have been a response to agendas not directly related to PSR care. There are now several part-time and one full-time non-religious ‘chaplains’ in paid posts. Although these are positive steps, the ratio of employment of chaplains by religion still has a long way to go to match demographic data. The most recent British Social Attitudes Survey showed that 52% of the population is non-religious, 12% Anglican/Church of England, 7% Roman Catholic, 14% other Christian, and 9% other non-Christian.9

The demographics of paid substantive chaplaincy employment do not come close to reflecting wider society and there has been very little progress in this direction in the last 20 years. Figure 1 are derived from data from the College of Health Care Chaplains’ 2016 Annual Report10 and reveal high levels of inequality in acute (hospital) trusts, where approximately 94% of chaplaincy hours are provided by Christian chaplains. Figure 2 is from a 2019 website search that shows lead chaplains who are Christian represent an even higher proportion. The fact that these inequalities have persisted for so long suggests that the current management of PSR care equality policy in the NHS is unsatisfactory.

9 http://www.bsa.natcen.ac.uk/media/39293/1_bsa36_religion.pdf
FIGURE 1: Inequalities in PSR provision - paid providers (2016)

FIGURE 2: Inequalities in PSR provision – lead chaplains (2019)
The percentage of full-time equivalent chaplains is taken from the College of Health Care Chaplains’ 2016 Annual Report and is indicated by the dark blue bar in Figure 3. The light blue bar, taken from the 2011 Census, shows the percentages of ‘minor religions’ as a percentage of all religions.

![Figure 3: Participation in PSR care by religion or belief](image)

Compared with Christians, participation in PSR care provision by all minority traditions is disproportionately low. This is particularly the case for Hindus, Sikhs and Buddhists and, those with non-religious beliefs.

### 2.2

#### 2019 Freedom of Information requests

In July 2019, the NPSRCH sent Freedom of Information requests to 187 NHS acute trusts across England, with the aim of establishing a deeper understanding of the current demographics of chaplaincy teams, and the impact that this is having on service delivery. Responses were received from 99 trusts, representing a response rate of 53%. While not ideal, the sample of data acquired does provide a good basis for analysis, particularly when considered in the wider pool of data from other sources.

Some trusts responded to requests by stating that they ‘did not record the data’ requested, or simply ‘did not want to provide the data’. While there is no legal requirement to record such data, it should be considered good practice to collect this data in order to better understand the impact of NHS services in line with the legal obligations of the Equality Act 2010. This further highlights the gap in data discussed within the literature search. By not understanding gaps in pastoral support, there is a risk that more diverse services will not be developed.
2.2.1 Overall patient demographics

![Percentage of Inpatient Episodes (April 2018 - March 2019)]

**FIGURE 4: Percentage of inpatient episodes by religion or belief**

Figure 4 shows the religion or belief of people admitted to hospital as inpatients. If a person is admitted more than once it is recorded as a separate episode. A total of 3,071,409 episodes of care were recorded between April 2018 and March 2019. The percentage breakdown is largely in line with the 2011 Census data, but Christian inpatient episodes at 66.6% are somewhat higher than the Census at 59.3%. This is probably an age effect. The mean average age of an admitted patient in England was 53 in 2015–16. The median age of the UK population was 40 in mid-2015. In 2016, patients aged 65–69 made up the single largest group of hospital admissions, when broken down into five-year age bands, with the exception of ages 0–4, which includes babies born in hospital. The prevalence of Christian beliefs in over 65s is higher than the national average, and this is reflected in these figures. However, although there is an age effect it should not be exaggerated.

Non-religious inpatient episodes at 27% are in line with the Census at 25%. It is also worth noting that although the percentages of Jain (0.01%), Sikh (1.64%), Humanist (0.01%), Hindu (0.92%), Buddhist (0.88%), and Bahá’í (0.015%) are low, these still account for thousands of inpatient episodes. Individuals in these groups (and the non-religious) may have specific needs related to their beliefs and should therefore be provided with access to someone who can provide appropriate PSR care while they are in hospital.
2.2.2 Utilisation of chaplaincy services

Figure 5 shows the percentage breakdown of specific requests for PSR support by religion or belief for a total of 78,114 referrals. Eighty-five per cent of all referrals were to those with Christian beliefs; this is particularly significant when considered in the context of the NHS England 2015 Guidelines, which suggest that all religions and beliefs should have access to appropriate PSR care. Christian patients may have more needs that can be met by the chaplaincy team (for example, specific Christian rites and rituals, etc.), or non-Christian patients may perceive chaplaincy services as not for them. It is noted that Catholic referrals may appear disproportionately high, however this may be accounted for by the sacramental requirements of Catholics whilst in hospital. For example, the Sacrament of the Sick is often administered from the Catholic priest who is usually on-call as part of a locally arranged rota of catholic priests. The findings are largely in line with YouGov (2017)\textsuperscript{11} data that showed 96% of non-religious people never making use of a chaplain, despite 45% saying they would access a non-religious carer if they were available. Similarly, this data also aligns with the YouGov finding that less than 10% of people think a ‘chaplain’ could be a non-Christian.

These findings also highlight the importance of having diverse and inclusive PSR teams, particularly in areas with a higher population density of certain groups. Patients of all major world religions and beliefs in our survey had requested support from the PSR team; the availability of a like-minded person who can meet specific needs related to religion and belief is essential to ensure equality of PSR provision.

**FIGURE 6: Recorded visits by chaplaincy teams by religion or belief (April 2018 - March 2019)**

Note: Anglican, Free Church, and Roman Catholic have been amalgamated as many responses only stated ‘Christian’ and did not segment the data.

Figure 6 is based on the 3,071,409 inpatient episodes from the same data set referred to earlier, where only 66% of all patients identify as Christian, and yet this data shows that 94% of all 211,578 recorded visits by PSR teams are to Christian patients. These statistics are quite alarming for a service that claims to be for ‘all faiths and none’, and when we consider that this question does not relate to specific referral requests but accounts for all recorded interactions with patients (e.g. bedside visits, etc.), there is a clear bias towards Christian patients. This data also suggests that PSR services are massively underutilised, with only 7% of all patients recorded as having been visited between April 2018 and March 2019.
FIGURE 7: Number of NHS-funded funerals by religion and belief

Figure 7 demonstrates the provision of 1,065 funerals provided by PSR teams in the time period and relates to the specific provision of ritual-based services for those of different religions and beliefs. The data reflects the inpatient episode demographic breakdown for the most part but, given the number of chaplains of different religions and beliefs who are employed by the NHS, there should be appropriate PSR team members available who can provide these services. One might ask, though, whether these are being appropriately outsourced to the relevant community. For example, is there an assumption that a Christian chaplain is able to provide a non-religious funeral, when it would be deemed inappropriate for a non-religious pastoral carer to conduct a funeral for a deceased individual with a Christian belief?
2.3

PSR staff and volunteers

FIGURE 8: Breakdown of paid hours by religion and belief

Figure 8 shows the percentage breakdown of over 5,649 allocated paid hours of chaplaincy team members by religion or belief. Ninety-four per cent of hours worked by all chaplains in the sample were undertaken by Christians; this is well above the 66.6% of all inpatient episodes that were recorded as Christian. At the other end, only 0.1% of all paid hours were undertaken by those with a non-religious belief system, despite the fact that 27% of all inpatient episodes were non-religious. Minority faith groups accounted for only 6.4% of all hours, with 5.5% of these being carried out by those from the Muslim tradition.

Table 1 showed that of the returns showing a religion or belief, only 15% of the NHS paid chaplaincy headcount are people with non-Christian or non-religious beliefs. In terms of paid hours this is even lower – just 6%. This means that, on average, individual non-Christians/non-religious are employed for fewer hours than their Christian colleagues. On average, for every hour that the NHS employs an individual Christian chaplain it employs an individual non-Christian/non-religious person for only 22 minutes. While the higher proportion of Christian patients accounts for the higher number of Christian paid hours, it is unlikely that such a large disparity is consistent with the equitable treatment of the various religion or belief groups. These figures are likely to be the result of a number of contributing factors, which are set out in the other sections of this report, including recruitment that is not informed by thorough equality processes, and greater opportunities for Christian-grounded PSR training, which increases access for those of the Christian traditions to paid positions over and above those people with non-Christian and non-religious beliefs.
**FIGURE 9: Volunteer hours worked by religion and belief**

Figure 9 demonstrates the percentage contributed by volunteers in PSR teams over the previous year by religion or belief for a total of 2,077 hours. The majority of volunteer hours were provided by those from Christian traditions: Christian volunteers contribute about 1,600 hours, nearly 20 minutes for every Christian paid hour. In contrast, Buddhist chaplains and non-religious pastoral carers contribute ten hours for every Buddhist/non-religious paid hour. Other minority faith chaplains (e.g. Jain and Baha’i) are only in volunteer posts.

This means that PSR care is essentially an NHS paid-for service if provided by Christians, but a voluntary service if provided by those with non-religious and non-Christian beliefs. This data reflects the findings of Bryant (2018), which showed an acceptance of minority faith chaplains and non-religious pastoral carers into volunteer positions, but with restricted opportunities to progress or acquire paid posts.


2.4 Conclusion

PSR care services exist to provide support to patients, staff, families, and carers regardless of religion or belief. While these services may be rooted in the Christian tradition and developed when the NHS was initially conceived, it is important to recognise that British society has changed significantly since that time by becoming increasingly plural and increasingly non-religious. Not only that, but with seven in ten young people now identifying as non-religious\textsuperscript{12} we can expect these changes to increase.

The evidence shows that PSR service provision has failed to change in our society, and this is having an adverse impact on the way services are provided and on those who may or may not use them. While diversity within PSR teams has increased slightly, the odds on a patient interacting with the PSR services while in hospital are low, particularly if that patient is anything other than Christian. Opportunities for minority faiths and non-religious carers to enter PSR teams as anything other than volunteers (for the most part) are reflective of this problem. There is ongoing resistance to changes in recruitment strategies and a number of barriers need to be addressed, particularly to encourage those from minority faith backgrounds, in order to provide equal opportunities.

The next section will consider the legal context for the recruitment of PSR staff and the current recruitment strategies that are being used.

\textsuperscript{12} 2018 British Social Attitudes Survey
3.1 Allotment of chaplaincy services

A 2003 NHS framework for best practice of PSR care provision breaks it into ‘care units’. It aims to provide one unit (3.5 hours) of chaplaincy-spiritual care for every 35 beds as a basic requirement and then provide additional units as necessary. Having calculated the total number of units required by each trust and the number required for management of the service, the remainder of units are then allocated based on the representations of faith and denominations of the patients and staff within the trust.13 PSR staff are expected to visit wards and departments, contribute to structured worship, supervise volunteers, organise memorials, liaise with funeral directors, and support the dying and incurably ill.

3.2 Job specifications and external endorsement

The advertisements for PSR staff specify the particular responsibilities and personal criteria required for each institution and its community. Often, the postings are general and refer to ‘own faith tradition’ or ‘own faith tradition or belief group’ and indicate a need for knowledge of, and enthusiasm to engage with, other faith and belief groups, while person specifications detail the type of qualifications needed. Most commonly, an ordained Christian minister is specified and this qualification can be found even at times when a chaplain of any faith or belief is sought.14 Person specifications often use Christian criteria including ordination and endorsement from a Christian authorising body. Inexplicably, this was even the case for a Muslim chaplain in one recent Gov.UK posting.15 If the person specifications do relate to the Muslim faith, a candidate might be required to either have a degree in Islamic Studies, be able to recite the Qur’an or have experience of working as an imam. Similar qualifications are required of the Jewish community.

Within health care chaplaincy, two authorising bodies are repeatedly cited in Job Descriptions and Person Specifications: the NPSRCH and the UKBHC. It is common to see a requirement that the faith/belief group of an applicant be represented on the NPSRCH and/or be registered as a Board-certified chaplain with the UKBHC.

The NPSRCH is an organisation to promote and support religious, spiritual, and pastoral care in the NHS in England and help it develop the capacity to offer this service. It aims to help bring about a shared understanding of PSR care and bring religion and belief groups together to discuss this and enable authorisation bodies to work together more closely.

The UKBHC is an organisation that aims to define and develop professional standards of PSR services and maintain and develop systems to promote and

14 See, for example, the posting on NHS Jobs – ref: 208-16-483-PT
15 Ref: 1512575
accredit the professional registration of chaplains. UKBHC criteria of acceptance requires compliance with its Code of Conduct, which includes a respect for equality and diversity of values and beliefs and developing and maintaining knowledge, skills and capabilities, as well as maintaining a recognised or accredited status with the member’s own faith or belief group. It also requires evidence of relevant qualifications and training, which includes evidence of study of theology, religious studies or philosophy of religion and belief, a Board-accredited postgraduate chaplaincy qualification, and evidence of a recognised or accredited status within a mainstream faith community or belief group.

3.3

Relevant equality legislation in the recruitment of NHS PSR staff

There are three pieces of legislation that are relevant to chaplaincy recruitment. It is worth examining these in turn.

3.3.1

Employment law

The first and most directly relevant area of law is that of genuine occupational requirements (GORs), which limit the range of circumstances in which an employer can require an employee to be of a certain religious or non-religious worldview.

England, Wales, and Scotland

For England, Wales, and Scotland, section 39 of the Equality Act 2010 states:

An employer (A) must not discriminate against a person (B) -

1. in the arrangements A makes for deciding to whom to offer employment;
2. as to the terms on which A offers B employment;
3. by not offering B employment. (emphasis added)

This includes discrimination on the basis of religion or belief, which includes both religious and non-religious worldviews. The above legislation requires the UK to abide by a European Union law called the European Employment Directive.

17 Section 10 provides that ‘Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.’ Section 10: http://www.legislation.gov.uk/ukpga/2010/15/section/10
The Directive defines and precludes discrimination in articles 1 and 2:

**ARTICLE 1**

*Purpose*

The purpose of this Directive is to lay down a general framework for combating discrimination on the grounds of religion or belief, disability, age or sexual orientation as regards employment and occupation, with a view to putting into effect in the Member States the principle of equal treatment.

**ARTICLE 2**

*Concept of discrimination*

1. For the purposes of this Directive, the ‘principle of equal treatment’ shall mean that there shall be no direct or indirect discrimination whatsoever on any of the grounds referred to in Article 1.

2. For the purposes of paragraph 1:
   
   (a) direct discrimination shall be taken to occur where one person is treated less favourably than another is, has been or would be treated in a comparable situation, on any of the grounds referred to in Article 1;

Article 4 then similarly provides for ‘occupational requirements’, albeit in slightly stronger language than domestic law.¹⁹

Let us imagine that an employer wants to hire someone to carry out certain activities, believing that only individuals of a certain religion can carry out those activities. In order to religiously restrict the post when recruiting, the employer would have to demonstrate the following:

1. that there is a legitimate objective to those activities being part of the job description, i.e. that it is not possible to advertise the job without those activities, or rearrange the workforce to minimise the number of employees required to carry them out;

2. that it is a genuine and determining requirement of those activities that the postholder shares that religion, i.e. that someone of a different religion would not be able to do the job;

3. therefore, from 1 and 2, it is proportionate to the nature of the role and the importance of those activities to it for the advert to be religiously restricted.

If this cannot be demonstrated, then the post cannot be religiously restricted. The employer should also go through this assessment properly before advertising the post, as opposed to trying to come up with some post-hoc justification for it.

3.4 Public sector equality duty

In England, Wales, and Scotland, the Equality Act 2010 says:

1. A public authority must, in the exercise of its functions, have due regard to the need to—
   
   (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
   
   (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
   
   (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

2. A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).

3. Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
   
   (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
   
   (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
   
   (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.20

The public sector equality duty (PSED) applies to everything that public sector organisations do: to eliminate discrimination and advance equality of opportunity, and to take steps to ensure that everyone’s needs are met. Plainly, providing a service to individuals of some religions/worldviews and not to other individuals, when the needs of all individuals for such a service are equal, could fall foul of the PSED.

When an employer chooses to recruit and is considering what requirements to put on the job, one of the first things to consider is the PSED. The way in which employers generally meet such considerations is by doing something known as an Equality Impact Assessment (EIA). This is a formal process by which the employer will comprehensively and rigorously consider whether the different policy options available will have a positive, negative, or negligible effect on individuals within each of the ‘protected characteristics’ of the Equality Act (i.e. religion or belief, race, gender, sexual orientation, disability, age, etc.). It will also consider whether

any negative impact is unavoidable and justifiable, given legitimate aims, or if it is avoidable; and, if the impact is unavoidable, whether it can be mitigated by taking alternative steps.

Given the outcome of the EIA, the employer should then be equipped to decide which policy to pursue. This decision should be made on the basis of minimising negative impact and maximising positive impact, while continuing to pursue the legitimate policy aims. The EIA should not be a box-ticking exercise constructed to fit pre-existing policy; instead, policy should be led by the EIA, which should be embarked upon with an open mind.

3.5

European Convention on Human Rights

The Human Rights Act 1998, which applies across the UK, makes it unlawful for a public body to act contrary to the European Convention on Human Rights. The Convention itself states:

**ARTICLE 9**

*Freedom of thought, conscience and religion*

1. 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.

2. 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.

**ARTICLE 14**

*Prohibition of discrimination*

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

The impact of this is, essentially, the same as that of the public sector equality duty, in terms of precluding discrimination against those of different religions or beliefs in the manifestation of those beliefs.


3.6

NHS England 2015 guidance

In March 2015, NHS England published new guidance, NHS Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual and Religious Care.\(^{23}\) This guidance included non-religious patients and pastoral support workers equally for the first time. The executive summary states: ‘The term ‘chaplain’ is intended to also [as well as referring to religious care by religious providers] refer to non-religious pastoral and spiritual care providers who provide care to patients, family and staff.’ It goes on to explain that non-religious individuals need pastoral support just as religious individuals require chaplaincy:

\[
\text{It is important to note that people who do not hold a particular religious affiliation may still require pastoral support in times of crisis.}
\]

\[
\text{Best practice for quality pastoral, spiritual or religious care for staff and organisations is achieved by: … Ensuring staff awareness of how to access chaplaincy services which includes the availability of non-religious pastoral and spiritual support.}
\]

\[
\text{In addition to religious needs chaplaincy managers must consider how best to determine and deliver spiritual care to those whose beliefs are not religious in nature. In doing this equality legislation, the NHS Charter and human rights obligations are of vital importance.}
\]

The guidance also makes clear that so-called ‘generic provision’ of chaplaincy or pastoral support by individuals not of the same religion or belief as the patient should if possible be avoided:

\[
\text{Wherever possible, patients should have access to a chaplain of their religion or belief to ensure appropriate pastoral, spiritual or religious care.}
\]

\[
\text{Patients and service users can expect to receive care from chaplains … in a manner authentic to the practices and beliefs of the community the chaplain represents.}
\]

Case law is clear that a public authority must consider relevant guidance before making any decision and must have sound reasoning if it chooses to depart from it. The NHS guidance should tip the presumption of any English NHS trust strongly in favour of ensuring a diverse and inclusive range of chaplaincy/pastoral support worker staff in its team.\(^{24}\)


\(^{24}\) At the time of publication, guidance in other contexts in England, and more generally in other parts of the UK, which is generally older, has not been similarly revised to be equally inclusive. However, given the already-explained statute, the presumption must also be in favour of an inclusive approach.
3.7
Recruitment intervention and analysis of impact

Since 25 May 2016, Humanists UK has been monitoring all NHS chaplaincy jobs in England. In line with the legislation and guidance, it is assumed that a strong majority of the adverts posted on NHS Jobs 25 have been unlawfully religiously discriminating.

3.8
NHS advert monitoring

The 2015 Promoting Excellence in Pastoral, Spiritual and Religious Care guidance (see section 3.6 above) introduced a new obligation on NHS bodies to provide pastoral support for non-religious patients that is equal to chaplaincy services provided for the religious. 26 However, this has not yet carried through to a change in advertising practices.

From 25 May 2016 to 1 August 2019, the following adverts have been logged: 27

25 https://www.jobs.nhs.uk/
26 https://humanism.org.uk/2015/03/06/new-nhs-obligation-provide-equal-pastoral-care-non-religious-england/
27 Six of the adverts were in hospices and the rest in hospitals. Of the six, one required a Christian, three required generically religious employees, and two were open.
TABLE 4: Numbers and percentages of PSR posts by religion or belief

<table>
<thead>
<tr>
<th>Restrictions</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious</td>
<td>143</td>
<td>25</td>
</tr>
<tr>
<td>Anglican/Free Churches</td>
<td>90</td>
<td>15</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>43</td>
<td>7</td>
</tr>
<tr>
<td>Christian</td>
<td>137</td>
<td>24</td>
</tr>
<tr>
<td>Muslim</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td>Open</td>
<td>122</td>
<td>21</td>
</tr>
<tr>
<td>Secular</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>Hindu</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Sikh</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Jewish</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Humanist</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Orthodox</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Protestant</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Methodist</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>579</td>
<td></td>
</tr>
</tbody>
</table>

Four out of five of these adverts have been the subject of religious discrimination. Some of this might be legitimate; for instance, the recruitment of the Catholic/Muslim chaplains, if there is no current Catholic/Muslim chaplain in post and there is a significant number of Catholics or Muslims in the local population. But probably most of it is not.

Almost half (48%) of all adverts are restricted to those with Christian beliefs – a high proportion. Just 6% of adverts specify a non-Christian religion/belief. When Humanists UK started monitoring adverts, all of the non-Christian adverts were solely for Muslims candidates. There has been an improvement over the past three years for other religious minority groups, such as Sikhs, Hindus, and Jews, but there are no adverts that say they are open to people with non-religious beliefs.
FIGURE 10: Proportion of job adverts by religious denomination for the year end 2016

FIGURE 11: Proportion of job adverts by religious or belief denomination for the year end 2018
Perhaps an easier way to see the scale of the problem is by using the figures, from which the following chart has been produced:

\[\text{TABLE 5: Breakdown of NHS PSR posts that can be applied for by religion or belief}\]

<table>
<thead>
<tr>
<th>Religion or belief</th>
<th>% of adverts specifically for you</th>
<th>% of adverts you can apply for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglican/Free Church</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>7%</td>
<td>76%</td>
</tr>
<tr>
<td>Other Christian</td>
<td>25%</td>
<td>70%</td>
</tr>
<tr>
<td>Muslim</td>
<td>4%</td>
<td>50%</td>
</tr>
<tr>
<td>Other non-Christian religious</td>
<td>1.5%</td>
<td>47%</td>
</tr>
<tr>
<td>Non-religious</td>
<td>0.5%</td>
<td>21%</td>
</tr>
</tbody>
</table>

The Anglican/Free Church can apply for 85% of jobs, having 15% restricted to them. Christians of any denomination who are not also Roman Catholics can apply for 70%. Those of other religions can apply for at least 47%. But those with no religion can apply for just 21% of the available jobs.

A further issue worth exploring is that, almost as a rule, the ‘generically religious’ adverts are not explicit about their being religiously restricted – as they should be if they are following best practice. Instead, they present themselves as open adverts, but then become de facto religious-only as a consequence of their requirements. The requirements that lead to generically religious’ ads include:

- Letter of support from a religious leader, licence from religious community, or in good standing with their religious community.
- Requirement to lead or partake in worship or prayer.
- Requirement to have a specialised knowledge of one’s own religious faith.
- Requirement to hold a theological qualification.
- Requirement to hold a qualification in religious chaplaincy.
- Experience of liturgical skills or requirement to work ecumenically (neither of these terms has a non-religious equivalent).

Sometimes, such requirements will have been set deliberately in order to religiously restrict the post. At other times, it is unclear. In a number of cases, the job advert explicitly says that it is intended to be open to those of no religion, only to subsequently put one or more of the above requirements on the post, which means that a non-religious person cannot apply. This is particularly true with requirements related to worship and UKBHC.

\[28\] The one ‘Anglican’ advert is grouped here with Anglican/Free Churches.
3.9 Conclusion

Over the last three years there has been a marked decrease in the number of advertised PSR posts that have a specific belief group restriction. From 100% restricted posts in 2016, the current figure is now around 80%. This is a significant and welcome change, which is key to reducing inequality of access for patients, staff, families, and carers of different religions and beliefs. However, given the overwhelming number of Christian chaplains already employed by the NHS, it is likely that the vast majority of the restrictions that are still being seen are being applied unlawfully.

It is highly likely that some of the issues related to recruitment are rooted in history, and that NHS systems and policies are yet to catch up. Until recently, it has been common practice that when an Anglican chaplain left their post there would be a like for like replacement. However, with changes in legislation and patient religion and belief demographics, NHS trusts need to consider the needs of the recipients of their services more closely and adapt recruitment strategies accordingly.

In reality, the opportunities for postgraduate training for Christian chaplains means that, even when posts are unrestricted, trusts are still likely to receive more applications from Christian chaplains who meet the threshold of skills and knowledge for the post. Nonetheless, the issue reinforces itself. The lack of diversity in employment means that those from non-Christian traditions are unable to influence change and, because so few posts are open to people from non-Christian traditions, the prospects of a career in PSR remain unappealing and, apparently, unattainable.

All this comes at a time when many PSR teams are struggling to recruit quality candidates. The pool of highly trained specialists is reducing, and yet a net of the same size remains. The restrictions that continue to be applied to posts often lack legal justification. Competent, capable, and dedicated individuals from under-represented groups should not be stopped from applying to become NHS PSR staff without good cause. There needs to be an immediate change in approach and policy for many trusts.

The NPSRCH has produced two guidance documents to support a legal and equitable approach to recruitment:

1. Recruitment of Pastoral, Spiritual and Religious Care Staff
2. Endorsement of Pastoral, Spiritual, and Religious Care Staff

These are available at: www.network-health.org.uk
Chapter 4: Education Pathways for PSR Staff and Volunteers
The academic route into paid positions

Given the broad range of specialist skills required by those working in health care services, the qualification level for paid positions is rightly set very high. Paid PSR posts range from entry roles at Agenda for Change (AfC) Pay Band 5, through to a ‘Consultant’ or ‘Lead Chaplain’ at Pay Band 8. In 2015, the UKBHC, as a professional standards body for chaplaincy, helpfully set out the qualifications, as well as the competency and capabilities, for a chaplain to meet the requirements of the job functions at each banding level. The Bandings and Duties Framework (2015) draws a distinction between paid posts and ‘Chaplaincy Support’ positions, which are voluntary; these will be considered later in this chapter.

In line with UKBHC criteria, entry-level chaplains at Band 5 are expected to possess a ‘degree in healthcare chaplaincy or equivalent’. At each step up in banding, there is an expectation that there is a parallel step up in academic qualification level, combined with post-qualification experience:

- **Band 5**: ‘Chaplain’, Degree in Healthcare Chaplaincy (or equivalent)
- **Band 6**: ‘Chaplain’, postgraduate qualification/diploma in Healthcare Chaplaincy
- **Band 7**: ‘Lead Chaplain’, Master’s in Healthcare Chaplaincy and five years’ experience in healthcare chaplaincy
- **Band 7**: ‘Specialist Chaplain’, Master’s in Healthcare Chaplaincy or Specialty (for example: Palliative Care) and five years’ experience in healthcare chaplaincy
- **Band 8**: ‘Consultant or Lead Chaplain’, Master’s in Healthcare Chaplaincy or above.

The UKBHC is registered with the Professional Standards Authority and recognises a number of postgraduate academic courses as a pathway to autonomous practice in a Band 6 post. In addition, the UKBHC recognises two foundation degrees that would enable chaplains to acquire chaplaincy posts at Band 5. Graduates of postgraduate programmes recognised by the UKBHC in combination with other requirements allow for registration with the Board. The UKBHC holds a voluntary register of chaplains; for this reason, membership cannot be set as an essential requirement on chaplaincy posts. However, registration and/or possession of a qualification from one of the UKBHC-recognised institutions can help to assure the NHS, as an employer, of the quality of its PSR employees and, in turn, patient welfare. While NHS trusts set their own requirements for academic qualifications, for the most part, new vacancy person specifications at each banding level tend to reflect the qualification level requirements recommended by UKBHC.

The postgraduate courses currently recognised and accredited by UKBHC, their entry requirements, study mode, length, and cost are set out in the table on the next page:

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29 https://www.nhsemployers.org/pay-pensions-and-reward/agenda-for-change/pay-scales/annual
31 http://www.ukbhc.org.uk/chaplains/training-and-education
TABLE 6: UKBHC-accredited postgraduate courses

<table>
<thead>
<tr>
<th>Institution</th>
<th>Qualification Level</th>
<th>Key Entry Criteria</th>
<th>Study Mode</th>
<th>Length</th>
<th>Costs per Annum</th>
</tr>
</thead>
</table>
| Guy’s and St Thomas’ NHS Foundation Trust (validated by London Southbank University) | Postgraduate Certificate in Healthcare Chaplaincy | – Registration with a mainstream faith and belief community  
– A first degree in a subject related to the person’s faith or belief group | On-site / placement | One year | £3,300 |
| | Postgraduate Certificate in Spiritual Care in Health | – As above but without the need for registration with a mainstream community | On-site / placement | One year | £3,300 |
| Cambridge Theological Federation | MA or PGDip in Pastoral Care and Chaplaincy | – First or good second-class honours degree in a relevant subject  
– Sufficient relevant ministry experience will be considered | Distance offered | One year part-time (full-time from 2019) | £3,750 – £7,100 |
| Cardiff University | MTheol / PgDip / PgCert in Chaplaincy Studies | – Suitable for chaplains (lay or ordained, and from different faiths) working full- or part-time in different sectors including health care | On-site and distance | Up to two years depending on level studied | £2,650 |
| Glasgow University | PGCert Healthcare Chaplaincy | – Already a working chaplain  
– Supervised by a UKBHC-registered chaplain  
– Recognised status in a faith or belief community | On-site and distance | 12 or 24 months part-time | £2,833 |
| New School of Psychotherapy and Counselling (validated by Middlesex University) | PgCert, PgDip, MA in Existential and Humanist Pastoral Care | Relevant first degree or equivalent and demonstrable interest in the field | Online, on-site, and through practice | Two years | Year 1 £5,520  
Year 2 £8,280 |
| St John’s Nottingham (validated by Staffordshire University) | PgCert / PgDip / MA in Chaplaincy with Children and Young People | – BA Honours degree at 2:1 or equivalent experience / prior learning  
– At least three years’ experience in ministry, as a volunteer or paid staff member | On-site placement at Birmingham Children’s Hospital | PG Cert one to two years, PG Dip two to three years, MA three to four years part-time | PGCert £2,000,  
PGDip £4,000,  
Master’s £6,000 |

33 https://www.theofed.cam.ac.uk/postgraduate/  
34 https://www.stpadarns.ac.uk/mth-chaplaincy-studies/  
35 https://www.gla.ac.uk/postgraduate/taught/healthcarechaplaincy/  
36 https://www.nspc.org.uk/courses/ma-in-existential-and-humanist-pastoral-care/  
37 https://cym.ac.uk/ma-studies-in-chaplaincy/
TABLE 7: Graduate courses recognised but not accredited by UKBHC (for Band 5 appointments)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Qualification Level</th>
<th>Key Entry Criteria</th>
<th>Study Mode</th>
<th>Length</th>
<th>Costs per Annum</th>
</tr>
</thead>
</table>
| St Mary’s University College     | Practitioners in Healthcare Ethics, Theology and Care FdA | - Three A-Levels or equivalent  
- GCSE grade C (or equivalent) in English Language  
- Employed in a health care setting (either paid or voluntary) for at least half of the working week | On-site and placement | Two years            | £4,940           |
| Markfield Institute of Higher Education | MA in Muslim Chaplaincy* | - An honours degree from a UK university                                          | On-site          | 12 months             | £5,500           |

*This course is now listed as an MA in Islam, Pastoral Care, and Counselling on the Markfield website

38 https://www.stmarys.ac.uk/foundation/healthcare-ethics-theology-and-care/  
39 https://www.mihe.ac.uk/course/ma-islam-pastoral-care-and-counselling
### TABLE 8: Courses available at various levels that are not currently recognised by UKBHC

<table>
<thead>
<tr>
<th>Institution</th>
<th>Qualification Level</th>
<th>Key Entry Criteria</th>
<th>Study Mode</th>
<th>Length</th>
<th>Costs per Annum</th>
</tr>
</thead>
</table>
| Waverley Abbey College | PgCert in Chaplaincy (also available as single CPD module) | - DipHE in a related subject or equivalent professional qualification  
- Degree in a related or non-related subject  
- Substantial experience (greater than three years) in a related area | On-site | Up to two years part-time | £3,850 for PgCert or £850 single module |
| Newman University | PGCert Chaplaincy and MA Work Based Learning in Chaplaincy | - Working as a chaplain or similar in a paid or voluntary capacity and demonstrate some knowledge and understanding of chaplaincy with young people  
- A good first degree | On-site and distance | 18 months part-time | £975 |
| Maryvale Catholic College | Certificate in Catholic Healthcare Chaplaincy | Recommended by Diocese and DBS | Distance | 12 months part-time | £560 |
| Markfield Institute of Higher Education | Certificate in Muslim Chaplaincy | - Good interpersonal skills  
- Experience of community work  
- Basic understanding of religion and theology | On-site and | Eight months | £1300 |
| St Padarn's Institute (accredited by Cardiff University) | Certificate in 'Beginning Chaplaincy' | - New to NHS chaplaincy with a year or less in post  
- Working part-time or full-time | Onsite | Five days | - |

One final course from Oasis College - CPD - Contemporary Chaplaincy is now no longer offered.

40 https://www.waverleyabbeycollege.ac.uk/programmes-of-study/postgraduate-programmes/chaplaincy-pg-cert/  
41 https://www.newman.ac.uk/course/chaplaincy-pgcert/part-time/  
42 https://www.maryvale.ac.uk/catholic-healthcare-chaplaincy.html  
43 https://www.mihe.ac.uk/course/certificate-muslim-chaplaincy  
44 https://www.stpadarns.ac.uk/beginning-chaplaincy
4.2

**Volunteer training pathway into PSR care**

According to UKBHC, the title ‘chaplain’ ‘is reserved for those who work and meet the capabilities and competencies at Band 5 or above’. However, most chaplaincy teams are supported by a large number of volunteers, who have varying roles in terms of the support they provide to patients. All work under chaplains at Band 6 or above, and their individual roles and titles, are defined at the level of the trust. It is not unusual for volunteers to function in the same way as a Band 5 chaplain in terms of the direct support they provide to patients.

It should be recognised that many volunteers bring relevant professional skills and qualifications from health care, counselling, social care, and other disciplines. These are not always fully acknowledged and valued.

4.3

**‘Starting Out in Healthcare Chaplaincy’ course**

The two-day course ‘Starting out in Healthcare Chaplaincy’ initiated by the Network for Pastoral, Spiritual and Religious Care in Health aimed to give more individuals from minority faith traditions the opportunity to explore working in health care chaplaincy through a short but focused ‘taster’ experience. Anecdotally, this course recruited some particularly under-represented communities, e.g. Black African participants from the Spiritans (RC), members of independent churches and Chinese Buddhists.

The taster course ran between 2015–2019, with 157 participants attending one of the four courses delivered in Manchester or one of the five delivered in London. Nearly two-thirds of those attending were from backgrounds other than Christian, and nearly 60% completed the full course, which included producing written reflective material of a notably high standard. Many of the participants have gone on to secure chaplaincy support positions and several are now in paid posts.

The course demonstrated a way forward towards engaging a more diverse population in PSR training and providing a more truly diverse health care PSR service; the discussion between different faiths and beliefs, for example, made a significant contribution to the delivery. The emphasis on reflective practice on a personal shadowing experience from a 20-hours placement in a health care setting laid an appropriate and firm foundation in chaplaincy practice, upon which it would be wise to build future effective CPD learning. The NHS England funding for the ‘Starting Out in Healthcare Chaplaincy’ course ended in 2019, and there are currently no similar courses available in England.
What does this mean for equality and inclusion within PSR services?

The vast majority of UKBHC-accredited academic courses have a Christian theological basis in terms of their approach to providing pastoral and spiritual care. That being said, there are no explicit restrictions on applicants to any of the courses being of a particular belief system. In theory, it is quite possible for someone with a minority faith or non-religious belief to study any of the qualifications listed in Tables 7, 8, and 9. Having said that, the modules on most of the courses tend to be described in relation to particular denominations. For example, the Cambridge Theological Federation describes its course as enabling ‘students to explore the history of pastoral theology and the practice of pastoral care in a variety of Christian traditions’. Equally, the Existential and Humanist Pastoral Care MA offered by the New School of Counselling and Psychotherapy states: ‘This is the first MA of its nature in the UK and we hope that it will provide a much-needed pathway towards professional work in pastoral care and chaplaincy from a non-religious perspective.’ Indeed, one of the core units of the MA is listed as ‘Skills in Existential and Humanist Pastoral Support’. As such, these courses are extremely unlikely to attract students who have beliefs that are in contrast with the primary theoretical paradigm of pastoral care referenced by a particular institution. For example, a Freedom of Information request response from one provider institution stated that ‘all our students on the course are Catholics as this is a course specifically to train laity for pastoral ministry on behalf of the Church’.

All the academic courses provide practical field experience and the majority require the applicants to already be working as a ‘chaplain’ and meet UKBHC standards. Mention of non-religious worldviews (e.g. humanism) is scarce on any of the course websites (aside from the Existential and Humanist Pastoral Support MA); it is notable, however, that the Guy’s and St Thomas’ course does include specific teaching on non-religious worldviews. Most courses also require an active managing chaplain (usually UKBHC-registered) to mentor students. This may be problematic for those with non-Christian beliefs, as it would mean that it is likely their mentor support would be provided by someone who holds beliefs that may be significantly different to their own.

The costs of training may also be a significant barrier to entering academic courses for those with non-Christian beliefs. While the fees for all the courses listed are by no means at the top end for postgraduate study, the fact that some course fees can be covered for those in Christian ministerial training may create an uneven playing field. The Cambridge Theological Foundation course, for example, states on its website that the fees for ‘ordinands will be covered by the church’. Even within the Christian faiths, there exists an inequality between different Christian

45 https://www.theofed.cam.ac.uk/postgraduate/ma-aru/ma-pastoralcare/
47 FoI request in July 2019 from the authors to an institution in England
48 https://www.theofed.cam.ac.uk/postgraduate/ma-aru/ma-pastoralcare/
denominations, for example, the unique role of the Catholic priest means they are unlikely to be able to fulfill all the academic requirements in addition to running several parishes.

Training for potential volunteers is very variable. Some religion or belief groups include training as part of their accreditation and authorisation processes, while some do not. Much of this is down to financial security, which raises equality and diversity issues, as those belonging to more financially secure religion or belief groups enjoy wider availability of training opportunities and therefore a greater chance of securing volunteer and paid positions. Volunteer training provided at the level of the trust or PSR team is also incredibly variable, with no standardised approach to training having being adopted.

4.5 Conclusion

The current lack of availability of academic courses to those of a non-Christian background and, in particular, to non-Christian minority faiths is a significant cause for concern. Specifically, there is a lack of courses that reflect the worldview, beliefs, and philosophies of those from minority traditions. Education pathways are meant to reduce inequality, but the current system only serves to reinforce it. Given that AfC Pay Bands are aligned to academic qualification, it means that very few minority faith chaplains are able to reach the qualification level in order to apply for paid positions even at the lowest banding level. The pathways into paid PSR roles for those from minority faith traditions are opaque and seem to rely on promotion from a chaplaincy support level in lieu of an academic qualification. However, as highlighted by Bryant (2018), opportunities for promotion from chaplaincy support are often limited by the training and development opportunities that are extended to volunteers in comparison to paid staff – it is a catch 22.

The additional funding available to cover course fees for those with Christian beliefs also increases inequality. It is highly unlikely that smaller communities would be able to fund their members to undertake such training, and the question has to be whether it would even be appropriate to do so? Given that placement mentors and course delivery are likely to have their first frame of reference centred on the Christian tradition, would attending such a course be as fulfilling? It is also important to not consider the academic pathways in isolation but in line with the restrictions on recruitment. Even if an individual from a non-Christian community was to pay the fee and graduate with an MA, they would still be prevented from applying to many of the job vacancies because of their belief system. In itself, this is likely to contribute to the disproportionately low numbers of those from minority faith traditions training to postgraduate level.

It is also concerning to see that within an area with such a high potential to contribute professionally to health care, individuals keen to train and learn face a bewildering lack of clarity on pathways into health care PSR services, and the experience is little better when the individual meets the huge inconsistencies
in practice on how their career pathway may develop. The closure of the one training pathway that looked to provide a clear route for new volunteers (‘Starting Out in Healthcare Chaplaincy’), due to a loss of funding, will no doubt continue to reinforce the inequalities that are present in volunteer recruitment and progression.
Appendix 1:

Literature Review Methodology

Desk research was focused on the UK context as there are unique circumstances and debates regarding PSR provision in the NHS due to it being a state-funded, secular, universal health care system. Operating in the rich multiculturalism of UK society, any PSR care provision must reflect the diverse belief systems of both NHS patients and staff. Data was sought that focused specifically on how far minority faiths and majority alternative beliefs have been able to contribute to and benefit from PSR care in health care settings. Particular value was given to research conducted by members of under-represented groups.

The collection of data was focused on the last 15 years, using 2003 as a stepping-off point for a major shift in PSR provision with the issuing of the NHS Chaplaincy Guidance (DoH, 2003) and Caring for the Spirit (SYWDF, 2003). Savage (2019) and Bryant (2018) provide useful summaries of the stages that led to an impetus to reform PSR care at the end of the 1990s, including a report by Orchard (2000), which raised concerns about how hospital PSR care was organised and questioned equality in access to PSR provision. In particular, Orchard (2000) highlighted the need for more inclusive structures rather than the prevailing dominance of Anglicans as chaplains. The literature search looked for information and evidence of progress towards inclusion of under-represented groups in teams and in service uptake, and used the following research questions to inform the search:

1. Who are the people doing research and publishing, leading the discourse? How representative are they?
2. How far do current models/systems of PSR provision include under-represented groups?
3. How successful is the PSR brand in conveying an inclusive provision for all patients, families and staff?
4. How equal is access to and use of PSR provision by under-represented groups (staff and patients)?
5. How far does PSR provision take an equally person-centred approach that meets the needs of under-represented groups?
6. What is the distribution and integration of under-represented groups in PSR teams (paid and unpaid)? How is this impacted by recruitment, training, retention and progression practices?
7. How inclusive and flexible are PSR physical spaces and how are they used?
Savage (2019), Bryant (2018) and Gilliat-Ray et al. (2013) were used as springboards for sources. The University of Sheffield Library database was the primary search engine. The Journal of Health Care Chaplaincy did not render anything but a few isolated articles related to under-represented groups; there were a few more in Health and Social Care Chaplaincy. Specific searches to find research data and opinion used combinations of the following search terms: chaplain, multi-faith, multi-belief, inter-faith, healthcare, pastoral, spirit, religion, non-religion, humanist, minority faith (and individual faith names), secular, ethnicity, NHS, diversity, discrimination, and equality.

It is clear that the literature on PSR care is dominated by a Christian perspective and less research has been conducted by those from minority faiths or alternative beliefs in health care PSR care (although Muslim PSR care has a growing body of evidence and discourse). Particular effort has been made to include as many perspectives as possible and especially those of minority faith and alternative beliefs, so as not to use the predominantly male (ordained) Christian discourse as the only reference point.
Appendix 2:

Comments From Our Member Organisations

Bahá’í Chaplaincy Team under the National Spiritual Assembly of the Bahá’ís of the UK

‘As members of the Baha’i Chaplaincy team we warmly welcome this new report with its findings into the inequalities in pastoral, religious and spiritual care within acute NHS settings. We are happy to be able to serve members of all faiths and none, whether patients or staff, and hope that this report will enable us and representatives of colleagues from all faith and belief groups to better meet the pastoral, religious, and spiritual needs of patients and staff in our local communities.’

Buddhist Healthcare Chaplaincy Trust

‘This report offers a compelling and well articulated case for the challenges those from minority communities have experienced as they work toward making a real contribution to Healthcare Chaplaincy. Well-argued, and based on a range of good evidence, the report highlights central questions in need of tackling if the needs of healthcare staff and patients are to be better met through a genuinely diverse chaplaincy service.’

Church of England

Regrettably, the Church of England cannot endorse this report. We welcome ways of exploring how the pastoral, spiritual and religious needs of patients can best be met through comprehensive and inclusive healthcare chaplaincy, but, unfortunately, this report is fundamentally flawed in its premises, methodology, content and governance. We view this report as a missed opportunity and we cannot support its publication.
Healthcare Chaplaincy for the Free Church Group

“We have been acutely aware of the historic inequalities in the opportunities for minority religious and belief chaplains. They are best placed to provide high quality person-centred care to patients and families who would either like specific religious support, or to speak to someone of a like minded worldview. We welcome this report. It not only shows how much more needs to be done, but also gives clear direction to key parties on how to move forward to more equitable provision.”

Jewish Visiting (Healthcare Chaplaincy)

“This report collates information from a number of sources and demonstrates clearly, with facts and figures, how the staffing of chaplaincy departments does not reflect the demographics of today’s society, particularly the existence of minority faiths and the non-religious. In keeping with the conclusions of the report, as far as the Jewish community is concerned, we would like to see increasing professionalization of the service, with more opportunities for high quality Jewish chaplains to apply for paid posts and less reliance by the NHS on community volunteers so as to ensure greater access for patients from the Jewish community”

National Council of Hindu Temples

“The foundation of today’s network were laid in 1997, when issues relating to the unequal provision of pastoral support within the NHS, were first expressed by members of minority traditions. Change of culture and entrenched beliefs is one of the most challenging objectives to achieve and is not possible without genuine commitment from policy makers and “gatekeepers”. The burden of sustaining and carrying the vision of genuine equality of provision in the NHS, which has been borne principally by volunteers, is to be gratefully applauded and urgent action based upon their observations.

The Non-Religious Pastoral Support Network

“This report draws attention to what we have known for a long time, that pastoral, spiritual, and religious care services need to urgently evolve to reflect rapid changes in societal demographics. As we become increasingly plural and non-religious as a society, there is a need for these services to be proactive so as to develop truly inclusive provision for the benefit of all patients, staff, families, and carers without exception.”
Sikh Healthcare Chaplaincy Group

‘This report highlights the fact that many of our highly skilled and dedicated chaplains, are often prevented from even becoming regular volunteers because of their Sikh beliefs. It is hoped that the findings of this report will encourage more NHS chaplaincy managers to welcome our participation more readily so as to contribute to this incredibly important NHS service.’

Vanik Council UK

‘The report draws attention to many of the challenges and experiences of those from minority faiths in acute Healthcare Chaplaincy. Jains have participated in some pastoral, spiritual, and religious care services for decades. However, despite the fact that the Jain community is eager to serve those of all faiths and none, our members often meet resistance from Chaplaincy Managers. Approaches by trained volunteers are largely ignored even where an NHS trust is within an area with a high Jain population density.’
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University Hospitals of Leicester NHS Trust, 2015. Report on the Public Consultation about the Appointment of a Non-religious Member of the Leicester Hospitals’ Chaplaincy Team. Leicester: University Hospitals of Leicester NHS Trust.


All patients, staff, families, and carers should be able to access high-quality pastoral, spiritual and religious care on an equal basis without exception.

More details on the group can be found at www.network-health.org.uk

Email: admin@network-health.org.uk

Twitter: @NPSRCH1