FaithAction

FaithAction NHS 10 Year Plan Consultation Response:
Summary paper

We desire to see:

- Faith recognised as a social determinant of health, and a core factor in what contributes to people's health and wellbeing.
- Acknowledgement of faith and spirituality explicitly included within NHS service delivery plans to achieve personalised care.
- Faith communities themselves explicitly included as a strategic partner within NHS forward planning.
- The faith-based sector included within NHS ambitions to work with "people and communities" and the wider voluntary, community and social enterprise sector.

This is because:

1. Faith is a large part of the life of the UK

"Religion or belief" is a characteristic protected under the Equality Act 2010, and over half of the UK population (57%) profess faith, with around 34% of the population attending a place of worship. *(Office for National Statistics, 2021)*

Moreover, over a quarter of charities (27%) have a faith basis.[1]

2. Faith is a social determinant of health

There is a growing literature arguing for the recognition of faith, or religion, as a determinant of health, mediating a range of health conditions and risks, promoting good health, and providing opportunity for intervention.[2]

Alongside this, there are vulnerabilities and risk factors associated with faith which ought to be considered. This may include misconceptions and myths in applying religious teaching to health and wellbeing, prevalence of stigma regarding certain health conditions and prevalence of alternative health beliefs. These realities mean faith cannot be ignored both as a protective contributor to good health and an arena for proactive intervention and health education.

3. Faith communities experience inequalities and are amenable to interventions

There is evidence to suggest several faith communities experience health inequalities due to social factors. The links between poverty and health inequality are well documented, and after accounting for ethnicity, certain religions are at higher risk of experiencing poverty.[3]

Disparities in physical and mental health outcomes for people from minority ethnic backgrounds, and the high proportion of people from such backgrounds professing a faith, means that referrals and signposting through faith communities is one way of addressing health inequalities and enabling people to gain timely access to the support they need.[4]

4. Good care is personalised and build upon what matters to people

You might argue that few things are more personal than where we place our faith. Any truly personalised approach to healthcare and prevention of ill health must take faith into account.

Moreover, studies have shown that people want their faith to be included in their care, and that they benefit when it is.[5]

5. Faith communities are strategic assets for the UK health system

FBOs themselves are positioned to promote good health among those the represent, including a range of high-risk groups such as black and minority ethnic people, refugees, the homeless, those living in poverty and isolated older people. Crucially, FBOs are positioned to work with those communities which statutory services typically struggle to reach.[6]

It goes without saying that a huge amount of faith-based activity complements the UK health and care system, whether through acting on social and economic determinants of health or addressing health and wellbeing issues more directly.

Ideas for change

1. Put the "F" in VCSE

ICSs should consider adopting the "VCFSE" acronym when referring to the voluntary sector, demonstrating the visibility and importance of FBOs within the wider sector. FBOs should be considered equal partners within local VCFSE networks and alliances.

- *In Lancashire and South Cumbria Health and Care Partnership the VCFSE sector has formed a "Voluntary Sector Partnership Alliance" with elected chairs in each of the five local health and care partnerships. An independent chair represents the whole Alliance on the ICS board. The voluntary sector is referred to as the "VCFSE" within the ICS, giving visibility to FBOs.*
- *In North East London ICB the VCSE provider collaborative has made the decision to explicitly include the "F" of faith, and are in the process of appointing a faith-based lead to represent the sector across the NEL footprint.*

2. Build upon what works

Relationships and communication channels forged during moments of challenge like the Covid-19 pandemic, cost-of-living crisis and refugee crises, should be built upon. Practical initiatives, like faith-based vaccine centres, food or medicine distribution, or targeted local health messaging, should be adapted for other contexts. The reach of FBOs could be considered within cancer prevention, for example, with targeted messaging helping to reduce inequalities in and barriers to cancer screening uptake.

3. Strategic involvement

FBOs should be made an integral part of any system-wide ICS strategies for engaging with people and communities. FBOs, like the wider voluntary sector, are a key source of intelligence and insight into diverse communities experiencing health inequalities. They demonstrate trusted leadership within communities and a nuanced understanding of the cultural spaces of at-risk groups, as well as the challenges they face, and have a strategic role to play in local health planning.

4. Integration of faith into the personalised care offer

Faith settings should be integrated into the wider personalised care offer, including social prescribing. This would take place through establishing two-way relationships with link workers and other allied professionals as a means of referral and signposting.

More broadly, faith should be considered as a core part of what constitutes “personalised care” for people of faith, impacting areas such as end of life and start of life/maternity care, as well as mental health.

5. Practical partnership to address inequality

Faith centres, such as Mosques, Churches and Gurdwaras, can be used for faith/health partnership working through inviting health professionals into these spaces. For example,

midwives could attend mother and baby groups in churches and mosques for advice sessions, as well as faith-hosted antenatal classes. Hosting health interventions in trusted spaces can improve the uptake and efficacy of these interventions.

The distinction between "faith-based" and "faith-placed" interventions may prove helpful, with the term "Faith-based" encompassing those initiatives which are co-produced with or owned by faith communities themselves, and "faith-placed" referring to health interventions co-located in faith settings.

6. Adoption of Faith Covenant framework

The Faith Covenant could be considered as a framework for encouraging co-production with FBOs and communities at system or place level. ICBs might consider how existing Faith Covenants can be incorporated within integrated care strategies.

- *The Faith Covenant was developed by the All-Party Parliamentary Group for Faith and Society to enable effective partnership working between local authorities (and other commissioners) and faith groups. It entails a joint set of principles agreed to by the local authority and faith groups across a region. It has been signed by 13 local authorities to date, with strategic projects undertaken on issues such as homelessness, loneliness and isolation and public health messaging. The county-wide Essex Faith Covenant, for example, is currently delivering a project with a range of statutory and VCFSE partners looking at how FBOs can be better integrated into social prescribing. Find out more at www.faithandsociety.org/covenant*

7. Collection and publication of data

NHS organisations within acute and primary care should routinely collect and publish data on ethnicity, occupation, and faith across all clinical data and death certification, to form a better understand of inequalities faced by particular groups, and how to address them.

VCFSE organisations should be involved in conversations around data and should be resourced and upskilled to gather data and evidence outcomes.

8. Improved faith literacy for workforce

Pursue better faith/cultural literacy amongst all clinicians to understand the interplay between faith/culture as well as intra-faith cultural differences and faith-informed care.

- NHS staff across ICSs, acute trusts and PCNs should undertake training on faith and belief. Resources are available to help navigate the faith calendar, for example, as well as things like food and clothing requirements.
- In line with the Equality Act NHS workforce should be educated and empowered to ask about faith and spiritual care within wholistic assessments, and actively consider faith-based perspectives within wholistic care.

Get in touch: info@faithaction.net