MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT
ADULTS AND OLDER PEOPLE

CHAPTER: Wider Determinants of Health

TOPIC: Faith and Health

WHY IS THIS TOPIC IMPORTANT?

An understanding of faith-based beliefs forms part of a more holistic approach to healthcare that considers the social, communal and spiritual dimensions of wellbeing as well as a person's physical and mental health. Religious and spiritual beliefs and practices are important in the lives of many patients and these beliefs and practices can be a major influence on their ethical outlook and can inform their health-related attitudes and behaviours. Health and care services should be sensitive to the spiritual or faith practises of individual patients and their families in order to ensure patient centred care. Faith-based groups are also actively engaged in delivering and supporting community health and health-care activities and services.

Definitions and classification

It is estimated that 84% of world's population is religiously affiliated. However, the size and complexity of faith groups presents substantial terminological and classification difficulties. Various attempts have been made to classify faith-related entities (sometimes referred to as 'faith-inspired' or, more commonly, 'faith-based' organisations) but, at present, no agreed convention exists. The term "faith community" can refer to a single group of regular congregants focused around a meeting place, a religious denomination or a collective term for people who profess varying beliefs and practices but are linked by a common identification as believers.

The Lancet series on faith-based health care uses the term 'faith-based groups' to include "entities that are self-defined by common religiously informed profession (faith) and practice (ethics or worship), their leaders and congregational infrastructures, and faith-linked health-care providers and non-governmental organisations."

Religion and health outcomes

A recent longitudinal study (Millard et al., 2015) looked at differences in mortality between people with different 'protected characteristics', including religion, in Scotland. It concluded that both males and females who reported that they were raised as Roman Catholic had generally higher mortality than other groups, although the estimates for 'Other religion' and 'Other Christian' were less precise. This may be linked to the fact that those raised as Roman Catholic were more likely to live in deprived areas, whilst those raised as Church of Scotland or as 'other Christian' were less likely to do so. For a similar reason, individuals who reported having 'no religion' also had higher mortality.

Fenelon et al. (2016) explored pooled samples from the General Social Survey to look at the relationship between religious disaffiliation and health and well-being. They found that religious disaffiliates, i.e. people who have left the religious tradition in which they were raised for no religious affiliation in adulthood, experience poorer health and lower well-being than those consistently affiliated and those who are consistently unaffiliated. These results point to the importance of the social processes surrounding religious disaffiliation and the dynamic relationship between religious affiliation and health.

A systematic literature review of the evidence in respect of the association between religion, spirituality and clinical outcomes in HIV-infected individuals (Doolittle, et al.

2016) evaluated 614 English language articles published between 1980 and 2016. Ten out of the fifteen studies which met the inclusion criteria reported a positive association between religion or spirituality and a clinical HIV outcome. The authors conclude that recognizing the religious or spiritual commitments of patients may serve as an important component of patient care for HIV-infected individuals, although they note that further research is required in order to clarify further the potential impact of religion and spirituality on HIV clinical outcomes.

Religion and mental wellbeing

There is a body of published evidence around religion and mental wellbeing which points towards a positive association between religion and spirituality and better health and psychological wellbeing (Puchalski, 2001; Koenig, 2004; Pargament et al., 2004).

A systematic review and meta-analysis of randomized controlled clinical trials designed to assess the impact of religious/spiritual interventions (RSI) in mental health care (Goncalves et al. 2015) identified a number of studies showing that RSI decreased stress, alcoholism and depression, although it pointed to the need for further studies evaluating the use of religiosity/spirituality as a complementary treatment in health care. A further systematic review based on 41 observational clinical studies (Anderson et al. 2016) concluded that frequent private prayer is associated with a significant benefit for depression, optimism, coping, and other mental health conditions such as anxiety.

Norko et al. (2017) looked specifically at the literature supporting the protective effect of religious affiliation on suicide rates. The proposed mechanisms for this protective effect include the existence of enhanced social networks and social integration, the degree of religious commitment and the degree to which a particular religion disapproves of suicide. This is supported by research looking at the relationships between religion (identification and group membership) and well-being among older adults (Ysseldyk et al, 2013), which suggests that religious social networks are an especially valuable source of social capital among older adults, supporting well-being directly and by promoting additional group memberships (including those that are non-religious).

End of life care

There is a growing body of literature documenting the positive effects of both religiousness and spirituality on human health, much of it focusing on older people or those who are diagnosed with a life-limiting illness. Research suggests that the religious beliefs and spiritual practices of patients can be powerful factors in coping with serious illnesses, making ethical choices about their treatment options and in decisions about end of life care (Puchalski, 2001; McCormick et al., 2012).

Harrington explored the concept of spirituality and spiritual assessment and described how the positive effects of spirituality can provide a buffer to help people cope with stressors such as those associated with mental illness, care-giving, substance abuse and social disruption resulting from war (Harrington, 2016).

However, It should also been recognised that there may be religious practices or cultural norms associated with some religious groups, such as a rejection of blood transfusions, which may have a significant impact on decisions taken in respect of clinical care and treatment at end of life.

Religion or belief in the workplace and service delivery

In 2015, the Equality and Human Rights Commission published a call for evidence on religion or belief in the workplace and service delivery. The evidence supplied by respondents provided a picture of religion or belief issues in the health sector (especially

hospitals). The biggest issue in relation to health services was whether, and if so when, it was appropriate for health care professionals to express or show their religious views and beliefs to patients or the students under their supervision.

Two main issues arose in relation to social care and social services. The first was similar to the issue in the healthcare sector about when it was acceptable to talk about religious beliefs in the delivery of social care. The second related to the increasing difficulties that faith-based organisations reported that they experienced in obtaining funding for work in the voluntary and community sector.

Hospital Chaplaincy services

Hospital Chaplaincy services play an important role in providing pastoral, emotional, religious and spiritual support to all patients, visitors and staff appropriate to their needs. Nationally, NHS funded chaplains cost an estimated £25m annually, with 916 full and part time posts in 2015. The NHS England Chaplaincy Programme and budget is project managed by the Free Churches Group on behalf of NHS England and assurance monitored through a Grant-based Service Level Agreement. The Department of Health and NHS England is not involved in directly commissioning local chaplaincy services. Hospital Chaplaincy services exist primarily in an acute care setting and there is a lack of such provision in the community care sector.

The Healthcare Chaplaincy Forum for Pastoral, Spiritual and Religious Care is a new structure which will help to support the strategic development of Healthcare Chaplaincy services in England and provide a forum for consultation for future policy and making recommendations for the development of good practice in Healthcare Chaplaincy.

The College of Health Care Chaplains is a professional organisation for chaplains and pastoral carers of all faith and belief groups. It is open to all recognised healthcare chaplaincy and spiritual care staff and works to promote the professional standing of chaplaincy and to support its members, both nationally and within health and social care organisations. Hospital Chaplains have a particular role in supporting patients and their families in end of life care scenarios. In recognition of this there is also an Association of Hospice and Palliative Care Chaplains (AHPCC). The UK Board of Health Care Chaplains (UKBHC) is another important national professional body that supports the work and training of healthcare chaplains.

Non-religious pastoral and spiritual care

The latest NHS England Chaplaincy Guidelines states that "it is important to note that people who do not hold a particular religious affiliation may still require pastoral support in times of crisis" and defines chaplaincy as "intended to also refer to non-religious pastoral and spiritual care providers who provide care to patients, family and staff". To that end, the guidance requires hospitals in England to consider the needs of non-religious patients by ensuring they have access to appropriate pastoral care.

Many Hospital Chaplaincy services now have a multi-faith focus and provide support for patients, their relatives and NHS staff whether they follow a faith or not. Although some humanists have objected to chaplaincy services being delivered in hospital settings, there has been an increase in recent years of some Chaplaincy Teams taking on either paid or volunteer staff from a humanist background.

Faith-based organisations, public health and social capital

Faith Action - a national network of faith and community-based organisations involved in social action - has summarised the research evidence on the relationship between faith and health and the role of faith communities in improving health and reducing health

inequalities. Their report published in 2014 highlights some of the main ways in which faith groups can have a positive impact on health and wellbeing including:

- support for ethnic groups who face health inequalities or are at greater risk of developing specific health problems
- social action to improve the lives of people who face problems such as poverty or homelessness
- articulating the health needs of their communities

Faith Action has also highlighted the role played by faith-based organisations in helping to keep pressure off hospitals by offering care and support within the local community.

There is also evidence from the literature to show that regular involvement in faith-based voluntary activity is linked with greater health and wellbeing for faith members. A number of studies have shown that regular participation in group spiritual activity is often associated with aspects of wellbeing such as feeling positive, happy, satisfied and useful (Spencer et al 2016). See: www.theosthinktank.co.uk/publications/2016/06/26/religion-and-wellbeing-assessing-the-evidence

THE MANCHESTER PICTURE

Religious affiliation and identification

Prior to the 2001 Census a strong user need for data on religion was identified. To meet that need, a question on this topic was included in both the 2001 and 2011 Censuses. The wording of the question is given below.


20 What is your religion?

This question is voluntary

- No religion
- Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- Buddhist
- Hindu
- Jewish
- Muslim
- Sikh
- Any other religion, write in

Note that the question was designed to capture people's *religious affiliation and identification*, that is, how respondents connect or identify with a religion, irrespective of whether they actively practice it (for example by regularly attending services, or not). If a person had no religion then a tick box could be selected. The inclusion of a write-in option for 'other religions' as part of the question allowed all groups to be recognised, including atheism and humanism.

Prior to the 2011 Census, ONS tested a number of different wordings of the religion question and concluded that religious affiliation was the concept that most closely aligned to the definition of religion in the equalities legislation and also that including the concept of *philosophical belief* within the religion question had a detrimental impact on the quality of the religious affiliation data collected.

The question on religion was treated as a voluntary question in both 2001 and 2011. Where the respondent chose not to answer the question, their response is categorised in the published data as 'not stated'. Despite this being a voluntary question, the response rate for this topic was high at 92.9%. It is ONS' intention that, if selected, this question will remain voluntary in 2021.

It is important to note that there are different denominations or branches within each of the main faith groups identified in the 2011 Census and it should not be assumed that all

members of a particular faith group operate their faith in the same way. This principle applies to all faith groups.

Figures published by the Equality and Human Rights Commission (EHRC) in 2015 as part of their five-yearly review of equality and human rights in Britain ('Is Britain Fairer?') indicate that there were 36.9 million Christians, 266,000 Buddhists, 850,000 Hindus, 275,000 Jewish, 2.9 million Muslims, 444,000 Sikh, 260,000 of 'Other' religion, 16.5 million people of no religion and 4.5 million people who did not state their religion living in Britain at the time of the 2011 Census.

Overall, 68.7% of the population of England and Wales as a whole (around 36.4 million people) identified themselves as being from a religious group in the 2011 Census and 24.7% said that they had no religion. 7.2% of the population chose not to answer the question. In comparison, 67.7% of the population living in Manchester identified themselves as being from a religious group, 25.3% said that they had no religion and 6.9% chose not to answer the question. A full list of the religious groups in Manchester as reported by people responding to the 2011 Census is given in Appendix 1.

Between the 2001 and 2011 censuses, the proportion of the population identifying themselves as Christian fell from 62.4% to 48.7%. Conversely, the proportion not identifying with any religion rose from 16% to 25.3% (an increase of 64,741 residents). The proportion of people identifying themselves as Muslim also rose from 9.1% of the population in 2001 to 15.8% in 2011 (equivalent to an increase of 43,690 residents of Muslim belief).

The proportion of the population identifying themselves as being Muslim or as having no religion increased in every ward in the city between 2001 and 2011. At ward level, the largest changes over this decade were in Cheetham, which saw an increase of over 5,000 Muslim residents, and the City Centre, where the number of residents stating that they had no religion increase by over 6,000. The greatest falls in the number of residents identifying themselves as Christian were in Rusholme (a decrease of just over 1,300 people), Burnage, Moston and Old Moat. The Jewish community remains centred on Crumpsall and, to a lesser degree, Didsbury West wards although, in both wards, the size of the Jewish population has decreased.

Health and wellbeing of faith communities

There is a paucity of reliable local data illustrating the health and wellbeing of individuals from different faith-based groups as well as people with no religion. However, national data summarised by the Equality and Human Rights Commission suggests that people from some faith-based groups in England are more likely to report bad physical or mental health but are less likely to smoke or drink excessively compared with people no religion. Specifically:

- Fewer people with no religion reported very bad health (4.6%), compared with Christians (6.7%) and religious minorities (8.5%) in 2012.
- Fewer people with no religion reported poor mental health (14.2%), compared with Christians (14.7%) and religious minorities (20.0%) in 2012.
- People with no religion were more likely to smoke (22.1%) compared with Christians (16.7%) or people from a religious minority (15.7%), in 2012.
- People with no religion were more likely to consume more than the recommended daily intake for alcohol (41.1%), compared with Christians (32.5%) and religious minorities (9.2%) in 2012.

- A higher percentage of Christians were recorded as being overweight or obese (66.6%), compared with people with no religion (55%). The percentage of religious minorities recorded as being overweight or obese was 56.4% in 2012.

Data from the 2011 Census allows us to look at levels of poor general health and long-term health problems or disabilities among people identifying themselves are being from different religious groups in Manchester (see table below).

	Bad or very bad health	Long-term health problem or disability
All Religions	7.1%	17.8%
Christian	9.0%	22.7%
Buddhist	6.1%	14.0%
Hindu	2.6%	7.1%
Jewish	8.4%	25.7%
Muslim	5.3%	12.7%
Sikh	5.7%	15.0%
Other religion	11.5%	24.0%
No religion	4.2%	10.9%
Religion not stated	9.0%	20.4%

Source: 20011 Census (Table DC3203EW). ONS: Crown Copyright Reserved

This reinforces the information published by the Equality and Human Rights Commission which indicates that people from some faith-based groups are more likely to report bad physical or mental health. In Manchester, people from one of main religions covered in the census question (Christian, Buddhist, Hindu, Jewish, Muslim, Sikh and 'Other') were more likely to report that their general health was 'bad or very bad' and that they had a long-term health problem or disability that limited their day-to-day activities than those who stated that they had no religion (with the Hindu population being the main exception to this rule).

People from Christian and Jewish faiths were the most likely to report having poor general health or a limiting long-term health problem or disability. In both cases, age is likely to be the main explanatory factor. Levels of poor general health and limiting long-term health problems both increase with age and people identifying themselves as having a religion were, generally speaking, older than those who did not, with the Christian and Jewish faiths having the oldest population of all.

Assessment of user requirements on the content of the 2021 Census for England and Wales has concluded that there is a clear user need for data on this topic at local authority level and below in order to enable central and local governments to plan services and policies to help meet requirements under the Equality Act 2010. There was a strong demand for continuity to allow comparison between censuses and therefore ONS intends to ask the same question in the 2021 Census as in the 2011 Census. Final proposals for the 2021 Census questionnaire will be included in the Census White Paper in 2018 before the questions are submitted to Parliament for approval in 2019.

Faith based health and care providers in Manchester

Broadly speaking, faith based health and care providers can be defined as providers who work specifically with, or on behalf, of faith-based groups or who are providers of services for the whole population run by faith-based organisations.

Feedback from the Manchester Health and Care Commissioning (MHCC) Contracts Team confirms that MHCC does not currently hold any contracts with faith-based healthcare providers. However, the former North Manchester CCG, has previously commissioned Jewish and Muslim community health education programmes from organisations such as the Al- Hilal Community Project.

Looking more broadly at the care home sector, records show that there are currently (July 2018) 76 care homes contracted to Manchester City Council, of which 25 are nursing homes. Of these, four (5.3%) are faith based establishments. The quality of care in these homes is monitored by the Care Quality Commission (CQC) in the same away as non-faith based providers. The current CQC rating for each home, along with a link to the latest inspection report is given in the table below.

Name	Specialisms/services	CQC overall rating (and link)
St Joseph's Nursing Home (Roman Catholic)	Adults aged over 65 years who require nursing or personal care for disease, disorder or injury.	Good http://www.cqc.org.uk/location/1-131623904
St Euphrasia's Care Home (Roman Catholic)	Adults aged over 65 years who require nursing or personal care.	Good http://www.cqc.org.uk/location/1-2542394334
St Mary's Nursing Home (Roman Catholic)	Adults (aged under or over 65 years) who require nursing or personal care for dementia, mental health conditions, physical disabilities or sensory impairments.	Not yet inspected http://www.cqc.org.uk/location/1-3745990010
Morris Feinmann Home (Jewish)	Adults aged over 65 years who require nursing or personal care for dementia or physical disabilities for the treatment of disease, disorder or injury.	Not yet inspected http://www.cqc.org.uk/location/1-3924984564

Following the transfer of certain public health functions from the NHS to local authorities on 1 April 2013, local authorities are now responsible for commissioning a range of public health services, including tobacco control and smoking cessation services, alcohol and drug misuse services, public health services for children and young people, NHS Health Check assessments and sexual health services.

In Manchester, the Population Health and Wellbeing Team is responsible for the management and delivery of 251 active contracts. These cover a range of services commissioned from primary care, NHS and non-NHS trusts and other voluntary and community sector organisations. Drug and alcohol services are covered by the Tier 4 Framework - a Greater Manchester Framework covering Drug and Alcohol Detoxification and Rehabilitation centres.

At the present time, contract monitoring systems do not record whether a service is contracted to a faith-based provider or not. However, an informal view of current contracts has identified that only the Tier 4 Drug and Alcohol framework has providers

on it who are faith-based. Specifically the framework contains three providers of drugs and alcohol treatment and rehabilitation programmes (Good News Family Care, Kenwood Trust and the Salvation Army) who identify themselves as following Christian values in some shape or form.

Faith-based voluntary sector organisations

The Greater Manchester faith audit identified the existence of a range of faith-based third sector/VCSE organisations providing services in Manchester. The data collected through the audit to date (November 2017) indicate that 28 faith based organisations are currently providing services within the Manchester local authority boundary. These have been grouped under the following five categories:

- Older People's Support
- Health and Well-being
- Children, Family and Young People
- Educational, Legal, Financial and Food Support
- Leisure

The number of organisations offering service within these categories are summarised in the table below. It should be noted that there may be other organisations that are not physically located within the city but which are nevertheless providing services for Manchester residents.

Service type	Number of organisations offering the service
Older People's Support	
Luncheon Clubs	9
Older People's Support Clubs	11
Befriending Services	10
Health and Well-being	
Health and Fitness Services	13
Emotional Support Services	12
Health Advice Services	6
Health Check Services	6
Complementary Health Services	2
Children, Families and Young People	
Children Clubs	13
Play Groups	8
Family Support Groups	7
Mentoring Services	8
Parenting Classes	2
Day Care Services	3
Educational, Legal, Financial and Food Support	
Educational Support Classes	12
Food Bank	17
Financial Counselling Services	6
Cooking Classes	5
Legal Guidance Services	1
Leisure	
Arts and Crafts	8
Outdoor activities	5

The Draft Interim Faith Audit Report incorporates a series of interactive maps which provide more detail as to where in Greater Manchester these services/activities are being offered. The maps also show which other services these groups plan to offer in the near future.

Hospital chaplaincy services in Manchester

The hospital providers in Manchester all employ, or provide access to, chaplains from a range of different faiths who visit the wards on a regular basis and support patients with their clinical treatment and recovery.

Hospital Chaplaincy Services in Manchester

Pennie Acute Hospitals NHS Trust / North Manchester General Hospital Chaplaincy and Spiritual Care Team (http://www.pat.nhs.uk/patients-and-visitors/chaplaincy.htm)

Manchester Royal Infirmary/Royal Manchester Children's Hospital (Manchester Foundation Trust) Chaplaincy and Spiritual Care Team (http://www.cmft.nhs.uk/information-for-patients-visitors-and-carers/chaplaincy-and-spiritual-care)

Wythenshawe Hospital (Manchester Foundation Trust) Chaplaincy Team (https://www.uhsm.nhs.uk/patients/inpatients/chaplaincy/).

Greater Manchester Mental Health Trust Chaplaincy and Spiritual Care service (https://www.gmmh.nhs.uk/chaplaincy-services)

Each hospital site also contains dedicated prayer/quiet spaces (e.g. Christian Chapels and Muslim prayer rooms) and hold regular services of worship. Jewish Shabbat rooms are also available on some hospital sites and special diets are provided for religious and/or cultural reasons.

LIVED EXPERIENCE

As part of their research to build up a picture of needs of different communities in the city, the Faith Network for Manchester produced an online questionnaire. The published report provides some information about people's issues, concerns, needs and gaps in their own words. The focus of the survey was wider than just faith-based communities but, nevertheless, it provides some valuable information on peoples lived experiences in Manchester. The range of concerns was extremely wide, covering health, career, finances, abuse, crime, drugs, racism and discrimination.

Specific quotes in respect of faith and health include:

"It is great to see people of different cultures and faiths living together."

"It's changed a lot in a good way. Manchester mixes nicely between races and religions - one of the best in the world I'd say."

"It is now harder to express and live out your faith than it was 10-30 years ago – the world has gone pc mad."

WHAT WOULD WE LIKE TO ACHIEVE?

The Equality Act 2010 includes 'religion or belief' as one of 9 protected characteristics and provides a legal framework to protect the rights of individuals and advance equality of opportunity for all. The provisions of the Act mean that people are protected from discrimination, harassment or victimisation linked to their religion or belief and that it is unlawful to discriminate against people because of their religion or belief in relation to the provision of goods and services, employment or vocational training in either the public or private sector. In addition, the public sector Equality Duty means that public bodies have to consider all individuals when carrying out their day-to-day work.

The existing research points towards a number of ways in which faith based groups can support Manchester Health and Care Commissioning (MHCC) and its partners to achieve their strategic objectives in respect of improving the health and wellbeing of people in Manchester, strengthening the social determinants of health and promoting healthy lifestyles, enabling people and communities to be active partners in their health and wellbeing and achieving a more sustainable heath and care system.

A Local Government Association report, published in association with the Faith Action Network, looked at how local authorities and faith groups can work together to improve the health and wellbeing outcomes of communities and highlighted examples of good practice from across the country, and from different faiths, to demonstrate the wide range of activity taking place. The report highlighted the benefits of joint working for councils, health organisations and faith groups, the barriers to collaboration and what local authorities can do to make sure the widest range of groups are involved. It also looked at ways of establishing effective partnerships and activities, including through adopting the national Faith Covenant.

Health and care organisations can proactively support and promote the contribution that faith-based groups make to the social, environmental, physical and spiritual health of their local communities. In particular, faith-based organisations often engage in a range of activities which have an impact on the social determinants of health. Denominational and faith-based groups also form part of a wider network of local assets which support work at a grassroots level to help build up the capacity of individuals and groups to manage their own health and improve the health and wellbeing of their local communities.

Faith-related buildings, such as churches and mosques, are important physical assets and can act as a 'hub' for local support groups and other community-based activities.

Case Study: Pre-Ramadan and Diabetes Awareness Campaign

In 2014, the Al- Hilal Community Project, working alongside North Manchester CCG, delivered a Pre-Ramadan and Diabetes Awareness Campaign to promote awareness of diabetes and promote safe management of diabetes during Ramadan. The campaign included a "Top tips for safer fasting with diabetes in Ramadan poster" in conjunction with a series of information stalls and health awareness sessions held in four mosques, including the two central Mosques in Cheetham Hill, which at peak times attract at least 2,000 people in their congregation. One of the strengths of the campaign was having local coordination and engagement with faith leaders and mosque committee members.

A crucial element of the campaign was the promotion of NHS Health Checks, which have the potential to identify patients with possible pre-diabetes and newly diagnosed diabetics, as well as those with raised cardiovascular risk. The presence of the

community health bus, combined with events in places of worship, was found to be appreciated by local councillors and residents. Having an NHS Health Check also encouraged residents to take practical steps to ensure that they prepare physically as well as mentally for long periods of fasting.

The "Top tips for safer fasting with diabetes in Ramadan" poster was updated in 2018 and was redistributed city wide in advance of Ramadan. A short top tips film in Arabic, English and Urdu can be viewed by visiting www.mhcc.nhs.uk/resources/.

Health and care organisations can also work with religious leaders to utilise their ability to inspire effective movements for social change and exert a potent influence on health-related attitudes and behaviours which, in turn, can make a substantial contribution to improving health outcomes (e.g. preventable maternal and child mortality). Faith leaders can also play a role in conveying health-affirming messages rather than those perpetuating harmful gender or cultural norms, many of which (like FGM) are not integral to religious beliefs but, rather, are cultural or social norms that have become embedded in the practices of some religious communities. Similarly, faith-based groups can be a vehicle for the delivery of accurate health messages by providing access to evidence based behaviour-change materials and co-produced educational guidelines that are tailored for use by a range of faith-based groups in diverse health settings.

Faith Action has explored the role of faith-based organisations (FBOs) in helping to keep pressure off hospitals through offering care and support within the local community. A report published in 2017 identified seven broad types of provision through which faith-based organisations can help to keep pressure off hospitals:

1. Preventative or 'upstream' support
2. More direct care that prevents people from needing to go to hospital
3. Specialist services that support general health and wellbeing
4. Spiritual care that supports general health and wellbeing
5. Support for transfer from hospital to the community
6. Professional social care
7. Strategic initiatives

In order to help FBOs to improve their work in this area, Faith Action has highlighted the need for better information and connections between different FBOs, between FBOs and the wider voluntary sector and also between FBOs and the health and care system.

Faith Action has also highlighted the role of faith-based organisations and groups in tackling specific public health issues, such as homelessness. A report from 2015 ("What a Difference Faith Makes to Homelessness") showed the dual role of faith-based organisations in homelessness in terms of providing practical frontline support and advocating to influence public and political debate. A series of case studies provide more information on the issues faced by faith-based groups working in this area and the 'faith factor' that influences their work.

WHAT DO WE NEED TO DO TO ACHIEVE THIS?

In line with the public sector Equality Duty, MHCC and its partners need to ensure that issues relating to religion are considered in a rigorous and thorough manner within the Equality Analysis that is produced alongside all business cases and service reviews. In order to ensure that issues relating to religion are routinely considered in this way, health and care organisations in Manchester need to provide staff and partners with the necessary information and advice relating to the needs of religious and faith-based

groups in the city as part of a mandated training programme. It also needs to put processed in place to ensure that the JSNA is reviewed and updated on a regular basis.

There are a number of issues and challenges that may need to be addressed when considering the impact and role of faith and faith-based groups on health and wellbeing. In particular, there can sometimes be a 'clash' between faith and medicine. For example some faiths may see sickness as a punishment or cleansing of sins. There may also be harmful health behaviours, attitudes or cultural practices prevalent among members of faith based communities and their leaders e.g. the use of holy water leading to people stopping their prescribed medication.

In relation to health and care service, there may be issues that need to be addressed in respect of the lack of engagement with services among some faith groups, particularly immunisation and screening programmes, cultural issues impacting on frontline delivery, the quality of faith based health and care providers and perceived discrimination against some faith groups amongst mainstream health and care providers.

It is also important to ensure that considerations of faith are incorporated in clinical practice and service delivery, particularly in primary care which represents the predominant point of contact with the NHS for most people. Examples of this include:

- Prescribing: Many medicines contain excipients (e.g. animal derived elements or alcohol etc.) that may negatively impact the concordance of patients to treatment prescribed. It is important to ensure that vegan, kosher and halal options of medication are listed within formularies despite the additional cost associated with offering these alternatives.
- Quality and safety: Religious practices, such as fasting, can lead to problems with the safety of medication and can cause problems such as acute kidney injury and hypoglycaemia (as patients take medication and then move in to a fasting state).
- Service delivery: Ensuring that appointments and waiting list initiatives take account of patients' faith obligations e.g. making sure that appointments are not booked for certain times on Fridays, Saturdays and Sundays.

Different religious beliefs and rituals should be considered at all stages of life but also at death. The human body is sacred to some religions and therefore a post mortem is unacceptable. There are also different religious practices which professionals need to be aware of, such as cleaning of the body, not leaving the body alone and ensuring that a burial takes place as shortly after the date of death as possible. With that in mind, post mortems should be restricted to cases where MRI scanning cannot achieve required results. Health and care providers also need to ensure that multi-faith chaplaincy services are in place and are actively involved in the whole of the end of life pathway - not just those elements that are hospital based. GPs, primary care professionals and care home staff should be knowledgeable of these different religious needs and their role in identifying and supporting them.

Health and social care professionals are often uncertain about whether, when, or how, to address spiritual or religious issues. Traditionally, physicians and other professionals have been trained to diagnose and treat disease and have had little or no training in how to relate to the spiritual side of the patient. Professional ethics also require physicians to not impinge their beliefs on patients who are particularly vulnerable at the time when they are seeking health care.

In May 2016, Faith Network for Manchester (FN4M) published a report summarising the results of a piece of research which sought to build up a picture of the needs of different communities in Manchester, describe people's views on the City's changing population

and develop an understanding of the issues that impact on different groups, including why BME women do or do not access specialist services. This report is based on the responses of 312 people in 2015 to a questionnaire produced by a partnership of the Faith Network for Manchester (FN4M), Women's Solidarity Forum (WSF) and Saheli.

More information access to services among people from different BME communities is contained in the JSNA Topic Report on Black and minority ethnic (BAME) communities.

The report contained a series of recommendations regarding the role of faith groups in undertaking community work to support people with both their physical and mental health, for example by developing befriending, mentoring and counselling projects to address mental health as well as the specific provision of services to support people into employment through skills development and access to work opportunities. The report also recommended that faith-based groups should explore social enterprise opportunities in housing projects for asylum seekers or others in need, in conjunction with Housing Associations and other housing providers.

A Faith Action report on the impact of faith-based organisations on public health and social capital contains recommendations setting out how faith-based organisations and public health bodies might work effectively in partnership to realise the potential for faith groups of improving health and wellbeing.

As part of the Greater Manchester Faith Audit, a number of consultation meetings and other forms of dialogue with leaders and representatives from a range of faith communities took place. This identified some of the barriers faced by organisations working to meet the health and social needs of the diverse range of individuals from the varying faith denominations. The most cited barriers were:

- Lack of funding to start or sustain what is already in place e.g. overheads, heating, materials etc.
- Under resourcing in terms of staffing to sustain already offered services/activities or to capacity build for the future
- Lack of appropriate skill mix of individuals to support and share expertise
- Lack of training funds to upskill current volunteers
- Lack of access to trained volunteers in order to sustain quality of services
- Lack of premises or access to premises to deliver activities on a regular basis rather than spending money on renting accommodation
- Lack of renovation funding to repair existing building/faith venues currently in use and thereby sustain current provision

Monitoring changes to the size, characteristics and distribution of religious groups in Manchester and of people's affiliation and identification with these groups remains a challenge. The 2021 Census will provide an opportunity to look at changes over the past decade but the quality of this data will be dependent upon achieving a good response rate to the Census. MHCC needs to work closely with Manchester City Council and the Office for National Statistics (ONS) in order to raise awareness of the Census among the faith-based organisations it works with in order to maximise response rates to this question in the city.

WHAT ARE WE CURRENTLY DOING?

Many medicines contain excipients (e.g. animal derived elements or alcohol etc.) that are prohibited to some faith groups and may negatively impact the concordance of patients from these faith groups to treatment prescribed. Manchester Health and Care

Commissioning (MHCC) has issued a reminder to prescribers regarding the importance of considering excipients in medicines and has emphasised the fact that prescribers should take the 'needs and wishes' of patients into consideration when prescribing medications. A full and comprehensive list of excipients in medicines can be found on the Summary of Product Characteristics website.

The former North Manchester CCG was involved in a number of pieces of work that focused on the needs of patients from faith groups in the North of the city.

- In 2014, the Al- Hilal Community Project, working alongside North Manchester CCG, delivered a Pre-Ramadan and Diabetes Awareness Campaign to promote awareness of diabetes and promote safe management of diabetes during Ramadan (see case study above). The timeliness of the delivering these messages was crucial to ensuring that clients would have sufficient time to meet with their clinician and safely prepare to fast or not to fast in Ramadan. GPs and diabetes specialist nurses were on hand at the main events to provide advice to individuals seeking advice about fasting and diabetes, as well as general advice about NHS health checks.
- A further Diabetes Awareness Ramadan Campaign was delivered in 2016 by Communities for All. This included a series of awareness presentations with an emphasis on healthy eating, together with clinically-led Safer Ramadan education sessions, Imams-led announcements at Friday prayers, a media campaign to raise awareness of healthy eating and safer fasting in Ramadan and the development of a booklet with 50 'top tips' for safer fasting during Ramadan. Events were held at primary schools, supplementary school, as well as women and men only events and mixed sessions.
- Local clinical guidelines were also developed by the Diabetes lead for North Manchester CCG in order to assist clinicians and their patients to fast safely where possible and overcome the dilemmas patients often face during the month of Ramadan. A Safer Fasting with Diabetes during Ramadan poster was also produced alongside short films in English, Arabic and Urdu. These can be viewed at https://www.mhcc.nhs.uk/publications/resources/.
- The North Manchester Health Fair in April 2017 took place in the Khizra Mosque in Cheetham Hill. The Health Fair included information stalls on a range of health issues, free health checks for cholesterol, glucose and blood pressure and free advice from GPs, dentists, pharmacists, nurses and specialist doctors on healthy diet and living healthily.

The North Manchester Macmillan Palliative Care Support Service pilot, which ran from April 2015 to November 2016, worked closely with the Spiritual Care Team at North Manchester General Hospital. As part of this pilot, the Spiritual Care Team agreed to 'follow' and 'reach out' to patients in the community and cared for by the palliative care team. The lead Chaplin is also a member of the multi-disciplinary team in the hospital (North Manchester) and, as such, supports patients and inputs to the plan of care. The spiritual care team also support members of the palliative care team following difficult deaths by offering 1:1 support. The pilot had a significantly positive impact, not only in terms of social, spiritual and psychological support for patients and their families, but also for clinical staff working with these people through improved flow of information, and the Team supporting and reinforcing clinical, and other, advice.

The Greater Manchester Healthcare Chaplaincy Collaborative - a group of healthcare chaplains across the Manchester area - are exploring how chaplaincy might have a more community focus. For example, in Tameside, a chaplain is working closely with a

GP practice in Denton to provide pastoral support within a local surgery setting, (see https://cofemanchester.contentfiles.net/media/documents/document/2018/04/crux_April2018_Web.pdf for more details).

Evidence highlights the ability of faith-based groups to facilitate access to hard-to-reach and marginalised populations, such as vulnerable migrant groups, refugees and asylum seekers.

Case Study: Equitable Access to Primary Care for Vulnerable Migrants

The Surrey Lodge Group Practice in Rusholme, Manchester works with the Medaille Trust to improve vulnerable migrants' experience of primary care. The Medaille Trust is a charity founded by groups of religious congregations in 2006 to work against "the evils of human trafficking" and is a significant provider of support and safe house provision for the victims of human trafficking.

By working with the Medaille Trust, the Practice is able to:

- ensure that, where possible, patients are given a nominated GP as they often find it difficult to engage with new people
- provide a much longer GP appointment of up to 45 minutes
- identify a nominated care worker/link manager as well as an interpreter as they very often find it difficult to engage and keep appointments
- recognise patients have complex medical history (in terms of both physical and mental health)
- acknowledge the patient can often come across as "hostile" although this is very often a language barrier or related to previous traumatic events
- use the practice address to ensure continuity of care

Links with faith-based organisations such as the Medaille Trust can help GP practices to ensure that the patient and their support workers receive continuity of care, particularly where the needs of patients are very complex and require time, compassion and understanding.

Faith Network for Manchester (FN4M) is Manchester's interfaith and multi-faith network. Its aims are to bring together people of different faiths across the city to speak to issues of regeneration, act as a means of communication between faith groups, be a resource to address issues of common concern, and represent the voice of faith in the life of the city, especially to public bodies. The Faith Network for Manchester is also part of the Greater Manchester Faith Leaders Forum, chaired by the Bishop of Manchester.

At Greater Manchester level, work is underway to support collaborative working between the Health and Social Care Partnership and the faith sector. For example, a faith audit has been undertaken by the Caribbean and African Health Network (CAHN GM) and the Critical Race and Ethnicity Research Cluster at Manchester Metropolitan University on behalf of the Greater Manchester Health and Social Care Partnership. The work sought to map existing health, well-being and advisory services provided by faith based organisations within Greater Manchester region and arrive at a better understanding of what faith organisations are already doing to address some of the health, social and well-being issues across the conurbation.

The Draft Interim Report of the faith audit was published in November 2017. Using an online survey, the audit captured the community service activities of 85 faith-based organisations. The audit reveals that faith communities across Greater Manchester offer

a range of community activities and services such as food banks, luncheon clubs, befriending services, play groups, day care, health and fitness sessions, parenting classes, educational support classes, emotional and mental health support, family support, mentoring, children clubs, older people support groups, financial counselling, cooking classes, complementary therapies, health checks and advice sessions, legal guidance, physical and outdoor activities and arts and crafts.

Mental health is a key issue across faith communities and the range of support from faith-based organisations is often not recognised. For example, befriending, counselling, mentoring and many other projects are run by churches, mosques, temples, synagogues and other charities. A series of conferences on Faith in Mental Health and the Voluntary Sector (held in September 2016 and November 2017) provided participants with an opportunity to discuss a range of issues in respect of the role of the faith sector in health and wellbeing and how these issues might be tackled. They also provided patients, carers and faith organisations with an opportunity to engage with health and social care professionals in order to share experiences, knowledge and expertise.

The key output from this work will be a Physical and Mental Wellbeing Memorandum of Understanding (MoU) between faith groups across Greater Manchester and the Health and Social Care Partnership. The aim is that this will result in closer partnership working and, ultimately, improve holistic support for people's physical and mental wellbeing.

OPPORTUNITIES FOR ACTION

Clinical practice and patient care

- Practitioners should be mindful when offering invasive testing (e.g. some mothers may decline ante-natal testing such as amniocentesis; some patients may decline blood or tissue sample testing)
- Provide medicines management/optimisation support to prescribers to ensure that drug formularies do not discriminate against any faith groupings e.g. by ensuring the availability of excipients (including immunisations) that are Halal; Kosher; Vegan and by not limiting prescribing of incontinence pads that may restrict religious observance etc.
- Ensure that all patients have access to evidence-based spiritual therapy where appropriate (e.g. religiously integrated cognitive behaviour therapy) and that patients experiencing a mental health crisis are able to access spiritual care.
- Ensure that care pathways and packages of care provide access to spiritual care advice and support services, including those offered by religiously affiliated groups, where required e.g. patients making life changing decisions about their health and care or those who are housebound etc.
- End of life care services should ensure timely access to spiritual care services (e.g. for patients in the last moments of life and parents who suffer the death of a child etc.)
- Ensure that clinical services are delivered in line with the religious practises of the patient, for example, by maintaining sanctity of the deceased (e.g. some faiths observe burial as soon as possible after death) and ensuring that human tissue removed during surgical procedures is disposed of in an appropriate manner, if it is safe to do so.

Service delivery

- Ensure care facilities support individual choice through provision of Halal, Kosher and Vegan meals etc.
- Ensure care settings and carers are sensitive to needs of individuals from faith communities, for example, by providing facilities that allow the independent performing of ablution or carer assisted ablution
- Ensure that opening times and appointment scheduling reflect religious practices (e.g. times of worship) and avoid religious holidays for non-urgent interventions if possible.
- Consider health promotion and prevention opportunities with faith based groups and in faith related premises e.g. Mosques, community centres etc.
- Ensure that up-to-date information on faith-based groups in Manchester and the services they provide (as captured in the GM Faith Audit) is made available as part of the 'asset map' of local groups and community organisations
- Build on the work being undertaken by the Greater Manchester Healthcare Chaplaincy Collaborative to investigate opportunities for exploring how hospital chaplaincy services in Manchester might have a more community focus.

Commissioning

- Ensure that commissioning plans and policies differentiate between religious and cultural practises that are legal (e.g. male circumcision) and those that are illegal (e.g. female genital mutilation).
- Ensure that religion and faith are considered adequately as part of the Equality Analysis process.
- Review and amend contract monitoring systems to ensure that they record whether a service is contracted to a faith-based provider or not
- Use commissioning of faith based services as a vehicle for building social, economic and physical capital for marginalised faith communities to develop sustainable health and care initiatives.
- Work with faith-based groups and providers of services to ensure that robust performance and evaluation processes are in place in order to generate evidence of the impact of work with faith-based groups and providers on patient/user satisfaction, access to services and patient outcomes.
- Engage with the work currently going on across Greater Manchester to develop a Memorandum of Understanding (MoU) between faith-based groups and the GM Health and Social Care Partnership via the Faith Network for Manchester

Workforce

- Ensure that training and continuing professional development (CPD) activities for doctors, nurses, social workers, other clinical groups and allied health and care professionals include faith-based issues alongside a consideration of how religious and spiritual factors may help the patient cope with their current illness or long term condition (or that of the person they care for).
- Ensure that health and care staff have access to Religious Awareness Training that is appropriate to their role in order to embed respect for patient values and

beliefs and foster patient centred communication that is cognisant and respectful of patients' cultural and spiritual values as part of optimal patient care.

- All health and social care staff should have access to spiritual advice and support where required

Communications and engagement

- Strengthen partnership working between public sector organisations and faith based groups and health and care providers as represented by the Faith Network for Manchester.
- Work directly with faith based groups to improve access to people from hard to reach or hidden communities in Manchester,
- Work closely with faith-based groups to raise awareness of the 2021 Census in order to maximise response rates and increase the value of Census data.
- Work with leaders of faith based group to address cultural practices that may be harmful or run contrary to best practice

REFERENCES AND LINKS

Anderson, J., Nunnelley, P. (2016) Private prayer associations with depression, anxiety and other health conditions: an analytical review of clinical studies, Postgraduate Medicine, 128:7, 635-641, https://doi.org/10.1080/00325481.2016.1209962

Bruce, F., Clennon, O.D., Miller, E. & Roberts, L. (2017). A Draft Interim Faith Audit Report to map existing health provision, well-being and advisory services provided by faith-based organisations within the Greater Manchester region. Manchester: Manchester Metropolitan University. https://doi.org/10.13140/RG.2.2.13863.85921/2

Doolittle, B. R., Justice, A. C., & Fiellin, D. A. (2016) Religion, Spirituality, and HIV Clinical Outcomes: A Systematic Review of the Literature. Aids and Behaviour https://doi.org/10.1007/s10461-016-1651-z

Equality and Human Rights Commission (2015). Is Britain Fairer? The state of equality and human rights 2015. https://www.equalityhumanrights.com/en/publication-download/britain-fairer-2015

Equality and Human Rights Commission (2015). Religion or belief in the workplace and service delivery. Findings from a call for evidence. https://www.equalityhumanrights.com/sites/default/files/rob_call_for_evidence_report.pdf

Faith Action (2014). The impact of faith-based organisations on public health and social capital. http://www.faithaction.net/wp-content/uploads/2014/09/FaithAction-Public-Health-Report.pdf

Faith Action (2015). What a Difference Faith Makes to Homelessness. http://www.faithaction.net/portal/our-projects/homelessness/.

Faith Action (2017). Keeping pressure off hospitals. Exploring the care and support offered by faith-based organisations within the local community. http://www.faithaction.net/resources/get/download-id/12861/

Fenelon, A., Danielsen, S. (2016) Leaving my religion: Understanding the relationship between religious disaffiliation, health, and well-being. Social Science Research; Vol. 57; 49-62. http://dx.doi.org/10.1016/j.ssresearch.2016.01.007

Goncalves JP. (2015) Religious and spiritual interventions in mental health care: a systematic review and meta-analysis of randomized controlled clinical trials. Psychol Med. (14):2937-49. https://doi.org/10.1017/S0033291715001166

The Guardian “Are hospital chaplains a waste of NHS money?” Tuesday 4 April 2017 https://www.theguardian.com/healthcare-network/2017/apr/04/hospital-chaplains-nhs-waste-taxpayers-money

Harrington, A. (2016) The importance of spiritual assessment when caring for older adults. Ageing and Society, 36(1), pp.1-16. http://journals.cambridge.org/action/displayJournal?jid=ASO

Koenig HG. (2004) Religion, Spirituality, and Medicine: Research Findings and Implications for Clinical Practice. Departments of Psychiatry and Medicine, Duke University Medical Centre. Southern Medical Association, Volume 97, Number 12, 2004:1194-1199.

Lancet series on faith-based health care Vol 386 October 31 2015 (Published Online July 7 2015) https://www.thelancet.com/series/faith-based-health-care

Local Government Association (2014). Working with faith groups to promote health and wellbeing. https://www.local.gov.uk/sites/default/files/documents/working-faith-groups-prom-6ff.pdf

McCormick TR, Hopp F, Nelson-Becker H, Ai A, Schlueter JO, Camp JK. (2012) Ethical and Spiritual Concerns Near the End of Life. Journal of Religion, Spirituality and Aging, 301-313.

Millard, AD., Raab, G., Lewsey, J., Eaglesham, P., Craig, P., Ralston, K.,

McCartney, G. (2015) Mortality differences and inequalities within and between 'protected characteristics' groups, in a Scottish Cohort 1991-2009. Int J Equity Health. 14:142. https://doi.org/10.1186/s12939-015-0274-8.

NHS England (2005). NHS Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual and Religious Care. https://www.england.nhs.uk/wp-content/uploads/2015/03/nhs-chaplaincy-guidelines-2015.pdf

NHS England (2005). NHS England Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual and Religious Care. Equality Analysis. https://www.england.nhs.uk/wp-content/uploads/2015/03/equality-analysis-nhs-chaplaincy-guidelines-2015.pdf

Norko, M., Freeman, D., Phillips, J., Hunter, W., Lewis, R., Viswanathan, R. (2017) Can Religion Protect Against Suicide? Journal of Nervous and Mental Disease. Vol. 205 (No. 1); p. 9-14. http://dx.doi.org/10.1097/NMD.0000000000000615

Office for National Statistics (ONS). The 2021 Census Assessment of initial user requirements on content for England and Wales: Religion topic report. London: Office for National Statistics, May 2016. https://www.ons.gov.uk/file?uri=/census/censustransformationprogramme/consultations/the2021censusinitialviewoncontentforenglandandwales/topicreport08religion.pdf

Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. (2001) Religious Struggle as a Predictor of Mortality Among Medically Ill Elderly Patients. Archives of Internal Medicine, Vol161, 1881-1885.

Pargament KI, Koenig HG, et al. (2004) Religious Coping Methods as Predictors of Psychological, Physical and Spiritual Outcomes among Medically Ill Elderly Patients: A Two-Year Longitudinal Study. Journal of Health Psychology, 9:713

Puchalski CM. (2001) Spirituality and Health: The Art of Compassionate Medicine. Hospital Physician, 30-36.

Spencer et al. (2016). Religion and wellbeing: assessing the evidence. Theos. www.theosthinktank.co.uk/publications/2016/06/26/religion-and-wellbeing-assessing-the-evidence

Weinberg, J. (2016). Manchester's Services for Minorities: Understanding Needs and Improving Services for Minority Communities in Manchester. Faith Network for Manchester. http://fn4m.org/newsletters/pdf/FN4M%20Manchesters%20Services%20for%20Minority%20Communities%20Report%202016.pdf

Ysseldyk, R., Haslam, S.A., & Haslam, C. (2013) Abide with me: religious group identification among older adults promotes health and well-being by maintaining multiple group memberships. Aging and Mental Health, 17(7), 869-879. http://www.tandfonline.com/loi/camh20#.U5cBy_mwKX8

OTHER RELATED JSNA TOPICS

- Black and minority ethnic (BAME) communities
- Diabetes
- End of Life Care
- Homelessness

Date: July 2018

Appendix 1: Religious groups in Manchester (full list), 2011 Census

Religion	No. of usual residents	% of all usual residents
All categories: Religion	503,127	100.0%
Christian	245,247	48.7%
Buddhist	3,879	0.8%
Hindu	5,452	1.1%
Jewish	2,613	0.5%
Muslim (Islam)	79,496	15.8%
Sikh	2,292	0.5%
Other religion: Total	1,889	0.4%
Other religion: Animism	9	0.0%
Other religion: Baha'i	48	0.0%
Other religion: Believe in God	42	0.0%
Other religion: Chinese Religion	11	0.0%
Other religion: Church of All Religion	6	0.0%
Other religion: Confucianist	5	0.0%
Other religion: Deist	18	0.0%
Other religion: Druid	20	0.0%
Other religion: Eckankar	6	0.0%
Other religion: Heathen	14	0.0%
Other religion: Jain	129	0.0%
Other religion: Mixed Religion	130	0.0%
Other religion: Mysticism	3	0.0%
Other religion: New Age	2	0.0%
Other religion: Occult	11	0.0%
Other religion: Own Belief System	19	0.0%
Other religion: Pagan	378	0.1%
Other religion: Pantheism	24	0.0%
Other religion: Rastafarian	123	0.0%
Other religion: Ravidassia	17	0.0%
Other religion: Satanism	26	0.0%
Other religion: Scientology	52	0.0%
Other religion: Shamanism	2	0.0%
Other religion: Shintoism	10	0.0%
Other religion: Spiritual	145	0.0%
Other religion: Spiritualist	191	0.0%
Other religion: Taoist	64	0.0%
Other religion: Theism	13	0.0%
Other religion: Thelemite	4	0.0%
Other religion: Traditional African Religion	12	0.0%
Other religion: Unification Church	2	0.0%
Other religion: Universalist	12	0.0%
Other religion: Vodun	6	0.0%
Other religion: Wicca	86	0.0%
Other religion: Witchcraft	10	0.0%

Other religion: Zoroastrian	58	0.0%
Other religion: Other religions	181	0.0%
No religion: Total	127,485	25.3%
No religion: No religion	124,331	24.7%
No religion: Agnostic	422	0.1%
No religion: Atheist	480	0.1%
No religion: Free Thinker	3	0.0%
No religion: Heavy Metal	150	0.0%
No religion: Humanist	149	0.0%
No religion: Jedi Knight	1,946	0.4%
No religion: Realist	4	0.0%
Religion not stated	34,774	6.9%

Source: 2011 Census (Table QS210EW) ONS Crown Copyright Reserved.