Bradford Teaching Hospitals
NHS Foundation Trust

The Bradford Model for Integrated and Inclusive Spiritual, Pastoral and Religious Care (SPaRC)

'With you, for you'

23 September 2021

Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)

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SPaRC
with you,
for you

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In recognition of their ideas and critiques; for their generosity in sharing their practice and for engaging with the process of articulating the Bradford Model together.

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With thanks to the following peer reviewers:

For their encouragement and critical comments that helped to refine and improve the preliminary draft.

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'Most health and social care users are not Christians, spiritual care for all, rather than religious care for a few, prevails, chaplains are employed by and accountable to public institutions rather than sending churches, and the whole health and care system is re-orienting itself towards patient empowerment, community prevention, promoting wellbeing, identifying individual and social assets, resilience, all against a background of financial austerity and the quest for ever-greater effectiveness and efficiency.'

Stephen Pattison. Forward to *Chaplaincy and the Soul of Health and Social Care, Fostering Spiritual Wellbeing in Emerging Paradigms of Care.* Edited by Ewan Kelly and John Swinton. 2020.

'NHS Employers has been privileged …… 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.'

Paul Deemer, Head of Diversity and Inclusion, NHS Employers. Forward to *Fit for the Twenty-First Century, The State of Inclusion for Acute NHS Chaplaincy Spiritual, Pastoral and Religious Care Services in England*. Published by the Network for Spiritual, Pastoral and Religious Care in Health. 2020

'In the end chaplaincy …. needs a public legitimacy firmly grounded in its response to diversity and in the ability to respond both with professional openness to human questions of meaning and identity, however they are expressed, and to the particular needs presented by the practices of identified faith and belief traditions.'

Andrew Todd, Responding to diversity: chaplaincy in a multifaith context.' In Being a Chaplain by Miranda Threlfall-Holmes and Mark Newitt 2011

'Most people recognize the deep humanity of both those in need and those who provide pastoral care, be they people with religious beliefs or people with non-religious beliefs. In either case, it is right that everyone should have the same opportunity to receive the like-minded care they need and, just as importantly, an equal opportunity to provide that care.'

Inclusivity in UK Pastoral, Spiritual, and Religious Care: A Humanist Perspective David Savage, HSCC 9.1 (2021) 11–26] https://doi.org/10.1558/hscc.40124 Equinox Publishing Ltd 2021

Forward

As part of the Trust's commitment to equality, diversity and inclusion, there has been a recognition of the responsibility to provide pastoral, spiritual and religious services to all. Muslim chaplains brought valuable new skills and perspectives to the service, followed by Sikh and Hindu chaplains who ensured that the team became richer and more representative in its inclusion of different belief groups. In 2020 there was a recognition that there was another population who need to be more consciously included in services; the third biggest belief group in Bradford of the non-religious. The appointment of a Humanist to the team generated dialogue and discussions which led to the articulation of the Bradford Model for Spiritual, Pastoral and Religious Care (SPaRC). This was a collaborative, iterative and consultative process where the wisdom and practice of the SPaRC team, included the unprecedented times of the pandemic, was harnessed and consolidated. The non-religious voice was properly represented and more deeply understood as not being about an absence of any belief, not being anti-religious, but rather being about adding value through its alternative beliefs and world views.

The Bradford Model is not a self-satisfied document about a current state of play; it is a starting point and sets an ambitious course. It takes a while to bring about change and make a difference and BTHFT is at the start of this journey. The Bradford Model sets a course for an inclusive and integrated service that has equality and person-centred care at its root. Religion is still part of the service, of course, for those who want or need it, but experience tells us that most of the work of the SPaRC team is not religious in nature. The intention is always to start from a point of common humanity and be led by the needs of the patient or member of staff to the conversations and interactions that are helpful to them. Our SPaRC team are all highly intuitive, non-judgemental and kind people who can provide a listening ear and a calmness at times when lives are disrupted or challenging. They work across beliefs which means that they are comfortable, knowledgeable and respectful of the range of beliefs they encounter and ready to respond on an individual basis, or to refer specific requests to their colleagues. They are a key part of our service at BTHFT and we are very proud of the work that they do.

The SPaRC team sits within the portfolio of Patient Experience and therefore can be scrutinised for its contribution to improving care. Due to the responsive and confidential nature of the work, SPaRC services can be difficult to monitor and evaluate. The Bradford Model offers a set of realistic and relevant service standards by which the service can be measured. There is ground to be gained in gathering data and evidence of impact, but now we have useful standards by which to gather data, plan and review our service in BTHFT.

The SPaRC team are to be commended on developing this model through their cross-belief ethos - their voices and ideas are evident in the way the Model takes care to find common ground and shared ways of working. Many thanks to the peer reviewers and colleagues who have taken part in its evolution, and to the Hospital Charity who funded the six-month Humanist post that created the impetus to generate the Model. The senior executive team are united in backing the Model, committed to its implementation, and will be monitoring progress closely.

Karen Dawber, Chief Nurse
Bradford Teaching Hospitals NHS Foundation Trust

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Summary

The Bradford Model proposes a new and refreshing cross-belief model for Spiritual, Pastoral and Religious Care (SPaRC), historically known as Chaplaincy, that is rooted in the reality of demographic trends and a firm commitment to equality. It puts to bed the commonly held view that you only call the chaplain (renamed in the Bradford Model as the SPaRC Practitioner) when there is a death, embracing instead the concept of a more proactive, integrated and holistic role.

The Bradford Model is described by the seven Anchors that secure SPaRC into the organisation. These seven Anchors are fixed points that maintain position and ensure stability but leave scope for change and choice. The model needs to be able to diversify, adapt and innovate, but the Anchors remain the same. The Bradford Model opens up the concept of SPaRC and makes transparent the intentions and values of the SPaRC team at Bradford Teaching Hospitals Foundation Trust (BTHFT). It offers relevant and inclusive service standards that can be used for evidence-gathering for service planning and review.

The Bradford Model has evolved from the lived experience of diversity, responsive to a range of beliefs and with the diverse representation in its team promoting an inclusive approach. The Bradford Model places collaboration at the centre of its practice, encouraging a joined-up approach in patient-centred care, cooperation with other services for staff wellbeing and connections with the community to ensure better outcomes.

The Bradford Model is dynamic and responsive but it is also ambitious. It advocates for spiritual wellbeing being an essential part of person-centred, holistic care; it describes intention and aspiration rather than a goal reached. It anticipates the adaptation of SPaRC services to inevitable changes in acute healthcare, but it also safeguards the service from a backward slide into less inclusive, self-regulating service by making its service standards explicit and transparent.

The SPaRC team encourages the notion of legitimate ‘spiritual space’ in the Trust through their interventions and contributions, promoting exploration of wider dimensions of human life and health. Rather than starting with a ‘visit your own’ ethos, the Bradford Model recognises the need for responses to be person-centred in the first instance, and to consciously work across beliefs in its delivery of SPaRC. When belief-based care is sought, this triggers a specific response from the SPaRC team to deliver guidance, ritual or prayer from a belief representative. The Bradford Model is not about taking the religion out, but about adding other worldviews in and broadening the appeal and relevance of the service to all.

The Bradford Model emphasises that high standards of professional practice in SPARC maintain currency and quality in the service and how important the ‘backroom’ operations are in driving efficiency and effectiveness as well as coordinating an evidence base for practice.

What this document is and is not

This explanation of the Bradford Model for *inclusive* and *integrated* SPaRC is not a polemic written for those debating and determining the course of SPaRC in the twenty-first century. It can be argued that the current discourse on SPaRC is rooted in the privilege of a Christian status quo and the challenge to break through to establish new models, incorporate diverse beliefs and alternative approaches is yet to be realised (although there are inroads, particularly in Scotland and notable pioneers, some of whom peer reviewed this document).

This Bradford Model is not waiting for change to happen and steps away from prevailing models and histories of SPaRC. It sets the course for a new paradigm for SPaRC in Bradford, derived from the innovations and adaptability at BTHFT, by Bradford people for Bradford people.

The route for its approval has been through the leadership team at the Trust who were provided with the reference documents, data and evidence that informs this inclusive and integrated approach. The Bradford Model offers synergies with the Trust's ambitions in relation to enhancing patient and staff experience through wider collaboration within BTHFT and through its communities, putting patients' needs first, regardless of religion, belief system or spirituality, ensuring equality across the service and feeding into continuous learning and development.

This document forms the basis for a separate implementation plan; it sets the course and defines the standards to be reached. The detail of how to operationalise the service standards is therefore not addressed here.

Getting the terminology right

The Bradford Model seeks to explain itself in accessible language and with transparency. This document uses the term Spiritual, Pastoral and Religious Care (SPaRC) rather than Chaplaincy (see rebranding section that follows for rationale). The establishment of common understanding of key terms was an important, collaborative process in developing the Model, and key to ensuring coherent and cohesive outcomes for the service.

Religion and Belief

'Religion and belief' is a protected characteristic under the Equality Act (2010) safeguarding the rights of both people who have religious beliefs (which may be defined as mainstream or alternative) and those people who have non-religious beliefs. Although the Act does protect religious and non-religious people equally in the law, it does unfortunately, still refer to non-religious people as being 'without belief'; stuck in a notion that formal religion is the default and defining belief as being entirely religious in nature.

The Bradford Model adopts the term 'belief' as an inclusive term that gives positive value to a full range of beliefs, encouraging an appreciation of the diversity within religions and across beliefs. Belief is advocated as preferable term to such phrases as '*all religions and none'* or '*those with or without beliefs'* as those with non-religious worldviews *do* have beliefs, morals and ethical frameworks by which they live; describing them as '*nones*' suggests a departure from a norm or a deficit (LGBTQ+ people own positive terms for their identity rather than being 'non-heterosexuals', and in parallel there is ground to be gained for the non-religious to claim more positive labels to describe themselves). Hence this Bradford Model recognises the *individuality* of beliefs, within or aside from religion; acknowledges that they are not static and can change and evolve over time; that they may be individual or shared; that they may include the divine or be entirely atheist.

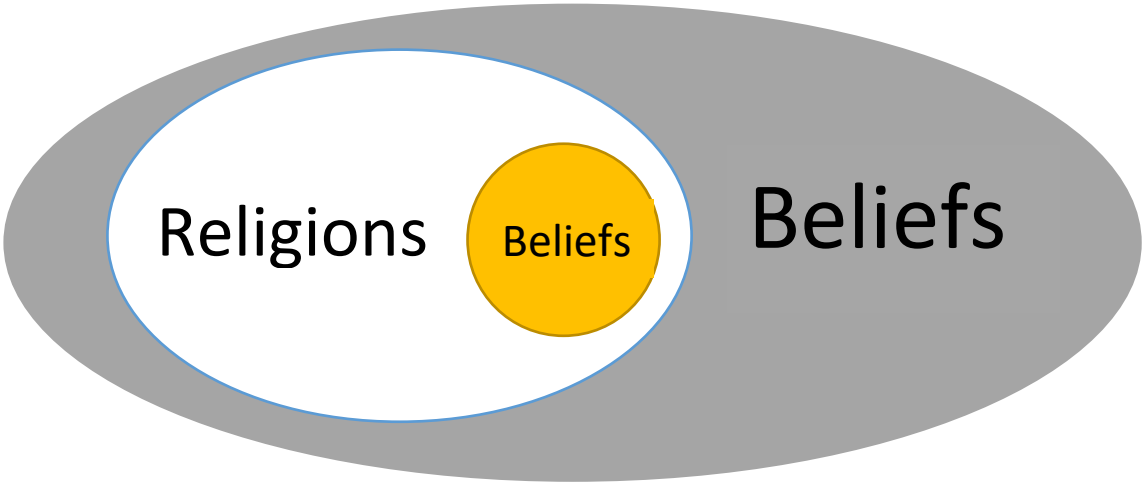

Figure 1: The inclusive term of 'belief'

Figure 1 offers a visual representation of how 'beliefs' is used as an inclusive term with religions sitting within this and within religions another set of beliefs that may be specific to a sect or denomination. This approach allows for a broader understanding of belief to include a range of cultural, religious or philosophical beliefs. There are cultural practices, as well as religious ones, that might be relevant to healthcare practice and spiritual wellbeing and the SPaRC team seeks to recognise and respect these practices (so long as they are not illegal or detrimental to human rights). To appreciate, for example, that a person may be *culturally* Christian or *culturally* Muslim, but not religious, is important and valid. Another example of cultural beliefs is the obligation in the Irish traveller community to attend and remain at the hospital when an elder is admitted at end-of-life. So, it is respect for the breadth, diversity and individuality of belief that underpins the Bradford Model.

To be protected as a belief under the Equality Act, there has to be a strong and genuine philosophical worldview that informs human life and behaviour. Hence the courts have said that the belief in man-made climate change and spiritualism are philosophical beliefs, but a political belief is not. To be protected, a belief must also be acceptable in a democratic society and not conflict with the fundamental rights of others, so there is no obligation in SPaRC to cater for beliefs that are harmful to others.

In line with this inclusive concept of belief, the work of the SPaRC team can be described as 'cross-belief' work rather than being 'interfaith' or 'multifaith' as it seeks to respond to the set of beliefs an individual holds and to work in full recognition of the overlap and complementary nature of different belief traditions to offer inclusive, informed and consistent care.

Cross-belief ethos

The Bradford Model advocates a cross-belief approach to working in SPaRC. The rationale for this is that cross-belief involves working to understand and integrate different beliefs and their traditions within the team and the service, playing to strengths, and matching knowledge and skills to needs. It recognises that social diversity as a positive, and that individuals have

a range of beliefs and practices, including those rooted in religion, cultural and family traditions, in the context of a secular society. Each individual will have a unique set of beliefs and the task is to work within *their* construct with respect and empathy.

In working across the different beliefs, rather than in separate zones of activity and influence, there is more likelihood of equality in the SPaRC service and greater scope for development and advancement of SPaRC Practitioners. It means being collaborative rather than territorial, and embracing the differences on the team as assets rather than deficits.

Cross-belief practice certainly does not mean an abandonment of own beliefs to a generic approach, but does enable SPaRC Practitioners to build confidence in offering an inclusive approach, using referrals to mobilise specific support from within the team or through community contacts.

Spirituality

This term may be widely used but is differently understood. Although there are many religious people who see their religion and their spirituality as one, there are also people who are culturally, rather than spiritually, connected to their religion and non-religious people who decline to call their inner world 'spiritual' and feel uncomfortable with the term. There are times in life when spirituality is more conscious and present than at other times. The language to express spirituality will be more accessible and familiar to some than others and, as a consequence, support may be sought in articulating spiritual questions and wonderings.

The Bradford Model uses spirituality as an inclusive term for the human search for meaning and purpose beyond the everyday routine and material experience of life. It is about a life-long journey to find the 'why?' for existing and to express that 'why?' in words and in actions. Spirituality is often expressed as connection; for some this connection is with a divine power; for others it is with a greater consciousness (or as some call it 'the more than human world'); for others the connection is with natural phenomena and the universe. Ultimately, these are individual expressions of personal, and possibly unique, spiritual experiences.

Spiritual need

An assessment of spiritual need contributes to holistic care, acknowledging as it does the need for assurance, comfort, connection, expression or resolution. Assessment of spiritual need is not merely about an allocation of religious affiliation from a picklist on hospital admission; it is more subtle and nuanced than this and needs a deeper probe. Religious observance may, or may not, be part of spiritual need and therefore no assumption should be made that offering prayer or sacred texts will be beneficial, but equally, for those religious people for whom their spiritual wellbeing is tied closely with their observances, such offerings can address spiritual need.

If spiritual wellbeing is assumed to be a feeling of being 'at ease' with life, or being 'at ease' with a greater power or divinity, then spiritual need may express itself as a dis-ease that undermines this sense of inner wellbeing. Spiritual need might in such circumstances, express itself in distress, anger, fear, depression, anxiety, withdrawal or sadness but it is important to remember that spiritual need can also be positive and be about expressing thankfulness, relief, intent or realisation.

Spiritual, Pastoral or Religious Care?

The language used in SPaRC inevitably draws on a religious heritage and can, as a consequence, be problematic for some. Definitions are important however to contextualise

these terms and define them for the Bradford Model. There may not be neat delineations between Spiritual, Pastoral and Religious Care as conversations may include elements of each. Although most conversations are pastoral in nature, sometimes they take on a deeper, more reflective dimension, exploring territories that might be described as spiritual. The religious elements should always be cued by the patient or colleague, not by the SPaRC Practitioner, with care taken to respond and relate to the person's own particular beliefs within their religion.

The Bradford Model regards all three elements of this care as important.

Spiritual Care

Spiritual care may involve a discussion about meaning and purpose, maybe wondering about bigger questions of existence and legacy, connections and possibly transcendence. Spirituality may be framed by religious beliefs, or by naturalistic worldviews, or by a fusion of beliefs that are highly individualised. It can deal with the metaphysical and the 'soul', although people may express this in very individual ways. With admission to acute care, people are often confronted with stark new realities or critical incidents that prompt a deeper review of their essence and beliefs. SPaRC Practitioners can assist in these reflections and recalibrations by being alongside people in these explorations.

Pastoral Care

Pastoral care focusses on the here and now, the experience of that person, that day; their feelings and emotions, their dilemmas and concerns. By giving attention and showing empathy, the person can feel attended to as they try to make sense of their circumstances; their concerns and feelings are appreciated and their individual humanity is validated. SPaRC Practitioners use their cultural and life experiences to find their points of connection for pastoral conversations but remain mindful that diversity in the SPaRC team means that some colleagues can respond with more insight than others.

Religious Care

Religious care recognises the meaning and value that religion has in some people's lives and seeks to support those beliefs through provision of resources, conversations and rituals as well as specific advice from suitably qualified religious representatives (for example to advise on fasting or medications). Religious care may take the form of familiar rituals or sacraments or draw on traditional prayers or scriptures. Some of these rituals are essential at critical times (end-of-life, birth, breaking fast). Religious care recognises the power of a god and a sense of the sacred, connecting the person to something greater than themselves; a higher power that can bring them comfort. Occasionally, deeper theological dialogue might arise, prompted by the challenge of new circumstances or the time alone to reflection. Every attempt is made to source SPaRC Practitioners of a similar belief from the SPaRC team or to locate faith representatives from the community who can be brought in to offer religious care.

Context

2020-21 was a very challenging time for the Trust and the vital role of SPaRC in navigating the stormy waters of the Covid-19 pandemic was recognised and acknowledged by the leadership. Everybody had to adapt and work in different ways, and SPaRC was no different in this. With disruption however comes opportunity, and there was a synergy of interests and opportunities to review and reconstruct SPaRC at Bradford Teaching Hospitals in a way that captured the innovations and experiences of a year of pandemic, but also looked to the

realities of the present and the future to build a service that was fair, adaptable and fit for purpose. The creative space to review and to innovate was supported by the leadership.

In recognition of the need to respond to the Pastoral and Spiritual needs of colleagues and patients with beliefs that are not religious in nature (at least a fifth according to the 2011 census, and over 52% nationally according to the British Attitudes Survey[1]), the Hospital Charity funded a 6-month post for a non-religious colleague to join the SPaRC team. A Humanist was appointed with a remit to advocate for the inclusion of other worldviews in SPaRC policy and practice and to gather evidence of need and fulfilment. Supernumerary to the rota, this role prompted rich dialogue and reflection within the team, offering time to observe, connect and consult, ensuring that good practice was captured. The role was supported by the open-mindedness and vision of the SPaRC Lead; guided by the strategic goals of the Patient Experience Lead and informed by the strong commitment to equality in the Trust. Significantly, there was little experience of resistance to the inclusion of other worldviews (non-religious) in the SPaRC service because it was understood from the start that this was about adding value and being fair, and not about diminishing or taking away.

The Bradford Model for SPaRC emerged from the observed practice and a collaborative, consultative process within the SPaRC team. The Model was further refined with feedback from stakeholders and peer reviewers (listed at beginning) who commented on its fit with their perspectives. The period also synchronised with a pending SPaRC service review that had been delayed by the pandemic. This prompted the inclusion of SPaRC service standards in the model by which to monitor and evaluate the BTHFT service. The standards do not necessarily represent where the service is now, but show the intention into the future.

What is unique about Bradford

Bradford is the third largest city in Yorkshire and Humber after Leeds and Sheffield and despite the decline in the textile industries it remains a manufacturing centre as well as employing significant numbers in financial services. There are challenges though as the city is in the top 10% of cities on the index of multiple deprivation. It is a very young city with over a quarter of the population under 16 years old.

Bradford is a City of Sanctuary and diversity runs through its core. According to the 2011 census, there are the three main belief groups: Christian (46%), Muslim (25%) and 'No religion' (21%) - the 2021 Census is likely to reveal a further decline in Christianity and an increase in 'No religion' (You Gov pre-census Poll Feb 2021[2]) with minority faiths staying constant. Christian worship can be dated back to Saxon times, and the city has had a Cathedral since 1919. The Roman Catholic heritage in the city reflects the inward migration of Irish people in the 19th century and currently it is East European residents who add to these numbers. The city has a tradition of non-conformity which means that there are a lot of chapels and more recently several large evangelical churches have become established. The significant South Asian populations (27% - 2011 Census) have their roots primarily in Pakistan, but also in India and Bangladesh. Bradford has an established Hindu population with the largest Temple in Northern England and the Sikh community has six gurdwaras. There is a growing Buddhist community and a declining Jewish community. The University of Bradford, located in the heart

[1] https://www.bsa.natcen.ac.uk/media/39293/1_bsa36_religion.pdf

[2] https://humanism.org.uk/2021/03/04/new-survey-reveals-how-census-question-leads-people-to-tick-a-religious-answer/

of the City, brings additional diversity in terms of students from across the UK, overseas, and has a high proportion of BAME students.

Although every city undoubtedly has its problems and conflicts, Bradford is a city generally familiar with and accepting of its diversity. There is a pride in the city and families are rooted and local to each other. There are commitments to work cross-culturally and collaboratively such as the Act as One initiative to establish a multi-agency partnership approach to health and care across the district.

Bradford Teaching Hospitals

Bradford Teaching Hospitals NHS Foundation Trust is responsible for providing hospital services for the people of Bradford and communities across Yorkshire. It serves a core population of around 500,000 people and provides specialist services for some 1.1 million. The 5,500 staff work over several sites, including Bradford Royal Infirmary, which provides the majority of inpatient services, and St Luke's Hospital, which predominantly provides outpatient and rehabilitation services. The Trust also manages four local community hospitals.

Bradford SPaRC history to the present day

This Bradford Model for SPaRC has evolved over time and nods to the innovations of the past with key leaders paving the way, as well as recognising the achievements of the present, and genuine intentions to do better.

The diversity of Bradford meant that traditional, Christian-centric models needed to be flexed if the service was to be relevant and appropriately skilled. From the late nineties, Muslim chaplains were included in the team, with Hindu and Sikh chaplains joining in the mid noughties. Alongside the Anglican, Free Church and Catholic chaplains, there were honorary chaplains for Jewish and Jehovah Witnesses and a solid core of volunteers who have been well trained to work in a person-centred way.

The SPaRC team has, over the years, provided training and advice on cultural competence and religious traditions that impacted on healthcare. Their advice to clinical teams and human resources has contributed to patient outcomes and staff cohesion. An outward focus into communities has meant that Bradford SPaRC could support other initiatives in the community, like the setting up of Court Chaplaincy through the sharing of a locum SPaRC Practitioner.

Back in 2006 plans had been drawn up to create a spiritual care hub as a base for the SPaRC team, but this was never realised. The team was based at St Lukes site until 2020 when they were relocated to the main Royal Infirmary site as part of the reconfigurations that happened in the pandemic year. They currently occupy a range of rooms and facilities scattered around the hospital which lack coherence and which detract from team cohesion. There is a temporary 'holding pattern' for accommodation at the present time.

The Covid-19 pandemic in 2020 called for rapid adaptations to the SPaRC service with high demand for Muslim SPaRC due to the disproportionate impact on this community. With shortfalls in SPaRC Practitioners and with volunteers stood down, a number of extra practitioners (locums) were appointed to meet need, changing some of the dynamics in the team and flexing the delivery model. More practitioners meant higher profile on the wards and the contribution of SPaRC in supporting patients, families and colleagues became evident and more widely understood. This has set the course for more collaborations and innovations to integrate SPaRC. Significant learning from the pandemic included recognition that religious observance at end-of life can mean inequalities in work demands for SPaRC Practitioners;

that a model of core team and locums offered flexibility and stability; that without a clear articulation of the Bradford Model, there is scope for drift from the core principles and characteristics. This Model is therefore informed by the pandemic experience, harnessing the learning and looking to a future where Bradford SPARC is robust, resilient and responsive in what it does.

Implementation of the Bradford Model

Implementation of the SPaRC team starts in 2021, supported by the Head of SPaRC in collaboration with the Patient Experience Lead Nurse. Regular reviews, education, engagement work, audit and reflections will be conducted to map the implementation process throughout. Initially, communication is key in widening the understanding of the breadth and range of the SPaRC service and in ensuring that gatekeepers are on board.

The Bradford Model offers the framework by which to plan services into the future ensuring integration into the wider Trust objectives to improve patient outcomes and support colleagues, connecting with inhouse services like staff wellbeing and psychology to maximise impact and minimise overlap. The Bradford Model not only clarifies the contribution of the SPaRC team to Trust ambitions, it also safeguards the service from drifting away from its equality objectives through its service standards which give the framework for audit and service review.

The Bradford Model informs recruitment to the SPaRC team, ensuring that people sign up to the ethos and approach at Bradford, challenging any preconceptions of the role or personal missions or beliefs that do not fit with the ethos of the SPaRC service (see the Characteristics in Appendix 5). It offers a framework for enrichment of SPaRC training and opportunities to develop research on inclusive SPaRC practice and outcomes.

There is opportunity to promote the Bradford Model in the locality to explore collaborations and resource-sharing with other trusts, services, hospices and voluntary organisations. Such resource-sharing is key in promoting a diverse and joined up SPaRC responses.

The SPaRC team - a new brand

Language is in a constant state of flux with words carrying history and context beyond their current usage and falling out of fashion with changing times. The language around ethnicity, disability and more recently gender identity, has evolved considerably over the last decades to be more inclusive and appropriate. Failure to move terms on, to better reflect society and to recognise diversity, suggests some conceptual stagnation. The ‘Orphanage’ no longer reflects how children are looked after; the ‘Steakhouse’ fails to attract the vegetarian customers; the ‘Working Men’s Club’ dwindles in its purpose and attendance with the closure of the Works and normalisation of women in the workplace. Terms are important and ‘Chaplaincy’ inevitably came under scrutiny in the process of developing this inclusive Model.

There is a valid argument that the term ‘chaplaincy’ is perceived as being about religion (82% of people surveyed in a YouGov Poll in 2017[3] believed this to be so, and indeed that they would expect it to be a Christian service). It follows that people with scepticism about religion, those who fear of judgement or those who hold non-Christian beliefs, might decline or not access the service. ‘Chaplaincy’ is too often associated with end-of-life which limits referrals

[3] Humanists-UK-polling-on-pastoral-care-in-the-UK.pdf (humanism.org.uk)

from colleagues and can frighten patients into thinking they are about to die. Although ground has already been gained in Bradford in breaking the stereotype of the 'Chaplain' being exclusively Christian, there is probably still a perception that it is a religious role and some confusion at times in translating the term into other languages. A rebrand is needed to be more inclusive and less loaded with expectations. Given the multi-lingual nature of patients at the Trust, care will be taken to translate 'SPaRC team' appropriately for other languages and cultures. The strap line 'With you, for you' aims to further support a wider appreciation of the service.

It is recognised that the term 'Chaplain' can offer a useful and legitimised 'way in' on the wards as the role is generally familiar and safe to colleagues. It is important to capitalise on this 'way in' with the rebranding so that relationships and access are kept open, but a change is signalled.

Summary of rationale for replacing the term 'Chaplaincy' with SPaRC (Spiritual, Pastoral and Religious Care)

1. Perceived by majority as primarily a religious role and strongly associated with Christian faith which disincentivises some to engage (because they have other beliefs, fear judgement or simply want to avoid a God talk)
2. An association of the Chaplain with death limits referrals made to SPaRC, and regularly frighten patients who assume that a visiting Chaplain brings bad news
3. Primarily owned by one faith who are comfortable with the term and their competence to deliver it; this can lead to a closed shop mentality regarding who can do it and how it is done, and a reluctance to cede ground
4. Opportunity to find an inclusive name that works across languages, cultures and beliefs and represents a modern SPaRC healthcare service, located in current realities rather than past traditions

A rebrand is not however just about changing the name (the outside), it is about changing perceptions and understandings (the inside). As the BTHFT implements this refreshed version of SPaRC, the communication of this new paradigm needs to be systematic, sustained and owned by the leadership.

Messaging around the SPaRC team positively and consistently emphasises the inclusion of a full range of beliefs (that may not all be religious) to overcome preconceptions that it is an exclusively religious service. A confident and accessible articulation of what the SPaRC team means needs to be embedded in systems such as electronic patient records (EPR), referral processes and multi-disciplinary teams (MDTs). Communications colleagues need to be involved in revised messaging including signage, webpages, patient information, voicemail messages, signatures and lanyards. Appendix 2 offers a sample information message for patients and families.

Communication of the integrated and inclusive ambitions of the SPaRC team also need to be clearly communicated to religious and belief communities in Bradford to be transparent about capacity and capabilities, to manage expectations and to recruit diverse SPaRC Practitioners. The realisation that you will meet 'your own' in the unfamiliar setting of a hospital can reduce

stress and anxiety, but expectations need to be realistic and related to capacity – most important is to feel that all beliefs will be respected and catered for.

Service Standards

The Bradford Model has a set of service standards that are ambitious but grounded in established cross-belief practices and insights. Initial attempts to use the recommended UK Board of Healthcare Chaplaincy service standards proved constraining and insufficient as they do not track neatly to the realities or aspirations of the SPaRC team, anchored as it is to equality and person-centred care, with a diverse team membership able to input and respond to specific belief needs and enquiries. The Bradford Model's standards have specific relevance and validity for BTHFT, setting a course by which the SPaRC team can be measured and held accountable.

The Bradford Model service standards can be adopted or adapted for other SPaRC services who aspire to put equality and person-centred care at the heart of their provision. Ownership of standards that are *meaningful* and *relevant* is key to confidence and commitment in the service. Appendix 1 offers mapping across to the UKBHC standards for reference purposes and makes explicit where the Bradford Model is differentiated, particularly apparent in the attention it pays to equality, person-centred care and data, and in the ambition it has to create inclusive, cross-belief teams rather than importing faith advice.

The Seven Anchors of the Bradford Model

The Bradford Model has seven Anchors which connect it to the organisation, stabilising its location and purpose. Anchors are fixed points but allow for movement in between and for differences to flourish. The Anchors are not about tying the SPaRC team down so tightly that it cannot adapt and move, change with rising tides and different weather conditions – going forward, it is clear that flexibility and responsiveness must be part of the Bradford Model. The Anchors bring clarity and transparency about the service and can form the basis for training and recruitment to ensure that understanding is shared and the service is consistent and fair.

Most importantly, the Anchors safeguard the SPaRC service from reverting to the familiarity of a belief-based service or from favouring some beliefs over others in the delivery of services and resources. The Bradford Model has service standards specified for each Anchor.

Anchor 1: Equality

Open to all

The SPaRC team believes in providing SPaRC services equally to all colleagues, patients and families with no belief more favoured in terms of access to SPaRC and no person more deserving than another. In the first instance, SPaRC Practitioners attend to SPaRC needs of whomever they come across, whether their belief corresponds or not. In an initial encounter, there is no judgement about life choices, levels of religious observance, or alternative beliefs: the intention is to be open and equal, focussing on the human connection.

However, treating people *equally* is not about treating people the *same*; with each set of beliefs there are important differences (e.g., end of life rituals, treatment choices, reincarnation beliefs, rituals of comfort, calls to prayer) that need to be recognised and addressed. There is much reassurance in connecting with a like-minded person with similar beliefs in the unfamiliar setting of an acute hospital, and this is factored into the SPaRC activity on wards.

It is important that no assumption is made about a person's belief or of compatibility with the beliefs of those of the SPaRC Practitioner, indeed for some people, an incompatibility can cause stress or anxiety (e.g., for apostates who be reluctant to speak to people from their former religion). Consequently, the distinction between inclusive and specific SPaRC needs to be reflected in service design and delivery, and there need to be safeguards to balance necessity and equity in terms of distribution of effort, resources and spaces, with care taken to offset the inequalities in social and financial capital across beliefs.

It is important not to rely wholly on referrals for contacts with patients and colleagues as there may be a filter at play that fast-tracks some over others. This can be countered by ensuring that the SPaRC team also 'walks the wards' in order to include those who may not be referred or who may not know of the service. This visibility and accessibility allow for 'in the moment' interactions with individual patients and staff, including those who may be overlooked.

The commitment to equity in SPaRC relates also to all the other characteristics outlined in the Equality Act (2010): age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; sex; sexual orientation. It is widely recognised that there are health and employment inequalities due to many other issues including poverty, education and class and the SPaRC team takes seriously its responsibility to recognise such inequalities and address them. The SPaRC team indeed recognises that the experience of disadvantage for some people may prompt conversations of a pastoral or spiritual nature that need to be heard with empathy and respect. Any conflict between religious teachings and equality legislation (e.g., in relation to sexual orientation, termination or divorce) must be firmly put aside in the SPaRC team: there is no place to judge or add to any doubts or misgivings a person may have. Where there is a conflict with the SPaRC Practitioner's ethical or religious beliefs, it is a dilemma to explore in supervision, not to impart to the person.

The SPaRC team recognises local demographics and trends to ensure that representation both in the core and wider team reflects the local distribution of beliefs, recognising the value that diversity brings to the team and the importance of including multiple perspectives in policy and practice development. It is the interpersonal qualities of the SPaRC Practitioners which is of significance and their ability to work comfortably in diversity that is called upon, so there is no restriction on SPaRC Practitioners of minority beliefs taking on more substantial posts, even if their belief community is small. The SPaRC team remains alert to equality issues within its own team, taking care to ensure that knowledge, responsibilities and opportunities are evenly shared and diverse qualities and approaches are valued. Care is taken to ensure that representation (age, gender, ethnicity, belief, etc.) is reflected in the core as well as the wider team so that changes (such as the withdrawal of volunteers during the pandemic) do not mean unfair disadvantage. When demand falls more heavily on some individuals in the team who have specific skills or attributes (e.g., on the Muslim female SPaRC Practitioner) steps are taken to redress this imbalance through recruitment or redistribution of responsibilities, use of locum SPaRC Practitioners or allocation of volunteers.

The SPaRC team offers leadership in the protected characteristic (Equality Act 2010) of religion and belief, having as it does, diverse membership and overview of the many of the issues and challenges. This knowledge and expertise mean that the SPaRC team can be an asset at an organisational level to contribute to equality training, proactive policy-making, monitoring and planning.

As advocates for equality, the SPaRC team seeks to exemplify harmonious cross-belief working and to value the diversity of its team members and the uniqueness of their contributions (see Anchor 6).

Bradford Model Service Standards: Equality

1.1	There is advocacy for equality across all beliefs and provision of resources, expertise, training and guidance to see this achieved
1.2	There is an equal understanding amongst service users of the safety, relevance and use of SPaRC, across all beliefs
1.3	Observations of inequality and discrimination are highlighted and challenged
1.5	Diversity and inclusion of a full range of staff and volunteers (age, experience, class, culture, belief, etc.) enriches and adds value, insights and functionality to SPaRC
1.6	Recruitment to SPaRC always involves an equality assessment and considers the opportunity to enhance diversity and knowledge in the team
1.7	Discourse, forums and practice sharing within the team, wider colleagues and indeed the public, increases skill sharing and trust in different approaches
1.8	Inequalities in SPaRC operations (such as referrals) are recognised and steps are taken to address this
1.9	Team identifies and trains its own equality champions to advocate for and safeguard inclusion in SPaRC services

Anchor 2: Person-Centred Care

Your agenda, not ours

SPaRC begins with the other person's perception of their needs and priorities. The focus on the individual human being (not their role, religion or their (mental) health status) means being entirely present with their concerns, feelings, dilemmas, or questioning; listening at a deep and empathetic level, being very cautious about offering anything that might be perceived as advice (specific religious advice is addressed in Anchor 3 Belief-Based Care). In reflecting back with people, they can be helped to come to their own conclusions and solutions. In a highly mobile and busy environment the stillness and presence of an active listener recognises the inner person and gives dignity and respect to their existence and uniqueness.

Person-centred care safeguards against the intrusion of other's belief at a time of vulnerability or precarity. In focussing on the person, it is possible to explore their own individual definitions of their spirituality, which may be linked to a recognised belief, or be a fusion of different beliefs that combine in their spiritual world, or be a loose and free-floating range of ideas and feelings that are untethered and possibly fleeting. It can, for example, be a deeply held spiritual belief to 'do no harm' and to follow a Vegan lifestyle as a consequence. People are very individual

in their beliefs and this is supported without assumptions; knowing a patient is a Christian, for example, does not automatically mean shared beliefs on papacy, LGBTQ+ rights, or the efficacy of prayer. There are people who have mixed families also where different traditions and beliefs combine and coexist. There is no need to shoehorn or categorise these definitions of personal spirituality; it is their expression and the valuing that is important in SPaRC.

Hospital can be an experience that feels quite disempowering and therefore it is important to clarify roles and remit so that the person can choose whether to engage with the SPaRC team or not, and give their consent for the interaction. Confidentiality is only breached with permission to share information for healthcare improvement, or because of a safeguarding issue. The neutrality of a SPaRC Practitioner can enable an exploration of alternative beliefs and a questioning of prior assumptions. There is no responsibility to steer these reflections back to a familiar path (unless invited to do so) or to inform others (e.g., family, priest, community leader) of any doubts expressed. Appendix 3 offers some useful prompts for opening and continuing person-centred conversations.

There is a recognition that although there may be some interactions that are about belief, some that may broach on topics that could be described as 'spiritual', the majority of conversations will be pastoral in nature and some may seem quite casual. There is no hierarchy of worthiness of any conversation over another and no prioritising of one referral over another on the grounds of belief.

The diversity of the SPaRC team means that there is scope to match support to need by connecting people together in ways that recognise their preferences and life experiences (e.g., an armed forces SPaRC Practitioner with a veteran, an older woman SPaRC Practitioner with a young mother). Such matching is more relevant in some circumstances than others.

Bradford Model Service Standards: Person-Centred Care

2.1 There is advocacy for spiritual needs being integral to holistic care and monitoring that spiritual needs are appropriately assessed and recorded for each patient admitted

2.2 The focus, range and pace of any conversation is led by the patient / colleague with consent obtained and active listening being the main response

2.3 SPaRC responses will always aim to inspire self-belief, recognise realities, affirm the lived experience and convey acceptance

2.4 No assumption is made that conversations will be about religion or belief; wishes not to engage with SPaRC are respected and protected, as is the right to change wishes on this

2.5 When specific requests are made to connect with SPaRC (e.g., about religious prayers, existential discussions, baby loss) best efforts are made to match the SPaRC Practitioner taking account of factors such as gender, language and culture

2.6 There is a mechanism / commitment for patient and staff involvement in the review of SPaRC

Anchor 3: Belief-Based Care

Guidance, ritual and prayer

Belief-Based Care is specific care that centres around the individual beliefs of the person, recognising and respecting the importance, meaning and resonance they have in their life. When the belief is religious in nature, such care can be characterised by ritual and prayer but also include reassurance or advice about adherence and teachings. Where beliefs are not religious in nature, or indeed are a reaction against religion (as in apostacy), Belief-Based Care will have none of these off-the-shelf tools for support and expression – the dialogue may well be exploratory and self-affirming, but could equally be inconclusive or even hopeless.

SPaRC draws on the authenticity and depth of its Practitioner's own beliefs. Although own beliefs may be the motivation and conviction to undertake the role, this is not a vehicle for ministry unless specifically requested by the colleague, family or patient. It is never appropriate to proselytise or persuade. This authenticity means that any cross-belief work needs to be carefully negotiated, not only with the SPaRC team, but also with the patient or colleague. Any reading of prayers or conducting of rituals from other beliefs is exceptional (e.g., Catholic priest saying prayers for an Anglican) but it is recognised that there are circumstances where this is important (e.g., Humanist SPaRC Practitioner supporting a nurse to baptise a baby). Close and flexible team working is required to make referrals for specific interactions to do with belief.

It is expected of SPaRC Practitioners that they are spiritual-and-existential-reflective people who can conceptualise and respect beliefs that are different from their own. The exploration of one's own spirituality, in dialogue with colleagues of diverse beliefs, directly informs the ability to listen and articulate responses in SPaRC, and to attend authentically to other's reflections on their essence, meaning, purpose, values and ethics. SPaRC Practitioners will inevitably operate in different ways, informed by their own belief, but this is always within the standards and characteristics of this Bradford Model so that the role boundaries for all SPaRC Practitioners are consistent. There is an expectation that SPaRC Practitioners will be comfortable operating across beliefs in a way that does not judge or undermine differences in theological positions or belief perspectives. Conversations across beliefs can be both illuminating and intimate; explaining the comfort of a relationship with Jesus or the challenge of an interfaith relationship does not require the listener to share the same beliefs – they listening is affirming that experience.

Colleagues may request specific advice on belief and the SPaRC team is ready to respond to these requests through membership of committees and working groups, resources, training input and 'on-call' advice (e.g., for a Psychology services supporting a colleague who is struggling to reconcile their scientific practice with their ethics). This is important to build confidence in where to draw the line between religious imperatives and cultural preferences (e.g., Can the release of a body for burial wait until the morning when staff and funeral directors are available?). Care should always be taken to ensure that any advice comes from an authoritative source and is rooted in a person-centred approach that recognises diversity within religions (e.g., between orthodox, reformed or progressive Jews) rather than blanket generalisations.

On request, colleagues, patients and families may need specific ritual, prayer or advice at times (for example over treatment options or end-of-life). When a person lacks capacity, care must be taken to ensure that no assumption is made about their needs, but equally, where

their wishes are known, these should be acted upon. Prayers or rituals should be offered by a person qualified to do this (Imam, Priest, Celebrant), with the SPaRC team sourcing the appropriate person where this is possible - very specific requests may prove difficult to fulfil, so compromise may be necessary. Appendix 3 offers some examples of how prayer requests can be temporarily fulfilled by non-specific words that give assurance, but do not compromise one's own beliefs or mislead.

After visiting for Belief-Based Care, the SPaRC Practitioner will ensure that they extend their inclusive visiting to engage with others on the ward whilst there, demonstrating the SPaRC service is accessible for all. In this way, patients whose beliefs are not necessarily represented in the SPaRC team on that day, are still acknowledged.

Most on-call referrals are likely to be religious in nature as they are to do with the urgencies of end-of-life care and the associated rituals that are prescribed by religion. Such call-outs fall more heavily on religious SPaRC Practitioners and this was especially evident in the pandemic with Muslim SPaRC Practitioners in high demand. A requirement to provide religious ritual or sacraments should not however restrict recruitment to core SPaRC posts, as it is the requirement to *mobilise* a swift response which is needed, not to conduct the rituals.

It can be assumed that on-call referrals may diversify as the breadth and inclusivity of the SPaRC team is more widely understood as not being exclusively about end-of-life or religious care.

To be sure that people are supported in their beliefs, religious artefacts, holy water and resources (e.g., Quran Cubes, rosaries, prayer cards) are sourced, respectfully stored and supplied for appropriate distribution. Resource boxes, holy books and information files are provided to each ward to ensure that information is to hand for critical times and to support staff's awareness of key issues and sensitivities regarding belief.

Bradford Model Service Standards: Belief-Based Care

3.1 Requests for religious or spiritual ritual, prayer or guidance are responded to promptly and knowledgeably

3.2 Scheduled prayer and ritual is facilitated where there is demand

3.3 Accurate and relevant advice about diverse beliefs is made available to all Trust colleagues and awareness is promoted through events and updates

3.4 Support is given on where to draw the line between urgent / essential religious duties or needs and what can wait, or be done in a different way

3.5 Any liaison with local community religious and spiritual representatives over patient admissions and discharge is managed by SPaRC to ensure that safeguarding is in place, there is patient consent and confidentiality is observed

3.6 SPaRC acts as a key contact for national and local faith and belief communities; taking care to foster and maintain positive relations and promote dialogue over SPaRC services

Anchor 4: Spiritual and Reflective Spaces

Safety, calm and focus

Spirituality is a (some would argue 'the') core dimension in what it means to be human and relates to a sense of self, connections with others and the wider universe or supernatural forces. Everyone makes meaning in their own way and describes their existence and purpose in a way that makes sense to them; for some this will be through specific religious practices and these will be supported and facilitated. Being at ease with a spiritual self has been demonstrated to be beneficial to mental and physical health. The space to acknowledge, explore or express the spiritual self can support wellbeing in patients and colleagues and help in efforts to humanise healthcare.

Creating spiritual and reflective spaces in the organisations is not just about the physical space. It is about quiet headspace which can be created at the start of a meeting, in a work break or through using online resources. The SPaRC team advocates for this headspace which is especially important for colleagues in high stress and demanding work environments and where work-life balance is compromised or for patients when they are recalibrating after life-changing news.

There needs to be safe and conducive spaces for spiritual and religious reflections. Spaces that are easily found, accessible and feel inviting and appropriate for colleagues, patients and families. This includes prayer rooms, suitably equipped with facilities and resources, green spaces and neutral quiet spaces for reflection or meditation. Such spaces need to be named to indicate their inclusive or specific uses (e.g., Muslim prayer room, Tranquillity Room, Meditation Space, Sacred Space) with due regard for diversity rather than neutrality. At times there may be organised events (e.g., lunchtime mindfulness, prayers, discussions groups) that take place in the spaces. Spaces should feel confidential and safe for individual pastoral or spiritual conversations.

Memorial events and gatherings provide a space that acknowledges a significant event or a period of difficulty (e.g., loss of a colleague, closure of a service) for groups of colleagues. In such circumstances, the SPaRC team can conduct a service or events to enable colleagues to share in the emotional and spiritual toll this might have had, focussing on communal wellbeing, their feelings and realities. The diversity of SPaRC Practitioners is a strength here in demonstrating togetherness and inclusion.

Spiritual and reflective space can also be created by marking religious events, such as Diwali or Christmas, or promoting reflective events, such as National Remembrance Day. The SPaRC team can highlight and facilitate these days by offering up spiritual or reflective spaces for people to use, individually or in groups, facilitated by SPaRC Practitioners who demonstrate how all beliefs are embraced and celebrated.

The digital space such as websites, apps and social media can offer other spiritual wellbeing resources but also signpost to finding other spiritual spaces to reflect, recover and develop. Digital space is likely to play a bigger role in SPaRC into the future whether through specific applications or through integration with Trust wide initiatives.

Bradford Model Service Standards: Spiritual and Reflective Space

4.1 Suitable reflective or quiet spaces are available where people of all beliefs can feel safe, comfortable and included

4.2 Suitable spaces are provided for religious observance and that these spaces are properly cared for, signposted and supplied

4.3 Resources are available on wards for people to create their own spiritual or religious space

4.4 There are quiet and private spaces for confidential support from SPaRC

4.5 Communal spiritual wellbeing is addressed in relations to significant events

4.6 A calendar of religious and reflective days prompts opportunities to promote explorations of spirituality and appreciation of other beliefs

4.7 Digital spaces offer resources and signposts for individual and group spiritual support

Anchor 5: Collaborative Practice

Adding value and expertise

It is a collaborative rather than a separatist ethos that drives the SPaRC team to be fully integrated and anchored in the Trust and this opens opportunities for evolution and greater integration into Trust practices and initiatives. The SPaRC team does not exist in a vacuum but must remain adaptive and responsive to the evolving needs in health care, ready to identify and fill any gaps in the SPaRC of colleagues, patients and families. Rather than operating in a default responsive mode, a shift to more proactive and collaborative intent can improve the SPaRC team's contribution to service improvement.

This means working closely on collaborative work schemes with bereavement services and palliative care in particular (as with end-of-life companions), but also other services such as security, psychology, wellbeing, admissions, volunteer services, etc. to make the most of the different skills and attributes of the different professions and not duplicate or confuse messages to patients (for example, the SPaRC Practitioner attends after a baby dies but bereavement counselling then takes over). It is recognised that the SPaRC team can contribute professional opinions and insights to MDT deliberations or where advocacy for a patient's spiritual beliefs may offer a useful contribution.

The SPaRC team can be called upon to offer additional just-in-time support and relieve services when additional person-centred care is needed (e.g., when bereaved parents are in denial and cannot organise a funeral, when a distressed person needs someone calm to talk to whilst having a procedure done, when a family dispute erupts at a deathbed). In acute care there are regularly incidents of trauma and distress and the SPaRC team can be called upon

to bring calm and assist in de-escalations arising from misunderstandings or heightened emotions, for example working collaboratively with the police community officer.

Collaboration at an organisational level means involvement on committees and groups where a spiritual or ethical dimension can contribute to the discussion and decision-making (e.g., to review of child deaths). In its responsibility to the wellbeing of its staff, the Trust can also integrate the SPaRC team in decisions around the promotion of communal spiritual wellbeing (e.g., to create tranquillity spaces) or use their input as part of the process of holistic debriefing after major incidents.

Collaboration on training and development is valuable as there are specific SPaRC skills and knowledge that can be usefully passed on to enhance the patient experience and enable colleagues to assess and respond to spiritual needs. Contributions to Medical and Nurse education can build the cultural and spiritual competences that will be needed in practice and a module in SPaRC, incorporating some cultural competences, can equip every member of staff with a basic awareness of holistic care in a diverse population.

Collaboration also includes connections with communities in Bradford. SPaRC Practitioners are likely to have connections with their belief communities, or interfaith groups, which provide bridges of understanding and insight both ways. The connections that the SPaRC team has with its communities can assist in collaboration over proactive public health initiatives but also be reactive when needed to mediate or advise in sensitive situations and avoid escalation of misunderstandings. SPaRC Practitioners may become figures of trust and information for the community, someone on the inside, a familiar face and name, a home language-speaker. Professional boundaries ensure that such connections are not exploited (e.g., the Roman Catholic priest does not share a shortcut to get his congregation their vaccines, a Sikh SPaRC Practitioner does not negotiate an exception to visitor rules for a lonely Sikh patient). Not only should these close connections with community not lead to privileged attention, but they should also not convey information back or forth that could breach confidentiality or lead to prejudice (e.g. about sexual orientation, substance misuse or apostacy).

There is scope for this collaborative approach to also extend beyond the Trust into the community to organisations and groups (where people organise around faith or belief, special interests or concerns). The SPaRC team can provide useful expertise in making connections and establishing presence in community-based initiatives and can collaborate with outreach services and health and social care organisations (such as hospices and mental health trusts) through service level agreements and resource sharing, for example in co-production of a preventative strategy to tackle loneliness in older people or in the promotion of spiritual wellbeing in teenagers.

The collaborative ethos is also reflected in how the SPaRC team operates, demonstrating high levels of mutual respect, understanding and cooperation across beliefs with curiosity and celebration of differences and recognition of common ground. Core to this collaboration is the opportunity to share practice and debrief together.

Bradford Model Service Standards: Collaborative Practice

5.1 Opportunities to collaborate are regularly identified, scoped, reviewed and evaluated

5.2 SPaRC supports staff and volunteers alongside Occupational Health and Psychology Services, making referrals with consent and contributing to wider wellbeing initiatives

5.3 Key contributions are made to Education Programme about SPaRC (inductions, medical training, nurse training, etc.)

5.4 A spiritual dimension is fed into organisational responses to major incidents, staff deaths, national disasters, anniversaries, etc.

5.5 An ethical dimension is fed into consultations and strategic planning around change and priorities in the organisation

5.6 SPARC Practitioners are available to contribute insights and perspectives to decisions about individual patients made by clinical teams

Anchor 6: Professional practice

Accountability and development

In terms of professional identity, the SPaRC team are all identified on their Trust badges as a 'SPaRC Practitioner'. This removes expectations that Practitioners will only 'see their own' or that they will deliver a particular type of service. It is important that presence on the wards is transparent and consideration is given to professional identifiers to assist with this (body warmers, badges, lanyards) which create an impression of unity in the team. Signifiers of faith (hijab, turban, collar) may be worn by SPaRC Practitioners in accordance with the Trust policy, with recognition that these signals may both encourage or discourage SPaRC interactions; the skill is in maximising the benefits (e.g., in reassuring relatives massing to visit the sick) and minimising the disadvantages (e.g., visiting wards together to give people options as to who they might speak to).

It is recognised that within their own religious communities, some SPaRC practitioners may still be identified as chaplains and indeed greeted as such on wards. Working under an inclusive role title whilst in the Trust, does not mean that the professional identity of 'chaplain', cannot be used in other faith-based contexts where the term has its historical and theological home and indeed where professionalism might be framed along religious lines.

The SPaRC team aims to embody equality principles, but hierarchies inevitably exist for the dissemination of information, allocation of tasks, quality assurance and accountabilities. The team operates collaboratively and collegially with high levels of respect and trust and a shared focus on the patient experience and staff wellbeing. Dialogue and practice-sharing are at the

root of the relationships between team members as is the actively working in a cross-belief manner to enhance understandings of others worldviews and experiences.

Demand and need will always outstrip supply of SPaRC services. To rationalise presence on the wards and management of referrals, the service operates with core SPaRC Practitioners having specific areas of responsibility, building relationships and working practices that are negotiated with wards and services. They each call upon their team of locum SPaRC Practitioners and SPaRC Volunteers to ensure appropriate but flexible cover. Demand will vary in different areas and at different times (for example, the disproportionate impact of the pandemic meant that more Muslim SPaRC Practitioners were needed for prayer and end-of-life rituals on Covid wards, whilst geriatric wards were more likely to seek Christian rituals and prayers). Every few months responsibilities and teams are shuffled to alleviate stress, to promote development opportunities, to keep practices fresh and consistent, and to respond to changes in Trust priorities. This approach builds resilience and accountability into the service.

Given that much of the work of the SPaRC team is independent and unsupervised, it is vitally important that all team members (paid and unpaid) receive thorough induction and regular supervision. Belief-specific supervision and belief-based professional development is sourced outside the Trust on an individual basis.

Observation is difficult in SPaRC, so open sharing of practice is an important part of monitoring and quality assurance. Reflective practice is therefore a cornerstone of SPaRC; there needs to be an ability to critically evaluate the quality of each interaction by looking at one's own actions, feelings, concerns, etc. and wonder about the impact and responses of the other person. Such reflections should be part of supervision in line management and through peer support. Peer support and practice sharing are important ensuring complementary approaches are maintained and evolved and a paired visiting on wards allows not only for mutual learning but also to demonstrate cross-belief working. Appendix 4 offers a format for shared reflections that was trialled as part of the development of the Bradford Model.

Given the complexity and changing environments of acute care, SPaRC Practitioners need to acquire new knowledge and skills on an ongoing basis through regular professional development. It is acknowledged that SPaRC traditionally has very low attrition rates and small teams which can conspire against progression to more senior roles within SPaRC, but SPaRC Practitioners should have opportunity for skill development (placements, projects and assignments), and further qualification (in spiritual and pastoral care) whilst at Bradford. Records of Continuous Professional Development (CPD) are usually a requirement of continued endorsement by accrediting / professional bodies with 15 hours per year being a suggested ratio and the Bradford Model supports this requirement. SPaRC Practitioners are encouraged to get involved in research on SPaRC and this could be particularly useful in monitoring and evaluation of the values and practice of the Trust.

The SPaRC volunteers are an important part of the SPaRC workforce. They obviously do not carry the same obligations for professional development; however, they do undertake thorough initial training, mandatory development sessions and regular supervision and must sign up to the Bradford characteristics (Appendix 5) in just the same way as paid colleagues, and being held to account on these.

The Bradford commitment to professional practice is transparent and aims for high standards and compliance with national frameworks. The UK Board of Healthcare Chaplaincy (UKBHC) holds a voluntary accreditation register and is responsible for the spiritual care competences

and code of conduct for healthcare chaplains. Diversity and inclusion do not appear to be strong drivers at the UKBHC and their gatekeeping on qualifications required for professional membership mean that regrettably, despite many years of experience and high levels of competence, BTHFT SPaRC Practitioners do not meet the UKBHC criteria, coming as they do from non-Christian career and education pathways. Registration with other accrediting bodies (the Network for Non-Religious Pastoral Care, the National Hindu Chaplaincy Governing Body, UK Sikh Chaplaincy group) is the alternative.

Bradford Model Service Standards: Professional Practice

6.1 All SPaRC Practitioners and Volunteers can demonstrate a personal capacity to reflect deeply on spirituality, ethics and life issues and explain how they deliver SPARC in a competent and professional manner

6.2 Supervision ensures colleagues are supported and quality assured; core SPaRC Practitioners engage in monthly supervision; locum SPaRC Practitioners have pro-rata arrangements

6.3 Reflective practice is shared to engender complementary approaches, offer critique and provide mutual support

6.4 Regular team meetings promote cohesion and engagement

6.5 Opportunities for professional development in relevant skill and knowledge areas are promoted and fairly distributed

6.6 SPaRC Practitioners keep records of their professional development to feed into annual appraisals which give opportunity to review and plan further professional development

6.7 SPaRC Practitioners are endorsed or accredited by suitable professional associations or belief-based organisations

6.8 Current research and best practice in SPaRC is regularly shared and discussed

6.9 A research approach is encouraged, whether collaboratively or independently

6.10 New and returning SPaRC staff are fully inducted

6.11 Training and supervision of Volunteers ensures they deliver services appropriately

Anchor 7: Data and organising

Process and evidence

There is a balance to be struck in the time taken to record data being time away from core activities. But whilst there is no ambition to burden SPaRC Practitioners with administrative load, data needs to be gathered to evidence the quantity and quality of the service. The

SPaRC team collects data on all interactions with colleagues, patients and families (e.g., pastoral conversations with 2 security staff; 1 spiritual interaction with patient on Ward 7; 1 religious prayers said with family at bedside on Ward 26) in order to quantify and locate its activity, to identify shortfalls, to evaluate its effectiveness and to safeguard equality ambitions. Anonymised records are kept of

- what referrals are made, for what reasons and by whom
- how referrals are fulfilled (visit to assess need, phone call, attendance with prayers, last rites, etc.)
- whether interactions have been urgent / non-urgent / general / specific / casual / pastoral / spiritual / religious

in order to have evidence as to where services are needed and to how services are used.

Although currently there is very limited access to Electronic Patient Records by the SPaRC team, the Bradford Model advocates for using EPR to locate patients and record interactions, but also to extract data for equality monitoring.

A central administrative point is essential from which to organise and maintain the 'backroom' of SPaRC. A core team runs the service with a flexible team of locum practitioners and volunteers providing additional hours and rotas ensuring an equal spread of visiting throughout the Trust. With a dispersed team often acting alone, it is essential that the team have access to digital devices and systems to coordinate with each other and to efficiently input and extract information.

Bradford Model Service Standards: Data and Organising

7.1 The work and values of SPaRC are clearly and consistently communicated with accessible information about policies and procedures

7.2 Records are kept of incidence, location, and nature of interactions which yield quantitative data

7.3 Qualitative data is recorded (as case studies, reflective accounts, feedback from families, survey responses, intervention summaries, etc.) in order to analyse expressions of need and range of responses

7.4 Data is used for service review, to measure impact, to monitor inequalities, trends and performance, to review staffing and volunteering, to allocate resources and to support research activities

7.5 Where SPaRC insights can support the MDT and patient experience, SPaRC interventions are recorded on the Electronic Patient Record (EPR)

7.6 Digital records are used to locate and refer patients and to track referral fulfilment

7.7 Digital and telecommunication systems and devices are effective and efficient in recording, communicating and organising (e.g., on-call)

7.8 In recognition that demand may fluctuate and will always exceed SPaRC capacity, ongoing decisions about staffing levels and priorities (e.g., on call) are based on evidence and equality

7.9 All data is safeguarded to protect confidentiality and stored in accordance with information governance policy.

Conclusions

The Bradford Model for *integrated* and *inclusive* SPaRC grows from the roots of cross-belief practice and the Trust's commitment to see SPaRC services play a transparent and constructive role in the spiritual wellbeing of colleagues, patients and their families. Under open-minded leadership and with the lens of equality, there was scope to review practice and envision the future in a way that poises the SPaRC team at a point of readiness to contribute to the changes and challenges ahead, as well as to attend to the recovery and recalibration arising from the pandemic.

This Bradford Model sets an ambitious course that everyone can witness, but also offers a means by which to reflect on progress, and stay accountable to the patients, colleagues, and communities of Bradford.

Appendix 1: Cross reference of the Bradford Model Service Standards with the UKBHC Service Standards (2020)

Anchor	Bradford Model Service Standards	Related UKBHC Service Standards
1 Equality	1.1 There is advocacy for equality across all beliefs and provision of resources, expertise, training and guidance to see this achieved 1.2 There is an equal understanding amongst service users of the safety, relevance and use of SPaRC, across all beliefs 1.3 Observations of inequality and discrimination are highlighted and challenged 1.5 Diversity and inclusion of staff and volunteers (age, experience, class, culture, belief, etc.) enriches and adds value, insights and functionality to SPaRC 1.6 Recruitment to SPaRC always involves an equality assessment and considers the opportunity to enhance diversity and knowledge in the team 1.7 Discourse, forums and practice sharing within the team, wider colleagues and indeed, the public, increases skill sharing and trust in different approaches 1.8 Inequalities in SPaRC operations (such a referrals) are recognised and steps are taken to address this 1.9 Team identifies and trains its own equality champions to advocate for and safeguard inclusion in SPaRC services	4.1 All patients receive written information on admission containing details of the spiritual care service available within the unit. 4.2 The written information contains an explanation of the spiritual care service, examples of situations in which the spiritual care service might be used and how contact with the spiritual care service may be obtained 4.3 The written information is supported by verbal explanation of access to the spiritual care service during assessment. 4.4 The admission procedure ensures a check that written information is given.

Anchor	Bradford Model Service Standards	Related UKBHC Service Standards
2 Person-Centred Care	2.1 There is advocacy for spiritual needs being integral to holistic care and monitoring that spiritual needs are appropriately assessed and recorded for each patient admitted 2.2 The focus, range and pace of any conversation is led by the patient / colleague with consent obtained and active listening being the main response 2.3 SPaRC responses will always aim to inspire self-belief, recognise realities, affirm the lived experience and convey acceptance 2.4 No assumption is made that conversations will be about belief; wishes not to engage with SPaRC are respected and protected, as is the right to change wishes on this 2.5 When specific requests are made to connect with SPaRC (e.g., about religious prayers, existential discussions, baby loss) best efforts are made to match the SPaRC Practitioner taking account of factors such as gender, language and culture 2.6 There is a mechanism for patient and staff involvement in the review of SPaRC	1.a.1. Spiritual needs are assessed and addressed. The service will advocate for service users, in a person-centred way, while considering their diverse spiritual background and needs. 2.2 The spiritual care service responds to requests from members of staff and volunteers for personal and professional support.

Anchor	Bradford Model Service Standards	Related UKBHC Service Standards
3 Belief-Based Care	3.1 Requests for religious or spiritual ritual, prayer or guidance are responded to promptly and knowledgeably 3.2 Scheduled prayer and ritual is facilitated where there is demand 3.3 Accurate and relevant advice about diverse beliefs is made available to all Trust colleagues and awareness is promoted through events and updates 3.4 Support is given on where to draw the line between urgent / essential religious duties or needs and what can wait, or be done in a different way 3.5 Any liaison with local community religious and spiritual representatives over patient admissions and discharge is managed by SPaRC to ensure that safeguarding is in place, there is patient consent and confidentiality is observed 3.6 SPaRC acts as a key contact for national and local faith and belief communities; taking care to foster and maintain positive relations and promote dialogue over SPaRC services.	1.a.2. Liaise with local or national resources for spiritual support and with the patient's permission contact relevant communities/individuals. 2.3 The spiritual care service responds to requests from members of staff and volunteers for spiritual and religious support. 3.1 Spiritual care services are an informed resource on spiritual and religious care for NHS staff and local faith and belief community representatives. 3.2 Spiritual care services will maintain links between the NHS and local faith and belief community representatives 3.3 A written protocol is in place for NHS staff to refer to local faith and belief community representatives. 3.4 A directory of contact numbers for representatives from local faith and belief faith and belief communities is available in hospitals and units. 3.5 The local directory should be regularly updated and the faith and belief communities consulted on its content and updating.

Anchor	Bradford Model Service Standards	Related UKBHC Service Standards
4 Spiritual and Reflective Spaces	4.1 Suitable spaces are provided for religious observance and that this is properly cared for, signposted and supplied 4.2 Suitable reflective or quiet spaces are available where people of all beliefs can feel comfortable and included 4.3 Resources are available on wards for people to create their own spiritual or religious space 4.4 There are quiet and private spaces for confidential support from SPaRC 4.5 Communal spiritual wellbeing is addressed in relations to significant events 4.6 A calendar of religious and reflective days prompts opportunities to promote explorations of spirituality and appreciation of other beliefs 4.7 Digital spaces offer resources and signposts for individual and group spiritual support	6.a.1 Access to quiet and private areas for confidential support of patients, carers, staff and volunteers. 6.a.2 Access to a space acceptable for the religious observance of all faiths and beliefs. 7.2 Events in the unit which are having an impact on staff and require a communal response or event. 7.3 Events external to the unit which are having an impact on staff and require a communal response or event.

Anchor	Bradford Model Service Standards	Related UKBHC Service Standards
5 Collaborative Practice	5.1 Opportunities to collaborate are regularly identified, scoped, reviewed and evaluated 5.2 SPaRC supports staff and volunteers alongside Occupational Health and Psychology Services, making referrals with consent and contributing to wider wellbeing initiatives 5.3 Key contributions are made to Education Programmes about SPaRC and cultural competence (inductions, medical training, nurse training, etc.) 5.4 A spiritual dimension is fed into organisational responses to major incidents, staff deaths, national disasters, anniversaries, etc. 5.5 An ethical dimension is fed into consultations and strategic planning around change and priorities in the organisation 5.6 SPaRC Practitioners are available to contribute insights and perspectives to decisions about individual patients made by clinical teams	2.1 The spiritual care service builds working relationships with members of staff and volunteers. 2.4 With the staff member's permission the spiritual care service facilitates referrals to other sources of support. 5.2 Spiritual care services contribute to staff induction for new members of the healthcare team 5.3 Spiritual care services contribute to the healthcare team's education and training programme. 5.4 Complex ethical issues. Spiritual care services make recommendations for educational and training resources. 5.5 Spiritual care services are available to the healthcare team as an informed resource for ethical issues and discussion. 7.4 An awareness of issues or events affecting the morale or functioning of the unit which require management awareness to resolve. 7.5 Requests for consultation on ethical issues relating to restructuring, changes in buildings, local priorities and working practices.

Anchor	Bradford Model Service Standards	Related UKBHC Service Standards
6 Professional Practice	6.1 All SPaRC Practitioners and Volunteers can demonstrate a personal capacity to reflect deeply on spirituality, ethics and life issues and explain how they deliver SPARC in a competent and professional manner 6.2 Supervision ensures colleagues are supported and quality assured; core SPaRC Practitioners engage in monthly supervision; locum SPaRC Practitioners have pro-rata arrangements 6.3 Reflective practice is shared to engender complementary approaches, offer critique and provide mutual support 6.4 Regular team meetings promote cohesion and engagement 6.5 Opportunities for professional development in relevant skills and knowledge areas are promoted and fairly distributed 6.6 SPaRC Practitioners keep records of their professional development to feed into annual appraisals which give opportunity to review and plan further professional development 6.7 SPaRC Practitioners are endorsed or accredited by suitable professional associations or belief-based organisations 6.8 Current research and best practice in SPARC is regularly shared and discussed 6.9 A research approach is encouraged, whether collaboratively or independently 6.10 New or returning SPaRC staff are fully inducted 6.11 Training and supervision of Volunteers ensures they deliver services appropriately	2.5 The use of one or more models of reflective practice is explicitly encouraged in policy documents associated with the spiritual care service. 5.1 Spiritual care services are committed to continuing professional development (CPD) with all chaplains are expected to keep evidence of at least 15 hours CPD per year pro rata 5.6 Spiritual care services initiate, support, and contribute to research within the healthcare setting 5.7 Spiritual care services are aware of current research and best practice and consider and implement its findings. 5.8 Each organisation should have a standard for an induction programme for new *(SPaRC)* staff. 6.a.7 All chaplains have regular appraisal (at least annually) to review professional development and training needs. Identified needs to be resourced 6.b.1 All chaplains are a member of a professional association for chaplains 6.b.2 All chaplains have a mature and reflexive world stance that evidences their 'intentional use of self'. To achieve this, health care chaplains should belong to a faith or belief community that provides a formational foundation for their values and behaviour out of which they can deliver their work

Anchor	Bradford Model Service Standards	Related UKBHC Service Standards
7 Data and Organising	7.1 The work and values of SPaRC are clearly and consistently communicated with accessible information about policies and procedures 7.2 Records are kept of incidence, location, and nature of interactions which yield quantitative data 7.3 Qualitative data is recorded (as case studies, reflective accounts, feedback from families, survey responses, intervention summaries, etc.) in order to analyse expressions of need and range of responses 7.4 Data is used for service review, to monitor inequalities, trends and performance, to review staffing and volunteering, to allocate resources and to support research activities 7.5 Where SPaRC insights can support the MDT and patient experience, SPaRC interventions are recorded on the Electronic Patient Record (EPR) 7.6 Digital records are used to locate and refer patients and to track referral fulfilment 7.7 Digital and telecommunication systems and devices are effective and efficient in recording, communicating and organising (e.g., on-call) 7.8 In recognition that demand may fluctuate and will always exceed SPaRC capacity, ongoing decisions about staffing levels and priorities (e.g., on call) are based on evidence and equality. 7.9 All data is safeguarded to protect confidentiality and stored in accordance with information governance policy.	4.5 There is a written protocol for referral to spiritual care services, including out of hours. 4.6 There is a systematic approach to recording keeping 6.a.3 Access to patient information systems for providing and facilitating appropriate spiritual or religious care and recording information and interventions. 6.a.4 Access to office accommodation and administrative support. 6.a.5 Access to communication systems to facilitate internal communication and on-call cover. 6.a.6 Appropriate level of staffing to meet the spiritual and religious needs of patients, carers, staff and volunteers, including out of hours cover 7.1 The spiritual care service has its policies and procedures clearly articulated

Appendix 2 – Sample introductory message for the *SPaRC team*

There needs to be accessible materials to make people aware of the service in plain English and with translated versions into local languages. There might be visiting cards, posters and postcards.

Spiritual, Pastoral and Religious Care at BTHFT

We have a variety of SPaRC Practitioners and Volunteers who can offer a neutral listening ear and some company at a difficult time. We are led by what you want to talk about, not by any other agenda.

Are you asking yourself:

Why is this happening to me? Is it something I've done?

Why am I suffering? When will my bad luck end?

Where does my life go from here? Where can I find strength and inspiration?

What is the point of it all? How can I make a new start?

How can I learn from this?

Maybe you are feeling:

Worried? Lonely? Sad? Nostalgic? Confused? Angry?

Conflicted? Lost? Thankful? Stuck? Frustrated?

Our diverse ***SPaRC team*** will make every effort to understand and respond to your individual needs. If your beliefs mean that you would like specific spiritual or religious support (for example prayers, sacraments, rituals, meditations or mindfulness), then please request this and we will try to find a practitioner who can attend.

Do ask for a visit from the ***SPaRC team.*** You can call us direct on XXXX or ask a member of staff to make the call for you.

Appendix 3: Person-centred cues and responses

Openers

- I can offer you a bit of companionship, if you fancy having a chat about anything on your mind?
- I am available to talk about how you are feeling at the moment, not the medical stuff, but the emotions and worries
- I come from The SPaRC team e.g., and we visit patients because we want to offer everyone the opportunity to talk to someone about what's on their mind
- It can be a bit isolating being alone with your thoughts in hospital, and can also be a bit worrying. I'm just wondering if you have anything on your mind that it would be useful to talk about today?
- It's interesting what thoughts come when you stop in a bed all day. Is there anything that is bothering you today?
- Have you had much contact with your friends and family since being here? How is that?

Prompts for spiritual conversations

- what guides you?
- where do you get your support?
- what sustains you?
- what are your beliefs?
- what is your journey in life?
- what is your destination?
- what prompts your awe and wonder?
- what motivates you to live?
- what holds meaning for you?
- what is your purpose in life?
- what are the mysteries in your life?
- where / with what do you feel connected?
- what inspires you?
- are there things in life that you can't explain or which surprise you?
- do you ever wonder if there is something more than life as you know it?

Closers

- Thank you for sharing – you have had a hard time and it does not seem fair that you have suffered so much. It seems like you have a strong sense of what you want and I hope that things fall into place for you.
- I need to move on now, but it has been so interesting to talk with you and hear what an amazing life you have led. Thank you for sharing your stories and feelings.
- We have covered quite a lot of ground there and I appreciate we touched on some quite painful memories. I need to go shortly but I want to check that you will be OK. Would it be useful for me to tell the nurse that you have been upset?
- Before I leave, I just wanted to check: you mentioned that you are a Catholic, would it be useful for the Priest to pay you a visit this week, if he is around? I can mention this to him if you like.
- You have some tough times ahead and some difficult decisions to make. But it sounds to me that you are taking a very careful and considered approach to your life. I hope your path will become clear and I wish you well.

Religious cues or referral options

- Is there anything else I can do for you today?
- We have people from all belief backgrounds on the ***SPaRC team*** – is there anyone you would particularly like to speak with?
- We have talked quite a bit about your religious beliefs, and I am wondering whether a prayer might be useful at this time?

Assurances (prayer-like but inclusive)

- I wish you strength and calm in your challenges, and peace in your decisions. May you benefit from the kindness and care of those around you.
- May your beliefs support and sustain you at this time. May you find contentment in the knowledge of all the good you have done in your life and the fact that your family holds you in such high regard.
- May your regrets be resolved so that you can be released from their hold over you. Although the past cannot be changed, your future is a new chapter and I wish you strength and success in all you do.

Appendix 4: Professional practice: shared culture of reflection

This reflection card (paper, app or online database) is a tool for recording reflections on interventions or critical incidents and sharing them with another member of the team. This could be in supervision with a line manager, with a mentor for a new SPaRC Practitioner, with a member of the core team after volunteering on a ward. The reflection cards become tools for dialogue and practice sharing on a very regular basis and the retention of these records give evidence not only of the types of interventions, but also the active reflection practised by the team.

SPaRC: Reflection card

Practitioner initials: JM Date: 04/02/21 Location (ward): 22

Account of experience or interaction (short bullet points, no names)

- Man in mid 70s distressed about leaving wife with dementia at home
- Reflected on his feelings realising that she will have to go into a home
- Appreciated all he had done for her over years to keep her at home
- Noted he needed to take care of himself now and that his sons were stepping up
- Recognised sadness of the disease of dementia and how it had taken her from him

Shared with (initials of colleague): IS

Reflection (main points raised):

Feelings it evoked in me:

Felt very sad for him, reminded me of my Dad. Tried not to make him feel uncomfortable about crying – sorry that men can find this difficult. Made me aware again about how precarious some people's lives become very suddenly.

Connecting with my beliefs:

Our kindness to others has physical and mental limits and reaching the end of the road does not devalue all that has already been given. There are others to share any burden with and this is not an act of disloyalty or weakness.

Learning to take forward from the experience and reflection

I felt that this man had been troubled by his guilt sitting on his own. I think my listening and reflecting back allowed him to release some of the worry and process some of his thinking about the new realities. I am not sure if I should have alerted the ward sister to his concerns and another time, I think I would ask his permissions to inform her.

Any actions arising: None

Appendix 5: The 12 Characteristics of the Bradford Model SPaRC Practitioner

As a Bradford Model SPaRC Practitioner, you are:

1. Appreciative of the diversity in the team, seeing it as a source of knowledge and a toolbox of skills, with you taking responsibility for your part in making it work well by being communicative, enabling and reliable.
2. Willing to engage with everyone with friendliness, curiosity and cultural competence, suspending your judgement and conveying your acceptance of their circumstances and life choices.
3. An attentive and patient listener who responds to the focus, range and pace of any conversation taking care to ensure that it is led by the other person and only pursued with consent; recognising their realities and lived experience, that they can feel truly heard.
4. Able to hold calm space for people as they explore their circumstances and feelings, in a way that inspires self-belief and agency rather than dependency, so that they may feel assured, make their own decisions and reach their own conclusions.
5. Responsive to the range of beliefs (religious and non-religious) that you might encounter with no sense of any beliefs having greater worth or value than others; respectful of individual interpretations and expressions of belief, and mindful that beliefs can and do change over time.
6. Humble and authentic in what you do, appreciative of the privilege of supporting others, respectful and mindful of their vulnerability, and taking real care with the information that is shared to ensure that it is kept confidential.
7. Solid and articulate in your own values, ethics and morals, underpinned by your own religion, belief or worldview and life experiences; but mindful that these are *your* beliefs, without assumption that others will share or need them.
8. Able to offer belief-based care, when this is specifically requested, or by tentative negotiation to ensure that it is wanted. For the religious, this might include prayer, sacrament or ritual, but for others it may be reflections or ceremonies that are more humanist in nature. Able to mobilise others with compatible beliefs to ensure a prompt response to requests for belief-based care.
9. Knowledgeable about the factors that impact on behaviour in an acute setting and able to deploy interpersonal skills to calm and deescalate situations.
10. An advocate for spiritual needs as part of holistic care and staff wellbeing; ready to contribute to strategy, education and research in this area.
11. Open about your practice and its impact on you; conscious of the need for self-care and prepared to review and learn in order to develop your practice. Able to explore any conflicts that arise between your SPaRC practice and your beliefs within your supervision, in order to maintain this non-judgmental approach.
12. Upholding of the values, procedures and policies of the Trust in all that you do with due regard for safeguarding and professional boundaries at all times.