

Bristol Health Partners

Conference 2025

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#3980126



Welcome to Conference

Primrose Granville

Activist, broadcaster
and public contributor



Housekeeping

- Need help? Find a Bristol Health Partners team member (yellow lanyard)
- If there is a fire alarm, please leave by staircases at each end of the room
- Toilets are at the opposite end of room from the entrance. Accessible toilets are at each end of the room
- If you need to leave the building and return, quote code 9537 to venue staff on re-entry
- Wi-fi: **We The Curious – Events** Password: **cuRiousHarbourside...**



Get involved

- **Make connections** during the networking sessions
- **Ask questions** using [slido.com #3980126](https://slido.com/join/3980126)
- **Share your day** on social media [#BHPconference25](https://twitter.com/BHPconference25)
- Scan QR code at the end of the day to **complete evaluation**

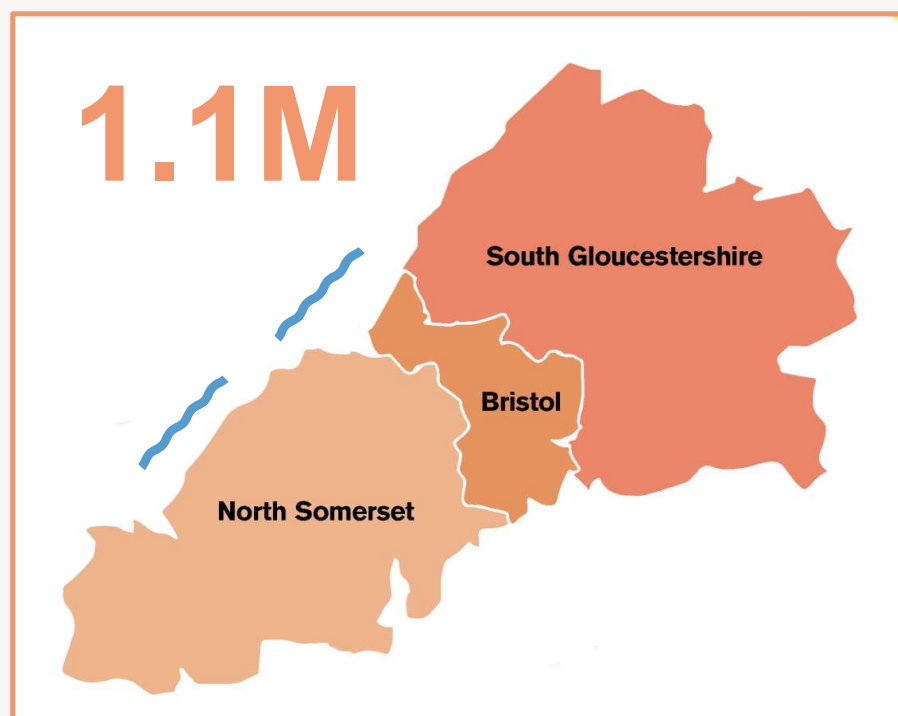


Maria Kane

Chair, Bristol Health Partners



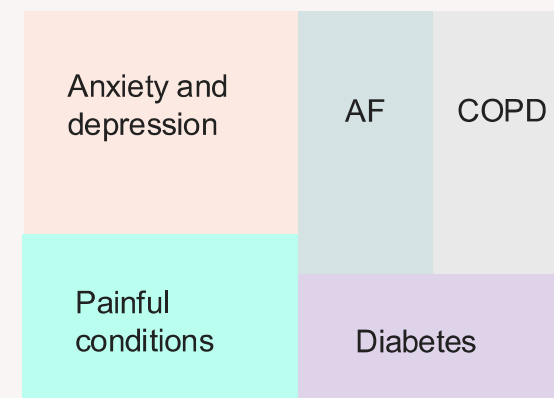
Welcome to our region



50,000
work across our
partnership



**Most 'impactful'
conditions on
day-to-day
health**



Opportunities and challenges

Innovation

- Our region receives the most Government funding to support health research of any Integrated Care System in England
- UK's most powerful supercomputer – Isambard AI

Inequality

- Legacy of slave trade and persistent health inequalities
- People in our region, particularly in most deprived areas, are spending more of their lives in poor health.



Our place in the system



Avon and Wiltshire Mental Health Partnership NHS Trust
Bristol, North Somerset and South Gloucestershire
Integrated Care Board
NHS Blood and Transplant
North Bristol NHS Trust
University Hospitals Bristol and Weston
NHS Foundation Trust



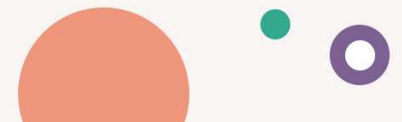
**Bristol Health
Partners**



International perspectives and partnership

Our shared opportunities:

- Tackling health inequalities
- Moving care closer to home
- Digital innovation
- Prevention



Helping you to connect ... today and beyond



The Danish Healthcare System Reform

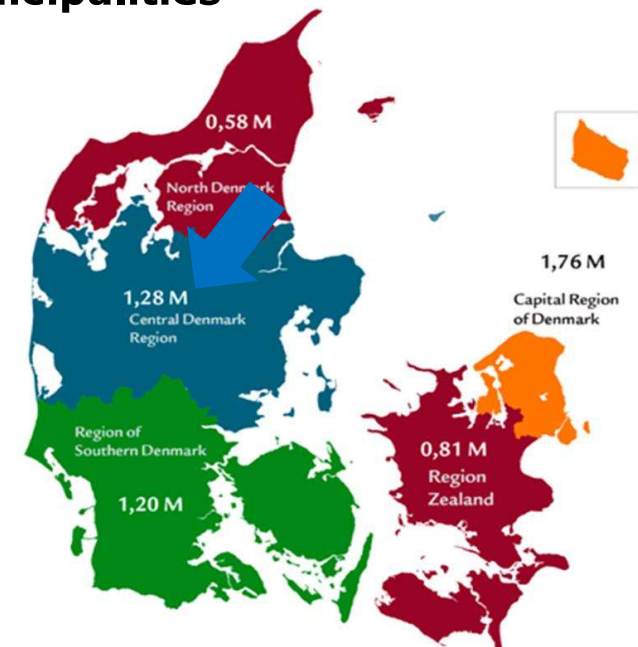
Integrating Hospitals, GPs and Municipalities using Clinic, Education & Research Communities (KUF)



Dr. Claus Brøckner Nielsen, Chief Medical Officer, Regional Hospital Central Jutland

Structure of the Danish healthcare system 2025

- The Danish tax system gives everybody **equal** and **free access** to health care services.
- 2022: 36 billion eur/pr. annum (47 % on hospitals); population 5,9 million
- State/political hierarchical **budget, planning** and **control**.
- Denmark is divided into **5 state-owned regions and 98 municipalities**
 - **Regions** are responsible for
 - Hospital services
 - Psychiatric services
 - GPs and specialists
 - **Municipalities** are responsible for
 - Home nursing, temporary care beds
 - Nursing homes
 - Public health
 - School health services and child dental care
 - Prevention and rehabilitation
 - Elderly care



Nationally decided:

- Government, National Healthcare authorities
 - Scientific societies, guidelines.
- **By Law:**
- Diagnosis and treatment guarantee:
 - 30 days: Diagnosis and treatment plan.
 - 60 days: Initial treatment started.
- Cancer packages guarantee:
 - 14 days from referral to start of clinical investigation
 - 28 days from referral to first treatment
- National goals for quality in the danish healthcare system



Regional Hospital Central Jutland

We are five hospitals – one unit



**12 times elected “Best Hospital in Denmark”
(medium sized hospital (4)/small hospital (8))**



**4370 colleagues in 18
departments/centers in 5 locations:**

- 390.000 outpatients annually
- 32.000 operations annually
- 55.000 patients discharged annually
- 508 beds (2023)
- 1.800 students/year (200 specialist doctor trainees)
- 191 active researchers, 103 FTE (2023)
- 217 peer-reviewed articles published



Health with Mind, Heart and Will



VI ER HER FOR DIG



VI VIL PATIENTEN FØRST
OG MEDARBEJDERNE ALTID.

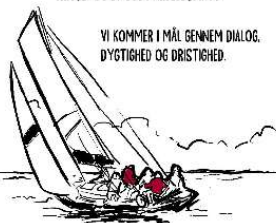
VI MØDER DIG MED OMSØRG I ØJENHØJDE.

DU BLIVER GODT BEHANDLET I TRYKKE RAMMER
OG STØTTET I AT KUNNE MESTRE DIN SUNDHED.

MED KOMPETENTE MEDARBEJDERE

VI STÅR FOR HØJ FAGLIG KVALITET.
VI TAGER UDANGSPUNKT I DET ENKELTE MENNESKE
UD FRA FUNDAMENTALS OF CARE.

VI PRIORITERER KOMPETENCEUDVIKLING,
TRIVSEL OG ET GODT ARBEJDSMILJØ.



VI KOMMER I MÅL Gennem dialog,
DYGTIGHED OG DRISTIGHED.

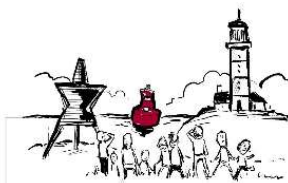


VI ARBEJDER I FÆLLESSKAB

VI VIL VÆRE KENDT
FOR GODE SAMMENHÆNGENDE PATIENTFORLØB,
GENNEM STÆRKE RELATIONER.

VI SKABER OG VEDLIGEHOLDER
VELFUNKTIONERENDE PARTNERSKABER.

VI UDVIKLER VIDEN OG METODER
I FORPLUGTENDE FÆLLESSKABER MELLEML KLINIK,
UDDANNELSE OG FORSKNING (KUF).



MOD NYE HORIZONTER

VI SKABER OG OMSÆTTER VIDEN
OG OPLEVELSER FRA PATIENTER,
PÅRØRENDE, MEDARBEJDERE OG PARTNERE.

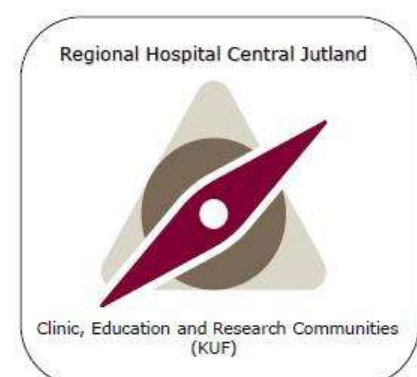
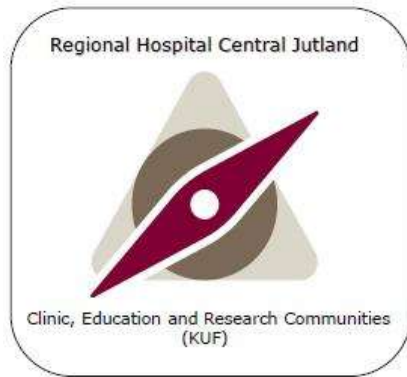
VI TILPASSES OS INNOVATIVT OG BÆREDYGTIGT TIL FREMTIDEN.

VI ER MED TIL AT TRANSFORMERE SUNDHEDSVÆSEN.

HOSPITALSENHED MIDT – VIBORG, SILKEBORG, HAMMEL, SKIVE OG LEMVIG
KURS MOD ET NÆRT SAMARBEJDE SUNDHEDSVÆSEN



KUF – Clinic, Education and Research Communities



In KUF communities, we collaboratively address future healthcare challenges and improve patient pathways.

Four professional communities, spanning across all 18 professional specialties composed of relevant clinicians (**K**), guidance and training officers (**U**) and researchers (**F**).



The KUF communities strategic topics

Rehabilitation

6 Departments:

Neurology, VCR (spine rehab)
Hammel (Neuro-rehab)
Diagnostic Medical Center
Cardiology
Service Dept.
Radiology

Themes:

- **Dysphagia screening**
- **Identification and monitoring of patients' nutritional status**
- Business intelligence (BI) – cycles in clinical practice

Multimorbidity

4 Departments:

Neurology, VCR (spine rehab)
Diagnostic Medical Center
Cardiology
Radiology

Themes:

- Obesity treatment in children and adolescents
- Improvement in treatment of patients with IBD and arthritis
- **Sector transitions for patients with multimorbidity**

Optimising patient pathways

5 Departments:

Cardiology
Pathology
Anesthesiology & Intensive Care
Center for Elective Surgery
Orthopedic Surgery

Themes:

- Optimisation path – from idea to project
- **Transitional Pain Service in orthopaedic surgery**
- Patient education programme constipation

Cross-sectoral pathways with interdisciplinary solutions

6 Departments:

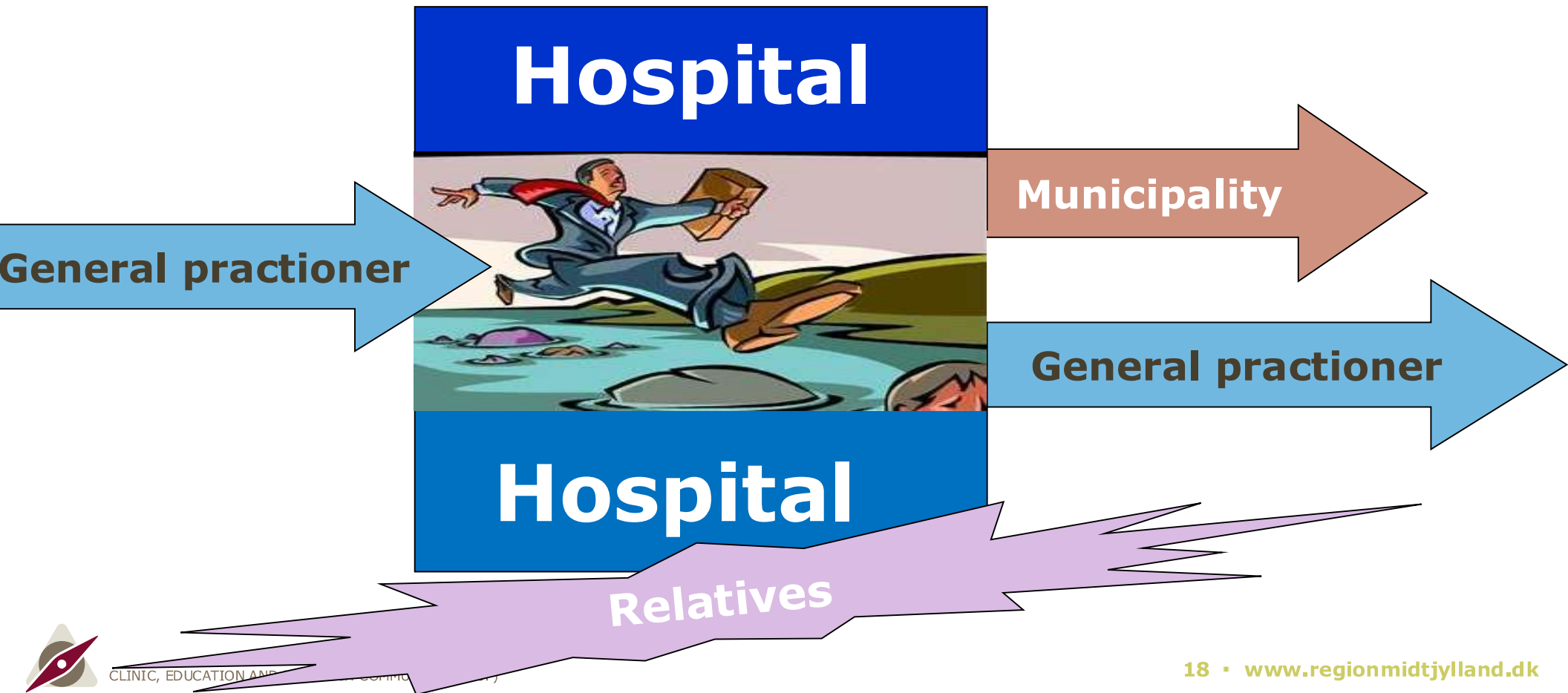
Diagnostic Medical Center
Emergency Dept.
Physiology and Nuclear Medicine
Biochemistry
Surgery
Pediatrics

Themes:

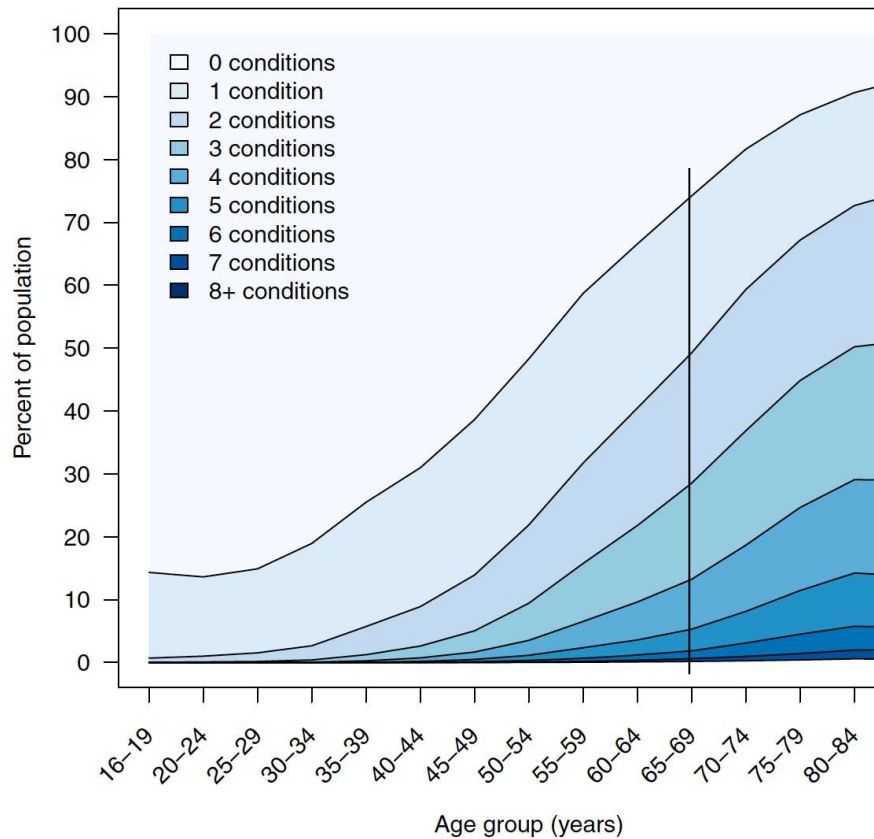
- Admission
- The right level and place of treatment
- **Socially vulnerable**



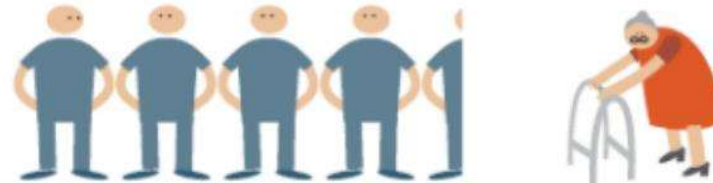
Patient pathways – Not integrated!



Challenges



2000 4,3 BORGERE MELLEM 18 OG 64 ÅR PR. BORGER OVER 65 ÅR



2016 3,2 BORGERE MELLEM 18 OG 64 ÅR PR. BORGER OVER 65 ÅR



2026 2,8 BORGERE MELLEM 18 OG 64 ÅR PR. BORGER OVER 65 ÅR



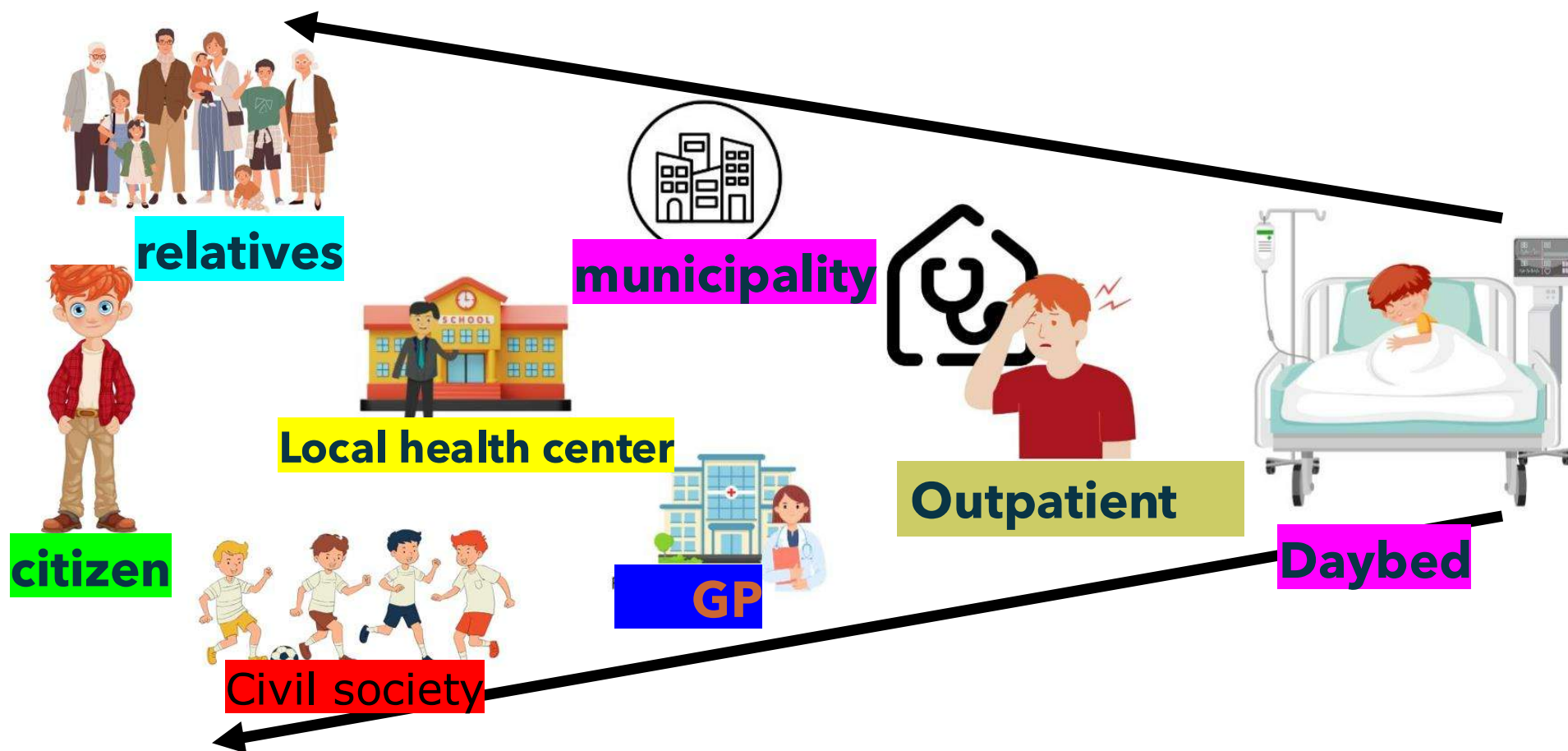
2036 2,3 BORGERE MELLEM 18 OG 64 ÅR PR. BORGER OVER 65 ÅR



Kilde: Baseret på tal fra "Tæt på fremtiden: den udfordrede fremtidens sundhedsvæsen", Høgaard & Kjølberg, KORA 033.7

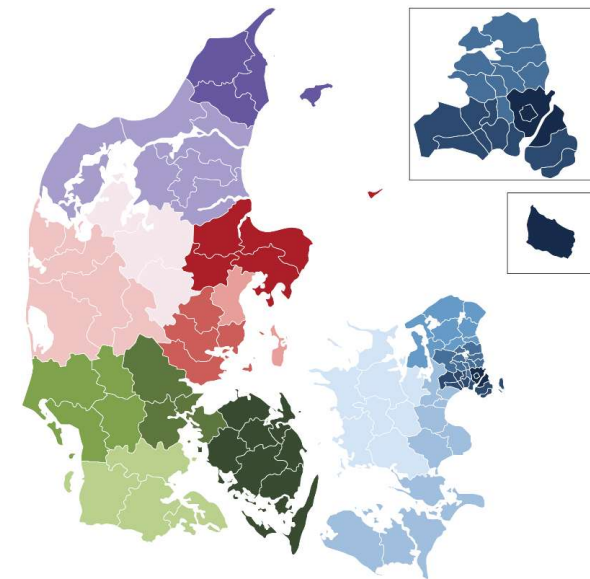
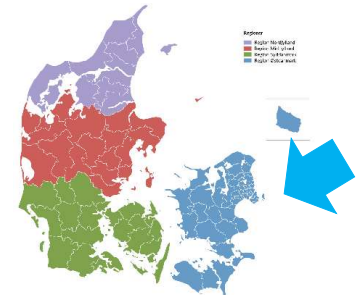


Healthcare system reform 2026



Structure of the Danish healthcare system 2026

- **Four state-owned regions, 17 Health Councils and 98 municipalities**
- **Regions** ultimately responsibility for the regional hospitals and health planning
- **Health Councils** responsible for the geographically defined local health area (3-9 municipalities within each region; council: regional and municipalities politicians- elected Nov.25):
 - Acute hospitals with integrated psychiatry
 - The GPs in the health area
 - Prevention and specialized rehabilitation
 - Former municipalities temporary care beds, home nursing
 - Treatment at home and "self care".
- **Municipalities** are responsible for (- 600 mill euros):
 - Nursing homes
 - Elderly care
 - Public health
 - School health services and child dental care



The KUF communities strategies 2026-28

Rehabilitation

6 Departments:

Neurology, VCR (spine rehab)
Hammel (Neuro-rehab)
Diagnostic Medical Center
Cardiology
Service Dept.
Radiology

Themes:
Rehabilitation and prevention across sectors – and to focus on “citizens and patients motivation factors”

Multimorbidity

4 Departments:

Neurology, VCR (spine rehab)
Diagnostic Medical Center
Cardiology
Radiology

Themes:
A new model for implementing research, education, clinical practice across sectors

Optimising patient pathways

5 Departments:

Cardiology
Pathology
Anesthesiology & Intensive Care
Center for Elective Surgery
Orthopedic Surgery

Themes:
Collaboration with GPs and to have special focus on “self-harming” patients

Cross-sectoral pathways with interdisciplinary solutions

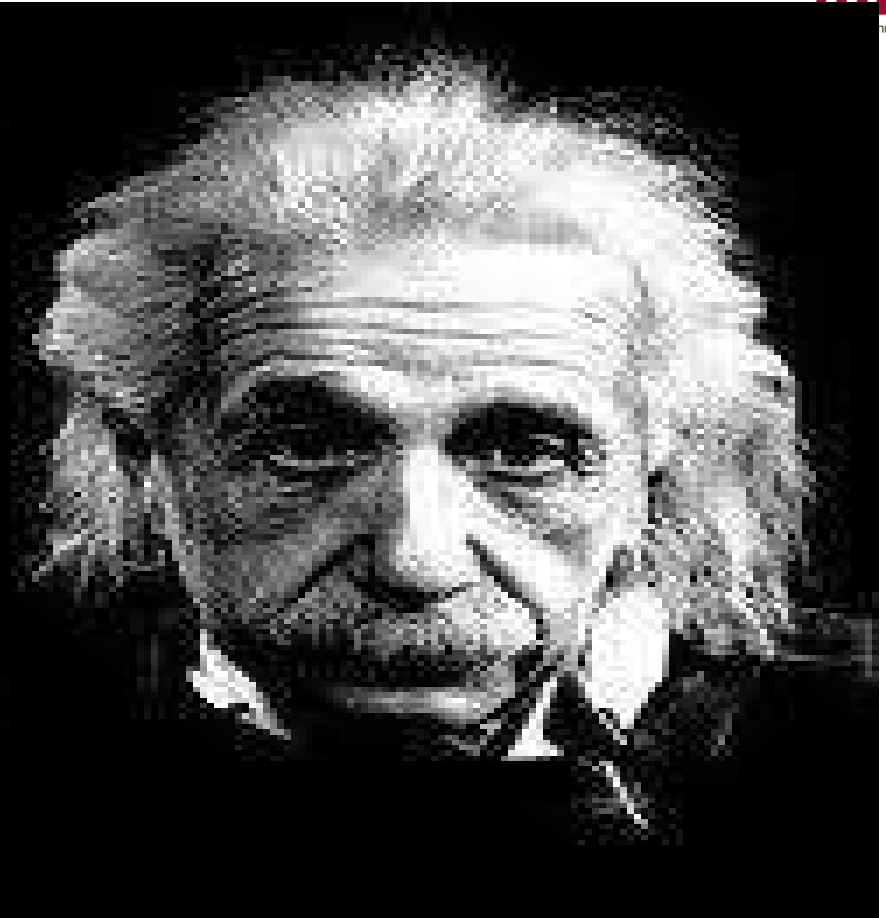
6 Departments:

Diagnostic Medical Center
Emergency Dept.
Physiology and Nuclear Medicine
Biochemistry
Surgery
Pediatrics

Themes:
Integration of sectors – to help vulnerable citizens and patients



"WE CANNOT
SOLVE OUR
PROBLEMS
WITH THE SAME
THINKING WE
USED WHEN WE
CREATED THEM"



Albert Einstein
1879-1955



Questions?



Professor David Wynick

Director
Bristol Health Partners

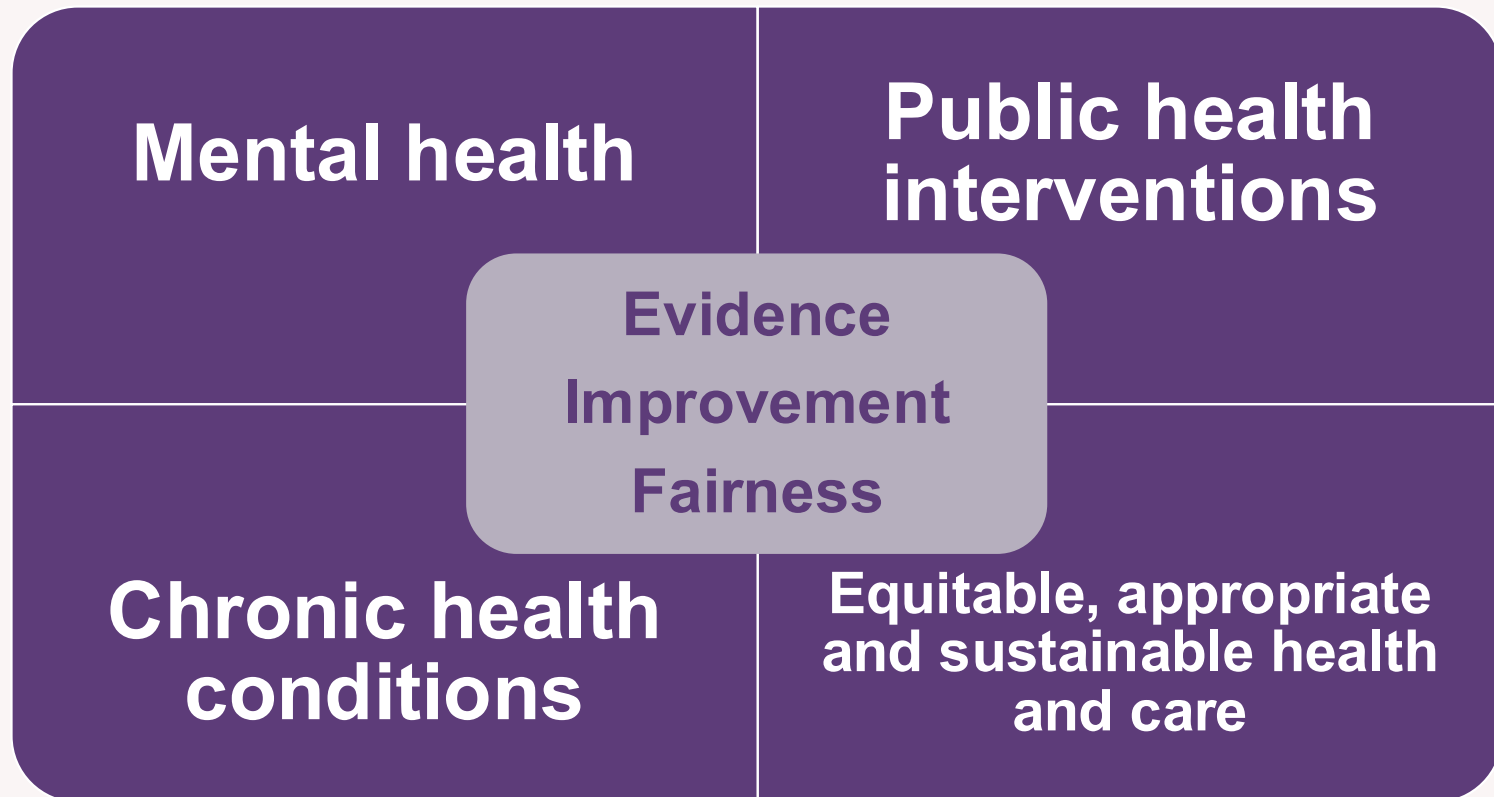


What is a Health Integration Team (HIT)?

- Locally evolved model to tackle important health and care priorities
- Self-formed groups
- Brings together patients and the public with healthcare professionals, researchers, managers and charities



Our HITs focus on ...

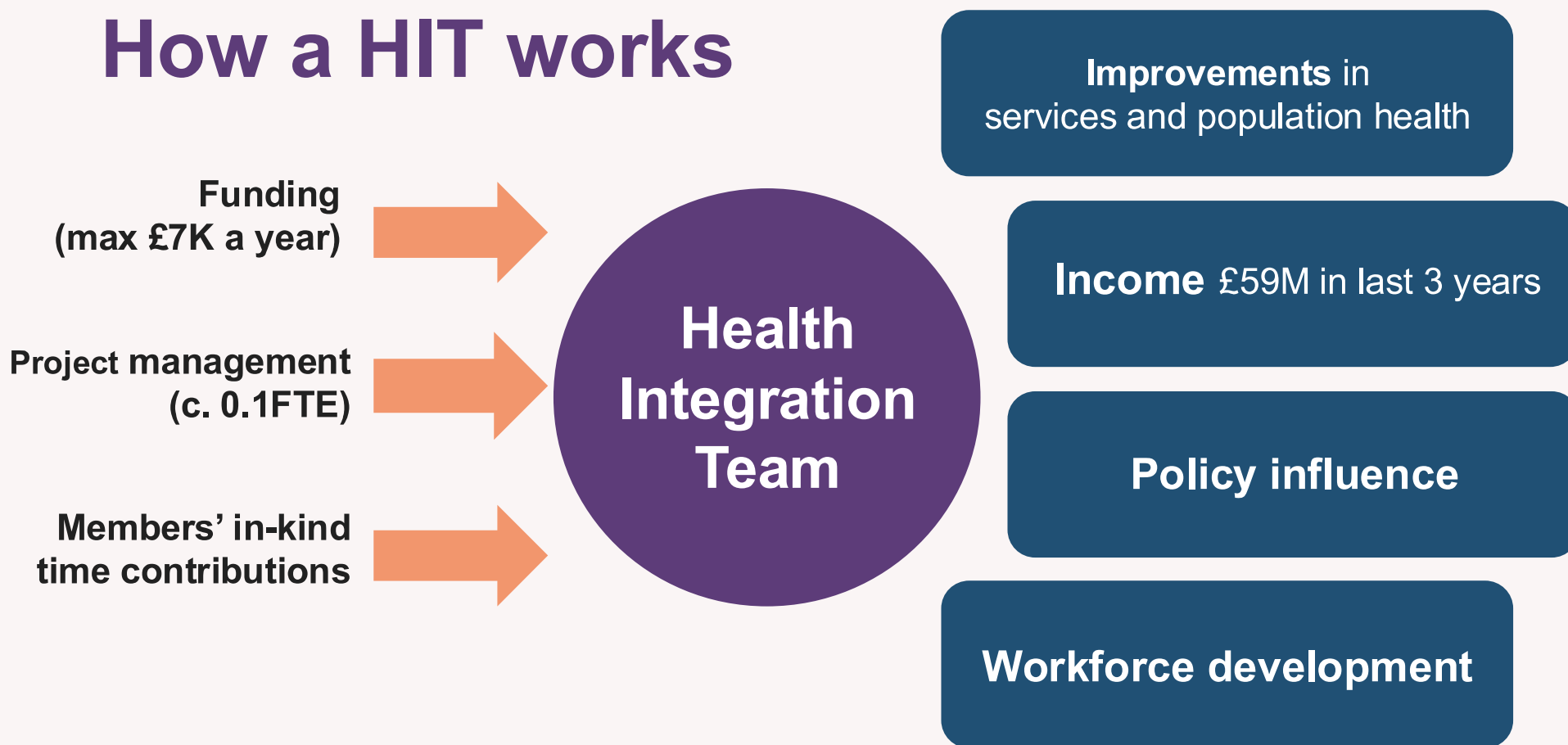


What can a HIT do?

- Generate evidence to inform better health and care
- Provide platform for lived experience to influence service improvements
- Develop workforce skills
- Evaluate effectiveness of existing and new programmes
- Work with NHS to change national guidance



How a HIT works



New HIT: End of Life Matters

End of life affects us all, at every age and in every community.

The End of Life Matters HIT has been created to improve care and support for people approaching the end of life and for the families and communities around them across the South West.

Our goal is to make care more joined up, fair and responsive to what matters most.



Meet our HITs today

Session 1: 11.25am

Active Lives
Adversity and Trauma
Bristol Immunisation Group (BIG)
Dementia
End of Life Matters
Healthy Weight
Kidney Disease
Perinatal and Infant Mental Health
Psychosis

Session 2: 3.15pm

Bladder and Bowel Confidence (BABCON)
Bones and Joints (BBJ)
Chronic Pain
Drug and Alcohol
Eating Disorders
Self-harm Matters
Sexual Health Improvement (SHIP)
Healthy Neighbourhoods (SHINE)
Stroke



Networking session 1

Health Integration Teams

Active Lives
Adversity and Trauma
Bristol Immunisation Group (BIG)
Dementia
End of Life Matters
Healthy Weight
Kidney Disease
Perinatal and Infant Mental Health
Psychosis

Guest exhibitors

BNSSG Integrated Care Board
Research team
Caafi health
Centre for Academic Primary Care at the University of Bristol
Health Innovation West of England
NIHR Regional Research Delivery Network South West
People in Health West of England



HITs in focus

- Stroke HIT
- Chronic Pain HIT





Improving Stroke Care together

IMPROVING THE STROKE CARE PATHWAY WITH PUBLIC CONTRIBUTORS

CLAIRE ANGELL - CO-DIRECTOR OF STROKE HIT AND LIVED EXPERIENCE LEAD

EMMA RICHARDS - CLINICAL AND OPERATIONAL LEAD FOR THE INTEGRATED COMMUNITY STROKE SERVICE

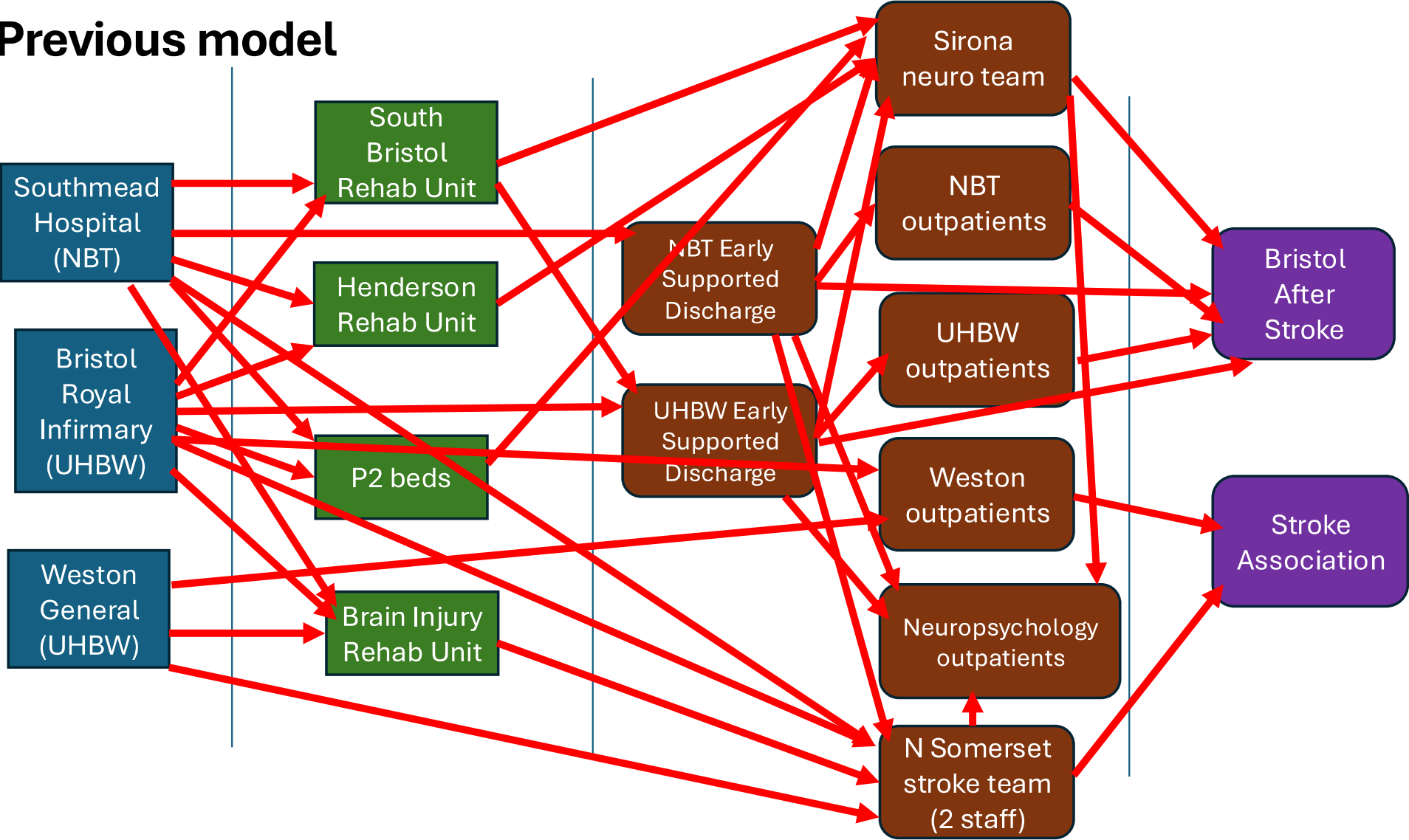
The role of the public contributor in co-design of the Integrated Community Stroke Service

- 1** Attending monthly meetings of the Stroke Programme Board and sub-groups (Integrated Community Stroke Service, Clinical Design, Early Discharge)
7+ years commitment with the remit to challenge and guide clinicians despite the individual difficulties brought about by stroke
- 2** Preparation of the Pre-consultation Business Case
Including Option Appraisal workshops and presenting at key governance reviews
- 3** Preparation for Public Consultation
Including advice for maximising accessibility
- 4** Development of Stroke HIT Lived Experience Group
Bringing patients, carers and voluntary sector together

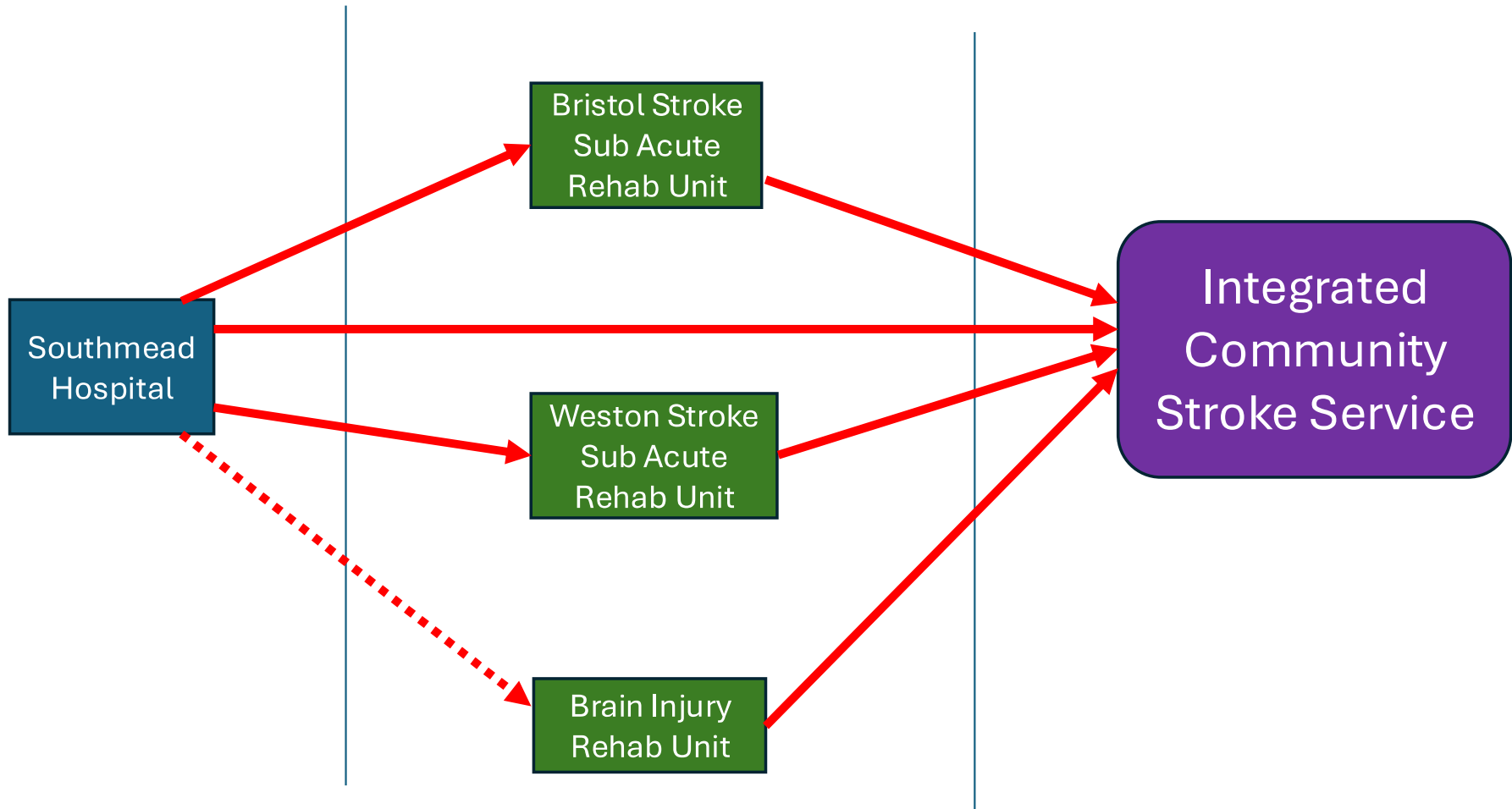
Gathering the voice of Lived Experience in co-design

- 1 Addressing the inequity of stroke service provision across Bristol, North Somerset and South Gloucestershire
- 2 Matching patient need to ease of manoeuvrability in the transition between different stages of the pathway
- 3 Preventing the patient experience of 'falling off a cliff' after discharge from acute and sub acute care
- 4 'Holding' the patient for as long as they have personal rehab goals in the community and offering a 'Life After Stroke'
- 5 Accepting that the patient has expertise by experience

Previous model



Current model



Results of the reconfiguration

- More streamlined pathway
- One Integrated Community Stroke Service (ICSS) team across the region
- Life after Stroke integrated into ICSS
- Stroke skilled workforce
- Better handover and equity of service
- Referrals back into same service
- 6-month reviews
- Health promotion and secondary prevention
- Neuropsychology



The support and care I
am receiving is
staggering. All staff show
genuine concern and
exceptional generosity

First class, just got
everything right. I
can now do my hair,
put earrings in, get
dressed, walk with
stick to shops. I got
my confidence back

Despite the circumstances of
our meeting (my stroke) I feel
genuinely privileged to have
met everyone of the team,
who not only supported my
physical recovery but also my
mental wellbeing throughout

Chronic Pain

Subitha Baghirathan, Research Engagement Network
Community Researcher and Public Involvement member

David Wynick, Honorary Consultant in Pain Medicine, University
Hospitals Bristol & Weston NHS Foundation Trust and Professor
of Molecular Medicine, University of Bristol

Enquiry: long term pain experiences of Caribbean and South Asian women

Nilaari Agency/
Research Engagement
Network (REN)

Sept '23 to May '24

Hearing directly from
women in these two
groups, through one-to-
one interviews

Carried out by Subitha
Baghirathan,
Community Researcher
and ongoing PI member
of REN

4 Caribbean women;
4 South Asian women

1 GP in central health
practice; 2 Social
Prescribing Workers

Key learning

- Length of time to diagnosis of health condition (often over 3 years)
- Many cited the influence of their ethnicity and sex on their interactions in medical appointments
- Very little/ no advice or signposting to non pharmaceutical support, or services. E.g. local low cost or free movement classes
- Most valuable sources of ideas and support for pain management outside of the medical/clinical field
- Scant awareness/info of local NHS pain management offers
- Clear difference between Caribbean and South Asian women ref. being able to share openly with peers and family
- Impact of menopause



We shared our stories - now what?

Smoother referrals to specialist professionals for quicker diagnosis of health conditions

Better info and signposting to current local pain management services including low cost/ free movement classes

Non pharma 'prescriptions' as the first offer, as a standard, for holistic health including diet, sleep, movement

Peer support group for menopause and/or living with pain, specifically for visibly minority ethnic/ Global Majority women

Other relevant resources/ info

- Bristol, North Somerset and South Gloucestershire- wide report on people living with long term/ chronic pain (2024)
- Nurofen report on long term pain and sex bias in treatment (2024)
- Public Health England enquiry into Opioid Prescriptions (2019)



Thank you

Thank you for your interest in future partnership working to improve the experiences of women, particularly those of Caribbean and South Asian ethnicities, living with long term pain in Bristol, North Somerset and South Gloucestershire.

Subitha Baghirathan, Research Engagement Network
Community Researcher and Public Involvement member

Chronic Pain

- Chronic Pain (CP) (lasting more than 3 months), represents a major global burden in terms of years lived with disability and the associated economic impact due to health resources used and work absenteeism
- National Institute for Health and Care Excellence estimated that Low Back Pain alone cost the NHS £2.1 billion in 2008, with additional informal care and productivity loss of £10.7 billion
- CP requiring regular prescribed analgesic medication for at least 12 months is the second most impactful condition on health services in Bristol, North Somerset and South Gloucestershire (BNSSG) after anxiety/depression, and the most impactful in the over 50s
- Common, affecting 70,631 (9.1%) of the adult BNSSG population:
 - More common in women than men
 - Significant under-representation in all ethnic minority communities
 - More common in deprived populations
 - Major geographic variations: highest prevalence in the Weston-super-Mare Primary Care Network which has the greatest deprivation (up to 1.4-fold higher than the BNSSG average)

Who is most affected by CP?

- There are high numbers of working-age people living with CP
- 44% of people with CP have anxiety/depression – 2.75-fold higher than those without pain.
- People who are housebound have a 6.2-fold higher prevalence of CP
- People with a learning disability have a 2.5-fold higher prevalence of CP when standardised for age and sex against the BNSSG population
- Those who are homeless have 2.4-fold higher prevalence of CP
- Worryingly, at least 5% of these patients are receiving both opioids and gabapentinoids and are at considerable risk from overdose and serious adverse effects
- The costs/head of population are x5 higher for those with CP compared to those without.
- Those with CP used 4.5M healthcare appointments/contacts costing £441M

Pain Management Programmes

- Pain Management Programmes (PMPs), usually delivered over 8 weeks, are the intervention of choice for people with CP which adversely affects their quality of life and where there is significant impact on physical, psychological and social function
- PMPs are based on cognitive and behavioural therapy, learning and conditioning processes, skills training, physical exercise and education and have a good evidence base for their efficacy compared with either no treatment or treatment as usual
- Improve participation in daily activities and enhance quality of life by focusing on increasing mobility, self-care, work, leisure and social activities, emotional well-being and reducing reliance on medication and healthcare use

Scale up of PMPs

- The current time from GPs starting prescribed analgesics to a patient with CP starting a hospital-based PMP in BNSSG is ~5-years, by which time they are more disabled and far less likely to be working, both of which are associated with greater healthcare usage
- We plan to test the clinical and cost-effectiveness of delivering PMPs at scale in local neighbourhood hubs close to where patients live (rather than in a hospital setting) and much earlier in the patient journey. This will maximise participation and minimise disability and medicalisation
- PMPs will be directly accessible to patients and primary care/community healthcare staff, rather than first requiring referral to secondary care
- This will fully support the government's aim of bringing care closer to where people live, as recommended in the NHS 10 Year Plan, through new neighbourhood health services to deliver more proactive and personalised care

Bristol Health Partners

Conference 2025

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slido

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Slido app on all computers you use



Audience Q&A

① Start presenting to display the audience questions on this slide.

Rising Voices Recovery Choir

Bristol Drugs Project



“We can't fix what we don't measure.” Understanding the under-representation in research participation

Connie Shiridzinomwa, Bristol Health Partners



Background

- Individuals from many minoritised communities and from areas of high deprivation are under-represented in research.
- Under-representation reduces the generalisability of findings, exacerbates poor patient outcomes and increases treatment costs.
- Very little data on Protected Characteristics or caring responsibilities is routinely collected clinically or from research participants. This makes it very difficult to identify under-represented communities/groups.



Why inclusion is important in research

How do we know that an intervention works for a certain population if we have never done research with that population?

- 1) Racial bias in pulse oximetry – Covid-19 ([NHS Race & Health Observatory](#))
- 2) Ethnic difference in pharmaco-absorption of oncology drugs
- 3) If a small number of people are involved, their side effects may be ignored as insignificant, compromising clinical safety ([Asthma drug](#) – Johnson et al 2025)



What we aimed to do

Bristol Protected Characteristics Project started in May 2024.

It aimed to establish a process to collect data on Protected Characteristics, caring responsibilities and deprivation from all participants in research across our region that was:

- Efficient
- Scalable
- Adoptable (REDCap)



Protected Characteristics



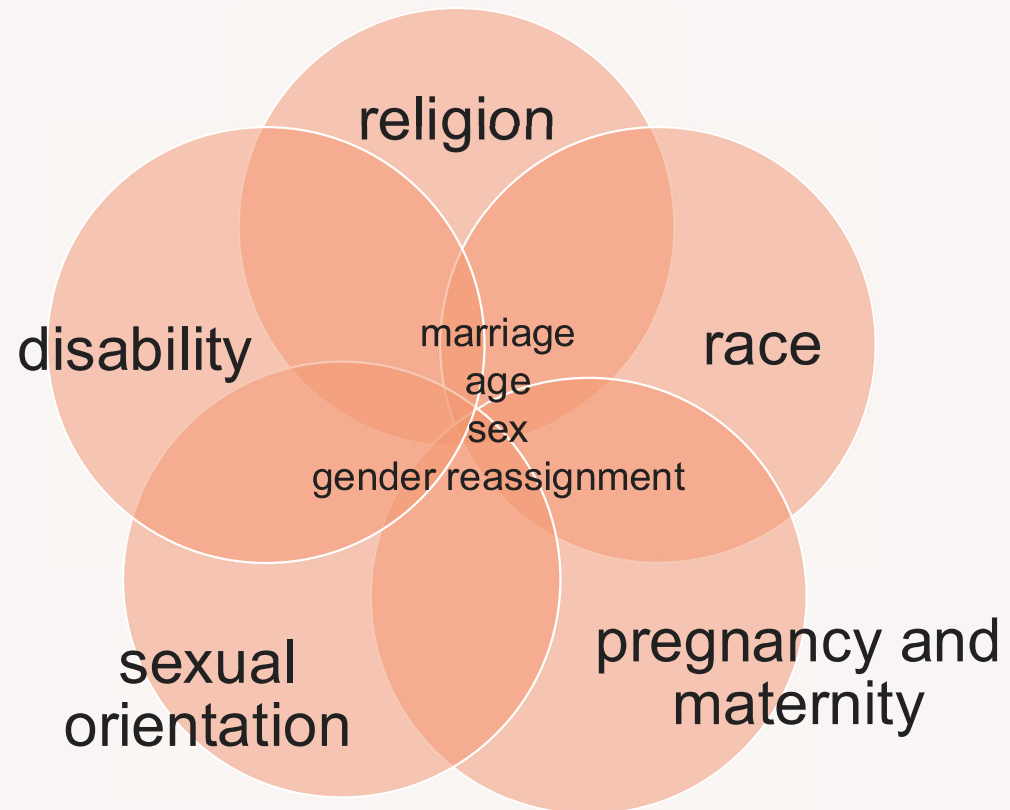
Also included



*Index of Multiple Deprivation

How we recruited the focus groups

- Advertisements, community groups and word of mouth
- Purposive sampling – intersectionality



Lessons learned from recruitment

- Be flexible in recruitment methods
- Understand the community leaders and how they function as gatekeepers
- Start with the community preference for venue and time
- Allow different methods to input in your study; e.g. email feedback
- Be flexible with payments – cash, vouchers
- Think about recruitment timings – avoid school holidays
- Prospective data collection is more effective

How we developed the questionnaire

How do you want us to collect your data?



How we collected the data

- Data was collected from those who took part in NIHR research studies across primary and secondary care in Bristol, North Somerset and South Gloucestershire between 1 January 2022 and 31 December 2023. These included paediatric studies.
- A URL link to the questionnaire was sent via email or text.
- Postal questionnaires were also sent.
- We used secure digital tools to contact people and store their responses (REDCap, DrDoctor and Twilio)

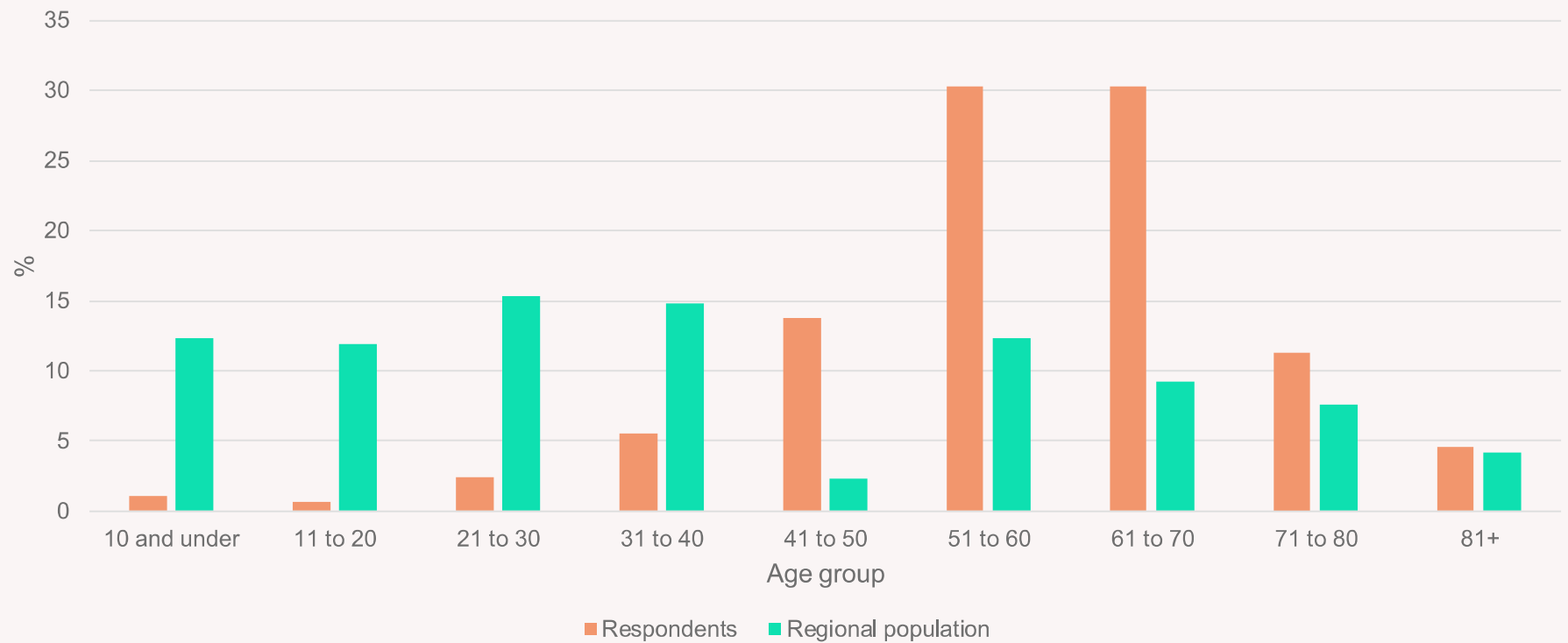


Results

- 39,939 participants from more than 410 primary and secondary care NIHR research studies responded
- Overall response rate was 37%
 - 54% responded by post
 - 41% by email
 - 17% by SMS



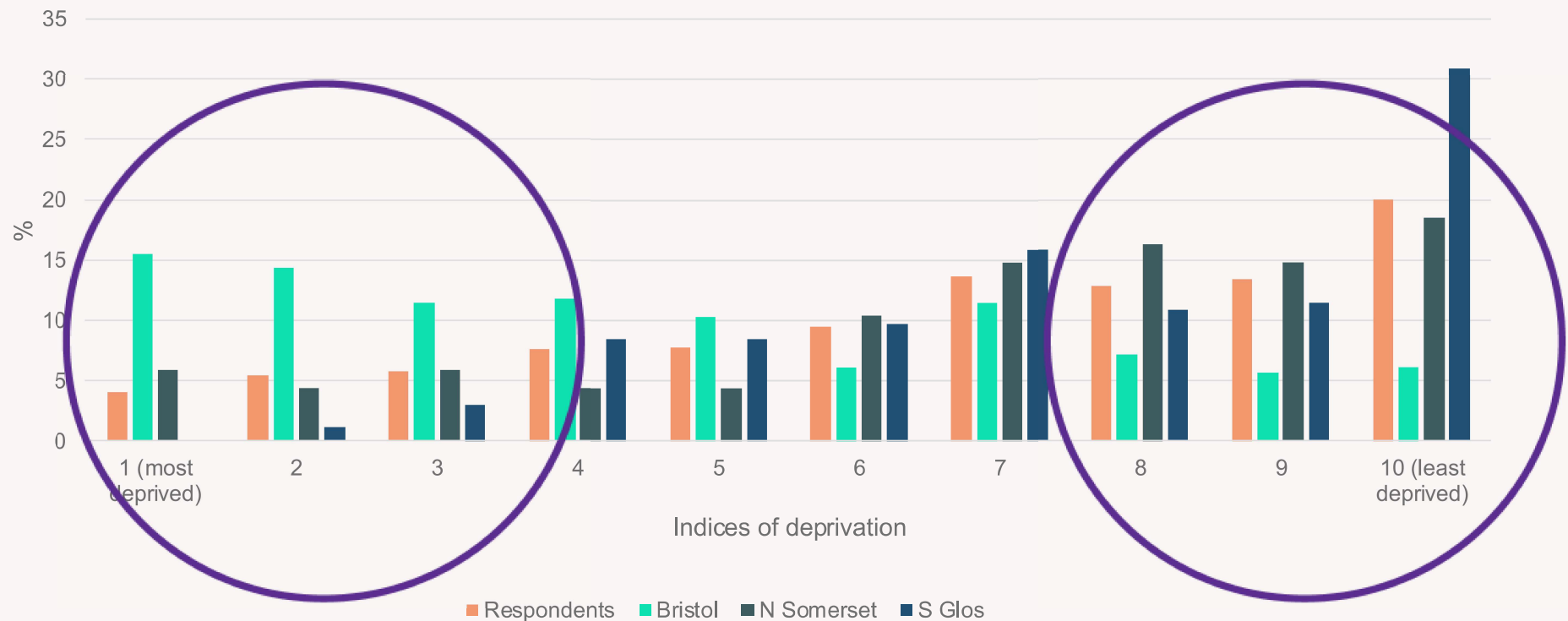
Over-representation of research participants aged 50+



Significant under-representation from Black African, Caribbean and Asian heritage communities



Three-fold under-representation in those who live in areas of greatest deprivation (comparing the three most and least deprived deciles)



What this means

- For the first time, we have detailed information about who is missing from our local research.
- We need to work in partnership with communities to address these gaps at all levels:
 - research questions we ask
 - public contributors we involve
 - participants we recruit
 - how we recruit
- We can measure whether these efforts work.

What we're doing

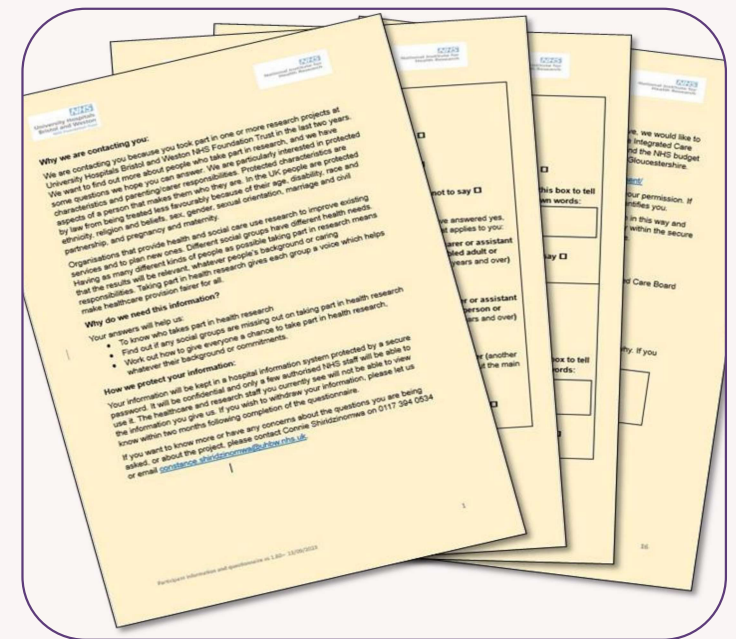
- 1) Regional collaborated effort to address under-representation:
 - Health Ambassador Programme (diverse Research Engagement Network)
 - Improved recruitment tools (People in Health West of England)
 - Trauma informed and anti-racist training for the research workforce
- 2) Adapted questionnaire to assess diversity of workforce and public contributors.
- 3) Commitment to repeat the survey in five years and review effectiveness of our interventions.



Using the questionnaire

The Bristol Protected Characteristics Questionnaire will soon be available for you to use when recruiting for your own research.

To find out more, go to bristolhealthpartners.org.uk/pc



Thank you

Connie Shiridzinomwa, Bristol Health Partners



Making a Difference Research in Practice

Christina Gray
Director of Public Health
Bristol

22.10.2025

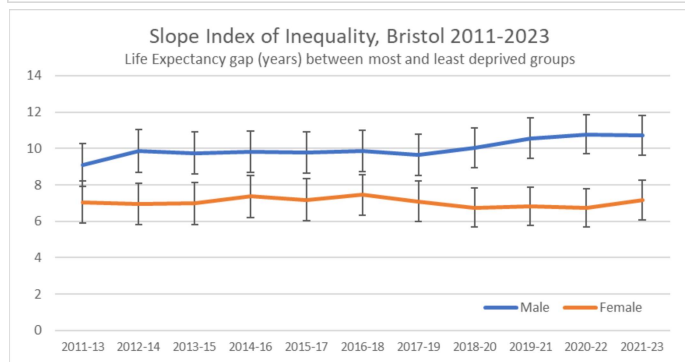
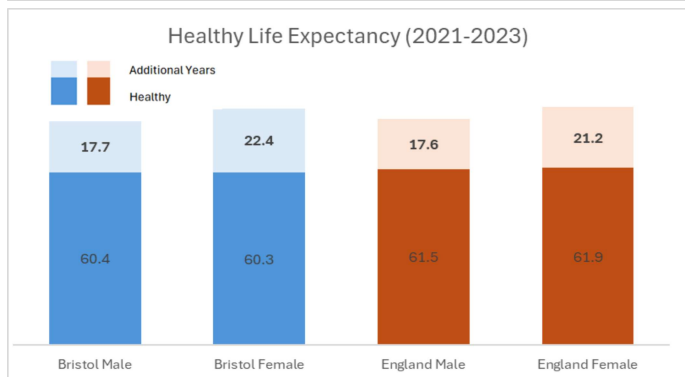
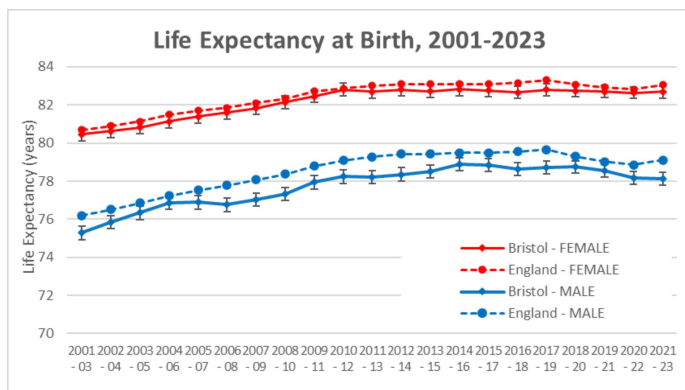


Acknowledgements



Dr Jo Williams FFPH, Consultant in Public Health
Sharea Ijaz, Embedded Researcher, Communities & Public Health
Bristol City Council

And with thanks for support, collaboration and inspiration from
research and academic colleagues across our research
communities

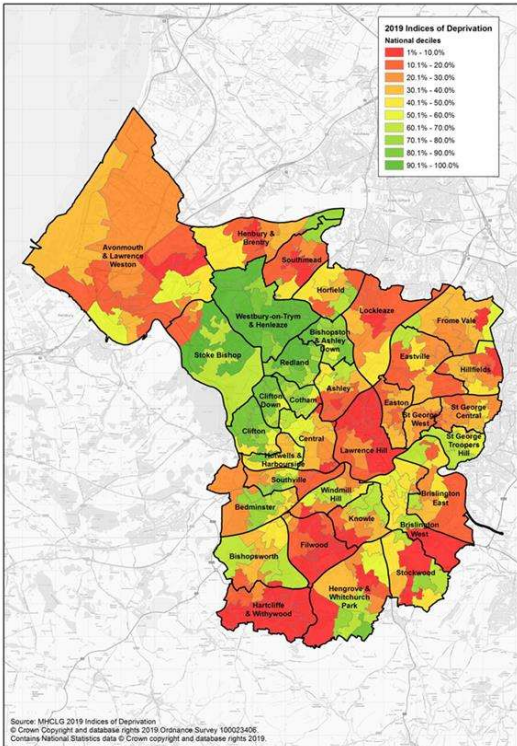
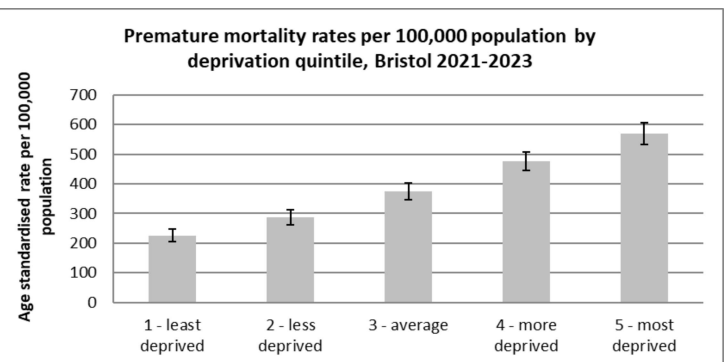


15% of Bristol's population live in the most deprived 10% of areas in England (IMD2019)

17,200 children (21%) and **13,600 older people** (17%) in Bristol live in income deprived households (IMD2019)

13.9% households with a smoker (ranging from 5.3% in Cotham to 21.6% in Ashley) (QoL 2024/25)

The challenge



48.4 violence offences per 1,000 population (ranging from 9.7 in Westbury-on-Trym to 131.4 in Central) (2024/25)

30.3 domestic abuse related incidents and crimes per 1,000 population (16+) (ranging from 3.1 in Clifton Down to 41.5 in Hartcliffe and Withywood) (2024/25)



Bristol as a city (Census 21 data)



**Health issue
or disability**
19.4%

Equality Act Disabled
(17.8% England & Wales, E&W)



**Born outside
the UK**
89,000

18.8% population
(16.8% in E&W)



No car
26.2%

Households with no car
(23.3% in E&W)



Veterans
9,491

2.4% population 16+
(3.8% in E&W)



Ethnicity
287+

Somalis are the largest ethnic minority group
in Bristol with a population of almost 9,200



Population
494,400
mid-2024

+11% 2014-2024
3rd fastest growing Core City



Qualifications
42.1%

with a degree or higher
Highest of E&W Core Cities (33.8% E&W)



LGB+
23,650

6.1% population 16+
(3.2% in E&W)



Trans
3,220

0.8% population 16+
(0.5% in E&W)



Main languages
90+

7,000 Polish speakers



Religion
45+

51% no religion
(37.2% in E&W)



“The Flying Lovers of Vitebsk

Painter Marc Chagall and his poet wife Bella, were partners in life and in art. They met in Vitebsk (or Vitsyebsk or Viciebsk), a small village in Russia (now Belarus).

Their life takes them through the Russian revolution, pogroms, two world wars, loss of home, displaced, destitute. They rise up, fight or flee a multitude of perils.

In the picture the couple fly above the homeland they love and belong to.

The couple in the picture painted as Marc and Bella could be any two people.

The painting is about people, perspective and place.

The questions



What is the problem we are trying to solve?



What counts as evidence?



Social Theory

Social psychology

Sociology

Meta theory

A priori assumptions

Narrative/s

The nature of truth/s

Paradigm/s

Marx, Durheim, Weber, Bruner,
Berger, Gergen.....

Critical theory

Structural racism

Discrimination

Baked in exclusion

Inequality



Developing a Framework for Research in Policy and Practice

Building a Bridge:

- Evidence into policy and practice
- Policy and practice relevant research
- Foundations of co-production with communities, system leaders and service providers

Through:

- Research activity
- Research connections
- Research capacity
- Research culture
- Research systems & governance



We will: “Co-create innovative and research-based solutions that address health and wellbeing inequalities in the city-region and beyond.”

Bristol Civic University Agreement 2023-2030

SHINE HIT - Mould and Damp in Homes

UK Housing stock is old and damp and mould is frequently a problem.

Bristol Health Partners via the SHINE HIT (and NIHR ARC West) supported public and stakeholder engagement which identified practical issues for healthcare staff supporting people living in unhealthy housing.

The HIT connected the Public Health team with academics, service leads, and local GPs.

Impact

- The City Council formed a fuel poverty damp and mould group and developed a damp and mould checklist to support patient-facing health and care workers.
- This checklist was piloted successfully across public and VCSE organisations.
- A Code was added to electronic health record system so GPs could flag and refer patients with unhealthy housing who need support to appropriate services.

Evaluation to follow



Trauma Informed Systems - Adversity and Trauma HIT

Bristol Health Partners support to provide Trauma Informed Systems leadership through a post hosted by the Integrated Care Board



About us Our work Your health Get involved Training and careers News and events Integrated Care Board

Home » What is trauma-informed practice?

Becoming trauma-informed

Contents

- [What is trauma-informed practice?](#)
- [Working in a trauma-informed way](#)
- [Pledge for partners](#)

What is trauma-informed practice?

Trauma results from an event, series of events, or set of circumstances that are experienced by an individual as harmful or life-threatening.

While unique to the individual, generally the experiences of trauma and adversity can have a profound and wide-reaching impact on the lives of individuals, families and communities. These experiences can influence people's interactions and how they interpret the world and their surroundings.

Trauma-informed approaches acknowledge the prevalence of trauma in society, recognise the signs and symptoms of trauma, resist re-traumatising people and respond by building our knowledge and understanding of trauma into all that we do.

NIHR | Applied Research Collaboration West

Sharing learning to embed trauma-informed systems across public services



We aim to understand:

- How organisations understand trauma-informed practice
- What work is being done to adopt these approaches through different organisations within the BNSSG area
- The factors enabling or preventing trauma-informed practice
- How to improve trauma-informed practice in organisations

The City at Night



39,000

work in health and social care at night

40,700

work in manufacturing, warehousing and freight transport at night

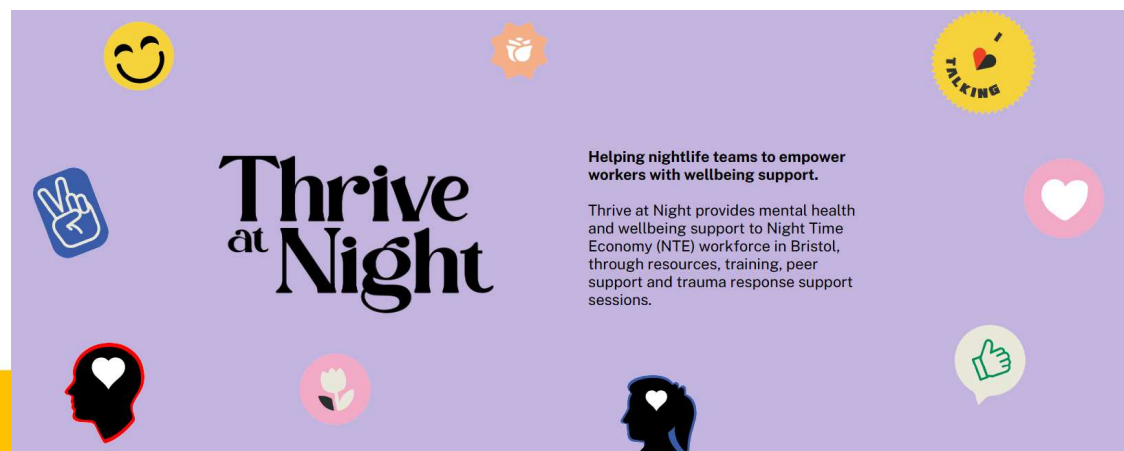
36,700

work in cultural and leisure sector at night

£74million plus generated through Bristol's night time economy

38% of the population is active at night

1/3 of total spend occurs at night¹



NIHR | Public Health Intervention Responsive Studies Teams

NIHR | public health intervention Responsive Studies Teams

Evaluations

Health & Care Professionals

Public Partnerships



[Home](#) > [Evaluations](#) > [Bristol Thrive at Night Evaluation](#)

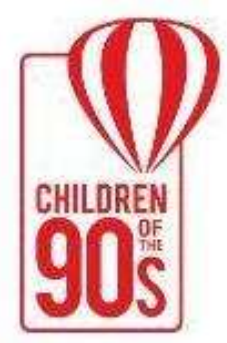
Bristol Thrive at Night Evaluation

Empty Shirts – Preventing Knife Crime

Dr Jade Levell with Professor Jo Staines, Dr Clare Torrible, Professor Roddy Brett, lead assistant researcher Tatania Powell, project assistants Lee Clay and Joseph McNulty Peres.



ALSPAC – Avon Longitudinal Study of Parents and Children



Dr. Alex Kwong tells us how mental health changed across the pandemic and



Dr. Kush Abeysekera discusses the prevalence of liver disease and how Children of the 90s can help understand this trend.

School dinners may encourage picky teenagers to eat better, says new study

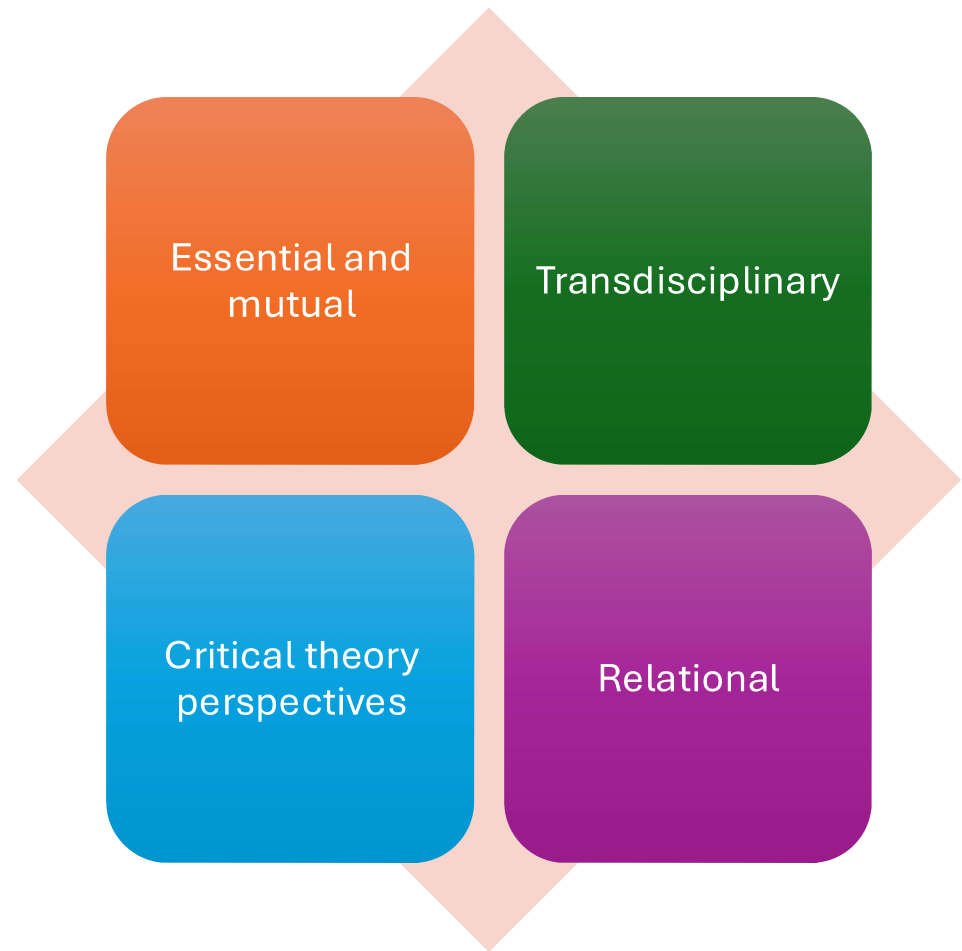
Press release issued: 15 May 2025

Having school dinners rather than packed lunches could encourage picky eating 13-year-olds to eat a wider variety of foods, according to a new University of Bristol-led study. The findings are published in the *Journal of Human Nutrition and Dietetics* today [15 May].



Generic image of two school lunches.
Image credit: istock

Research into practice



Thank you

christina.gray@bristol.gov.uk

jo.williams@bristol.gov.uk


[Download full issue](#)

Public Health in Practice

Volume 6, December 2023, 100447



EDUCATE lesson provides information about the HPV vaccines in schools

It is aimed to help young people's decision-making

The research tested its effect and found that the lesson was positively received by school staff and young people.

The EDUCATE lesson is now available in the public domain for enhancing information about the HPV vaccine in schools.

Towards successful implementation of public health research into practice: Experiences and lessons learned from EDUCATE

Harriet Fisher ^a , Suzanne Audrey ^a, Tracey Chantler ^b, Matthew Dominey ^c, Karen Evans ^d, Lizzie Henden ^e, Matthew Hickman ^a, Louise Letley ^f, Alix Towson ^d, Clare Thomas ^{a g}

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<https://doi.org/10.1016/j.puhip.2023.100447>

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Open access

Home > Evaluations > Evaluation of the Bristol City Council Substance Use Support Team (SUST) Trauma Informed Recovery Pathway (TIRP)

Evaluation of the Bristol City Council Substance Use Support Team (SUST) Trauma Informed Recovery Pathway (TIRP)

Evaluation completed September 2024

[Read the evaluation report](#)



What does the research mean for Local Authorities?

The evaluation of the TIRP aims to produce learning about the early delivery of a newly implemented intervention to address barriers to service use among clients with substance use and complex needs. Local evaluation partners and stakeholders have indicated that they would use the evaluation findings to inform improvements to the delivery of TIRP in future as well as potentially informing future commissioning decisions about drug and alcohol services in the city. Although the intervention is modest in scale, our evidence review suggests an evaluation can also contribute to addressing a gap in scientific evidence as much of the research on trauma-informed approaches has been undertaken in the US context.

Bristol Advertising Policy

Advertising and Sponsorship Policy



Prohibits advertising of:

- Food high in fats, sugar, or salt
- Alcohol
- Gambling

The Bristol Evaluation of Advertising Restrictions (BEAR) study: Findings from the baseline data



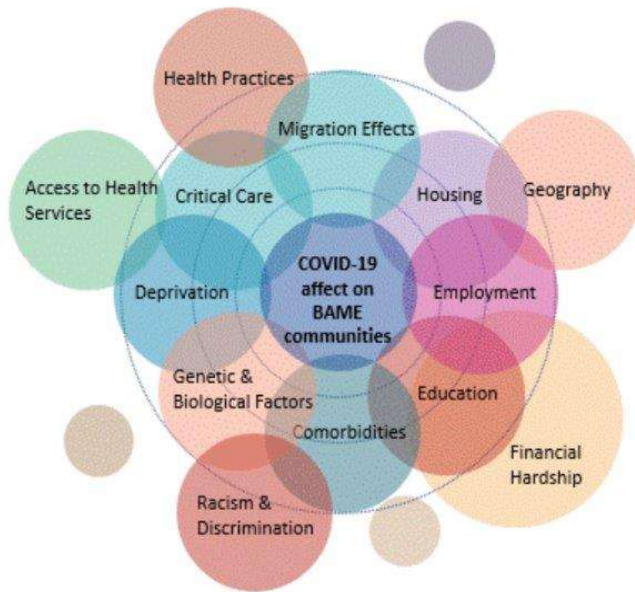
Image credit: Ad Free Cities

Covid 19 – Advisory Group

NIHR | National Institute
for Health Research



The impact of COVID-19 on black, Asian and minority ethnic communities



“You cannot tackle health inequalities alone without tackling the wider determinants”
Previous Deputy Mayor Asher Craig



Home About us Research Patient and public involvement Training Publications News

ARC West rapid review explores disproportionate impact of COVID-19 on black, Asian and minority ethnic communities

18 June 2020

The risk of death from COVID-19 is higher among black, Asian, and minority ethnic (BAME) people than the white British population. An **ARC West rapid review** commissioned by Bristol City Council and led by Dr Loubaba Mamluk and Dr Tim Jones explores why this is the case and offers a summary of policy recommendations that could help reduce these health inequalities.

The researchers found a complex mixture of factors, including being poorer, where people live, overcrowded housing, types of job, other illnesses and access to health services, all influenced BAME communities' outcomes. No one factor alone could explain all of the disparities found.

Bristol Health Partners

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Audience Q&A

① Start presenting to display the audience questions on this slide.

HITs in focus

- Sexual Health Improvement Programme (SHIP) HIT
- Drug and Alcohol HIT



Common Ambition Bristol

Improving sexual health

Improving HIV healthcare for African and Caribbean heritage communities

Matthew Wilson,
Common Ambition Bristol Project Coordinator



Plan

Why CAB was needed

What CAB does

The impacts so far

What we have learnt

Why co-production matters

**Common
Ambition
Bristol** 

Why Bristol needed CAB

- High HIV prevalence and late diagnosis rate
- People of African & Caribbean heritage make up almost 6% of Bristol's population ...
- ... But 28% of people in Bristol living with HIV are of African & Caribbean heritage
- Lower uptake generally of sexual health services by these communities
- This reflects ongoing health inequities
- 2019: Bristol became 'Fast Track City' – working to meet goal of zero HIV transmission by 2030
- 2020: Common Ambition Bristol (CAB) was funded



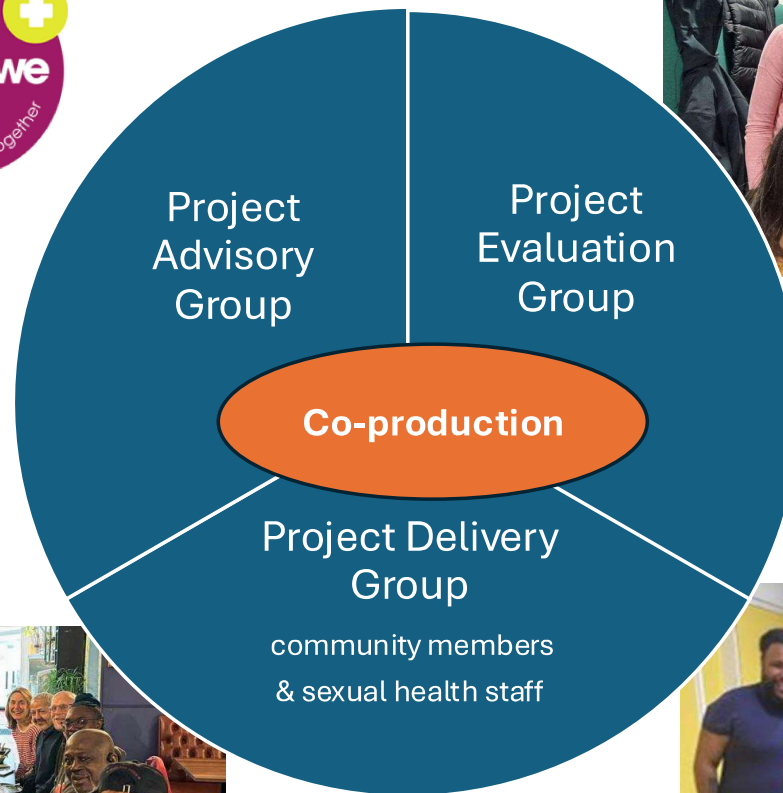
Common Ambition Bristol (CAB): Aims

Community driven co-production project to tackle HIV inequities experienced by people of African & Caribbean heritage in Bristol.

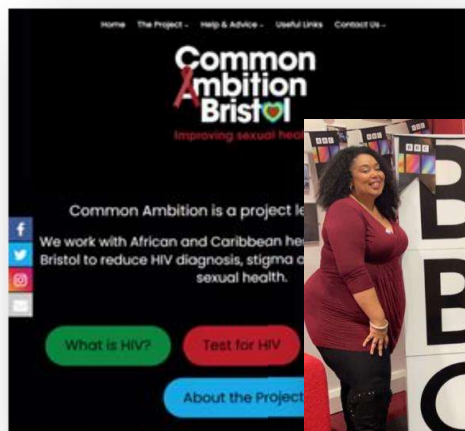
Aims to:

- Increase HIV knowledge
- Reduce HIV stigma
- Improve sexual health services access
- Increase uptake of HIV testing and PrEP





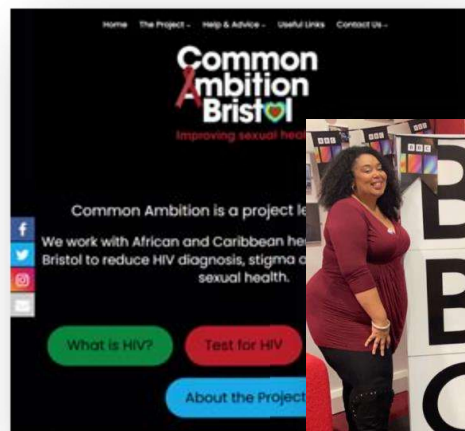
What do we do? CAB Interventions





What do we do?

CAB Interventions



Multimedia
Resources

Community
Outreach

Community
Testing
Clinics

Targeted
Health
Promotion
Events



CAB impacts...so far



Funding and sustainability

- 2021 – 2024 Health Foundation / NIHR / BCC
- 2025-35 BNSSG commissioned sexual health service



Impact

- HIV testing uptake increase in Bristol's ACHC communities
- CAB updated HIV knowledge, challenged stigma, sign-posted and normalised HIV testing



Teaching and training

- University of Bristol, NHS staff
- Co-production toolkit –local authorities + NHS trusts + UKHSA



Awards

- 2024 PENNA Patient Experience Network national award
- 2025 HSJ Award Highly Commended



“CAB: Your approach is a game changer”
(Healthcare Trust Board Directors)



Improving sexual health

What have we learnt?

Ways to facilitate equal power-sharing and decision-making



Recognise and address power imbalances



Encourage mutual learning from lived and professional experience



Value personal and professional similarities



Co-create fair decision-making processes, with space to work through differences



Agree on a common language that reflects these ideas



Why co-production matters



Relevant and effective

Trust and visibility

Engagement

Empowers communities

Innovation and shared learning

Equity and accountability

Sustainable change



[@commonambitionbristol](https://www.instagram.com/commonambitionbristol)



[@CommonAmbitionBristol](https://www.facebook.com/CommonAmbitionBristol)



[@commonambitionbs.bsky.social](https://bsky.app/profile/commonambitionbs.bsky.social)





Download CAB's co-production Toolkit

Get in touch

Matthew Wilson – CAB co-ordinator

MatthewWilson@brigstowe.org

NO WRONG DOOR Group:

The Art of the Possible



Advancing Mental Health Equity Quality Improvement projects

**Emma: Associate Director of Psychological Therapies & Allied Health Professions,
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)**



The screenshot shows the website of the Royal College of Psychiatrists. At the top, there is a navigation bar with links for 'ABOUT THE COLLEGE', 'NEWS AND FEATURES', 'INTERNATIONAL', 'LOGIN', and 'DONATE'. Below this is a secondary navigation bar with links for 'Become a psychiatrist', 'Training', 'Members', 'Events', 'Improving care', and 'Mental health'. The main content area features a breadcrumb trail: 'Home > About the College > Equity, diversity and inclusion > Advancing Mental Health Equity Collaborative'. The title 'Advancing Mental Health Equity Collaborative' is displayed in large blue font. Below the title, a paragraph describes the collaborative as a quality improvement initiative supporting mental health providers. To the right, an orange box contains the text 'NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH'.

RC
PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS

ABOUT THE COLLEGE NEWS AND FEATURES INTERNATIONAL LOGIN DONATE

Become a psychiatrist Training Members Events Improving care Mental health

Home > About the College > Equity, diversity and inclusion > Advancing Mental Health Equity Collaborative

Advancing Mental Health Equity Collaborative

The Advancing Mental Health Equity (AMHE, formerly known as Advancing Mental Health Equality) Collaborative is a quality improvement collaborative that aims to support mental health providers to advance mental health equity in their local areas.

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

We want to make services and care better for people who use alcohol and drugs and also have mental health difficulties. To do this, we need your help.



'No Wrong Door Anymore'

People need trauma-informed, integrated services where there is 'no wrong door' and they are directed to the right support for them.

We would like to invite colleagues working in – and people with lived experience of accessing – mental health and substance use services to come along and explore together what 'better' services would really mean in practice.

North Somerset - Thursday 30 January,
Regency Room, Weston-Super-Mare Pier

Bristol - Tuesday 4 February, Vassall Centre,
Fishponds, Bristol

South Gloucestershire - Tuesday 4 March,
Vassall Centre, Fishponds, Bristol

All events are from 10:00am -3:30pm (arrival from 09:30).

Each event is about services in that local area – please come along to the event where you live or work, or whichever suits you best: anyone is welcome to join any and all of the events.

There will be refreshments, but please bring your own lunch.

We think these quotes say it best:

"I thought my partner was going to die while she was 'hot potatoed' between substance misuse and crisis mental health services. Until prison saved her life."

"After five decades of suffering, an organisation really heard me for the first time and immediately took action, that week, and I was saved."

"I needed someone to really hear me and to pay attention to what was not being said."

"Let's try and create a service fit for everyone and not everyone to fit the service."

Book your place now by clicking on the location links for each event.

- Three co-produced events funded by the Drug & Alcohol HIT
- Embedded AWP approved service evaluation
- 'Hot potato-ed'



HIT Event 2025

30th January, 4th February and 4th March 2025, 09:30 to 3:30pm



HIT Event	
09:30 – 10:00	Arrival, Registration and Welcome Drinks
10:00 – 10:15	Introduction and welcome • Chairs welcome • Invited speaker • The importance of No Wrong Door
10:15 – 10:40	Increasing communication Lived experience perspective: what are the ingredients of No Wrong Door experience of services? Group activity: What is the goal?
10:40 – 11:00	Themes that unite us across the system Introducing Hazel Renouf: Trauma Informed Care Presentation
11:00 – 11:20	Break
11:20 – 12:00	Group activity: Working together to make no wrong door care happen
12:00 – 12:30	Shared learning

An experience of joined up care	
12:30 – 1:20	Lunch break
1:20 – 2:10	Facilitated conversation: Working together across the system
2.10 – 3:10	Group exercise: Harnessing the learning/Starting to building the No Wrong Door Toolkit
3.10-3.30	Drawing things together – the next step Closing remarks

Events included:

- Three definitions fed into the overarching definition
- “Facilitated Conversation across the System”

‘Hot Potato-ed’ to Partners:

Rebecca: Co-production Service Coordinator, Changing Futures

What it was like then	What it's like now	What I'd like it to be like
		

Overarching Definition

Justine: Person with Lived Experience

“No Wrong Door means that no matter where we go for help, we will be supported. All services work together as part of our community, building trust, sharing information and responsibility; so we do not fall through the gaps. The focus is on our strengths, our power, and what matters to us. It’s about making care personal, trauma informed-responsive and joined-up—so every door you open is the right one”.

Impact of No Wrong Door events: North Somerset experience

Stephen: AWP North Somerset Service User Involvement Coordinator

- **1st August 2025:** linked with AWP Swindon service, to share best practice.
- **20th August 2025 AWP & Substance use Service Meeting :** Joint assessments (AWP Primary Care Liaison Service & With You). Currently working together to ensure updated service information available across our services.
- **7th October 2025 North Somerset Co-Occurring Substance Use & Mental Health Disorders Group** – audit recently completed. Working group focusing on case record system access for Substance Use Service.
- **November 2025:** Planning joint training co-produced and co-delivered.

What's next?

Evaluation analysis and creation of an **SBAR**

Tania: Coproduction Team Manager Changing Futures

Situation: A brief overview of the current problem.

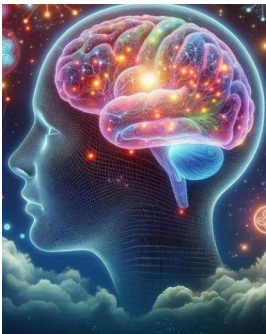
Background: Context & history relevant to the situation.

Assessment: Analysis or evaluation of the problem.

Recommendation: What action you believe is needed

Take to Integrated Care Board, then across the system

Please let us know if you would like to join the No Wrong Door Group/ help with the evaluation 😊



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Audience Q&A

① Start presenting to display the audience questions on this slide.

Networking session 2

Health Integration Teams

Bladder and Bowel Confidence (BABCON)
Bones and Joints (BBJ)
Chronic Pain
Drug and Alcohol
Eating Disorders
Self-harm Matters
Sexual Health Improvement (SHIP)
Healthy Neighbourhoods (SHINE)
Stroke

Guest exhibitors

BNSSG Integrated Care Board
Research team
Caafi health
Centre for Academic Primary Care at the University of Bristol
Health Innovation West of England
NIHR Regional Research Delivery Network South West
People in Health West of England





Reimagining Health and Care

creating the Better Health & Care Hub @ King's

Prof. Irene J Higginson & Dr Wendy Prentice
Palliative Care Clinical Academic Group
Bristol Health Partners Conference 2025



<https://www.kcl.ac.uk/research/better-health-care-futures>

Contact: BetterHCF@kcl.ac.uk

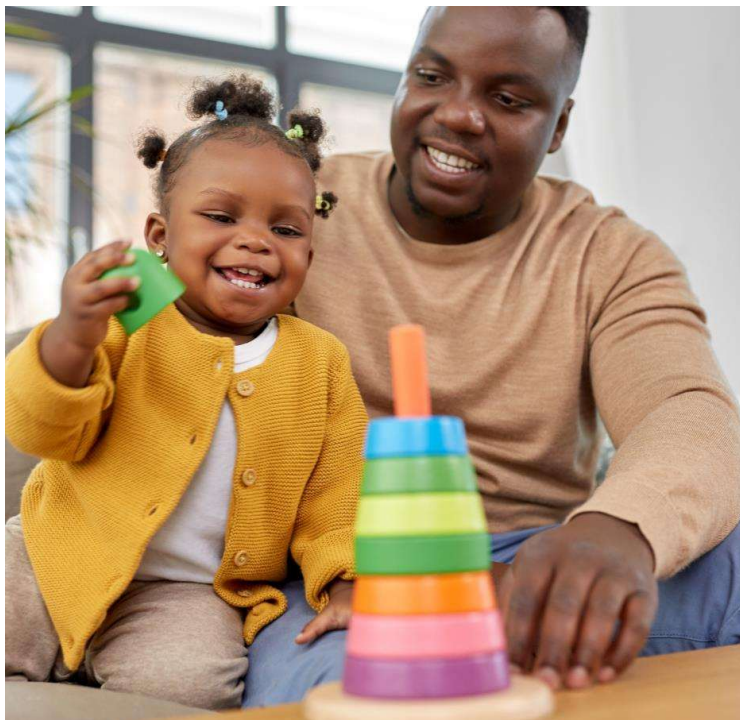
KING'S
College
LONDON

**Better Health
& Care Hub &
Palliative
Care CAG**

**Forging and
sustaining better
health and care
futures for those
with the most
complex needs**

**Cicely Saunders
International**
Better care at the end of life

**KING'S
HEALTH
PARTNERS**



Chronic and multiple conditions already common

By 2035, an estimated

50%

of the UK population will live with two or more chronic conditions, and 17% will have four or more.

Carers UK estimated that

5.7m

people in the UK provided unpaid care in 2021, valued at £162 billion a year – around total cost of the UK's National Health Service (NHS).



Changing Landscape of Societies, Health and Care: Gaps in Current Approaches



Breathlessness



> 5 health conditions



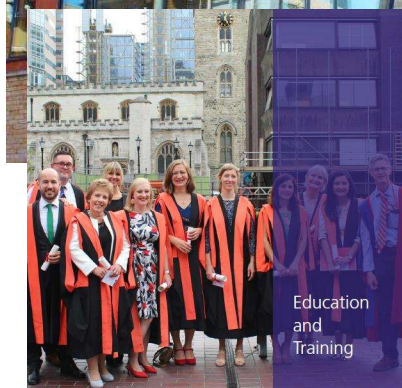
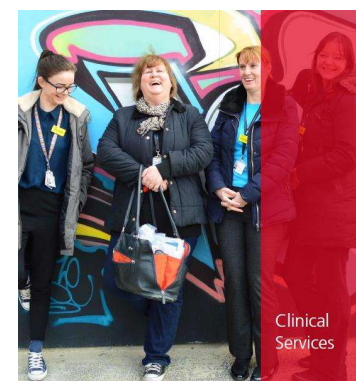
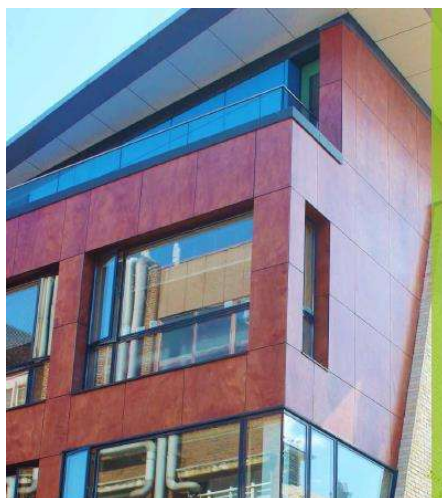
Frailty / dementia



- Two-thirds of adults >65 years expected to be living with multimorbidity by 2035
- Health care spending as % GDP $\uparrow$ 50% in last 20 years
- Global fiscal challenges
- Health care creates 4.4% of emissions worldwide
- Solutions largely overlooked for most complex patients, (highest cost, poorest outcomes)
- Many people with multimorbidity leave hospital more ill than when they entered
- Inequity is widening, ..emergency attendance in deprived areas double
- Workforce shortages
- Population challenges increasing most rapidly in lower & middle income countries

Palliative Care Clinical Academic Group

KING'S
College
LONDON



King's College Hospital



1000+ bedded hospital SE London – international, national referrals but also DGH for local population. Breathlessness is experienced by 20% of ED attenders at King's College Hospital.

75yr old man, presenting to ED.

Found cold and unresponsive by carers who called 999.

GCS 3/15 and in Type 2 Respiratory Failure.

Background

- Severe / end stage COPD, recurrent admissions – 4 admissions in last 4 months.
- Limited exercise tolerance.
- Other comorbidities – AF, Hyponatraemia.

Active management in ED / medicine - NIV / antibiotics.

Referral made to hospital palliative care team.

Palliative care assessment:

Physical – breathless on minimal exertion, continues to smoke, tolerates NIV but keen to stop it

Psychol – significant component of anxiety and panic; scared about hospital environment

Social – limited support, isolated at home, struggling to get around flat, wife died 6 months previously

ACP – had never really thought about this, happy for referral to community palliative care for support

Family / carers – nil significant identified, but enjoys going to pub

Recommendations

Physical – Oxygen weaned, trial of low dose IR morphine, open window and hand-held fan. Referral to OT and physio.

Psychol – Discussion regarding triggers, thoughts and feelings. Breathlessness resource pack. Opportunity to discuss wife's death and sign posting to support in the community.

Social – Keen for home, supported rapid discharge, ongoing therapies support at home, referral made to community palliative care, including opportunity to attend day care services.

ACP – had never really thought about this, happy for referral to community palliative care for support, discussed use of 'universal care plan' to share preferences now and in the future.

Family / carers – nil significant identified.

Research into practice

An integrated palliative and respiratory care service for patients with advanced disease and refractory breathlessness: a randomised controlled trial

Irene J Higginson, Claudia Bausewein, Charles C Reilly, Wei Gao, Marjolien Gysels, Mendwas Dzingina, Paul McCrone, Sara Booth, Caroline J Jolley, John Mochar

Summary

Background Breathlessness is a common and distressing symptom, which increases in many diseases as they progress and is difficult to manage. We assessed the effectiveness of early palliative care integrated with respiratory services for patients with advanced disease and refractory breathlessness.

Methods In this single-blind randomised trial, we enrolled consecutive adults with refractory breathlessness and advanced disease from three large teaching hospitals and via general practitioners in South London. We randomly allocated (1:1) patients to receive either a breathlessness support service or usual care. Randomisation was computer generated centrally by the independent Clinical Trials Unit in a 1:1 ratio, by minimisation to balance four potential confounders: cancer versus non-cancer, breathlessness severity, presence of an informal caregiver, and ethnicity. The breathlessness support service was a short-term, single point of access service integrating palliative care, respiratory medicine, physiotherapy, and occupational therapy. Research interviewers were masked as to which patients were in the treatment group. Our primary outcome was patient-reported breathlessness mastery, a quality of life domain in the Chronic Respiratory Disease Questionnaire, at 6 weeks. All analyses were by intention to treat. Survival was a safety endpoint. This trial is registered with ClinicalTrials.gov, number NCT01165034.

Findings Between Oct 22, 2010 and Sept 28, 2012, 105 consenting patients were randomly assigned (53 to breathlessness support service and 52 to usual care). 83 of 105 (78%) patients completed the assessment at week 6. Mastery in the breathlessness support service group improved compared with the control (mean difference 0.58, 95% CI 0.01–1.15, $p=0.048$; effect size 0.44). Sensitivity analysis found similar results. Survival rate from randomisation to 6 months was better in the breathlessness support service group than in the control group (50 of 53 [94%] vs 39 of 52 [75%]) and in overall survival (generalised Wilcoxon 3.90, $p=0.048$). Survival differences were significant for patients with chronic obstructive pulmonary disease and interstitial lung disease but not cancer.

Interpretation The breathlessness support service improved breathlessness mastery. Our findings provide robust evidence to support the early integration of palliative care for patients with diseases other than cancer and breathlessness as well as those with cancer. The improvement in survival requires further investigation.

Funding UK National Institute for Health Research (NIHR) and Cicely Saunders International.

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Introduction

Breathlessness is a common and distressing symptom in many advanced chronic diseases, causing considerable disability, anxiety, and social isolation.^{1,2} Worldwide, more than 75 million people have breathlessness every year, including more than 90% of the 65 million people with severe lung disease,³ more than 50% of the 10 million with incurable cancer, and 50% of the 23 million with heart failure.^{4,5} Breathlessness increases as the disease progresses,⁶ is frightening for patients and families, and often results in emergency hospital admission because it is accompanied by feelings of loss of mastery over breathing and panic.^{1,8}

Once treatment of the underlying disease is optimised, breathlessness that continues is deemed refractory.⁷ Patients with refractory breathlessness in advanced

disease have many symptoms and concerns that are complex and interact; consequently palliative care has been recommended.^{9,10} In this study, we developed and assessed a new short-term breathlessness support service. This provided one point of access for patients, brought together palliative care and respiratory medicine, and responded to the call for shared care at an earlier stage in disease than usual.¹⁰ We hypothesised that patients attending the breathlessness support service, compared with those receiving standard care, would have better mastery of breathlessness at 6 weeks.

Methods

Study design and participants

This trial was a randomised controlled, parallel group, pragmatic, single-blind fast-track trial in South London,

Lancet Respir Med 2014

Published Online

October 29, 2014

[http://dx.doi.org/10.1016/S2213-2600\(14\)70226-7](http://dx.doi.org/10.1016/S2213-2600(14)70226-7)

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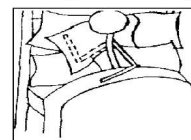
StChristopher's

Breathlessness Management Service

BREATHING CONTROL

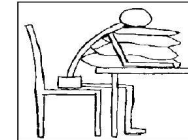
King's College Hospital NHS
NHS Foundation Trust

1. High Side Lying



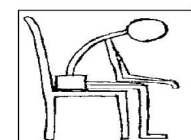
- Make sure your head and chest are supported
- Bend your top leg up
- Put your lower arm under the pillows

2. Forward lean sitting



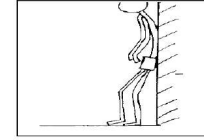
- Pile several pillows on a table
- Relax your head onto them
- Relax your arms on the table
- Do not try this position if you have neck problems or are uncomfortable with things near your face.

3. Relaxed sitting position



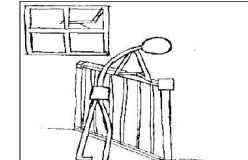
- Sit on a chair
- Rest your elbows on your thighs
- Relax your hands and wrists

4. Relaxed standing



- Lean against a wall
- Relax your shoulders, arms and neck

5. Forward lean standing



- Lean against a banister, fence or wall but keep a comfortable distance
- Relax your hands, wrists and neck

Collaborative care with community partners

Patient Tool Kit

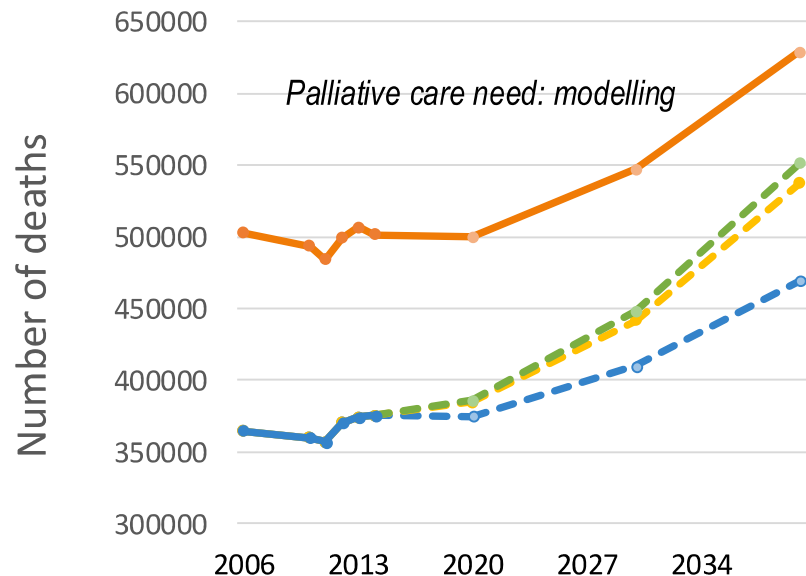
- **Handheld fan / water spray**
- **Information sheets**
 - Breathlessness commonly asked questions
 - Managing breathlessness
 - Pacing
 - Hand held fan
 - Distraction techniques
 - Positions to ease breathlessness
- **Relaxation CD**
- **Crisis plan**
- **Breathlessness poem** (Jenny Taylor)
- **Home visit by physiotherapy/ occupational therapy provides walking aids, home adaptations, exercise DVD or equivalent & ideally reinforces clinic advice**



<http://www.kcl.ac.uk/lsm/research/divisions/cice/lysaunders/research/symptom/breathlessness.aspx>

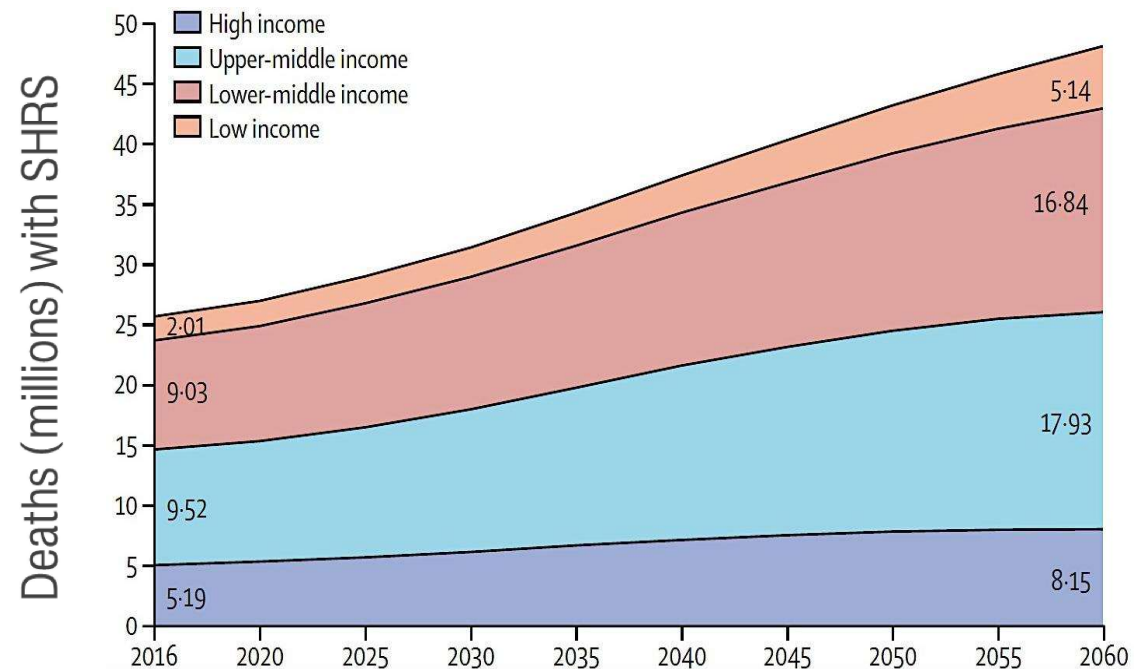
Escalating need for palliative care, globally, trends to 2040-60.. Covid brought some of this in 2020-1

All deaths in England and Wales (ONS data and official mortality projections)



Sources: Etkind et al. BMC Medicine (2017) 15:102
Bone et al Palliat Med. 2017 Oct 1:269216317734435.

Deaths with serious health related suffering (SHRS) are projected to climb



Sleeman et al, The Lancet Global Health 2019



Inequity and challenge?

Individuals on lower income experience significantly worse health outcomes.

By **2035**

complex multimorbidity is expected to disproportionately affect populations experiencing socioeconomic deprivation.

Gaps: Unless we act wisely, things will get worse .. everywhere



Breathlessness



> 5 health conditions



Frailty / dementia



Multimorbidity increases by age, by deprivation, and is increasing over time

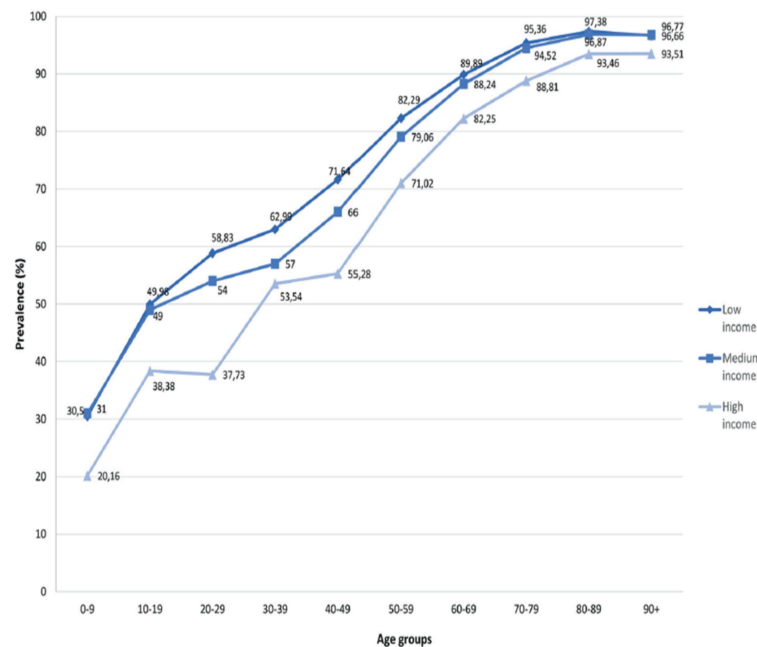


Figure 2. Prevalence of multimorbidity by age group and annual gross income. Annual gross income based on the prescription co-payment rate (low income <€18000, medium income €18000-€100000, and high income >€100000).

Source: Moreno-Juste A et al, *J Glob Health* 2023; 13:04014.

People living in deprived areas are:

- less likely to be cared for at home towards the end of life
- less likely to die at home
- less likely to access palliative care

Source: Davies JM, et al *PLoS Med*.

New health policy changes may miss benefiting those people in deprived areas, those with multimorbidity, those from different ethnic groups or races.

Sources: Bajwah S, et al, *BMJ Support Palliat Care*.
Higginson IJ, et al, *BMC Med*

Is a risk with new initiatives such as virtual wards

..

Worldwide health & care workforce shortage

- Workforce shortages strain health and care systems, leading to overburdened staff, longer wait times, and reduced care quality.
- Adequate staffing is crucial for service availability, accessibility, and effectiveness. Shortages increase costs due to inefficiencies and missed early-stage diagnoses.

The Association of American Medical Colleges projects that physician demand will continue to grow faster than supply, with the US United States seeing a shortage of between 13,500 and 86,000 physicians by 2036.

UK NHS Long Term Workforce Plan highlighted an expected shortfall of 260,000 to 360,000 staff by 2036/37.N5

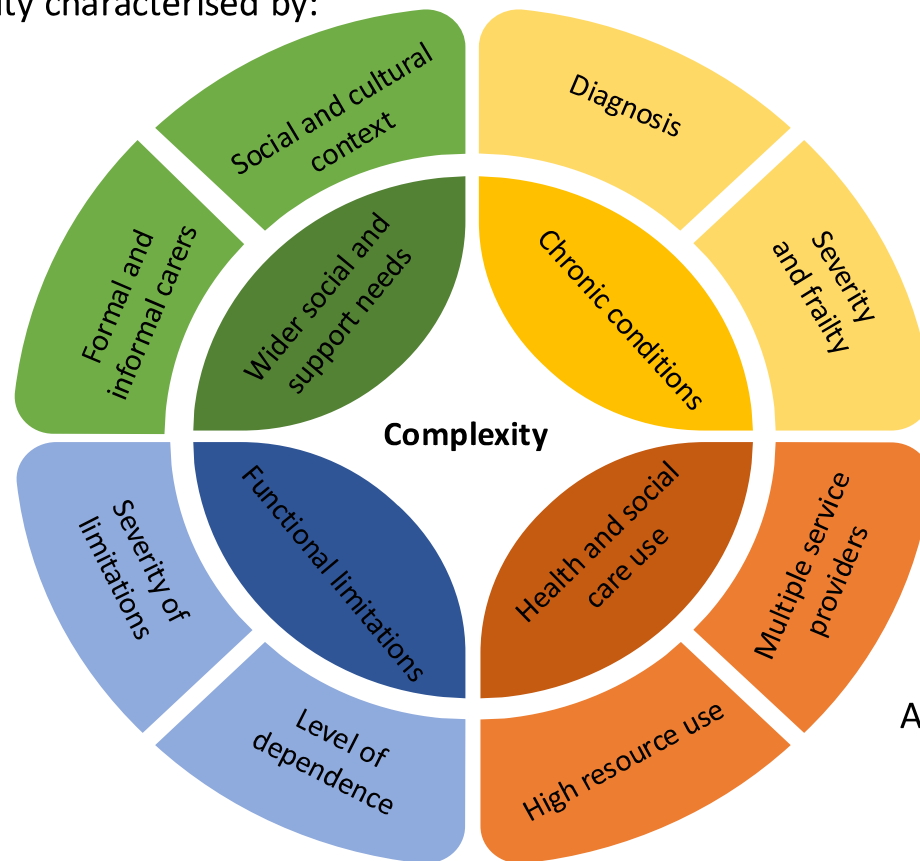
• WHO report: State of the World's Nursing Report - 2020

The global nursing workforce is 27.9 million, of which 19.3 million are professional nurses. This indicates an increase of 4.7 million in the total stock over the period 2013–2018, and confirms that nursing is the largest occupational group in the health sector, accounting for approximately 59% of the health professions. The 27.9 million nursing personnel include 19.3 million (69%) professional nurses, 6.0 million (22%) associate professional nurses and 2.6 million (9%) who are not classified either way.

The world does not have a global nursing workforce commensurate with the universal health coverage and SDG targets. Over 80% of the world's nurses are found in countries that account for half of the world's population. The global shortage of nurses, estimated to be 6.6 million in 2016, had decreased slightly to 5.9 million nurses in 2018. An estimated 5.3 million (89%) of that shortage is concentrated in low- and lower middle-income countries, where the growth in the number of nurses is barely keeping pace with population growth, improving only marginally the nurse-to-population density levels. Figure 1 illustrates the wide variation in density of nursing personnel to population, with the greatest gaps in countries in the African, South-East Asia and Eastern Mediterranean regions and some countries in Latin America.

Focus on complexity – this is a particular challenge for health and care..

Complexity characterised by:



All ages (children and adults)

Source: Figure adapted from Jarvi S, Richardson G, Flemming K, Fraser LK. Numbers, characteristics, and medical complexity of children with life-limiting conditions reaching age of transition to adult care in England: a repeated cross-sectional study, NIHR Open Res. 2022 Apr 8;2:27. doi: 10.3310/nihropenres.13265.1. PMID: 35923178; PMCID: PMC7613215.

Looking to the Future: Potential Solutions and Innovations

NEJM
Catalyst

NEJM Catalyst | September 11, 2024

COMMENTARY

Reimagining Health and Care to Tackle the Rising Tide of Inequity, Multimorbidity, and Complex Conditions

Irene J. Higginson, OBE, BMedSci, BMBS, PhD, FMedSci, FRCP, FFPHM, FKC, Jenny Shand, PhD, MPH, Glenn Robert, PhD, MSc, Annette Boaz, PhD, MSc, Catherine French, PhD, MSc, Andreia Carvalho N'Djai, PhD, Mary Malone, PhD, RN, RM, PGDip HV, Ingrid Wolfe, OBE, BSc, MBBS, MSc, PhD, FRCPC, FFP, Charles Normand, BA(Hons), MA, DPhil, Matthew Hotopf, CBE, BSc, MBBS, MSc, PhD, FRCPsych, FMedSci

DOI: 10.1056/CAT.24.0266

<https://catalyst.nejm.org/doi/full/10.1056/CAT.24.0266>

“

The current focus on the health care workforce tends to emphasize staff numbers and shortages of health care professionals, often neglecting the potential of the broader care workforce and the interconnectedness between health and social care.”

“

Empowering individuals, their carers, and volunteers with training, tools, and support — together with technologies such as remote monitoring, home diagnostic tests, and real-time training tools — could significantly extend the reach of the health and care system.”

“

***Fugitive coproduction* — when individuals and groups within communities collaborate with staff in ways that significantly shape the provision of local services to meet an immediate perceived need rather than strategic change, *without* permission or authorization from relevant authorities — could provide the basis for more radical thinking and solutions.”**

King's Better Health & Care Hub

Pioneering novel evidence-based community, co-production and self-care approaches to solve the global problems of health and care, focussing on those people with the most complex illnesses and solutions that can be delivered at scale with early impact.

KING'S
College
LONDON

Who we benefit

People with complex needs and multimorbidity, where health and social care costs are highest, have the poorest experiences and outcomes, experience the greatest health inequities, and often lack access to care.

By 2035, 70% of adults >65 years are expected to have multimorbidity

Adjusting for population size and age, NHS and many other countries' health care funding is decreasing

20% of health and care spending is in the last year of life

Global workforce shortage of 18 million health workers by 2030

Health care creates 4.4% of emissions

Harnessing expertise from across King's faculties



CAREFORCE

- Expanding the definition of workforce, to include people that are ill (self-management), and those important to them (informal carers) as part of the delivery system and improving access to education and skills building.
- Bridging volunteer and professional boundaries to build skills-based approaches that respond to patient and system needs, working with education providers to build an agile and adaptable future care and workforce.



FRUGAL INNOVATION

- Doing the basics well, efficiently, at low cost through frugal innovations, e.g technology, repurposed medicines.
- Using data, technology and new models of care to improve home-based support and reduce time in hospital.



COMMUNITIES

- Broadening definitions of value in health and care, including quality of life, symptoms and daily living. Develop and test measures across races, ethnicity and cultures to help reduce health and care inequalities.
- Advancing theory and methods underpinning the co-production of health and care through citizen engagement and community empowerment.

Impact



Global
Impact of global relevance through focussed international collaborations.



National
Multi-site programmes to ensure generalisability and scale.



Local
Demonstrator cases in Southwark and Lambeth via KHP.

Strategic benefits

- Accelerate delivery of KCL Vision 2029
- Pioneer new solutions to complex systemic problems
- International impact through collaboration
- Policy influence and profile

Future funding sources

- External grant income
- Consultancy
- Education provision
- Philanthropic



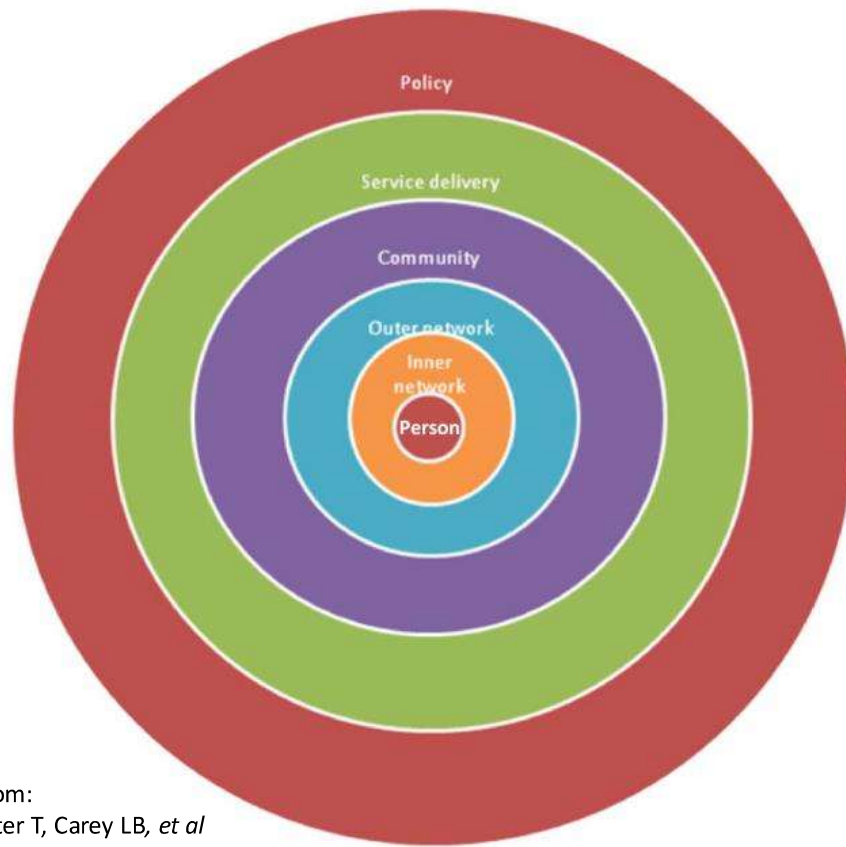
The Careforce: a holistic approach

Careforce expands the traditional workforce by empowering patients, informal carers, and communities to take active roles in care, highlighting the critical roles of nurses, midwives, allied health professionals, plus volunteers and social care professionals.

BetterHCF@kcl.ac.uk



‘Careforce’ (our term) builds on the circles of care model



Adapted from:
Abel J, Walter T, Carey LB, *et al*
Circles of care. *BMJ Supportive & Palliative Care* 2013;**3**:383-388.

The Circles of Care Model

- Care is delivered through interconnected layers:
 - Individual and family
 - Community networks
 - Health and social care teams
 - Wider system and policy support
- Together, these elements form an integrated, person-centred system that promotes continuity, quality, and compassion in care.
- Each layer is essential – when layers are not aligned, care is fragmented, less effective, and harder to sustain – reducing quality, continuity, and resilience for patients, families, and professionals alike.

Why Careforce

- To reflect the equal value of all who contribute – professionals, volunteers, patients, and carers – BH&CH developed the term “**careforce**” rather than workforce.
- **Careforce** recognises shared responsibility, mutual respect, and the power of collaboration across all layers of care.

Frugal innovation: rethinking technology for accessible and equitable care

Frugal innovation
focuses on cost
effective solutions that
optimise resources,
improve access,
maintain quality and
can be applied in
people's homes.



BetterHCF@kcl.ac.uk



Community co-production: partnering with patients and communities

Communities are central to our approach as they are key to ensuring care is tailored, inclusive and sustainable, addressing both local and global inequities.

Health solutions work best and are more likely to be sustained when they are co-produced with communities.



What is needed to provide home care in complex illness

The importance of competence, skills and presence, especially in home care

model shows from research the 'key ingredients of being able to support people at home'

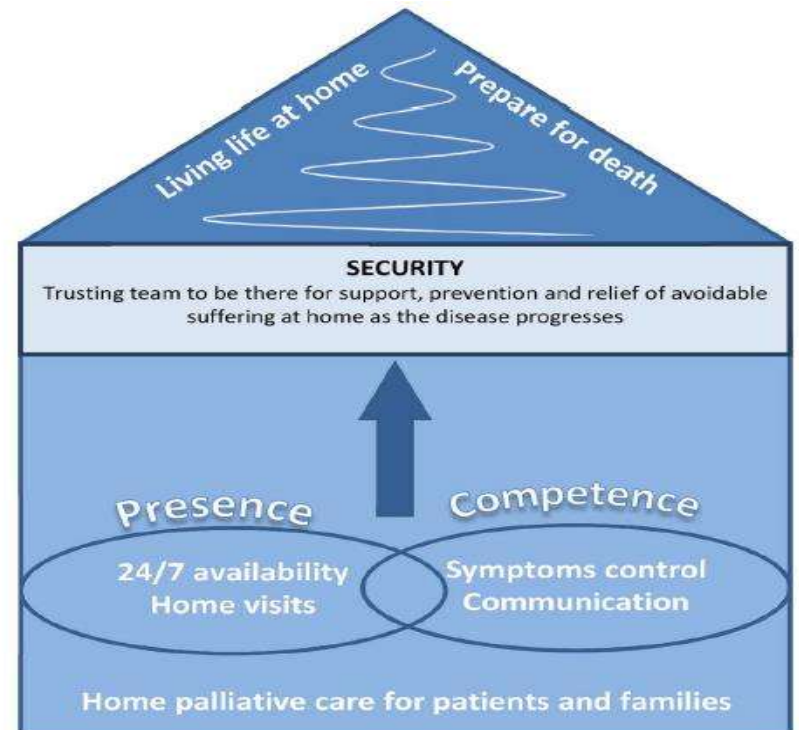


Figure 1 Lines-of-argument synthesis: simplified model of the experiences of patients' and caregivers' with home palliative care.

Results of a meta-ethnography

Source: Sarmento et al BMJ Support Palliat Care. 2017 Feb 23.

KCH: Improving Equity of Access



Within our local population of Lambeth and Southwark, 50% patients have a minority ethnic background. There are high levels of poor literacy.

Those from ethnically diverse groups who attend ED are more likely to be admitted.

Improving Equity of Access: Addressing Ethnicity and health literacy imbalances

Aims:

- To adapt the breathlessness support services resources to better meet the needs of those from ethnically diverse groups.
- To improve access to breathlessness support service resources for those from ethnically diverse groups

Methods:

- Review of 4 breathlessness support resources by health literacy company
 - Review of language
 - Imagery
- Adapted resources reviewed by PPI group
 - 6 individuals from ethnically diverse groups, 1st and 2nd generation immigrants
 - Varying educational levels
- Translation
- Filming for videos

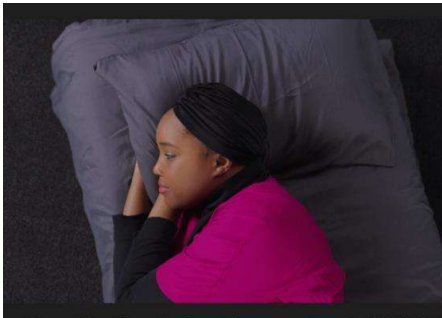


Q is led by the Health Foundation
and supported by partners across
the UK and Ireland

Acknowledgements: Project lead: Dr Sabrina Bajwah, Project team: Prof Irene J Higginson, Dr Joanne Bayly, Nikel Hector-Jack
Co-developed with patient and public involvement

Improving Equity of Access

yoruba spanish italian somali
portuguese polish
gujarati
urdu
welsh bengali
punjabi
romanian



FACT SHEET

Using a hand-held fan

We have made this fact sheet to help you when you are feeling short of breath. **Get advice from your GP if being short of breath is new for you, or if your breathing is getting worse.**

Will using a fan help me when I feel short of breath?

Cool air from a fan may help you to feel less breathless. Electric fans with three or more spinning blades seem to work best. The air flow should be medium or strong.

How should I use the fan?

- Sit up in a comfortable position.
- Hold the fan about 6 inches or 15 centimetres in front of your face.
- Point the fan at the **middle** of your face.
- Feel the moving air around the **sides of your nose and above your top lip**.
- You should feel less breathless within a few minutes.

**When should I use the fan?**

You can use the fan for as long and as often as you wish. A fan may help:

- if you are suddenly short of breath
- when taking a rest from an activity.

Remember to recharge the fan or take spare batteries when you are out of the house.

Is using a hand-held fan safe?

There are no known problems with using a fan when you are feeling short of breath.

If a hand-held fan doesn't feel right for you, try:

- fans that stand on the floor or on a table
- opening windows to let cool air in
- using a cool flannel on your face.

Acknowledgement

Original resources were provided by the Breathlessness Intervention Service at Addenbrooke's Hospital. Adapted and trialled in the NIHR and CS International funded Breathlessness Support Service trial (2010) at King's College Hospital. Adaption of the resources for the "Breathlessness Support: addressing the ethnicity and health literacy imbalance" project (2024) was funded through Q Exchange by the Health Foundation.

તથ્ય પત્રક

હાથ પંખાનો ઉપયોગ કરવો

જ્યારે તમને શ્વાસ લેવામાં તકલીફ થઈ રહી હોય ત્યારે અમે તમને મદદ કરવા માટે આ તથ્યપત્રક બનાવ્યું છે. જો તમારા માટે શ્વાસનો અભાવ નવો છે, અથવા જો તમારો શ્વાસ વધુ ખરાબ થઈ રહ્યો છે, તો તમારા જી.પી. પાસેથી સલાહ મેળવો.

જ્યારે મને શ્વાસ લેવામાં તકલીફ પડે ત્યારે શું પંખાનો ઉપયોગ મને મદદ કરશે?

હાથ પંખામાંથી ઠંડી હવા તમને શ્વાસ લેવામાં મદદ કરી શકે છે. ત્રણ અથવા વધુ સ્પિનિંગ બ્લેડવાળા ઇલેક્ટ્રિક પંખો શ્રેષ્ઠ કામ કરે છે. હવાનો પ્રવાહ મધ્યમ અથવા મજબૂત હોવો જોઈએ.

મારે પંખાનો ઉપયોગ કેવી રીતે કરવો જોઈએ?

- આરામદાયક સ્થિતિમાં બેસો.
- તમારા ચહેરાની સામે પંખાને લગભગ 6 ઇંચ અથવા 15 સેન્ટિમીટર પકડી રાખો.
- તમારા ચહેરાની વચ્ચે પંખાને પોઇન્ટ કરો.
- તમારા નાકની બાજુઓની આસપાસ અને તમારા ઉપલા હોઠની ઉપરફરતી હવાનો અનુભવ કરો.
- તમે થોડી મિનિટોમાં આરામદાયક રીતે શ્વાસ લઈ શકવા જોઈએ.

**મારે પંખાનો ઉપયોગ કેવી રીતે કરવો જોઈએ?**

તમે ઇચ્છો તેટલા લાંબા અને વારંવાર પંખાનો ઉપયોગ કરી શકો છો. પંખો મદદ કરી શકે છે:

- જો તમને અચાનક શ્વાસ લેવામાં તકલીફ થાય
- કોઈ પ્રવૃત્તિમાંથી આરામ લો છો.

જ્યારે તમે ઘરની બહાર હોવ ત્યારે પંખાને રિચાર્જ કરવાનું અથવા વધારાની બેટરી લેવાનું યાદ રાખો.

શું હાથ પંખાનો ઉપયોગ સુરક્ષિત છે?

જ્યારે તમને શ્વાસની અછત લાગે ત્યારે પંખાનો ઉપયોગ કરવામાં કોઈ જાણીતી સમસ્યા નથી.

જો હાથ પંખો તમારા માટે યોગ્ય હોય એવું ન લાગે તો આ અજમાવી જુઓ:

- ફ્લોર કે ટેબલ ફેન
- ઠંડી હવાને અંદર આવવા દેવા માટે બારી ખોલવી
- તમારા ચહેરા પર ઠંડી ફ્લેનનો ઉપયોગ કરીને.

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Progress: Better Health & Care Hub

RESEARCH

- Postdoctoral Fellowships – 4 all present today
- Seedcorn Funded Projects – first group underway,
- Grant applications in progress
- Accelerator Grants Call Networking event earlier today
- Accelerator Grants opening
- Reader and Professor/Reader post advertised

GOVERNANCE & ENGAGEMENT

- Monthly reporting to University Portfolio Committee
- Key Governance Groups
 - Advisory Executive
 - Partnership Panel (from all Faculties and beyond)
- Patient and Public Involvement Panel
- Community and wider engagement, across university and trusts,

ENGAGEMENT

- Consultation Launch – 24th September 2024
- House of Lords Launch – November 2024
- Website – <https://www.kcl.ac.uk/research/better-health-care-futures>
- Webinar series – launched 1st May 2025
- NEJM Catalyst publication
- Brochure
- Careforce pamphlet underway with Policy Institute
- Summit – 10 Sept 2025

EDUCATION

- MSc in Healthcare Management
- Second offering in discussion, .. Possible Digital Health.. And short courses



Research and Impact: Seedcorn projects to develop next level of larger scale research



Assistive devices to support indoor and outdoor mobility for people living with advanced illness

Improving the quality, acceptability and uptake of assistive devices to support indoor and outdoor mobility for people living with advanced illness



Home neurophysiology diagnostics for children with complex needs

A study to test the ability of home video-electroencephalography (EEG) telemetry (VT).



Improving care for lesbian, gay, bisexual and/or trans (LGBT+) people facing advanced illness: from patient experience to policy

To understand and improve the patient experience of LGBT+ people facing advanced illness.



Inclusive and effective collaboration in health and social care contexts

A study to develop and test user-friendly, practical resources to support inclusive and effective collaboration in health and social care contexts.



Innovative hands-free two-way automated monitor and communication device for virtual breastfeeding support

To create an innovative hands-free two-way automated monitor and communication device for virtual breastfeeding support



Instrumented motion sensor squeeze ball to inform community rehabilitation support

Using an instrumented motion sensor squeeze ball to understand the ability of patients to perform activities of daily living.



Unlocking Better FUTUres for Informal CARErs and Families through Interdisciplinary Research (FUTU-ICARE)

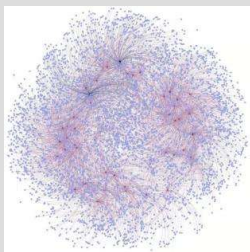
To identify evidence-based interventions to support informal carers of people with breathlessness.

Better Health & Care Hub: Postdoctoral Fellows

Dr Britt Regal

Optimising the governance and management of integrated health and social care services

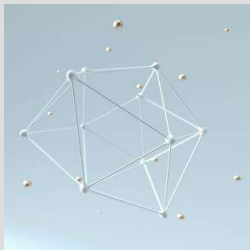
Britt is working on research to improve people's access to and engagement with public services when they need support from multiple service systems.



Dr Phoebe Averill

Optimising the organisation and delivery of care under mental health legislation

Phoebe is working on research to improve people's access to the right emergency mental healthcare at the right time.



Dr Joseph Suglo

Engaging Informal Caregivers to Improve Diabetes Foot Care: A Pathway to Better Self-Management

Joseph is adapting & co-designing a family-integrated diabetic foot care intervention to strengthen caregiver support & promote diabetes self-management.



Dr Ragy Tadrous

Developing an Intervention to Increase Physical Activity in Community-Dwelling Arab Older Adults in the United Kingdom

Ragy is co-producing a culturally appropriate intervention to support and increase physical activity among Arab older adults living in UK communities.



THANK YOU!

Reflections:

- What are the opportunities for Cicely Saunders Institute and Cicely Saunders International?
- Feedback / suggestions ?
- <https://www.kcl.ac.uk/research/better-health-care-futures>
- Contact: BetterHCF@kcl.ac.uk

Bristol Health Partners

Conference 2025

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