Sirona care & health

SOCIAL IMPACT REPORT

Making a difference to our community during the pandemic

July 2021

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1. Welcome from our Chief Executive, Janet Rowse

2020 was always going to be a big year for Sirona care & health as we started our new contract for community healthcare services for adults and children across Bristol, North Somerset and South Gloucestershire.

This meant transferring more than 2000 staff into Sirona which more than doubled the size of the organisation. What none of us could have foreseen was the global pandemic and a national lockdown just two weeks prior to its commencement.

We rapidly had to adopt new ways of working and get to know our new teams virtually. This included the ramp up of our technological capability across the board, with digital appointments, e-prescribing and the need to support remote provision of care and working from home in line with national guidance.

Our service users remained our prime focus, but we knew that without the skill, dedication and commitment of all our staff we could not respond in the way needed. They had to face new challenges in dealing with a previously unknown virus; anxiety about their own safety as well as that of the people they were supporting; coping with working from home whilst, for many, also having to undertake home schooling and working incredibly long hours to meet the demands placed on us.

We were fortunate to be part of a system where collaborative working was already embedded and we had enormous support from countless individuals and companies who provided much needed Personal Protective Equipment (PPE). It was also heartening to see the generous donations of food and treats for our hardworking teams and we are grateful to everyone who stepped in to help us. One thing this crisis has done is brought us closer to our communities. We could not have managed without the army of amazing volunteers across all areas and it was a privilege to work so closely with an array of charities and third sector organisations to ensure that together we kept people safe and supported.

This is something we will hold onto as we move forward. Working with our new **People's Council** we want to ensure that all members of the community feel they have a voice in helping to shape the way community healthcare services are delivered so that together we can continue to make a real difference for all.

2. What is social value?

2.1 Introduction to social value

Social Value is at our heart. It is written into our constitution as a Community Interest Company and drives our purpose to contribute to the wellbeing and resilience of individuals and communities. At its simplest, it is a way of describing the difference we make to the communities we serve.

Through this report we aim to evidence how and when we have introduced social value into our service delivery and the impact that this has made. We are involved with a lot of people creating really positive benefits in our communities.

Due to the wide and diverse range of activities delivered it is not possible to report everything in this report. Instead we provide a representative sample of activities we have developed and delivered.

We know that the work we do creates different outcomes and means different things to different people. The value that others place on these changes helps us decide how to build on these.

We will continue to work hard to make real impacts on lives and communities.

2.2 Our Diabetes Service

The pandemic meant a reduction in face-to-face consultations with people. Due to the emerging Covid-19 data that people with diabetes and the Black and Ethnic Minority communities were at a greater risk of poor outcomes, we teamed up with a pharmaceutical company MEG (Medical Educational Grant) and Diabetes UK to translate our resources for people with diabetes.

We have also collaborated with Diabetes UK and our **Health Links team** to deliver a Somali online session to support increasing knowledge and what care to expect during the Winter Season to keep well with diabetes.

You can read more about our Diabetes Service **here**.

2.3 Connecting with our communities

Over the past year the pandemic has demonstrated the importance of working collaboratively with other organisations to support the people and communities we serve. This has been especially so in supporting people as they are discharged from hospital.

We've been working closely with organisations that support people home from hospital. Working with the **British Red Cross**, we introduced follow-up phone calls following a discharge for everyone over 65 who had an overnight stay in hospital. This has resulted in the following outcomes:

- People have an improved experience of hospital discharge;
- People are connected to local sources of non-medical support in their community, where needed;
- Any needs that haven't been identified as part of the hospital discharge process can be met and connections made to the relevant source of support.

3. Embracing change

Covid-19 has prompted a wide range of innovative practices across healthcare and we have embraced these changes.

We had to rapidly transform a wide range of services and the introduction of remote appointments were one of the first major changes we made:

- In our **Musculo-Skeletal Team** this helped maintain safety for the individual and also had a positive impact by reducing the need to travel to appointments.
- Our **Neurology Team** moved to early video consultation to ensure that those with the greatest need could still be seen quickly. This has had very positive feedback and for some people, the provision of appropriate advice and guidance was all they needed which helped enormously with reducing the waiting times by a number of weeks meaning more people could be seen and treated.
- The **Haven** is one of our specialist services supporting the health care needs of Bristol's asylum seeker and refugee population. The service is continually evolving to meet the needs of people the city welcomes. Throughout the pandemic it has also served as a public health hub, distributing government guidance in many languages, but also ensuring the welfare needs of the cohort are not overlooked.

A young person who I have seen for several years face-to-face struggled to sit and engage with his health assessment. During a video consultation he was so engaged and talkative, it was lovely. "

Children's Doctor

In the past six months the Haven has seen around...

370 PEOPLE, these include people from:

4. Working with our community

2020 was an unprecedented year for healthcare providers working amidst a global pandemic.

However this crisis brought the community together, working very closely with our staff.

We had donations from local schools and companies providing much-needed Personal Protective Equipment (PPE); we saw many retired staff returning to help with the response and many of our colleagues moved roles to support the covid response.

We also ran a vital staff wellbeing campaign throughout the year to support colleagues at this challenging time.

4.1 Vaccinations: protecting our communities

In March 2020 when the Covid-19 pandemic started in the UK national guidance was to stop both school and community immunisation clinics. As a result a number of young people who were unable to receive their vaccinations as planned in line with the national schedule within Bristol, North Somerset and South Gloucestershire (BNSSG) for the academic year 2019/2020.

In July 2020 we started a catch-up programme for all secondary **school immunisations** for school cohorts where the vaccination sessions were cancelled due to Covid-19 lockdown measures and we achieved over 3,000 vaccinations across 55 clinics in two months.

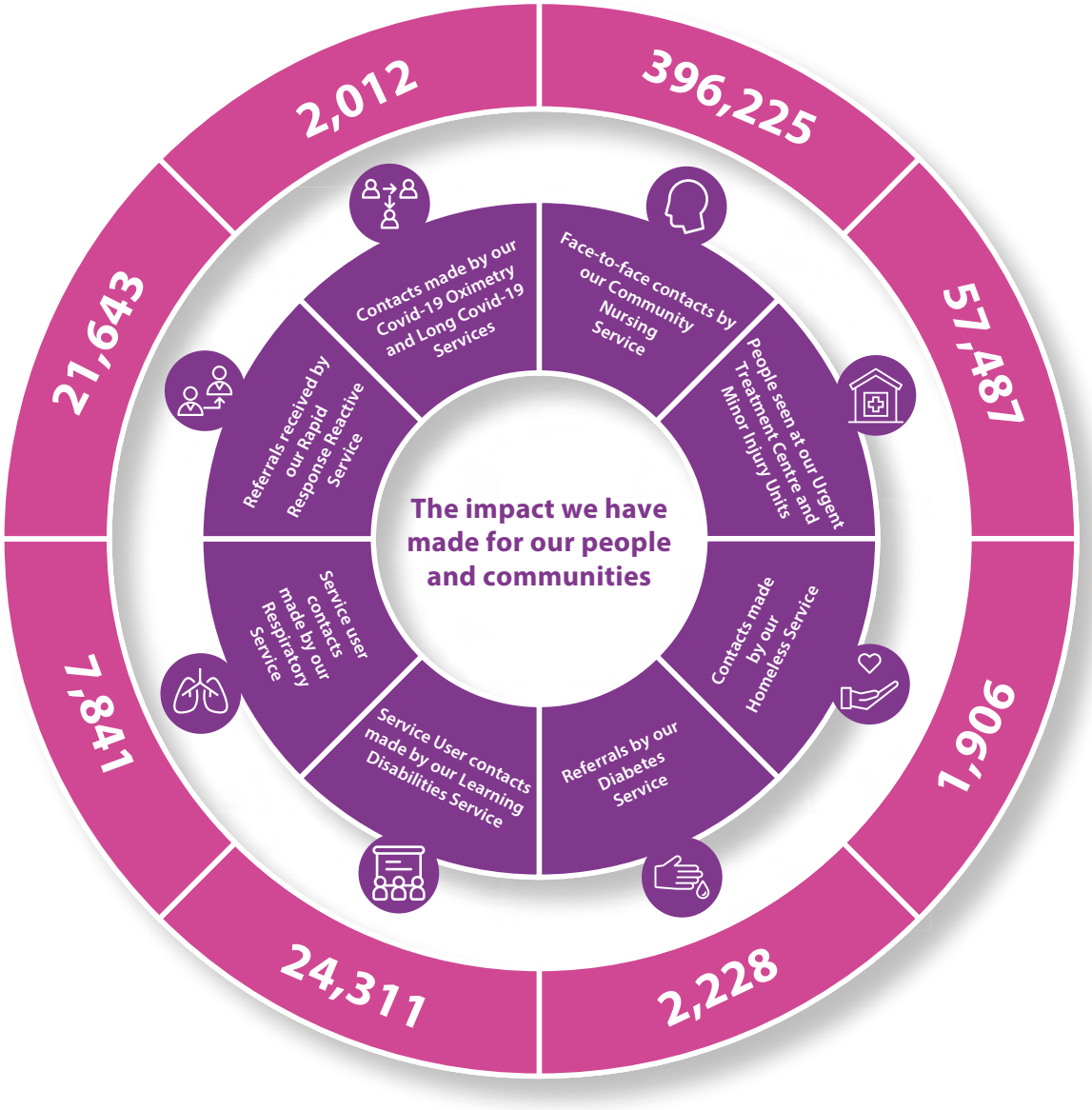
Vaccination facts

88% Staff vaccinated against flu

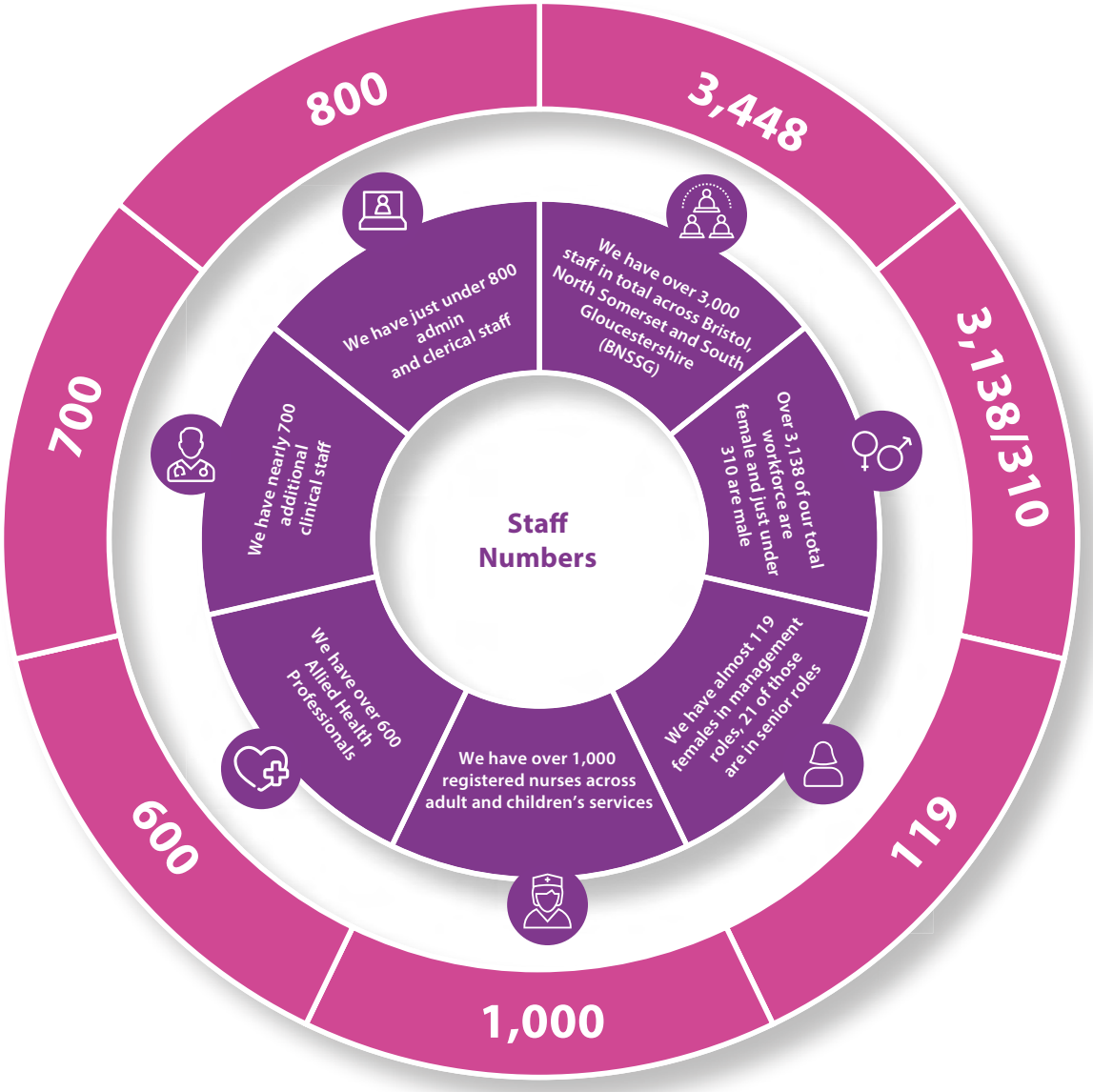
82% Frontline staff vaccinated against Covid-19

100k Children in year groups reception to year seven reached through flu immunisation programme

The impact we have made for our people and communities



Staff numbers



5. Partnerships and Community Development

We've all seen the outpouring of community support that has come about as a response to the pandemic. Very often our communities were the quickest to respond to the needs of their neighbours for practical support such as food and prescription collection.

We worked with six Lead Voluntary, Community, Faith and Social Enterprise (VCFSE) Locality Partners to ensure that we worked closely with the communities we serve.

Locality	Lead VCS Locality Partner
Bristol North & West	**Southmead Development Trust**
Bristol Inner City & East	**Wellspring Settlement**
Bristol South	**Knowle West Healthy Living Centre**/ **BS3 Community**
North Somerset Woodspring	**Citizens Advice North Somerset** / **VANS**
North Somerset Weston, Worle & Villages	**Citizens Advice North Somerset** / **VANS**
South Gloucestershire	**Southern Brooks Community Partnerships**

Through these relationships we were able to have a greater understanding of the needs of our very different communities and we will continue to build on these relationships.

5.1 Autism Hub

We work in partnership with a wide range of organisations and one example is our new Autism Hub.

An innovative **new Hub** to streamline autism assessments for young people in Bristol and South Gloucestershire was opened by the Community Children's Health Partnership (CCHP).

The new approach enables most children and young people referred for an autism diagnostic assessment to be assessed in a single visit, with access to a wide range of clinicians in one place on the same day.

Depending on each young person's need they are seen by two or more specialists, including Speech and Language Therapists, Specialist Nurses, Clinical Psychologists, Community Paediatricians and Early Years Practitioners. Some children continue to be seen for an autism assessment in their locality (clinic, school or early years setting) dependent on their individual need.

The hub is a partnership between us, Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group **(BNSSG CCG)**, **Barnardo's**, **Avon and Wiltshire Mental Health Partnership**, **Bristol City Council**, **South Gloucestershire Council**, and **Bristol** and **South Gloucestershire** Parent/Carer Forums.

5.2 Diabetes peer support

We have also been working in partnership with **Brigstowe** to deliver peer support for those recently diagnosed with diabetes.

The service user meets with a trained volunteer mentor who is also living with type 2 diabetes and trained in befriending, coaching, motivational interviewing and SMARTER planning techniques. The mentor & mentee meet once a week to share experiences, give advice, goal-set, as well as to provide information based around the mentees' diagnosis and how to manage lifestyle changes that will benefit their health.

5.3 Supporting our local economy

In the April 2020-2021 tax year, our paybill was over £100m with the majority of staff living in the areas we serve. Therefore local spend boosts their community economy.

£67,500	The Sirona Foundation approved £67,500 for staff development
68	We ran 68 preceptorships
£3,000	The Foundation spent £3,000 on our Secret Santa scheme
£600	The Foundation spent £600 on Christmas presents for the units
£7.6m	We spent £3.8m on local suppliers in the first half of the financial year
£100m	In the April 20-21 tax year we spent over £100m on our pay bill

6. Equalities

As we expanded to cover the whole BNSSG area, we recognise there are different demographic pictures for each of our distinct areas and we are keen to learn more about the diversity and experience of our communities.

Within our Partnership and Community Team, Equality, Diversity and Inclusion has had a central and robust focus and remains high on our agenda. Lockdown and the Covid-19 pandemic have highlighted huge disparities in our communities, and research has showed us that existing health inequalities have been exacerbated as a result of the pandemic.

We have worked collaboratively across our areas; linking in with voluntary sector partners and agencies and making virtual connections to support all our communities.

We have made great progress in the roll out of an accessible approach to technology and digital services. With so many of our services now being offered online, it has been vital that we support our teams to look at how we can ensure we are supporting our service users, who may face barriers in accessing our digital support. This has resulted in some innovative ways of working with our volunteers who are technically aware and want to support others in understanding our new virtual worlds.

For communities where English is not their first language, we have been supported by our **Health Links Team**, who provide interpretation, translation and advocacy support, particularly in the central area of Bristol. We have moved from face-to-face interpretation to utilising video and telephone based support. For many of our staff and for our communities, this was a challenge, but with support it has been well received.

The results from our Health Links Team

125 Over 125 people and their families were supported between May and December 2020

70% Video connections were successful in 70% of cases

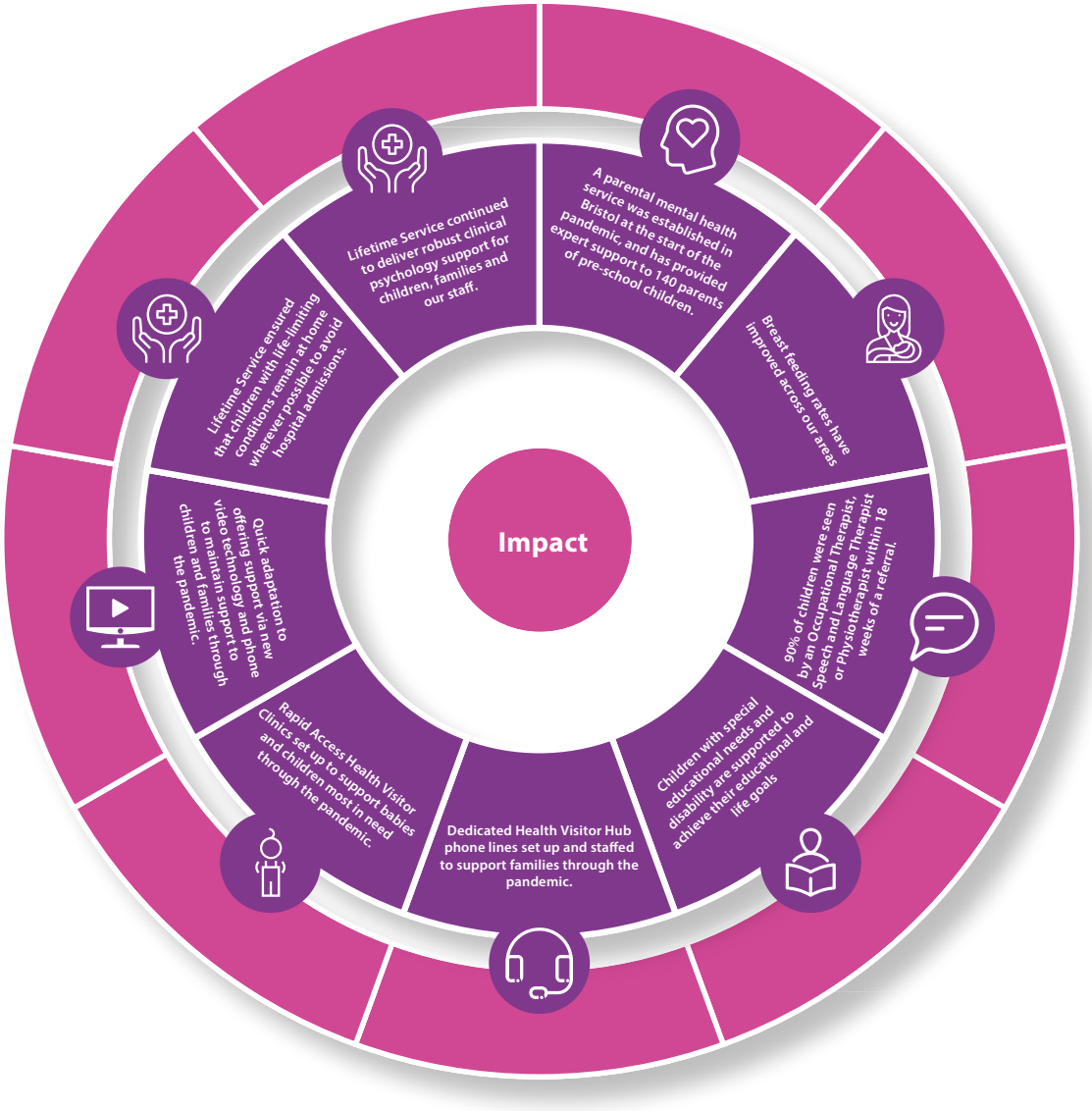
People fed back that they liked being able to see the interpreter and clinician's faces

79% Where experience was recorded 79% of individuals reported good or excellent experiences

Our **Health Links team** remain a focal point for many of our diverse communities, helping us to ensure that we provide information that is easily accessible to them and services that are sensitive to their particular needs and cultures. The team supported many people to take up their 'flu vaccination towards the end of 2020 and have been supporting their communities throughout the pandemic and now with the Covid-19 vaccination programme.

7. Children's Services

Children's Services during the Pandemic



Pandemic facts

2,141 In the first nine weeks of 2021, we received 2,141 referrals from our local hospitals, an average of 238 people per week

65% Between October and December 65% of people were discharged from hospital and supported to recover at home

30% During the same period, 30% of people were supported by our teams to be discharged into our rehabilitation units (community beds)

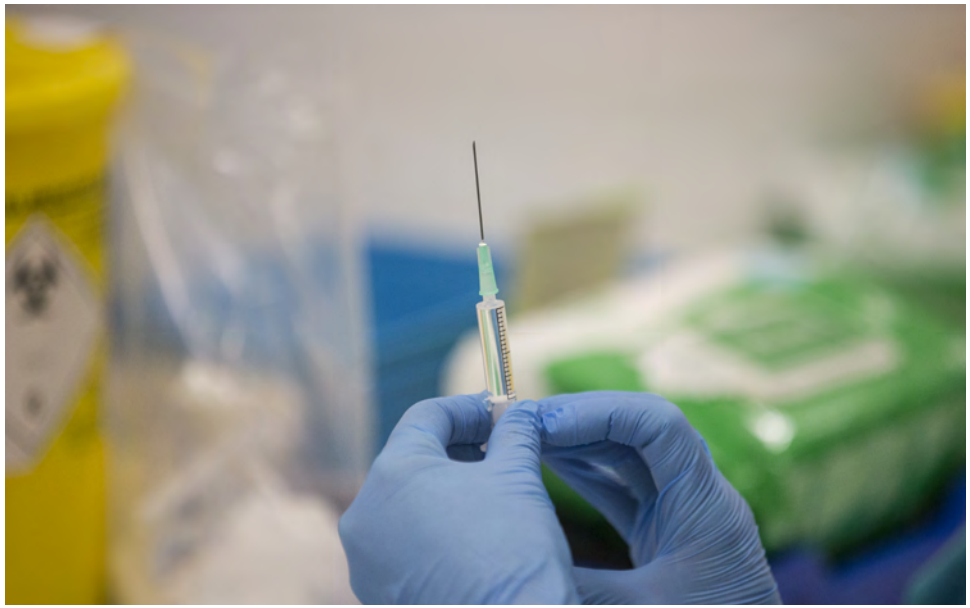
10% In the same period, the community nursing teams have provided over 94,000 contacts, an average of 10,521 per week, 10% above the pre Covid-19 forecast activity

11,474 Teenage immunisations completed

74 We have been able to support 74 of Student Nurses, Physiotherapists, Occupational Therapists and other staff through a wide range of apprenticeships during the last year, in spite of the pandemic

61,061 While Covid-19 posed its challenges with school children having to isolate when vaccines were being rolled out, the team successfully vaccinated over 60,000 children.

5,853 We had 5,853 contacts with Children's Services between April and July



The Family Nurse Partnership Team (FNP) continued to support their clients throughout both lockdowns and offered a blend of face-to-face and digital support

We supported our people through many difficult situations and managed to flex the programme to meet each individual's need. We managed an increase in safeguarding cases and continued to recruit new people into the service. Many individuals have expressed the positive impact the FNP service has had on them and their children and have valued the personalised support offered.

A new outcomes based assessment tool called the New Mum's star was launched nationally in September and rolled out with clients and aims to personalise the programme to better meet individual client need.

1,381 **...contacts including face-to-face and video calls between July 2020 and March 2021.**

100+ **The School Nursing team delivered virtual sessions with 100+ parents joining.**

This year has been so terrible, my mental health got very bad and if I hadn't had my family nurse I think it would have been so much worse. She was there to talk to and help me

Client aged 17 years

Read more about our **Children's Services**.

8. Care in the Community: a selection of adult services

8.1 Care home support

When our Care Home Support Team were introduced to the Care Manager of a local learning disability care home, she requested a whole home review as she had been dealing with some very complex admissions to hospital during the first lockdown.

Before the pandemic, our Residential Home Support Team had always offered care homes that were new to the service the opportunity for us to work together to complete a base line assessment for all of their residents.

This particular home in North Somerset was our first learning disabilities care home. We offered our service to this home as we were mindful of the increasing frailty of this group of people and wanted to offer support, which the Care Home Manager was very willing to accept. As this took place in early 2020 we were not able to complete visits in person due to the lockdown restrictions so we supported with regular phone calls that were initially Covid-19 status focused.

We were unable to visit due to the pandemic so as an alternative we jointly agreed to discuss all residents via MS teams, an online tool to allow people to meet virtually, and see how it would work trying to achieve the same outcomes virtually by identifying anyone who may benefit from preventative support such as referral on to specialist teams, sign posting, clinical advice and equipment ordering.

Completing the review in partnership with the Community Learning and Disability Team (CLDT) made it more person centred, timely, and holistic.

The Care Manager really enjoyed the process and stated that she felt like she had handed over all her stress and worries and felt confident she would not have to follow up or chase up different professionals to ensure agreed actions completed.

8.2 Virtual Ward

In November 2020 we launched our 'Covid Virtual Ward' service. This is a service where community healthcare staff are using pulse oximeters to remotely monitor blood oxygen levels from home or care and residential homes for people with Covid-19 who are considered to be at risk including those with a long term health condition and Learning Disability.

Pulse oximeter devices clip on to a person's finger and use light beams to analyse blood oxygen levels. These levels will be monitored daily by community health care staff checking for the risk of silent hypoxia (unknown low oxygen levels) and will intervene if a person's oxygen level falls below a certain threshold.

The service is run in partnership with GPs, who support decision making about what to do if an individual requires further support and the voluntary sector who which supports the service by delivering monitors to people's homes seven days a week.

The Covid Virtual Ward is also now supported by a fully automated digital app that records an individual's oxygen levels, and then feeds this data to a remote 'dashboard' that can be monitored by healthcare professionals. This remote approach will allow for earlier intervention for people at risk of silent hypoxia, as well as helping healthcare partners tackle Covid-19 surges across the area.

The pulse oximeter scheme was the first step in the roll-out of a comprehensive virtual ward approach in BNSSG, which in time will allow community staff to provide a range of services to people living in their own homes as well as residential care settings.

8.3 Integrated Community Care Bureau (ICCB)

This built on the work of eight organisations across health and social care including commissioning colleagues, to make sure people leaving hospital, after a period of being unwell, were supported home or to a suitable location as soon as they were well enough to do so and that support was given in a respectful, responsive and easily accessible way.

The **ICCB** 'adds value' to the service user's experience by ensuring that they get 'the right care, from the right person, in the right place, at the right time – first time', reducing confusion and delays. Over 4,000 people with complex needs were supported to leave hospital in the last year and received community services to help them recover and rehabilitate.

8.4 Active Ageing

The Active Ageing Service is one of our commissioned prevention services. The principal aim of the service is to provide information and support to older people to enable them to take control of their health and well being, keep them well and independent living in their community and to prevent any unnecessary hospital admissions

Active Ageing places the older person at the centre of a robust, yet proportionate, home-based assessment. The service uses a validated tool designed for later life home based assessments, embedding the principles of the comprehensive geriatric assessment.

The service provides a rapid and prioritised response to referrals predominantly from an individual's own GPs to reduce the risk of needing to require domicillary or residential care prematurely and to prevent avoidable admissions to an acute hospital.

The service works in partnership with our staff, social care, GPs, the not-for-profit sector and families, to ensure vulnerable individuals and groups are safeguarded and risks are modified.

8.5 Dementia Advisors

Dementia Advisors provide personalised, non-clinical, emotional and practical support and advice to people of all ages diagnosed with dementia and their carers, who are registered with a South Gloucestershire GP. We provide this service in the North of the locality while the **Alzheimer's Society** provides a service in the South of the locality.

8.6 Integrated Network Approach

The Integrated Network Teams are teams of professionals working together to deliver wrap around care to support people to live in their own homes, including care homes, as independently as possible. The philosophy behind this approach encompasses the following principles:

- Ensures the consistent, efficient and effective utilisation of resources.
- Fully integrated 'out of hospital' services, delivered in close collaboration with primary and social care.
- Comprehensive model of integrated personalised and seamless care that builds on what service users told us works well.
- The opportunities to align with Localities and Primary Care Networks.
- Supports and empowers people to stay and age well, reduce the demand for emergency hospital services and long-term care placements.
- Targeted approach in areas where health outcomes are poor, supporting carers and care homes.
- Increases focus on prevention and reduces inequalities across physical and mental health.
- Continuous improvement of services and improved outcomes for individuals.

Add click **here** to read more about our Adult's Services.

9. Specialist Services

Our Wound Care Service is a passionate and dedicated group of Tissue Viability Nurses who have united together with a positive and proactive approach to form their new team.

Our Wound Care Team have embraced the recent changes to our organisation with professionalism going above and beyond to find ways to support service users and staff.

This team is available and responds quickly with remote advice, utilising photographs and video consultation enabling them to reach all parts of the organisation. Working together, the team developed online resources and self-care guides on a variety of skills and made these available to the Community Teams, Practice Nurses and care homes.

Together with the Learning and Development Team, a series of mini films have been produced demonstrating wound care skills for service users, carers and staff. These will be a valuable resource for our new Community Nurses and promote our self-care model with patients.

"I understand my wound better and feel more confident managing it since I have been seen by your service"

Service user

Here are some of the outcomes for people accessing this service:

- Improved independence
- Improved health and wellbeing
- Improved confidence and ability to manage health condition
- Reduced hospital admissions, GP and outpatient appointments
- Ability to maintain independence and self-manage condition
- Supported people in underserved populations to access healthcare through teams like the Haven
- Number of remote appointments enabling access and lowering risk for individuals

10. Our Rehabilitation Units

Our local hospitals connect with the community in many ways

Our three Community Rehabilitation Units include **Elton** at North Somerset Community Hospital, **Skylark** in Yate and **Henderson** in Thornbury. For our units in Yate and Thornbury, we work in partnership with local Care Providers (Windmill Care and Order of St John's Care Trust respectively), our hospitals and South Gloucestershire Local Authority to provide active therapy, nursing and medical input to over 500 people per year. We work to support people to return to their own homes, wherever possible and to regain as much independence as they can, giving practical advice and therapeutic input to make sure everyone is 'as great as they can be.

We work with local schools and colleges to provide volunteering opportunities for pupils that hope to pursue careers in health or care sectors and support others to undertake awards such as the Duke of Edinburgh, enriching the lives of our service users as well as these young people.

We also provided Residential Services in Bath and North East Somerset until 1 October and continue to provide Community Equipment Services in this area.

Closing remarks

This report outlines the many services we offer to the our people and communities and we hope it has demonstrated how we strive to deliver a personal, caring and effective approach to healthcare and the social value we bring to all the people we come into contact with.

The Communications Team can help you to obtain a hard copy or a copy in a different format. Please contact us on 0300 124 5401 or by emailing **sirona.communications@nhs.net** and we will be very happy to help you. **If you're viewing this on the website you can use the Browse Aloud tool which reads the website to you.**