# NHS Tayside: Involving People in how we communicate change

How Tayside's Public Partner Network helped Reshape Diabetes Care





# NHS Tayside's Public Partner Network

- Statutory responsibility to involve people in designing, developing and delivering healthcare services
- Opportunity for the public to share their views, influence decision-making and help to improve local health services
- People from diverse backgrounds with good, commonsense values and an interest in health and health-related issues
- People who are able to freely and willingly give up their time
- Improvement activities range from information leaflets to new developments





#### Project Background

#### **Reshaping Diabetes Care**

Move patient blood test appointments closer to home

Appropriate level of care dependent on bloods results

Removal of some patients from waiting lists

Effective communication of changes to patients

### **Preparatory Materials**

- Provided background detail about the improvement
- Provided draft letters communicating the changes to Public Partners



Letter 1: advising patients they will go to their GP practice/CTAC for bloods but will continue to be under secondary care



Letter 2 advising patients they will attend their GP practice/CTAC for bloods and be under the care of their GP



Letter 3: providing patients with a summary of their results and asking them to make an appointment to see a

Consultant

- Asked PPN members to read the letters and consider points they wish to make
- Hybrid meeting allowed PPN members to attend in person or online and some submitted written comments

#### On the day

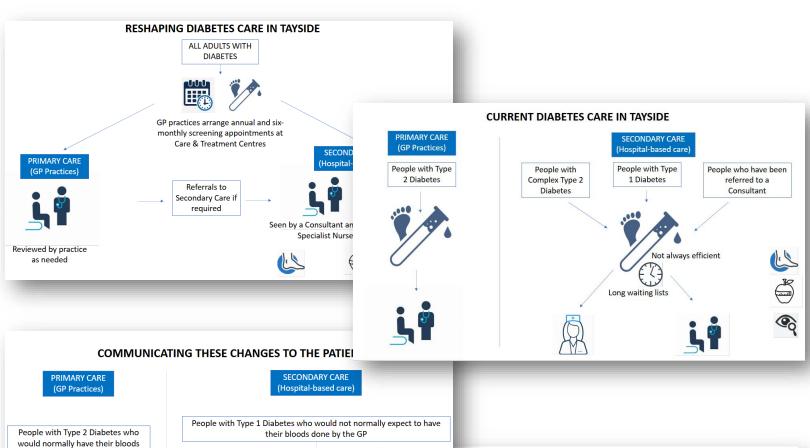
- Presented flow charts
- Went through each letter line by line
- Recorded PPN feedback on the letters

done by the GP

GP Practices will inform all people with Diabetes that they will soon begin to receive screening

appointments at the Care & Treatment Centres if this is

something that doesn't already





ALL ADULTS WITH DIABETES



GP practices arrange annual and sixmonthly screening appointments at Care & Treatment Centres

After having bloods done at a Care & Treatment Centre, LETTER 3 is sent to people under secondary care, together with a Care Summary Booklet, and lets them know they need to make an appointment to see a Consultant







Seen by a Consultant annually and by a Diabetes Specialist Nurse six months later



**LETTER 1** will be sent to everyone who currently sees a Consultant for

their Diabetes care letting them know about the planned changes

People with Type 2 Diabetes who are currently under Secondary Care

#### PPN Suggestions

"Patients need to be reminded they're still under the care of their Consultant"

"Explain what a CTAC is"

"Provide information on where to go for dietary advice and support" "Removing you from the waiting list' is too Draconian!"

"Include 'in the meantime' so patients aren't left wondering"

"Explain what 'MyDiabetesMyWay' is"

"Let patients know they'll be contacted again so they know they're not going to be lost in the system" "These changes are really important - put an article in the local newspaper to let people know"

"The flow charts you've shown us are really informative – include these or a video when you let patients know about these changes"

"It would have been good to have been consulted about the changes and not just about how you communicate them"

#### Post-PPN Meeting Feedback



PROVIDED DETAILED
FEEDBACK ON HOW WE
USED THEIR SUGGESTIONS



EXPLAINED WHERE AND WHY SOME FEEDBACK WAS NOT USED



DESCRIBED HOW AND WHERE WE DID USE THEIR FEEDBACK



OUTLINED NEXT STEPS FOR THE VIDEO AND PRESS RELEASE

#### Press Release



#### Diabetes care scheme will help all, says NHS



TAILORED TREATMENT: Members of the NHS Tayside community care and treatment service team at the south locality hub in Bridge of Earn.

CHANGES to diabetes care services in Tayside will cut waiting times, reduce travel and improve patient experience, NHS bosses have claimed.

More than 26,000 people in the region are living with diabetes and NHS Tayside is preparing to change the way people receive regular blood tests and screening appointments.

The new approach aims to deliver care closer to home and ensure patients receive the right tests at the right time from the appropriate healthcare team.

The redesign of diabetes monitoring services across Tayside will bring care closer to home with a view to enhancing patient experiences and health outcomes.

#### BY LOGAN HUTCHISON

All individuals with diabetes, regardless of type, will now attend blood test and monitoring appointments at their local GP practice or community treatment and care service, reducing the need for unnecessary hospital visits.

Following blood tests and monitoring appointments, patients will then receive care tailored to their results.

Those requiring further assessment or support from hospital-based specialist care teams will be offered review appointments, either in person or via telephone or video consultations - depending on what best suits their needs.

Patients whose results indicate no need for hospital care will continue to be managed by their GP practice.

It is also hoped the change will reduce waiting times for hospital appointments and cut down on emissions caused by unnecessary travel.

Lynn Smith, chief officer of acute services at NHS Tayside. said: "By bringing care into local communities we are reducing travel, cutting waiting times and improving the overall patient experience. This is a significant step forward in delivering personcentred, efficient and sustainable

care for those living with diabetes." A pilot study of the new approach has been successfully tested in Perth and Kinross in recent months, with many patients already benefiting from local

convenience of appointments at local community treatment and care service locations or at their GP practices rather than travelling to Perth Royal Infirmary or Ninewells Hospital in Dundee.

Christine Craig, who has diabetes, said: "It is easier for me to get to the Bridge of Earn hub as Ldon't drive. I prefer coming to the hub as it is closer to home.

The rollout of the new service to all GP practices and community treatment and care services across Tayside is expected by early 2025.

Professor Ewan Pearson, NHS Tayside's clinical lead for secondary care diabetes, said: "The new diabetes care pathway will fully co-ordinate care between the GP and secondary care team, minimise duplication and ensure patients receive the most Patients have appreciated the appropriate care for their needs."

#### Video

- Worked closely with NHS Tayside Comms Team to develop the video
- Created voiceover
- Received Project Board for approval
- Sustainability Lead wanted to include sustainable element
- Final version of video approved

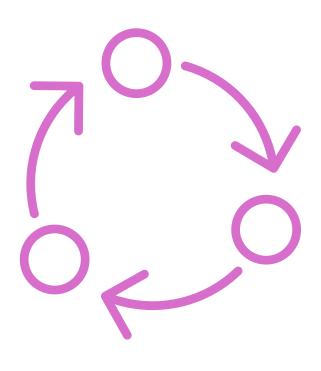


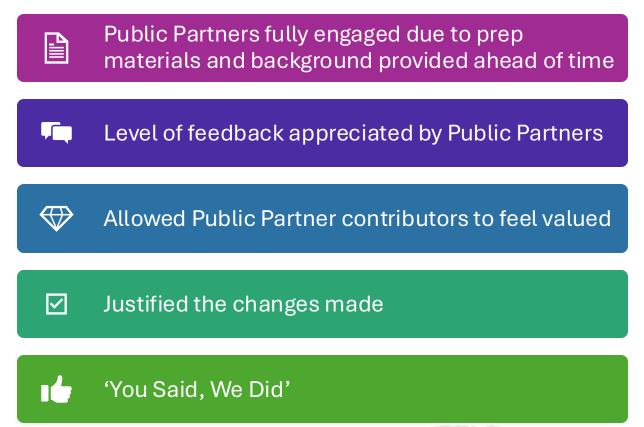
#### Where is the Video now?

- NHS Tayside social media
- NHS Tayside MCN website
- Links at the end of patient letters
- GP practice websites and social media
- GP practice and CTAC waiting areas
- Presented at Diabetes Conference, Perth Concert Hall



#### Closing the Loop





### Any Questions?