

How can we improve uptake of structured diabetes education?

In this section, a panel of multidisciplinary team members give their opinions on a recently published paper. In this issue, we discuss the reasons people with diabetes give for not attending structured education, and how we can encourage more of them to attend.

Reasons why patients referred to diabetes education programmes choose not to attend: a systematic review.

Horigan G, Davies M, Findlay-White F (2016) *Diabet Med* 21 Mar [Epub ahead of print]

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Reasons for not attending structured diabetes education

- 1 The 2014 National Diabetes Audit revealed that structured education was offered to only 3.9% and 16.7% of people with newly diagnosed T1D and T2D, respectively, and that only 0.9% and 3.6% attended.
- 2 Therefore, this systematic review of the literature was conducted to determine people's expressed reasons for not attending structured education.
- 3 Five electronic databases were searched for the period between 2005 and 2015, and 12 studies with

a total of 2260 participants were included in the analysis.

- 4 Education programmes were mainly for T2D; however, four studies also included programmes for T1D.
- 5 In the eight studies that reported on gender, 80% of non-attenders were male. Findings related to age, socioeconomic status and educational attainment were inconclusive.
- 6 Across the studies, 36 separate reasons for non-attendance were given, which were grouped into two themes: reasons why people were unable to attend and reasons why they were unwilling to.
- 7 People who were unable to attend had three broad factors involved: logistical (e.g. lack of time, work commitments, venue being too far away), medical (e.g. illness or disability that prevented attendance)

and financial (e.g. travel costs, lack of health insurance coverage).

- 8 For people who were unwilling to attend, the factors involved could be grouped into four categories: lack of perceived benefit (including lack of enthusiasm from the healthcare professional offering the education), knowledge (either feeling that they already knew enough or receiving insufficient information about the course), emotional (e.g. anxiety about group classes or preferring not to hear about the negative consequences of diabetes) and cultural (e.g. language and cultural issues).
- 9 The authors note that, in the last 10 years, efforts to improve structured education have rightly focussed on content and quality. Now, however, more patient-centric developments need to be made to improve attendance.



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Structured diabetes should be mandatory, and the rationale for this is simple: in diabetes, as in life, education has proven effectiveness and is a basic human right. Medications and technologies are prescribed to support self-management, yet, arguably, education is the most fundamental of (oral and aural) therapies and deserves prescription also. Indeed, as Horigan and colleagues note, it is also one of the most cost-effective therapies available to the NHS.

The authors' systematic review found that those who were unable to attend structured education gave logistical, medical or financial reasons. No person affected by a condition as serious as diabetes should feel they have to compromise their current and future health because they cannot afford to take time off work or to pay for childcare to attend. It should be mandatory for people with diabetes to attend structured education and for employers to allow them to take sick leave to do so; and provision should be made to cover travel and other costs incurred by the individual if affordability is an issue. Ultimately, however, while all of these issues are important to overcome, their resolution does not increase uptake significantly.

The reasons given by non-attenders categorised as those who were *unwilling*

to attend are much more revealing than the reasons given by those who were *unable* to attend. The former perceived no benefit, felt they already had sufficient knowledge or expressed emotional or cultural reasons. This is unsurprising. Indeed, many people may have reported logistical or financial reasons for non-attendance to conceal their real reasons, such as perceiving little benefit or perhaps not wanting to "go back to school".

As the authors report, the biomedical and psychological benefits of structured education have been established in numerous academic papers and are now promoted in influential guidelines. Some argue that technology is more effective than education but, for many years, there has been speculation that the benefits of technology were due, at least in part, to the additional education and training received at uptake. This has been confirmed in recent trials (Little et al, 2014; White et al, 2014), providing an even more compelling argument for structured education being made a mandatory early element of a stepwise clinical pathway (Choudhary et al, 2015).

Despite proven benefits, in the real world few products sell themselves to the consumer, and structured education is no exception – it needs to appeal to the person with diabetes. Yet very little marketing budget and expertise is afforded

to the promotion of education. Diabetes UK's recent campaign, Taking Control (available at: www.diabetes.org.uk/taking-control), was a large step in the right direction, but much more work is needed in terms of increasing both appeal and reach. Fundamentally, uptake of structured education is a behaviour. Many relevant behaviour change techniques can be identified in Horgan et al's review; for example, providing information on consequences (benefits of action, costs of inaction), barrier identification, encouragement, modelling and social comparison (Abraham and Michie, 2008). These can inform the design of leaflets, posters and future campaigns, which can be evaluated in terms of their effectiveness in increasing uptake, attendance and engagement with structured education.

One crucial behaviour change technique is currently under-utilised: the persuasive power of the healthcare professional. At best, clinicians suggest or recommend that people with diabetes attend structured education. At worst, as Horgan and colleagues demonstrate, people with diabetes report their healthcare professionals being unenthusiastic about education, denying the need for it and discouraging attendance. Furthermore, many healthcare professionals make their own evidence-free judgements about who they think would be best suited to structured education, often not offering it to those with

longer diabetes duration or lower general educational attainment for their own preconceived reasons. This is unacceptable.

Making structured education mandatory is not about forcing people to attend. It is about demonstrating that it is an essential step in acquiring the knowledge, skills and beliefs to live well with diabetes and optimise both biomedical and psychological outcomes. Commissioning agencies and healthcare professionals need to put their full support behind structured education and extol its evidential benefits to all people with diabetes. Investing in evidence-based, theoretically-informed but creative and engaging marketing strategies will ensure that its benefits can be realised and experienced by all people with diabetes. ■

Abraham C, Michie S (2008) A taxonomy of behavior change techniques used in interventions. *Health Psychol* **27**: 379–87

Choudhary P, Rickels MR, Senior PA et al (2015) Evidence-informed clinical practice recommendations for treatment of type 1 diabetes complicated by problematic hypoglycemia. *Diabetes Care* **38**: 1016–29

Little SA, Leelarathna L, Walkinshaw E et al (2014) Recovery of hypoglycemia awareness in long-standing type 1 diabetes: a multicenter 2 × 2 factorial randomized controlled trial comparing insulin pump with multiple daily injections and continuous with conventional glucose self-monitoring (HypoCOMPaSS). *Diabetes Care* **37**: 2114–22

White D, Waugh N, Elliott J et al (2014) The Relative Effectiveness of Pumps Over MDI and Structured Education (REPOSE): study protocol for a cluster randomised controlled trial. *BMJ Open* **4**: e006204



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Should structured education be made mandatory? Although in theory this sounds like a plausible solution – “we’ll improve things by forcing people to attend” – in reality, people would still fail to turn up. As the NHS does not have the funds to go around knocking on doors to collect people to ensure that they attend, mandatory programmes are unlikely to improve attendance.

Another suggestion is to make the courses shorter. However, evidence from a systematic review informs us that programmes need to be between six and ten sessions, with a minimum of 12 hours, to be effective (Steinsbekk et al, 2012). Thus, cutting the hours may increase uptake but will do little for the health and wellbeing of the diabetes population. We don’t want structured education to become subject to a tick-box mentality.

Instead, I believe uptake can only be improved by improving the service. Following liaison with NHS organisations at the heart of implementation – some in the midst of high deprivation and diverse populations – I have drawn up a number of top tips to significantly improve uptake and engagement. They are as follows:

- Services should be delivered by trained, competent and quality-assured educators who can communicate using simple language and visual aids, build a rapport and enable informed decisions.
- Referring agents need to be familiar with the content and delivery of the education package so that they are able to talk about it positively with patients and inform them that it is integral to their diabetes management.
- There should be involvement from GPs and practice nurses. Go Jefferies (2012) showed that, where primary care staff received educator training, their dietary knowledge improved and was translated into improved patient outcomes. Prior to training, there was a lack of awareness that outdated information was being delivered.
- Outcomes should be recorded and analysed to ascertain effectiveness.

- There should be patient choice over when to attend, with courses available at different times of the day (morning, afternoon and evening) and on different days (including weekends). People should be asked about their preferred period to attend (i.e. when initially diagnosed or once they have come to terms with the diagnosis). School holidays should be avoided for parents and grandparents.
- Venues should be easily accessible, on a bus route, have free parking and be places where people do not feel threatened.
 - Local circumstances should be considered, such as times in the day when free bus passes can and cannot be used.
 - A full spectrum of venues, including community centres, church halls, mosques, commercial property (often available via companies’ corporate social responsibility programmes), libraries, supermarket training rooms, social service buildings and fire stations, should be utilised.
- Ensure people feel supported by inviting them to bring a family member with them to the sessions.
- Phoning people to book them into a programme enables them to ask questions and alleviate any fears or misconceptions. Reminders (email, text or phone) should also be sent before each session.
- Provide alternatives to group-based sessions by ensuring structured education is also delivered via different media, such as DVDs and online learning.

Traditional NHS services have not always been flexible to meet the needs of the user, but if we want people with diabetes to utilise and benefit from structured education, putting them at the heart of the service is key. ■

Go Jefferies JK (2012) *The role of context and professional agency in the spread of healthcare innovation: an exploratory study of healthcare professionals’ views of diabetes self-management and the X-PERT Programme* (thesis). University of Nottingham, Nottingham. Available at: <http://eprints.nottingham.ac.uk/12942> (accessed 09.06.16)

Steinsbekk A, Rygg LØ, Lisulo M et al (2012) Group based diabetes self-management education compared to routine treatment for people with type 2 diabetes mellitus. A systematic review with meta-analysis. *BMC Health Serv Res* **12**: 213