

# Implementing structured education: Time to act for primary care trusts

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## Article points

1. Patients must have accurate information to help them make informed choices in self-care.
2. Primary care trusts (PCTs) needed to allocate funds to provide structured patient education for people with diabetes from January 2006.
3. PCTs are confronted by many challenges in implementing the directive to provide structured patient education for people with diabetes.
4. With new programmes taking up to 3 years to develop to meet the criteria, PCTs need to examine their resources carefully in order to plan ahead.

## Key words

- Structured patient education
- DAFNE
- DESMOND

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In 2003 the National Institute for Health and Clinical Excellence (NICE; formerly the National Institute for Clinical Excellence) published guidance on patient education models for diabetes through Technology Appraisal 60 (NICE, 2003). Normally Technology Appraisals are accompanied by a directive to provide funding to carry them out. In this case the funding directive was waived in favour of development of local schemes. In 2005 an influential working group published a new report on patient education (Department of Health [DoH], 2005b). A press release in June of that year heralded the report, reinstated the Technology Appraisal and directed that primary care trusts needed to allocate funds to provide structured patient education for people with diabetes from January 2006 (DoH, 2005c). Two national programmes met the report's criteria for structured patient education: Dose Adjustment for Normal Eating (DAFNE; *Table 1*) and Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND; *Table 2*). There are other local programmes in various stages of development.

The National Institute for Health and Clinical Excellence (NICE; formerly the National Institute for Clinical Excellence) Technology Appraisal on patient education models for diabetes (Technology Appraisal 60; NICE, 2003) defines structured patient education as:

*'a planned and graded programme that is comprehensive in scope, flexible in content, responsive to an individual's clinical and psychological needs, and adaptable to his or her educational and cultural background.'*

What structured patient education is not is the old medical model of a healthcare professional telling a patient what to do and expecting good results. It recognises that it is only through patients' engagement in their own care that true empowerment can take place. Structures are needed that ensure people with diabetes have access to accurate information in whatever form suits them best and at a speed with which they can cope.

Key criteria required to deliver this effective teaching and learning system (Department of Health [DoH], 2005a) accompanied the report on patient education (DoH, 2005b).

### Structured curriculum

The curriculum needs to:

- 1 have a philosophy of supporting self-management attitudes, beliefs, knowledge and skills for the learner
- 2 be person centred, incorporating the assessment of individual learning needs
- 3 be reliable, valid, relevant and comprehensive
- 4 be theory driven and evidence based
- 5 be flexible and able to cope with diversity
- 6 be able to use different teaching media
- 7 be resource-effective and have supporting materials.

The curriculum also needs to be recognised as an evolving one based on new evidence, new situations and the ability to adapt to changes that affect individuals and the care system.

### Trained educators

Trained educators need to:

- 1 have an understanding of education theory appropriate to the age and needs of the programme learners
- 2 be competent in the delivery of the education theory of the programme they are offering
- 3 be competent in the delivery of the principles and content of the specific programme they are offering.

### Quality assurance

A quality assurance programme needs to be in place. The programme needs to be peer reviewed by independent assessors who assess against agreed criteria:

- 1 environment
- 2 structure
- 3 process
- 4 content
- 5 use of material
- 6 whether the programme has actually been delivered
- 7 evaluation and outcome information.

### Audit

The outcomes from the programme need to be audited. The outcomes might include:

- 1 biomedical
- 2 quality of life
- 3 satisfaction

**Table 1. The Dose Adjustment For Normal Eating (DAFNE) course (www.dafne.uk.com [accessed 27.02.2006]).**

- The main principles of the DAFNE course are:
  - 1 skills-based training to teach flexible insulin adjustment to match carbohydrate in a free diet on a meal-by-meal basis
  - 2 emphasis on self-management and independence from the diabetes care team
  - 3 the use of adult education principles to facilitate new learning in a group setting.
- Participants attend the course for the full 5 consecutive days in groups of six to eight people. In theory, those using twice-daily insulin regimens might benefit, but in practice, participants in DAFNE switch to a multiple injection regimen on the first day of the course to maximise the opportunities for dose adjustment.
- The course consists of three main areas:
  - 1 nutrition topics
  - 2 insulin dose adjustment at meal times and during special circumstances (such as exercise and illness)
  - 3 other topics such as hypoglycaemia, complications, sick-day rules and pregnancy.
- There is also a course handbook for participants.

- 4 patient experience
- 5 user involvement
- 6 the degree of self-management achieved as a result of the programme.

### Education session format

Group education sessions were highlighted as effective measures (NICE, 2003) but the report recognised that in some cases one-to-one consultations would continue to be appropriate. This is particularly true for disadvantaged groups (such as housebound people, those in care, travellers, non-English speakers and those with learning difficulties).

### Why is structured patient education needed?

The National Service Framework for diabetes (DoH, 2003) advocated that education be built into patients' reviews and rated its impact very highly.

Programmes that meet the criteria have demonstrated improvements in quality of life as well as improved metabolic control and a consequent reduction in complications (DoH, 2005b). And people with diabetes appreciate it (Audit Commission, 2000):

*'My attitude has always been "it ain't going to beat me" and I believe that the most*

### Page points

1. Group education sessions have been highlighted as effective measures, but it has been recognised that in some cases one-to-one consultations will continue to be appropriate.
2. The National Service Framework for diabetes (DoH, 2003) advocated that education be built into patients' reviews.

**Page points**

1. It is thought that most people diagnosed with diabetes are offered some sort of education, at least when they are diagnosed.
2. There is, however, huge variance in how this education is delivered and how its effectiveness is measured.
3. Patients must have accurate information to help them make informed choices in self-care.
4. New ways of engaging the public in self-management of long-term conditions are needed and structured patient education is a hugely important part of that change.

*important care is education in all aspects of the disease [...] I have been insulin dependent for 43 years and can still do 10 press-ups [...] It is not all doom and gloom!*

It is thought that most people diagnosed with diabetes are offered some sort of education, at least when they are diagnosed (NICE, 2003). There is, however, huge variance in how this is delivered and how its effectiveness is measured. NICE (2003) summed it up thus:

*'the length, content and style of educational options varies greatly between services; some of the educational programmes offered are unstructured, very few have been formally evaluated, and few individuals who deliver education have been formally trained for this purpose.'*

What healthcare professionals and patients themselves perceive as a priority in education are not necessarily the same. Individuals are

more likely to learn if they have identified a need (DoH, 2006). Most of the time it is the patients who will make decisions concerning their health. Healthcare professionals see them for a relatively short time in the average year – patients must have accurate information to help them make informed choices in self-care. Patients and carers need to be involved not only in receiving education but in planning it to fit their needs.

Care plans and education that encourage people with diabetes to identify goals and targets for their own care are fundamental – and it all takes time. The National Diabetes Support Team found that lack of time was a large factor in changing practice (Table 3). New ways of engaging the public in self-management of long-term conditions are needed and structured patient education is a hugely important part of that change.

These views are offset by evidence (DoH, 2006) from some self-care approaches that investment could reduce:

- visits to GPs by up to 40%
- visits to outpatient clinics by up to 17%
- visits to accident and emergency units by up to 50%
- drug expenditure.

**How can practices and PCTs implement structured patient education?**

The onus is on primary care trusts (PCTs) to provide this structured patient education, but with Dose Adjustment For Normal Eating (DAFNE) and Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND) programmes not coming cheaply (DAFNE costs £545 per person [NICE, 2003], for instance), and with many PCTs struggling to break even, practice staff need to work with them to encourage this improvement in care.

**Standards**

Standards for education programmes have been set (NICE, 2003).

- 1 It is recommended that structured patient education be made available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis, based on a formal, regular assessment of need.

**Table 2. The Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND) project (www.desmond-project.org.uk [accessed 27.02.2006]).**

- This structured patient education programme is for type 2 diabetes.
- The programme has the following characteristics.
  - 1 It provides 6 hours of structured group education according to a formal curriculum.
  - 2 The 6 hours of structured group education can be offered either as a 1-day course, or as a 2 half-day course – the 2 half-days being no more than 2 weeks apart.
  - 3 Groups consist of six to ten people newly diagnosed with type 2 diabetes.
  - 4 Each person attending a group can choose to be accompanied by a partner, family member or friend.
  - 5 Each person attending a group is provided with patient material specially developed to accompany the programme and intended as a reference guide subsequent to attending the course.
- The programme is delivered by two healthcare professionals who:
  - 1 have attended a 2-day initial formal training programme to graduate as DESMOND Educators
  - 2 will submit to a quality assurance programme in the first year of 'graduating', and subsequently every 3 years
  - 3 will use defined resources to deliver the programme
  - 4 will deliver five courses annually to maintain competency as a DESMOND Educator.

- 2 There is insufficient evidence currently available to recommend a specific type of education or provide guidance on the setting for, or frequency of, sessions. However, to achieve maximum effectiveness some principles of good practice are clear.
- a Educational interventions should reflect established principles of adult learning.
  - b Education should be provided by an appropriately trained multidisciplinary team to groups of people with diabetes, unless group work is considered unsuitable for an individual.
  - c Sessions should be accessible to the broadest range of people, taking into account culture, ethnicity, disability and geographical issues, and could be held either in the community or at a local diabetes centre.
  - d Educational programmes should use a variety of techniques to promote active learning (engaging individuals in the process of learning and relating the content of programmes to personal experience), adapted wherever possible to meet the different needs, personal choices and learning styles of people with diabetes, and should be integrated into routine diabetes care over the longer term.
- 3 Multidisciplinary teams providing education should include, as a minimum, a diabetes specialist nurse (or a practice nurse with experience in diabetes) who has knowledge of the principles of patient education, and a dietitian. Input from other disciplines, such as podiatry, has potential value. The composition of the team and the way that members interact may vary between programmes, but team functioning should be tailored to the needs of different groups of people with diabetes.

### Subjects

Diabetes UK has provided topics that should be covered by education programmes for people with diabetes. These topics come under the following headings: nature of diabetes; day-to-day management of diabetes; specific issues; living with diabetes; and 'sick day' rules.

Guidance on each of these topics is expanded upon in *Recommendations for the provision of*

*services in primary care for people with diabetes* (Diabetes UK, 2005).

### What are the implications for practice and for people with diabetes?

People with diabetes deserve high-quality education to enable them to self-care. Historically patients handed over their medical problem for the doctors to cure. Even if that was an acceptable way to practise, it is not sufficient for today's modern NHS. People are living longer, there are increasing numbers of older people, and people are expecting more from their health care.

In the future, self-management may evolve into 'expert patients' running education programmes for themselves and inviting doctors, nurses and others to support them as they see fit. The Expert Patients Programme (DoH, 2001) encourages just that, with individuals learning how to ask appropriate questions and take action based on answers they understand. The next generation will grow up in the ethos of 'self-care' and will need effective 'tools to do the job'.

### What are the challenges?

PCTs are confronted by many challenges in implementing the directive to provide structured patient education for people with diabetes. The majority of people with type 1 diabetes are seen, at least initially, by specialists and will receive their education there, through attending DAFNE courses where provided. Type 1 accounts for only around 15% of all cases of diabetes; the majority of people with type 2 are likely to be seen in primary care. In order to meet the NICE requirements listed above, PCTs need to consider the following key features.

### *Programmes must have a structured, written curriculum*

What is being taught and discussed between patient and what we should now call 'educators' has to be formalised. There should be demonstrable links to further education institutions. This works well in group sessions and has been shown to be effective (DoH, 2005b). Primary care teams need to record if a person is attending a group session and put systems in place to address the education needs of those who cannot.

**Table 3. Lack of time is a significant factor in changing practice (Department of Health, 2004).**

There is no doubt that a major concern of professionals was the adverse impact on their time that implementing a system of care based on empowering patients would have. Many considered that involving patients in the decision making process would lead to increased consultation times and a further pressure on already heavy workloads.

### Page points

1. In the future, self-management may evolve into 'expert patients' running education programmes for themselves and inviting doctors, nurses and others to support them as they see fit.
2. Primary care trusts are confronted by many challenges in implementing the directive to provide structured patient education for people with diabetes.

*‘Primary care trusts have a tight deadline to meet to provide structured patient education targets and, with new programmes taking up to 3 years to develop to meet the criteria, need to examine their resources carefully in order to plan ahead.’*

**Programmes must have trained educators**

Practice nurses have led the field in education in general practice yet few have had training in teaching methods, behaviour change and motivational interviewing techniques. It is important to ensure learning is taking place. Simple and effective strategies involving open questions elicit understanding (Table 4).

Teaching groups requires new skills and an understanding of teaching and learning methods. PCTs may not have availability of people with these skills and may need to budget to get local personnel trained. DAFNE and DESMOND programmes contain ‘train the trainers’ schemes in their setup and more are being developed.

**Programmes must be quality assured**

PCTs will have to consider how to relate quality assurance issues to structured patient education in their areas, including whether the programme has been delivered to a set standard. This again fits group education better than the traditional short clinic appointment with the nurse, but primary care teams should consider how they ensure that their education plans are being delivered in the most effective manner. New ways of working may be appropriate, involving the whole team.

**Programmes must be audited**

This audit should include not only the clinical indicators that fit the new General Medical Services targets but patient experience and learning. The views of people with diabetes and their carers should be sought and used to improve how their education is provided in the future. Primary care teams need to be brave here – changes to practice to suit the patient may not always suit the staff!

**Concluding remark**

PCTs have a tight deadline to meet to provide structured patient education targets and, with new programmes taking up to 3 years to develop (DoH, 2005b) to meet the criteria, they need to examine their resources carefully in order to plan ahead. ■

**Table 4. Empowering patients through questions: the old model versus the new model (adapted from Funnell, 2000).**

Patient says...	Doctor responds...	
	Old model	New model
‘I hate this exercise plan.’	‘Try walking after dinner every night with your husband for 10 minutes.’	‘What do you hate about it? What would help you do better at it?’
‘I don’t think I can quit smoking.’	‘Smoking is the leading cause of preventable death.’	‘Why do you think that? What has happened in the past when you tried to quit? What concerns you when you think about trying to quit?’
‘I haven’t been able to test my blood sugar four times a day.’	‘It’s hard at first, but just keep trying. You really need to keep track of it.’	‘What is preventing you from doing that? Do you know what the numbers mean?’

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