Structured education criteria ... why bother?

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I offered to write this editorial following a conversation with the editor about the value and purpose of self-management education programmes meeting NICE (2003) guidelines. These were explored in more detail and developed into criteria by the joint Department of Health and Diabetes UK patient education working group (2005), and were further developed into a self-assessment tool (DH et al, 2006). The editor, like many others, asked a very important question: "what is the value of a programme meeting the criteria?". So I said I would try to respond to that question from my personal perspective.

The development of the criteria focused on three points. First, the need to highlight the requirement for better access to high quality self-management programmes for people with diabetes. Second, the recognition that the evidence for "what is best" was lacking and that some programmes were not achieving what they set out to achieve. Third, the cost to the NHS of diabetes education courses that were not known to be of value. The sections that follow consider each of the criteria.

Patient-centred philosophy

Over the years I have realised that what I believe influences how I behave, and on occasion this can cause conflict if my beliefs are different from those of another. We, as diabetes nurses, may believe we share the same philosophy but this may not be true (Anderson and Funnel, 1999; Pill et al, 1999).

The value of exploring our role and beliefs and values in relation to people with diabetes has been pivotal in being able to be clear about the design of any programme I am involved in.

If one person believes that the giving of information by an expert is key to the delivery then the programme will be delivered differently than if someone believes that people already have information but need support to act on it. Be aware though that there is no "right" philosophy – only an explicit one!

A structured curriculum

A written document that guides all "educators" as to the key components of a programme has assisted me in making very clear to others in the team what I think is going on in the sessions and vice versa!

The need for a theory-driven programme is a move towards developing a programme that is evidence-based, for example using (tested) behavioural change theories to guide your interactions *if* your programme is about behaviour change. This was possibly the steepest learning curve in my journey (Skinner et al, 2003), but now it allows clarity for the assessment of whether you are getting the changes you want from a programme.

One of the theories underpinning the DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme is the health belief model. DESMOND was designed, among other things, to elicit health beliefs and track health belief changes, and it was found that the intervention made a difference in terms of this (Davies et al, 2008).

Trained educators

If a programme was only going to be delivered by yourself and possibly one other, and you agreed on the curriculum, then trained educators may not be vital. However, your quality assurance and audit approach may guide you as to the need for further training if you are not achieving what you want to be. I know that I needed to be helped to reflect on my practice and to consider how I could change from being a keen information-giver to an effective information-processor. I realised that the people on our programmes in Portsmouth knew the information, but did not seem to apply it to themselves or be able

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to work out how to. The Portsmouth team, like the DESMOND team, spent many hours deciding what the key components of our programme were before we could see if we were delivering on them.

Quality assurance

Quality assurance of your programme is a natural next step if you have spent time on the previous steps. You will want to know if people (including yourself) are able to deliver the programme as outlined in the curriculum. Locally, we have used structured peer review (using an agreed feedback model) to support this process, whereas national programmes such as DESMOND have developed external reviews. What they share is the need for a clear description of the processes and structure of the programme, so that objective feedback is possible. A full quality-assurance assessment will include a review of the reach of the programme (how many of the intended participants are able to access the programme), and participant feedback on the value of the programme.

Audit

Audit is, again, a natural step: is my programme having the effect I hoped it would, and how does it compare with other similar programmes? In hindsight, I wish we had set up an audit process at the beginning, but we were so keen to get our programmes up and running. However, we are slowly developing data collection sheets from our participants and analysing our information. The Diabetes Education Network (http://www.diabetes-education.net/) is seeking to help all teams planning structured diabetes education by producing a set of data collection criteria (including those for data on biomedical parameters, quality of life, patient experience and the degree of self-management achieved as a result of the programme) for use on non-national programmes. In Portsmouth, we have taken the responsibility for collecting the data and entering the full audit cycle (changing the programme as a result) as part of the delivery of education. The initial stages of this work on one of our programmes is outlined in more detail by Kate Marsden and her colleagues in this edition (page 88).

Conclusion

I believe that the criteria developed from the NICE guidance, however complex and possibly imperfect they may be, have helped me and others understand how to develop a "structured" approach to developing educational interventions that may be of more value than what was delivered previously. ∎

Anderson RM, Funnell MM (1999) Theory is the cart, vision is the horse: reflections on research in diabetes patient education. *Diabetes Educ* **25**: 43–51

Davies MJ, Heller S, Skinner TC et al (2008) Effectiveness of the diabetes education and self management for ongoing and newly diagnosed (DESMOND) programme for people with newly diagnosed type 2 diabetes: cluster randomised controlled trial. *BMJ* **336**: 491–5

Department of Health, Diabetes UK (2005) *Structured Patient Education in Diabetes: Report from the Patient Education Working Group*. DH, London

Department of Health, National Diabetes Support Team, Diabetes UK (2006) *How to Assess Structured Diabetes Education: An Improvement Toolkit for Commissioners and Local Diabetes Communities*. DH, London

NICE (2003) *Guidance on the Use of Patient-Education Models for Diabetes*. NICE, London

Pill R, Rees ME, Stott NC, Rollnick SR (1999) Can nurses learn to let go? issues arising from an intervention designed to improve patients' involvement in their own care. *J Adv Nurs* **29**: 1492–9

Skinner T, Cradock S, Arundel F, Graham W (2003) Four theories and a philosophy: self-management education for individuals newly diagnosed with type 2 diabetes. *Diabetes Spectr* **16**: 75–80