What nurses can do to improve attendance at structured education programmes

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Diabetes is a common, serious and costly disease affecting about 4 million people in the UK (Diabetes UK, 2015a). About £10 billion is spent by the NHS on diabetes (Hex et al, 2012), with 80% of the costs related to the treatment of preventable complications, such as foot ulceration leading to amputation and retinopathy causing potential blindness (Khunti et al, 2012).

The use of structured patient diabetes education is one of the strategies for diabetes management in the UK. It improves health outcomes and reduces the onset of diabetic complications in both type 1 and type 2 diabetes (DAFNE [Dose Adjustment For Normal Eating] study group, 2002; Deakin et al, 2006; Khunti et al, 2012). National guidance recommends people with diabetes are offered education programmes, both around the time of diagnosis and on a regular basis (Health and Social Care Information Centre [HSCIC], 2014).

Unfortunately, however, attendance to these programmes in the UK is poor, with less than 1.0% of people with type 1 diabetes and 3.8% with type 2 recorded as attending structured education in England (HSCIC, 2014).

Yet, anyone passionate about providing diabetes care will know managing diabetes well is challenging and demands constant commitment. People need the skills and confidence to look after their diabetes. After all, people with diabetes spend only an average of 3 hours a year with a healthcare professional. For the remaining 8757 hours, they manage their diabetes themselves (Department of Health, 2007).

Attending group education programmes requires willpower, courage, and a desire to learn and change. The evidence suggests that healthcare professionals do not explain in clear, motivating language the benefits of attending these programmes (Lawal, 2014). Clinician inertia may result in not referring or promoting the benefits of attending (Dale et al, 2014; Diabetes UK, 2014; Lawal, 2014; Winkley et al, 2014). Poor programme organisation, including long waiting times, a lack of information and poor contact with facilitators prior to the programme all impact on recruitment (Lawal, 2014).

On an emotional level, the stigma and shame of diabetes (Winkley et al, 2014), a low perception of the seriousness of diabetes, and the individual's belief that they already have the knowledge and skills may also prevent attendance (Lawal, 2014). Group education for many is intimidating. It can conjure up "negative feelings" and remind people of school or a previous insensitive interaction with a healthcare professional (Diabetes UK, 2014; Lawal, 2014).

Older age, socioeconomic deprivation, low income, belonging to an ethnic minority, male gender and diabetes duration ≥3 years may also be associated with poor uptake of diabetes education and less satisfactory health outcomes (Dale et al, 2013; Lawal, 2014). To achieve good attendance at these programmes, nurses must have the confidence to articulate what diabetes education can offer and to dispel the negative connotations that surround the word "education".

It is important to remember that different people learn in different ways. In Scotland, diabetes education is provided in three levels that can help capture the needs of different individuals (Scottish Intercollegiate Guidelines Network [SIGN], 2010):

- Level one: Information and one-to-one advice.
- Level two: Ongoing learning that may be quite informal, perhaps through a peer group.
- Level three: Structured education that meets nationally-agreed criteria (SIGN, 2010; NICE, 2011), including an evidence-based curriculum, quality assurance of teaching standards and regular audit.

All three levels are important and also incorporate the valuable role of non-medical staff as part of a highly trained and skilled multidisciplinary team approach.

Evidence-based structured educational packages have emerged in the UK over the last decade. The largest and most established for type 1 diabetes only

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is DAFNE (DAFNE Study Group, 2002). For those with, or at risk of, type 2 diabetes, there is DESMOND (Diabetes Education for Ongoing and Newly Diagnosed Diabetes) and for both type 1 and type 2 diabetes there is X-PERT (Deakin et al, 2006). All three models are delivered in groups with variations in mode of delivery, course duration, quality assurance and follow-up. The clinical benefit of attending these programmes is that they can increase diabetes knowledge and self-management skills, and result in improvements to glycaemic control, adherence to medication and episodes of hypoglycaemia (DAFNE Study Group, 2002; Deakin et al, 2006).

Tips for turning referrals into attendance

Nurses can turn referrals into attendance by being positive and enthusiastic about the benefits of education and making it clear that attending an education course is an essential part of diabetes management. The key is preparation and communication, and recognising people may be open to structured diabetes education and behaviour change at diagnosis, during their first complication and following an acute hospitalisation.

Attending a taster session

Promoting DESMOND, X-PERT and DAFNE is easier if the nurse is familiar with the timetable and programme resources. Nurses can reassure all of their patients that those who attend share similar concerns, challenges and characteristics as themselves.

Listen to the barriers to attending

Avoid the term "structured education", as many find it off-putting. Instead use the words "course" or "training". A large number of people with diabetes are working age and have poor diabetes outcomes (Diabetes UK, 2015a), but for many, negotiating time off work can be difficult. For this reason, writing to employers to explain the positive outcomes, such as reduced sickness and risk of complications, can help.

Make recruiting straightforward

Offering a choice of times, dates and venues in a clear leaflet will help promotion. People leaving their nursing consultation with a course date, information and facilitator details are more likely to attend. Until there is culture change in a service, a nurse may need to take on the additional role of programme administrator.

Being an agent for change

Clinic waiting room posters can promote programmes and the benefits of attending. It is helpful to raise awareness of the Diabetes UK *Taking Control* campaign (Diabetes UK, 2015b). Presenting patient experience and outcome data can motivate others to raise the agenda at a commissioning level.

Conclusion

Nurses are uniquely positioned to influence people with diabetes. We are usually able to offer continuity, and deliver one-to-one education and support over many years. It is during these contacts that nurses can sow the seed to enable individuals to recognise the important role of diabetes education. We know this under-utilised resource can improve the lives of adults with diabetes and yet health services fail to robustly promote it. This is a travesty that needs to be addressed. We need to be passionate in our belief that diabetes education is an opportunity not to be missed. We need to utilise all the resources available to advocate for people living with diabetes and make sure everyone has the opportunity to attend a programme that can change, and potentially add years to, their lives. ■

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