

# Transforming the “educational wasteland” into a “learning landscape”



**Rosie Walker**

Director, Successful Diabetes

If clinical appointments were experiencing a less than 30% attendance, it is likely there would be an urgent investigation.\* And yet this is the situation for diabetes education programmes. Why?

Education in diabetes might currently be likened to a “wasteland”, when it should be a vibrant, thriving, multi-faceted “learning landscape”. Learning should be part of every aspect of the diabetes care system, integrated from the moment of diagnosis, and on every step of the journey thereafter, because successfully living with and managing diabetes is all about learning and reflection. This is not the case at present. Instead, the metaphorical “wasteland” is bordered on the one side, by laudable recommendations that everyone should receive an education programme when they are diagnosed with diabetes, and statements on the central importance of this (All-Party Parliamentary Group for Diabetes, 2015; Diabetes UK, 2015; NICE, 2015), and on the other side by what, in my view, are worryingly small numbers of people being referred for, let alone receiving, education programmes (Diabetes UK, 2015).

There is no lack of recognition of this situation, or efforts to rectify it, on the part of many providers. However, they are often frustrated by not being able to access extra resources to provide education programmes or, perhaps, simply to find time in their hectic day to give sufficient attention to what people want to learn. Even in the areas most successful in prioritising access to structured education, such as South London, only about 50% of people are attending education programmes (Health Innovation Network [HIN] South London, 2014).

## Challenges for primary care

I believe that something is going badly wrong, and unless we urgently invest in a learning infrastructure that pervades the whole of diabetes services rather than having education being seen as something “other”, and align practice with policy, the landscape will deteriorate rather than thrive. Below are what I see as some of the main challenges that primary care faces.

## Insufficient provision

There are not enough places on education programmes for all people with diabetes. Put another way, insufficient programmes are commissioned to be able to provide every person with diabetes with an initial learning programme, as recommended. There is also insufficient variety of provision, with usually only one, group-based programme being offered. Along with unmet need, this practice also builds in inequality of access.

## Lack of integration

Education provision is, in my experience, too often seen as a job tangential to “real diabetes” (i.e. medical management), rather than clinical encounters themselves being the “learning landscape”.

## Lack of engagement

A common complaint among providers of structured education is that, although people are referred, they do not attend. This is often not the person’s fault as the need for, or availability of, education may not have even been discussed with them at diagnosis (see below), nor the views of people with diabetes been sought or acted upon during the commissioning process. This results in programmes being commissioned which do not necessarily meet the needs of the people for whom they are provided.

## Rewarding the wrong actions

One consequence of rewarding practitioners for referral to structured education – for example, via the Quality and Outcomes Framework in England – is that referrals go up. However, this is not always with the knowledge and agreement of the individuals themselves, but through a paper exercise that they may or may not know about. Unfortunately, an unintended side effect is that people may end up being blamed for not attending, when they did not even know they were being referred. I’ve termed this, for some time now, the “patientless referral”, and its existence was further illuminated recently (Winkley et al, 2015).

## Notes

\*Thanks to Dr Charles Gostling for this analogy.

†For an example, email: [enquiries@successfuldiabetes.com](mailto:enquiries@successfuldiabetes.com)

All-Party Parliamentary Group for Diabetes (2015) *Taking Control: Supporting people to self-manage their diabetes*. Available at: <http://bit.ly/1B6bqEv> (accessed 09.04.15)

Diabetes UK (2015) *State of the Nation: Challenges for 2015 and beyond – England*. Diabetes UK, London

Health Innovation Network South London (2014) *Structured Education for Type 2 Diabetes: A toolkit for optimal delivery*. Available at: <http://bit.ly/1zjw3mn> (accessed 09.04.15)

Lawal M (2014) Barriers to attendance in diabetes education centres: a systematic review. *Diabetes and Primary Care* **16**: 299–306

McDowell J, MacRury S (2015) Structured Diabetes Education in Scotland. *Practical Diabetes* **32**: 24–8

NHS England (2014) *Action for Diabetes*. NHS England, London

NICE (2014) *Type 1 diabetes: diagnosis and management of type 1 diabetes in adults* (CG draft). NICE, London

NICE (2015) *Type 2 diabetes: diagnosis and management of type 2 diabetes in adults* (CG draft). NICE, London

Pulse (2015) *Labour to 'toughen rules' on following NICE guidelines as part of 'wide-ranging review'*. Available at: <http://bit.ly/1zcOIFt> (accessed 09.04.15)

Winkley K, Evwerhoma C, Amiel SA et al (2015) Patient explanations for non-attendance at structured diabetes education sessions for newly diagnosed Type 2 diabetes: a qualitative study. *Diabet Med* **32**: 120–8

## Barriers to attendance

There is good and growing evidence of what the barriers are to attendance at structured education programmes (HIN South London, 2014; Diabetes UK, 2015; Lawal, 2014; Winkley et al, 2015). These include lack of explanation, lack of communication of the seriousness of diabetes, and lack of education being seen as an essential part of treatment. Also, sometimes the decision about whether to refer someone to a programme depends on the health practitioner's own assumption of whether it is something they need.

## Expectations of healthcare professionals

Most of us set out to be clinicians, not educators. So it is not surprising that even though, for many, education has become part of their job description, they may not be experts in facilitating learning, particularly in a group setting. A number of clinicians have told me that concentrating on learning is scary and that they feel out of their professional “comfort zone”. Even more are concerned about how time-consuming it can be. Despite best intentions, it is easy to fall back into the “teaching as telling” model hard-wired into our clinical services, despite recent policies to be more personalised (NHS England, 2014).

## Potential solutions

Here are some ideas for how we could make a difference to the rhetoric–reality divide that currently exists for diabetes education:

- Transform referrals into more enticing “invitations” and involve people with diabetes in their design, wording and how they are offered.†
- Remunerate or reward referrers for attendance, not referral.
- Alter the language on education (e.g. “education” could change to “learning” or “information”, “self-management” to “looking after yourself”, and “programme” to “meeting”).
- Encourage people to help themselves to information and other forms of self-help by providing a menu of reliable sources of information and support, and inviting them to choose what will suit them best.† Use consultations to discuss what they have used and how helpful it has been for them.
- Invest in a variety of programmes that all can take part in, with sufficient places for local numbers.

- Invest in the skills of clinicians, to enhance their effectiveness and confidence in this area, particularly skills which make learning enjoyable, interactive and participatory as well as those related to working with groups.
- Create different expectations – why should education not be seen as much a treatment for diabetes as any medication? One single “dose” of education (e.g. a learning programme) could give someone the knowledge, skills and confidence to manage their diabetes much more than several standard visits to the surgery.
- Treat each consultation or appointment as a learning opportunity as much as a clinical one. For example, starting by inviting and answering people's questions may be more helpful than prioritising our own agenda.
- Use a personalised care planning approach that enables people to receive and consider their clinical results in advance, and create an agenda of items they would like to address at the appointment.

## A way forward?

With the various pressures that every primary clinician faces, it is not surprising that such solutions are not yet widely implemented. Nevertheless, some services are proving that it can be possible. HIN South London, for instance has produced an engaging toolkit (HIN South London, 2014). Scotland seems to have the makings of a comprehensive national system that addresses and documents attendance (McDowell and MacRury, 2015). And I have some relevant personal experience, through my work at Successful Diabetes ([www.successfuldiabetes.com](http://www.successfuldiabetes.com)), where we provide support and resources including: tips on encouraging attendance; a ready-made menu of reliable self-help opportunities; a one-to-one education programme (available for commission and directly to people with type 2 diabetes); books; and training in educational skills.

Draft updated NICE guidelines emphasise educational recommendations to be implemented as a priority (NICE, 2014; 2015), and this guidance might be enforced a little more vigorously in future if election promises are to be believed (Pulse, 2015). But much more needs to be done, and soon, if the “wasteland” is to be transformed into the “learning landscape”. Spring is here – let's sow some seeds! ■