Meeting the criteria for structured education and competences

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The publication of the *Structured Patient Education in Diabetes* report (Department of Health [DoH], 2005) last spring gave us all until January 2006 to have in place funded plans and up to April 2006 for full implementation of structured education. Any programme being developed was to ensure it met the following standards.

- It must be evidenced based.
- It must have a structured, written curriculum.
- It must include trained educators.
- It must be quality assured.
- It must be audited.

There is a wealth of literature supporting diabetes education as an essential component of effective diabetes care. The National Institute for Health and Clinical Excellence (NICE; 2003) states that the aim of education for people with diabetes is:

> ***'To improve their knowledge and skills, enabling them to take control of their own condition and to integrate self-management into their daily lives.'***

The ultimate goal of education for people with diabetes is to achieve an improvement in control of all diabetes-related risk factors, the management of diabetes-associated complications and to improve quality of life. The National Service Framework for diabetes (DoH, 2001) standard 3 states that all people with diabetes will:

> ***'Receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle.'***

NICE's technology appraisal number 60 (*Guidance on the use of patient-education models for diabetes*; NICE, 2003) recommends that:

> ***'Structured patient education is 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.'***

Therefore a diabetes education package must:

- provide knowledge and skills
- be tailored to the needs of the individual
- include skills-based approaches to education.

The education package must ultimately aim to help people with diabetes:

- adopt and maintain a healthy lifestyle
- improve their vascular risk factors
- manage related complications.

The education package must result in:

- improved quality and control of the individual's lives
- integrated self-management.

The package must also require healthcare professionals to:

- encourage partnerships in decision-making
- support the individual to manage his or her condition.

What is the evidence that if we are able to incorporate all of the above into structured education programmes we will achieve the biomedical and quality of life outcomes desired by both healthcare professionals and, more importantly, the people with diabetes?

There is a distinct lack of evidence for structured education, the best evidence available being a systematic review of randomised controlled trials that does not cover type 1 diabetes. A Cochrane Database review published on type 2 diabetes education (Deakin et al, 2005) – including 11 studies that met the inclusion criteria of being randomised controlled trials or controlled trials, having an intervention including at least one session with a minimum of six participants, and having a follow-up of longer than 6 months – concluded that while group education results in statistically significant clinical and health-related outcomes, 'educational interventions are complex

interventions, [and] it is difficult to identify the active ingredient with any precision' (Deakin et al, 2005), predominantly because the healthcare professionals delivering the programmes do not describe what they actually do in the education sessions. Clearly, further research is needed in the effectiveness of structured education, and some guidance on undertaking research in this field would be helpful.

Current education programmes

There are three programmes that are currently heralded as meeting the criteria as outlined by the DoH's document (DoH, 2005), these being Dose Adjustment For Normal Eating (DAFNE), Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) and X-PERT. It is suggested in the report that it can take 3 years to develop such programmes; however, they do provide an opportunity to buy a programme off the shelf, as is the case in the many centres undertaking both DESMOND and DAFNE programmes.

There is also the opportunity to reflect on locally existing programmes. In Chichester we have run 'structured type 2 education' for some years, and I believe it ticks some of the boxes in terms of a written curriculum delivered by trained educators (if that means we hold a teaching qualification). While we have audited the outcomes periodically it has been on an ad-hoc basis and we have yet to quality assure it. In terms of education for people with type 1 diabetes we have used this time to visit a number of centres delivering programmes such as the Bournemouth Type 1 Intensive Education Programme (BERTIE, Bournemouth Diabetes Centre), Juggling Insulin Goals for Success And Well-being (JIGSAW, Portsmouth Hospitals NHS Trust and Portsmouth City Primary Care Trust), InSight (Churchill Hospital, Oxford) and DAFNE (Sheffield Teaching Hospitals, Northumbria Healthcare Trust and King's College Hospital, London). Supported by the Type 1 Education Network we aim to develop our own education course, having also discussed with our South coast colleagues the opportunity for peer review when we are up and running.

Jill Hill and colleagues (see pages 58–63) give a comprehensive overview of the DoH report and the implications for practice, for us and our primary care colleagues. The article also reflects on the practice nurses' role in delivering education, and how we need to embrace them as part of the team delivering structured education.

It has become increasingly important for all staff delivering diabetes care to be able to demonstrate their competency to do so. The Skills for Health Diabetes National Workforce Competence framework (Skills for Health, 2004) comprehensively sets out the range of competences required to deliver diabetes services, ranging from the condition's diagnosis to its clinical management. With this is mind it makes sense when developing diabetes training programmes that they are mapped against these competences.

Mags Bannister and Claire Vick describe the process they and their colleagues have undertaken in Bradford to ensure that the education modules they are offering reflect the competences and support the healthcare professionals' development in providing diabetes care (see pages 65–9).

The implication for some of us is a busy year: mapping our structured patient education programmes against the DoH criteria and ensuring that our healthcare professionals' training programmes enable them to meet the Skills for Health competencies. All of this will contribute to improved diabetes care and services. ■

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