

Education, education, education: a surge of interest in education for diabetes self-management

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Introduction

I was taken aback by unattributed criticism of '*consultant clinicians*' (sic) in the minutes of a recent meeting of the UK APPG for Diabetes investigating the provision of education for people with diabetes.¹ Apparently they '*lamentably have failed to champion education across the country. They have failed their patients and failed their profession...*'. When questions about access to diabetes education were included in the National Diabetes Audit for the first time, it appeared that provision was low across England and Wales with 6% of all people with type 2 diabetes being offered structured education.² However only 1.6% of people with type 2 diabetes who were offered structured education participated.

At the subsequent APPG meeting, I listened to articulate and passionate consumers of diabetes education and some articulate and passionate providers of the same – some of whom were consultant clinicians! Some people were very pleased with the education they had received (notably via DAFNE, DESMOND and X-PERT courses), but not all were so impressed. Low attendance at courses was seen by some as inevitable, but others had made efforts to address this and driven attendance up.³ Perhaps it is in the nature of users of an NHS that is free at the point of need to take what they want and leave what they do not fancy – usually preventative measures such as screening, immunisation and education. There might appear to be an absence of carrot and stick.

Incentives

It has been said that a lack of interest in education *per se* is a national characteristic, so we face a cultural challenge to make engagement in diabetes education attractive. Schemes to encourage behavioural change, such as smoking cessation, have utilised cash payments, vouchers, entry to luxury goods competitions etc to encourage participation or reward individual success. Pleasing outcomes have been achieved during programme delivery, but these have not been maintained in the longer term.⁴

A corollary to personal reward (beyond health improvement) is a participate-for-pay scheme, i.e., employees are given paid leave to attend a diabetes education course (this of course is not an option

Abbreviations and acronyms

APPG	All Party Parliamentary Group
DAFNE	Dose Adjustment for Healthy Eating
DESMOND	Diabetes Education and Self Management for Ongoing and Newly Diagnosed.
IMAGE	Development and IMplementation of A European GuidelinE and Training Standards for Diabetes prevention
NHS	National Health Service

Table 1 Cost of diagnosed diabetes in the USA in 2012⁵

Total cost of diagnosed diabetes	\$245 billion
Increased absenteeism	\$5 billion
Reduced productivity while at work	\$20.8 billion
Diabetes-related disability prohibiting working	\$21.6 billion
Uncontrolled diabetes/complications increases diabetes costs	2-8 fold
Time off work to care for relatives with diabetes	Not costed ^a

^aBut loss of productivity is recognised

for those who run their own business). Such an approach requires a change of mindset whereby employers see 'building' a healthy workforce as a vital component of a successful business. From the outside, this may be negatively viewed as intrusive, patronising or paternalistic, or positively perceived as caring. Regardless of emotive impressions, data from the USA show it makes economic sense (Table 1).⁵

One reason for failure to attend for diabetes education is unwillingness on the part of employers to release employees for something that is not seen as essential or as having any value for the business. Sickness absence for a preventable episode of diabetic ketoacidosis (considered unavoidable by employers and colleagues) is acceptable, but five days paid leave to attend a DAFNE course is not. Similarly, in general, the person with diabetes does not consider the course to be worthy of five days annual leave. It would appear that 'education in the bosses' time' is a situation amenable to legislative support, and ABCD has proposed that the APPG gives this 'win-win' initiative serious consideration.³

Is education worthwhile?

Some health care professionals may be guilty of giving the impression that they do not regard education about self-management as particularly valuable, and have low expectations of benefit.³ By contrast in Germany, an insurance-based health service, diagnosis of type 1 diabetes triggers instant education according to a standard curriculum as an inpatient, until essential

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self-management skills have been demonstrated. This intervention and subsequent annual educational refresher courses are valued and paid for by the insurance companies.⁶ It is difficult to know whether the pessimists or the optimists are correct, as there is a paucity of cost-effectiveness data for structured diabetes education. The DAFNE economic analysis suggested that it met the conventional definition of a cost-effective intervention, albeit with assumptions about the sustainability of the improvements obtained at 6 and 12 months.⁷

Adult learners have preferred learning styles, so it should not surprise us that one size does not fit all. They are from a range of backgrounds and present with a diversity of attitudes to education, level of schooling and intellectual capacity – all challenges to the delivery of effective education for each learner. While group education sessions may suit some people, others would rather run a mile in the opposite direction (acquiring a health benefit the while). Some providers of diabetes services have produced web-based education programmes that evaluate well.⁸

There is also a demand for information and support for patients and carers when they encounter a novel situation and are unsure what to do. Standard sources of advice – GP, NHS, 111 – are not universally perceived as helpful. Some specialist diabetes services have provided telephone helplines, but funding for these is not secure. Pharmaceutical companies offer a similar service, but confined to people using their own products. In order to meet the requirements for the best practice tariff, some paediatric diabetologists across a region collaborate to provide out-of-hours advice for children with diabetes, and perhaps this model merits consideration for adults with type 1 diabetes.⁹

Increasingly, patients and carers are turning to peer support, especially online. One active group is the Diabetes Online Community (#Doc), whose members engaged enthusiastically with the APPG enquiry by participating in an APPG-hosted Tweetchat.¹⁰ I admit to being a social media sceptic, but I can see that peer support is a valuable resource, although quality control is a real challenge.

Education for prevention

The fact that politicians are so interested in education for people with diabetes reflects the belief expressed most recently in the Five Year Forward View from NHS England that unless patients with long term conditions take more responsibility for self-management the NHS will not be able to cope with the rising demand caused by complications and unplanned hospital admissions, even with a further injection of cash.¹¹ This, coupled with more effective preventative measures, is seen as essential.

Diabetes prevention is a work in progress which has received substantial EU support and was the theme for one of our 2011 issues.¹² Of note is the IMAGE programme which has produced a European guideline for prevention of type 2 diabetes, a toolkit and curriculum for the training of diabetes prevention managers.¹³⁻¹⁵

Future support

It will be interesting to see whether the final UK APPG report will have the clout in an election year to deliver a boost to diabetes educational initiatives, in collaboration with 'consultant clinicians', who aspire to do better.



Key messages

- Availability and uptake of structured diabetes education is low
- Statutory paid leave to attend structured education would remove one barrier to uptake
- Patients and carers are using social media for information and support

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References

1. APPG for Diabetes. Minutes of meeting of 25 June 2014. http://www.jdrf.org.uk/downloads/Public_Affairs/APPG_Minutes_June_2014.docx (Accessed 27 Oct 2014)
2. Health and Social Care Information Centre. National Diabetes Audit 2012-2013. Report 1. Care processes and treatment targets. 2014, pp32. <http://www.hscic.gov.uk/catalogue/PUB14970/nati-diab-audi-12-13-care-proc-rep.pdf> (Accessed 27 Oct 2014)
3. APPG for Diabetes. Minutes of meeting of 10 September 2014. https://gallery.mailchimp.com/ef9cff8167f369e82c413dafd/files/APPG_Minutes_September_2014.pdf (Accessed 27 Oct 2014)
4. Cahill K, Perera R. Competitions and incentives for smoking cessation. *Cochrane Database Syst Rev* 2011;**13**(4): CD004307. <http://dx.doi.org/10.2337/dc12-262510.1002/14651858.CD004307.pub4>
5. American Diabetes Association. Economic costs of diabetes in the U.S. in 2012. *Diabetes Care* 2013;**36**:1033-46. <http://dx.doi.org/10.2337/dc12-2625>
6. Krone N, Hogler W, Barratt TG. Thoughts on paediatric diabetes care in the UK. *Br J Diabetes Vasc Dis* 2009;**9**:259-67. <http://dx.doi.org/10.1177/1474651409350950>
7. Kruger J, Brennan A, Thokala P, et al. The cost-effectiveness of the Dose Adjustment for Normal Eating (DAFNE) structured education programme: An update using the Sheffield Type 1 Diabetes Policy Model. *Diabet Med* 2013;**30**:1236-44. <http://dx.doi.org/10.1111/dme.12270>
8. Bournemouth Diabetes and Endocrine Centre. BDEC diabetes learning programme. <http://www.bdec-e-learning.com> (Accessed 27 Oct 2014)
9. Vizard M. Unlocking funding for childhood diabetes in the UK. *Br J Diabetes Vasc Dis* 2013;**13**:249-52. <http://dx.doi.org/10.1177/1474651413506169>
10. Juvenile Diabetes Research Fund website: APPG tweetchat. <http://www.jdrf.org.uk/campaigns/delivering-research/appg-for-diabetes> (Accessed 27 October 2014)
11. NHS. Five year forward view. October 2014, pp39. <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
12. Diabetes Prevention themed issue (pt 4): *Br J Diabetes Vasc Dis* 2011;**11**:159-222. <http://dvd.sagepub.com/content/11/4.toc>
13. Paulweber B, Valensi P, Lindström J, et al. A European evidence-based guideline for the prevention of type 2 diabetes. *Horm Metab Res* 2010;**42**(suppl 1):S3-36. <http://dx.doi.org/10.1055/s-0029-1240928>
14. Lindstrom J, Neumann A, Sheppard KE, et al. Take action to prevent diabetes: the IMAGE toolkit for the revention of type 2 diabetes in Europe. *Horm Metab Res* 2010;**42**(suppl1):S37-55. <http://www.dx.doi.org/10.1055/s-0029-1240975>
15. Kronsbein P for the IMAGE Study Group. IMAGE project: curriculum for the training of prevention managers. Type 2 diabetes. *Br J Diabetes Vasc Dis* 2011;**11** (Suppl 2). http://dvd.sagepub.com/content/suppl/2011/09/02/11.4.DC1/final_supplementary_file_11-4.pdf