NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATOR DEVELOPMENT PROGRAMME

Briefing note

Potential output: Recommendations for indicator development

Date of Primary Care QOF Indicator Advisory Committee meeting: 3 June 2010

Introduction

At the December 2009 committee meeting, the Advisory Committee reviewed a topic suggestion on structured education for diabetes. The Committee agreed that the structured education was both clinically- and cost-effective, but did not recommend the topic for indicator development due to concerns about the availability of services across the UK, and concerns about how the evidence base relates to minority ethnic groups where the prevalence of diabetes is significantly higher than in the general population. This briefing note presents further information on diabetes structured education and the evidence base in relation to ethnicity and service provision.

Background

Diabetes is a progressive long-term medical condition that is predominantly managed by the person with diabetes and/or their carer, as part of their daily life. Accordingly, understanding of diabetes, informed choice of management opportunities, and the acquisition of relevant skills for successful self-management play an important role in achieving optimal outcomes. Delivery of these needs is not always assured by conventional clinical consultations. Structured programmes have been designed not only to improve people's knowledge and skills, but also to help motivate and sustain people with diabetes in taking control of their condition and in delivering effective self-management.

NICE recommends that structured education should be offered to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and

review as an integral part of diabetes care (see appendix A for related recommendations).

In 2003, NICE published the technology appraisal ‘Guidance on the use of patient-education models for diabetes’ (NICE technology appraisal guidance 60). This technology appraisal assessed the clinical effectiveness and cost effectiveness of patient education models for diabetes. As a technology appraisal it carried with it a 3-month funding mandate – a policy whereby funding should be made available within 3 months of publication for the treatment of patients whose clinicians recommend treatments in line with NICE appraisals.

In 2008 the recommendations in NICE technology appraisal 60 relating to type 2 diabetes were replaced by recommendations in NICE clinical guideline 66 ‘Type 2 diabetes: National clinical guideline for management in primary and secondary care (update)’, which has in turn been updated and partially replaced by clinical guideline 87 ’Type 2 diabetes: The management of type 2 diabetes’. The recommendations relating to type 1 diabetes remain covered by the original technology appraisal.

Both the original technology appraisal and the subsequent clinical guidelines considered structured education models for diabetes to be both clinically- and cost-effective.

Diabetes structured education and minority ethnic groups

The evidence base assessing both the acceptability and patient benefit of diabetes structured education among specific minority ethnic groups is limited.

No evidence was identified to suggest that diabetes education programmes are of less benefit in certain minority ethnic groups than others or that diabetes patient education is less acceptable among differing minority ethnic groups. A Healthcare Commission review published in 2007 found that, of people with diabetes, people from minority ethnic groups particularly wanted to attend a diabetes education course but had not been offered the opportunity to do so.

A systematic review[1] of educational interventions for migrant South Asians with type 2 diabetes was published in 2008. Some beneficial outcomes identified from the trials and studies identified included: improvements for those with a high HbA1c for those attending more than two group sessions; improvements in blood pressure and cholesterol; and increased knowledge.

However, in common with the review of the evidence conducted for NICE clinical guideline 87, researchers noted that the quality of reporting in some studies was limited, and selected studies included a range of group and one-to-one interventions with varied knowledge, psychological and biomedical outcome measures. The low number and heterogeneity of the selected studies made identification of factors linked to effectiveness difficult and meta-analysis inappropriate.

The review emphasised that it was important not to take a homogenised approach to the development of educational interventions noting that: “tailored or flexible approaches may be needed.” This requirement is reflected in recommendation 1.1.5 of NICE clinical guideline 87 (see appendix A).

A randomised controlled trial evaluating the effect of structured education for people with established diabetes in a multi-ethnic population is due to report in approximately 2 years time.

Structured education programmes have been adapted, as recommended by NICE, for differing minority ethnic groups including people from the South Asian community. The programme DESMOND BME has been developed through work with black and minority ethnic groups with diabetes. Participants in the development work have come from communities in Peterborough (Muslim and Urdu-speaking) and Leicester (mainly, but not exclusively, Gujarati-speaking), and the West African and African–Caribbean communities of Southwark. The adapted version of DESMOND has since been rolled out to over 16 primary care trusts.

Service provision

The position statement on service provision (previously circulated to the NICE QOF Advisory Committee) outlines that the availability of services should not be the basis on which topics are recommended for indicator development or recommended for

consideration for inclusion on the NICE menu of indicators. Where indicators from the NICE menu are not included in the national QOF, they are available for PCTs to adopt for local quality schemes using local contracts, informed by NICE's advice on clinical- and cost-effectiveness evidence.

Information obtained from Diabetes UK suggests that in 2009, 100% of local health boards' and 80% of primary care trusts' diabetes education courses run over the last 12 months for type 2 diabetes met national guidelines for structured education.

Key considerations

Structured educational programmes are designed to improve people's knowledge and skills of diabetes self-management and to help motivate and sustain people with diabetes in taking control of their condition and in delivering effective self management.

Structured educational programmes are considered clinically effective and cost effective.

No evidence has been identified to suggest that black and minority ethnic groups are less likely than the general population to benefit from education programmes that have been adapted to meet their needs.

A Healthcare Commission review published in 2007 also found that, of people with diabetes, those from black and minority ethnic groups particularly wanted to attend a diabetes education course but had not been offered the opportunity to do so.

Advisory Committee actions

The Advisory Committee is asked to consider the issues outlined in this briefing note and consider recommending the topic for indicator development.

Appendix A: NICE recommendations on structured education from clinical guideline 87: Type 2 diabetes ‘The management of type 2 diabetes’; technology appraisal 60: ‘Guidance on the use of patient-education models for diabetes’

NICE clinical guideline 87: Type 2 diabetes ‘The management of type 2 diabetes’

Patient education

1.1.1 Offer structured education to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform people and their carers that structured education is an integral part of diabetes care.

1.1.2 Select a patient-education programme that meets the criteria laid down by the Department of Health and Diabetes UK Patient Education Working Group[3]:

- Any programme should be evidence-based and suit the needs of the individual. The programme should have specific aims and learning objectives, and should support development of self management attitudes, beliefs, knowledge and skills for the learner, their family and carers.
- The programme should have a structured curriculum that is theory driven and evidence-based, resource-effective, has supporting materials, and is written down.
- The programme should be delivered by trained educators who have an understanding of education theory appropriate to the age and needs of the programme learners, and are trained and competent in delivery of the principles and content of the programme they are offering.

- The programme itself should be quality assured, and be reviewed by trained, competent, independent assessors who assess it against key criteria to ensure sustained consistency.
- The outcomes from the programme should be regularly audited.

1.1.3 Ensure the patient-education programme provides the necessary resources to support the educators, and that educators are properly trained and given time to develop and maintain their skills.

1.1.4 Offer group education programmes as the preferred option. Provide an alternative of equal standard for a person unable or unwilling to participate in group education.

1.1.5 Ensure the patient-education programmes available meet the cultural, linguistic, cognitive and literacy needs in the locality.

1.1.6 Ensure all members of the diabetes healthcare team are familiar with the programmes of patient education available locally, that these programmes are integrated with the rest of the care pathway, and that people with diabetes and their carers have the opportunity to contribute to the design and provision of local programmes.

---

[3] Structured patient education in diabetes: report from the patient education working group. Available from: www.dh.gov.uk

Technology appraisal 60: ‘Guidance on the use of patient-education models for diabetes’

1.1 It is recommended 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.

1.4 It is considered that the Dose Adjustment for Normal Eating (DAFNE) programme may be a suitable option for individuals with type 1 diabetes, being one means of enabling people to self-manage this condition.

Appendix B: Suggested indicators suggested by stakeholders

The percentage of patients who within 24 months of diagnosis have completed or attended a structured education programme that has been locally accredited as meeting the criteria developed by the Department of Health and Diabetes UK joint Patient Education Working Group.

The percentage of patients newly diagnosed with diabetes who have been referred to a structured education programme.

The percentage of patients newly diagnosed with diabetes who have been offered attendance at a structured education programme.

References

1. Khunti K, Camosso-Stefinovic J, Carey M, Davies MJ, Stone MA (2008) Educational interventions for migrant South Asians with type 2 diabetes: a systematic review. Diabetic Medicine 25: 985−992