A joint Department of Health, National Diabetes Support Team and Diabetes UK initiative

# How to Assess Structured Diabetes Education:

## An improvement toolkit for commissioners and local diabetes communities

**The toolkit contains:**

## Structured Education Programme Improvement Tool

## Educator Improvement Tool

August 2006

## DH INFORMATION READER BOX

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| **Policy** | Estates |
| HR / Workforce | Performance |
| Management | IM & T |
| Planning | Finance |
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| **Contact Details** | Madeleine Percival<br>Diabetes Team<br>Wellington House, 133-155 Waterloo Road<br>London<br>SE1 8UG<br>(020) 7972 4656 | | |
| **For Recipient's Use** | | | |

# Contents

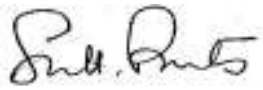
# Foreword

High quality patient education is a vital part of any diabetes service. People with diabetes have a key role to play in managing their condition on a day-to-day basis and providing them with good quality structured education can help them to achieve this.

The importance of structured education in supporting self management is set out in the Diabetes National Service Framework (NSF) and was reinforced by the National Institute for Clinical Excellence Health Technology Appraisal (NICE HTA) on patient education models in diabetes. To help service providers to put the NSF and NICE HTA principles into practice, the joint Department of Health and Diabetes UK patient education working group developed key criteria for structured education programmes. After the publication of the working group report, in June 2005, it became clear that local service providers would benefit from the development of further guidance, which local programme coordinators could use to measure their programmes against the criteria.

To respond to this need, and to help local service providers to deliver high quality structured education to their diabetes populations, the Department of Health, the National Diabetes Support Team and Diabetes UK have worked in consultation with a number of stakeholders, including the Healthcare Commission, to produce this Structured Diabetes Education Improvement toolkit.

We are confident that the tools will enable those involved in delivering diabetes patient education to assess robustly their programmes, to enhance their skills and to continue to improve the educational support given to people with diabetes.



**Dr Sue Roberts**

National Clinical Director for Diabetes

**Douglas Smallwood**

Chief Executive, Diabetes UK

# Introduction

Supporting people to self care is a crucial aspect of any high-quality diabetes service, and the Diabetes NSF sees structured education for people with diabetes as a vital part of this.[1]

Standard 3 of the Diabetes National Service Framework (NSF) states that all people with diabetes "will receive a service which encourages partnership and decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle". The Diabetes NSF also lists structured education as a key intervention needed to achieve Standard 3. Structured education can improve knowledge, blood glucose control, weight and dietary management, physical activity and psychological well-being, particularly when this is tailored to the needs of the individual and includes skills-based approaches to education.

The NSF is supported by the NICE Health Technology Appraisal (HTA) on patient-education models for diabetes.[2] This defines structured education as "a planned and graded programme that is comprehensive in scope, flexible in content, responsive to an individual's clinical and psychological needs, and adaptable to his or her educational and cultural background" and provides the following guidance:

*The aim of patient education is for people with diabetes to improve their knowledge, skills and confidence, enabling them to take increasing control of their own condition and integrate effective self-management into their daily lives. High-quality structured education can have a profound effect on biomedical outcomes, and can significantly improve quality of life and satisfaction.*

*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.*

*Self-management education should be provided by an appropriately trained multidisciplinary team to groups of people with diabetes, unless group work is considered unsuitable for an individual.*

So it is apparent that, from the perspective of both NICE and the Diabetes NSF, a structured diabetes self-management education programme is an essential component of improving the care of people with diabetes. Over the years skilled, enthusiastic and innovative healthcare professionals have responded to the need for patient education by developing local models to cater for their diabetes populations.

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[1] Department of Health, *National Service Framework for Diabetes: Standards* (December 2001); Department of Health *National Service Framework for Diabetes: Delivery Strategy* (January 2003).
See:http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4002951&chk=09Kkz1 and http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003246&chk=lKNg9r

[2] National Institute for Health and Clinical Excellence, Diabetes (types 1 and 2) - patient education models (No. 60): The clinical effectiveness and cost effectiveness of patient education models for diabetes (April 2003). See: http://www.nice.org.uk/page.aspx?o=TA060_

However, there was no consistency in content or in method of delivery and programme standards varied widely across the country.

To help local providers assess and improve their structured diabetes education programmes, the Diabetes UK/Department of Health Working Party Report on structured patient education in diabetes identified key criteria that a structured education programme should meet to fulfil the NICE requirements.[3] These key criteria were:

- Patient centred philosophy
- A structured curriculum
- Trained educators
- Be quality assured
- Be audited.[4]

Following the publication of the report, Rosie Winterton, Minister of State for Health Services, announced the reinstatement of a ministerial funding directive to accompany the NICE Health Technology Appraisal on patient education. This places a legal obligation upon Primary Care Trusts to implement all the NICE HTA recommendations. Compliance with NICE health technology appraisals is assessed by the Healthcare Commission as part of its annual health check under Core Standard C5 (a).[5]

To help local services meet the obligation of delivering patient education, the Department of Health, the National Diabetes Support Team and Diabetes UK have produced two Structured Diabetes Education Improvement tools, in consultation with a number of stakeholders, including the Healthcare Commission. The first tool is a Structured Education Programme Improvement Tool to help local service providers to assess whether the programmes they are delivering and commissioning meet the NICE criteria, and to identify gaps in current provision, so that the programmes can be improved. The second tool is an Educator Improvement tool, which serves as an adaptable framework to enable diabetes educators to reflect on their current practice and enhance their skills. It contains a number of useful resources including a patient course evaluation.

The use of these tools is voluntary and will help to develop best practice in the delivery of diabetes education. There is currently no formal accreditation body in England to accredit national or local patient education programmes. However, service commissioners and diabetes networks can use these tools as a means of ensuring that education programmes are of high quality.

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[3] Department of Health/Diabetes UK, *Structured Patient Education in Diabetes: Report from the Patient Education Working Group* (June 2005). See: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4113195&chk=aJYiBB

[4] Department of Health/Diabetes UK, *Structured Patient Education in Diabetes: Report from the Patient Education Working Group* (June 2005), appendix C (pp. 59-60).

[5] http://www.healthcarecommission.org.uk/_db/_documents/04017427.pdf.

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# Structured Education Programme Improvement Tool

# Section 1: Background

The key drivers behind improving diabetes patient education are the Diabetes NSF, The NICE criteria and the DH/Diabetes UK report. The report from the Diabetes UK and Department of Health Working Party on Patient Education integrated the NSF philosophy and the NICE HTA. It outlined in detail what the key components of effective patient education should be. These are that a programme should:

- Provide knowledge and skills
- Be tailored to the needs of the individual
- Include skills-based approaches to education
- Help people to adopt and maintain a healthy lifestyle
- Improve vascular risk factors
- Prevent and manage complications
- Improve quality of life
- Enable people to have control of their own lives
- Integrate self management
- Encourage health care professionals to be involved in partnership and decision-making
- Encourage health care professionals to facilitate and support self management

For the purposes of this Structured Education Programme Improvement Tool, a structured self management education programme is also:

- identified as a result of a needs assessment
- planned (defined and organised)
- graded (builds on prior learning)

## Purpose of the Structured Education Improvement Tool

This Structured Education Improvement Tool has been produced as part of a self assessment toolkit to help Service Commissioners (advised by their diabetes networks) to reflect on their current provision of structured education to people with diabetes and how it maps onto the NICE criteria. It provides:

- A clearer understanding of what the criteria mean in practice
- A means for diabetes teams/local health commissioners to assess their local structured education programmes against the NICE standards and criteria
- A means to help identify any gaps in the delivery of these programmes so that future action can be developed to fill these gaps.

The use of this improvement tool is voluntary and it is not an accreditation tool. There is no accreditation scheme for diabetes patient education programmes currently in

place. The tool will help commissioners to ensure that they are commissioning quality programmes.

Once you have completed the tool you will be able to demonstrate, with appropriate evidence, how the criteria have been met, and where criteria are not met, you will know what you need to do to meet those criteria. It may be helpful to complete the tool annually so that progress can be assessed and new actions can be formulated as appropriate.

## How to complete the structured education programme improvement tool

**Section 2** is to be completed by the diabetes lead for the service commissioners or equivalent

**Section 3** is to be completed by the programme lead educator (or equivalent) for each structured diabetes education programme, working in collaboration with the education programme delivery team.

**Section 4** is to be completed jointly by the people who have completed sections 2 and 3

When working through the sections which look at future action (2b and 3b) it may be helpful to liaise with others like the Diabetes Network Manager, the National Diabetes Support Team and Diabetes UK who may be aware of best practice in other localities to avoid 're-inventing the wheel'.

# Section 2: Local Overview for Commissioners and Diabetes Communities

Section 2 is to be completed by the diabetes lead for the service commissioners or equivalent.

Section 2 is made up of two parts:

2a. Population Needs Assessment and Provision mapping – The Local Population

2b. Gap analysis and Future Action

As you answer the questions, remember that evidence of what is actually done is important. Some questions have background notes in Section 5 to give greater clarity on definitions used or what evidence is being asked for.

## Section 2a: Population Needs Assessment and Provision Mapping - The Local Population

| | | Box for Completion | Evidence |
|---|---|---|---|
| 2.1 | What is the total population served by this primary care organisation? | | Written evidence containing the sources of the data |
| 2.2 | What is the total identified population with diabetes? (see note) | | Written evidence containing the sources of the data |
| 2.3 | What details of the population with diabetes have been identified and used to inform the needs assessment for structured education? | | See note for the information necessary for a complete needs assessment. |
| 2.4 | Does the local service provider, Diabetes network or other organisation undertake a needs assessment for structured education? | | See evidence boxes for questions 2.5 and 2.6 |

| | | | |
|---|---|---|---|
| 2.5 | **If yes:** What was the date of the last needs assessment? What were the main recommendations? Was a strategy for future action developed to implement the recommendations? | | Written record of the review (e.g. dated report)<br>Written evidence of future action |
| 2.6 | **If no formal regular needs assessment was carried out:** what sources of evidence has the organisation used to inform its provision of programme/s? | | Written evidence of sources used and decisions made (e.g. meeting papers and minutes) |

2.7 Details of local structured education programmes (refer to introduction for explanation of a structured diabetes education programme if necessary). This may need to be completed by liaising with the appropriate programme educator leads.

| List all education programmes provided | Name of Programme Educator Lead(s) | Who is this programme targeted at? What are the target population numbers? | Capacity: how many patients per year? | What is the gap between target population and capacity? (under or over provision) |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |

# Section 2b: Population Needs Assessment and Provision Mapping - Gap Analysis and Future Action

## Identify gaps

Based on your completion of section 2a; please use this section to guide your strategy for future action for needs assessment and provision mapping

**1. Needs assessment:**

- Is the needs assessment complete?
- If not, what further information is needed?

**2. Provision of programmes:**

- What are the details of any groups requiring provision of structured education, for which there is currently none:
- What are the details of groups requiring provision of structured education for which there is under provision?

**Identify Future Actions to Address These Gaps:**

- to include identification of stakeholders, prioritisation, resourcing and milestones (Evidence: Written record (e.g. report) of the gap analysis and steps to address these gaps: future actions, responsibility for these actions, timescale and date achieved)
- It may be helpful to refer to Note 3.15 when considering commissioning or developing quality structured education programmes

# Section 3: Programme assessment, Gap Analysis and Future Action

**To be completed for each of the listed programmes in Section 2 by the Programme Educator Lead in collaboration with the education programme delivery team. Please complete Section 3 separately for each programme.**

Section 3 is made up of 2 parts:

3a. Programme assessment

3b. Gap analysis and Future Action

As you answer the questions, remember that evidence of what is actually done is important. Some questions have background notes in Section 5 to give greater clarity on definitions used or what evidence is being asked for.

## Section 3a: Programme Assessment

Programme Name:

Educator Lead:

Target Patient Group:

If this is a national programme (e.g. DAFNE, DESMOND, X-Pert) has it been modified in any way?:

If yes, in what ways? E.g. duration, timing, content, resources:

Details of changes:

### Philosophy

| | | Box for Completion | Evidence |
|---|---|---|---|
| 3.1 | What is your philosophy for structured self management education? (see note) | | Agreed written statement containing the philosophy |
| 3.2 | Describe how this philosophy has been developed. | | Written record of the development process (e.g. meeting minutes) |

| | | | |
|---|---|---|---|
| 3.3 | What are the identified roles and responsibilities of those with diabetes and health care professionals that are derived from the philosophy, so that self management is supported? | | Written statement defining the roles and responsibilities of all involved |
| 3.4 | Explain how users contribute to the ongoing development of the programme | | Written evidence of user contribution (e.g. patient experience questionnaires, report and future actions) |

## A structured curriculum

| | | Box for Completion | Evidence |
|---|---|---|---|
| 3.5 | Give an example of a group that is unsuitable for this programme | | Written evidence from the curriculum and the needs assessment highlighting who is suitable or unsuitable |
| 3.6 | Explain how this programme identifies and incorporates the learning needs of the individuals undertaking the course | | Written evidence from the curriculum |
| 3.7 | Are there specific aims and learning objectives (or learning outcomes) for each section of this programme? | | Written evidence from the curriculum |
| 3.8 | How are these shared and with whom? | | Written evidence of this process |
| 3.9 | Provide examples of how the curriculum has been assessed to be relevant and comprehensive to the needs of the group it has been designed for | | Written evidence of the assessment process (e.g. meeting papers, minutes etc.) |

| | | | |
|---|---|---|---|
| 3.10 | Provide dates of the last time the written curriculum was assessed for its reliability, validity, relevance and comprehensiveness | | Written evidence of the assessment process (e.g. report) |
| 3.11 | What changes were made to the curriculum, as a result of its assessment (as stated in 3.9)? | | Written statement of the changes or copies of the original and revised curricula |
| 3.12 | What are the underpinning theories of the programme? (see note) | | Agreed written statement containing the theories |
| 3.13 | How were these agreed upon? | | Written evidence of the decision-making process (e.g. meeting papers, minutes etc.) |
| 3.14 | What are the key processes in the programme that demonstrate that this/these theories are being implemented? Please provide an example of how each theory is being implemented, stating the theory and an activity that arises from this in each case | | Written evidence from the curriculum |
| 3.15 | What is the evidence base for the design and content of your programme? (see note) | | Written document containing the evidence |
| 3.16 | Give 2 examples to illustrate how your programme is flexible and responds to the needs of the individual participants | | Written evidence from the curriculum |
| 3.17 | Give 2 examples of how your programme is able to cope with diverse groups of participants | | Written evidence from the curriculum |

| | | | |
|---|---|---|---|
| | (e.g. hearing impaired, learning disability, depressed) | | |
| 3.18 | List at least 3 different teaching methods that are used within the programme and can be identified within the curriculum. | | |
| 3.19 | Describe two ways that demonstrate effective use of human and financial resources (See note) | | Written evidence from the curriculum |
| 3.20 | What support materials do you provide for those attending the programme? | | Copies of materials used |
| 3.21 | Who is responsible for holding and updating the curriculum? | | Written account containing the information |

## Trained Educators

| | | Box for Completion | Evidence |
|---|---|---|---|
| 3.22 | What training have the educators received to enable them to be proficient in the educator role? | | Written account of the training process and a list of trained educators with dates of training |
| 3.23 | How are the educators trained to deliver this programme in the style of the underpinning theories as stated above? | | Written account of the training process |
| 3.24 | How is the educator's understanding of the theories underpinning the programme assessed? | | Written account of the assessment process |

| | | |
|---|---|---|
| 3.25 How is the educator competency to deliver this programme, in the style of the underpinning theories as stated above, assessed? | | Written account of the assessment process |
| 3.26 How is the educator competence in relation to content delivery of this programme assessed? | | Written account of the assessment process |
| 3.27 What are the arrangements for ongoing review and competency development of the educators? | | Written account of the ongoing review and competency development process |
| 3.28 What are the arrangements for training educators as the programme is updated? | | Written account of the ongoing training process |
| 3.29 Provide an example of a recent training event attended by your educators. Provide an example of a completed personal educator development plan as a result of the training event. | | Written evidence of the event (e.g. an agenda or copy of the programme) and a copy of the personal development plan |

## Be quality assured

| | Box for Completion | Evidence |
|---|---|---|
| 3.30 Describe the internal (personal and peer review) and external components of your quality assurance/improvement programme. | | Written statement describing the quality assurance process |

| | | |
|---|---|---|
| 3.31 How often does internal quality assurance/improvement take place? | | Written evidence to support this (e.g. report from the last review) |
| 3.32 How were the criteria for internal/external assessment agreed? | | Written evidence of the decision-making process (e.g. meeting papers, minutes etc.) |
| 3.33 What tools were used to objectively assess these criteria? (see note) | | Copy of the tools used |
| 3.34 When was the last external quality assurance review undertaken? (see note) | | Written evidence to support this (e.g. report from the last review) |
| 3.35 How was the trained, competent, independent external assessor identified? | | Written evidence of the identification process (e.g. meeting papers, minutes etc.) |
| 3.36 Provide examples of a) positive feedback and b) areas for improvements, with actions taken, from the external review. | | Copy of the document produced by the external reviewer and copy of the document produced in response |

## Be audited

| | Box for Completion | Evidence |
|---|---|---|
| 3.37 What specific audit data are collected in relation to the specific aims and objectives of the programme?<br>• Biomedical<br>• Quality of Life<br>• Patient experience<br>• Degree of self management<br>• Skills/knowledge | | Written evidence of the audit data collection (e.g. completed forms, report) |

| | | |
|---|---|---|
| 3.38 How often is this data collected and on what percentage of patients who attend the programme? | | Written, dated evidence of the data collection process, incorporating the total number of patients included in the process and the percentage of total programme participants they represent (e.g. completed forms, report) |
| 3.39 What arrangements are in place to compare/benchmark this data with other centres providing similar programmes? | | Written evidence that any arrangements listed are in place |

## Section 3b: Programme Assessment Gap analysis and Future Action (to be completed for each programme)

### Identify gaps:

1. Philosophy
2. Structured Curriculum
3. Trained Educators
4. Quality Assurance/Development
5. Audit

### Future Action to Address These Gaps:

to include identification of stakeholders, prioritisation, resourcing and milestones (Evidence: Written record (e.g. report) of the gap analysis and steps to address these gaps: future actions, responsibility for these actions, timescale and date achieved)

# Section 4: Achievements

Please describe your achievements in diabetes structured education by completing the two boxes below.

| Please give a short description of any progress and developments in the delivery of structured education to people with diabetes. |
|---|

| Please give a short description of ONE thing that you or your staff are particularly proud of in the delivery of structured education to people living with diabetes. This could be an innovation, or an area where you do something particularly well. Please include what evidence you have of its value (e.g. patient feedback, evaluation, etc.). |
|---|

**If you would like to share this section then please click here to send it to the National Diabetes Support Team and Diabetes UK websites**

# Section 5: Notes

## Section 2a

**2.2** These data may have been identified as part of QOF data collection, National Diabetes Audit or other projects. Information about the National Diabetes Audit can be found at: http://www.icservices.nhs.uk/ncasp/pages/audit_topics/diabetes/default-new.asp

**2.3** For a complete needs assessment the following information is necessary - demographic variables, such as ethnic background, formal education level, reading ability, and barriers to participation in education, must be considered to maximize the effectiveness of self-management education.

This ideally should include at least the following:

a. Type of diabetes and age demographics (prevalence and incidence)
b. Ethnicity (An ethnic group is a community of people who share cultural and/or physical characteristics including one or more of the following: history, political system, religion, language, geographical origin, traditions, myths, behaviours, foods, genetic similarities and physical features (Ref http://www.ethnicityonline.net/ethnicity_is.htm)
c. Other cultural / environmental issues
d. Positive and negative issues with the target population
    - Educational levels (e.g. low literacy)
    - Transportation issues
    - Economic issues

Potential barriers to obtaining education (e.g. visually impaired, hearing impaired, those with some communication difficulties in English)

Adapted from: ADA/AADE 2005 Diabetes Self Management Education Standards and Guidance for Accreditation

http://www.diabetes.org/uedocuments/6theditioninstructions-April32005revisionFINAL.pdf

## Section 3a

**3.1** What is meant by philosophy?

For the purposes of this document, a philosophy of self-management education is defined as a set of ideas and commitments about the purpose and value of education that guides your practice and helps you make choices. In other words, a philosophy of education addresses why we educate so that we make better choices about who, what, where, when, and how we educate. A philosophy of self-management education sets the benchmark for measuring the appropriateness of your educational methods, the assessment of participant learning, and the effectiveness of one's teaching. It is an agreed

personal (individual or group) “mission statement" for anyone who helps others learn and defines the standards for the individuals delivering a self-management education program. As such, a philosophy is not a factual statement that can be proven to be true using empirical means.

It is also important to note that although “empowerment” or “patient-centred care” are philosophical views, they are not a philosophy of self-management education. These philosophical viewpoints need to be articulated in terms of the roles and responsibilities of educators, as different educators will interpret these viewpoints differently.

Further reading:-

Anderson RM, Funnell MM. Patient empowerment: reflections on the challenge of fostering the adoption of a new paradigm. Patient Educational Counselling. 2005 May;57(2):153-7

Anderson RM, Funnell MM. Theory is the cart, vision is the horse: reflections on research in diabetes patient education. Diabetes Educator. 1999 Nov-Dec;25(6 Suppl):43-51

T.C. Skinner, S. Cradock, F. Arundel, and W. Graham. Four Theories and a Philosophy: Self-Management Education for Individuals Newly Diagnosed With Type 2 Diabetes. Diabetes Spectrum 2003 16: 75-80.

**3.12** A theory is a set of statements organized in a way to allow us to explain and predict events and that has been empirically tested. Theories used will usually be from the world of education, behavioural science and/or psychology.

It is important to make a distinction between theories and philosophies. For example, empowerment and patient-centred care are philosophies and not theories. This is because they: i) are interpreted differently by different individuals, and therefore do not allow us to consistently explain, predict, or control events; ii) as they are view points, and subject to interpretation, they do not generate consistent testable hypothesis, rather they provide a paradigm or framework in which theories can exist.

**3.15** What constitutes evidence?

Evidence means either

(1) Evidence generated externally through data published in peer reviewed journals where the programme has been developed by others and shown to be more effective than a psychologically equivalent placebo or RCT. This includes the results from DAFNE, DESMOND and X-Pert as well as other programmes.

(2) Internal evidence that people who attend a programme which has been developed locally, show statistically and clinically meaningful improvements in relevant key outcome measures including Quality of Life. This evidence should be used within a system of benchmarking, which enables comparison with similar programmes for similar populations compared to those who don’t attend a course, so as to support quality improvement of courses nationally.

**3.19** Be resource effective: this encompasses the need to be aware of using health care resources wisely; not reinventing wheels; using human resources effectively; seeking and sharing best practice (via networks etc): in service re-organisation and replacing current ineffective activity.

**3.33** Objective assessment tools for every area: this prevents subjective, non specific and unreliable assessment of the delivery. This should also include a check list of key processes that indicate the implementation of the relevant theories.

Examples of objective assessment in the theoretical area could be: if Social Learning theory (Bandura) is used then it would be expected to see checklist items indicative of using each of the 4 strategies for promoting self efficacy.

If Behaviour Change Counselling (Rollnick, Mason and Butler) is used then it would be expected to see checklist items indicative of using the 3 key components required for behaviour change to occur.

**3.34** A Quality Assurance/Development Visit report should address all the following questions:

How is the whole system/service organised so that the delivery of the programme is supported? (Organisational System: e.g. access to course including referral process, bookings, follow up, attendance/attrition, participants' preparation, transport, resources availability, timely availability of tests, investigations and their results, venue suitability and access.)

How is the programme venue assessed for suitability?

What is the evidence that the curriculum has been reviewed for structure, process and content?

Were the materials used in the way the curriculum described?

What is the process for the review of the actual delivery (as outlined in the curriculum) of the programme?

When was this last undertaken?

Provide an example of how peer review by the educators has influenced the development of the course.

Describe your patient evaluation process.

How often is this undertaken?

At the last review, what changes were made as a result of patient feedback?

How does the audit process feed into the development of the programme?

What is the process by which the review of the audit data is used to alter the structure, process or content of the programme?

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# Educator Improvement Tool

# Section 1: Introduction

## Users, aims and purpose

This aid is intended to support the review of courses in the self-management of diabetes. It aims to provide tools to help in assessing course quality. Such reviews can identify what could benefit from improvement in a course.

## Kinds of review

The tools may be used in several ways. These include:

- an assessment of the quality of a whole course by those who deliver it (referred to here as a Self Review),
- an assessment of a part of an on-going course to improve the teaching of subsequent sessions (referred to here as a Quick Review).
- an assessment of the quality of a course by someone external to its delivery (referred to here as an External Review).

## Patient evaluation and the review process

*Patient Course Evaluation* is the perception of the course by those who receive it, that is, the patients. A process of Self Review alone may overlook strengths and weaknesses in a course and may misjudge the quality of some of its features. Self Review is more effective when it incorporates patient evaluation. Similarly, an External Review that takes due account of patient evaluations can be better founded. How patients' views can be collected and taken into account is also described.

## Tool flexibility

The tools include a variety of items. Some may not be immediately relevant to the particular course you want to review. These may be disregarded or re-worded to suit your needs. But, in a Self-Review, items that an external reviewer would find relevant should be included. Space has been left for you to add other items, if needed.

# Section 2: What the tools do

## TOOL 1: Self Review Tool

TOOL 1 is for a Self Review, that is, it is for use by those who deliver a course. An educator may use it to evaluate his or her own contribution to a course or, by choosing relevant items, evaluate his or her teaching of a self-contained section of it. Alternatively, it may be used by members of a team who are working on a course to evaluate one another's contribution.

## TOOL 2: Quick Review Tool

TOOL 2 is for a quick review of a teaching session. It does **not** evaluate all aspects of a course but focuses on what has happened during one teaching session. It is **not** intended to replace TOOL 1. The Quick Review Tool is to help you plan for more effective teaching during a course and improve it as you proceed. It is to help you think about matters which might improve your next teaching sessions.

## TOOL 3: External Review Tool

TOOL 3 is an extended version of TOOL 1 and is for use by external reviewers of a course. External reviewers will need to gauge the quality of the same aspects of a course as someone who works on the course. They may also want to know how, for instance, those who deliver a course strive to maintain or improve its quality.

## TOOL 4: Patient Course Evaluation

TOOL 4 is to help you collect patients' views that are relevant to the quality of a course. You could collect information with TOOL 4 in two ways:

- anonymously, in writing, and
- face-to-face, orally.

Patients may feel they can comment more freely with a paper version of TOOL 4, particularly if they do not have to include their names. On the other hand, when face-to-face you can ask supplementary questions to clarify and extend responses. Patients may prefer one or other ways of responding. When the preference is mixed, you may be able to combine the advantages of one with the advantages of the other.

## Other resources

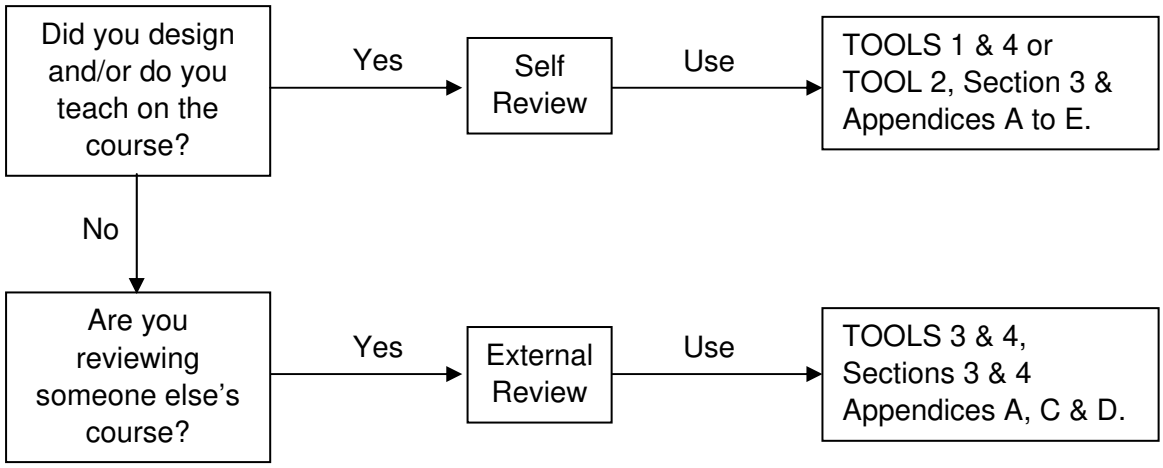
The appendices offer supplementary information you may find useful in preparing a course and in conducting a review.

In particular:

- Appendix A lists key criteria that a structured education programme should meet to fulfil the NICE criteria. The items in the tools largely stem from these criteria. There are links from the criteria back to the questions in tools 1 and 3
- Appendix B (TOOL 5) lists some patient characteristics you might collect to help you tune a course to suit those taking it.
- Appendix C gives some examples of Self Review entries made in TOOL 1.
- Appendix D gives some examples of External Review entries made in TOOL 3.
- Appendix E (TOOL 6) describes how you might use a Review to help you develop a course.
- Glossary of terms.

## Summary: What suits your task?

The diagram below summarises the purpose of the Tools and other resources.



# Section 3: Self Review

## Who reviews?

You may Self Review your own contribution to a course yourself. If you are a member of a team who teaches the course, you may assess a colleague's teaching on his or her behalf, sometimes called Peer Review. If you assess others on their behalf, you will need to observe them as they teach. Interpret and select the items of TOOL 1 or 2 to suit the situation.

Reviewing yourself is usually non-threatening. When others review you, it can make you feel anxious about the outcome as you are open to criticism. If you have not undergone a review like this before, you may prefer to begin by reviewing yourself. This can also be helpful if you are to review the contribution of a colleague later as it makes you more aware of what is involved. When judging others, a considerate honesty in your judgements and specific evidence to support them is expected. Bear in mind, too, that you can be wrong.

## Judging the quality of a course and providing specific evidence

When using TOOL 1 or 2, you will make a judgement about quality.

*For example, TOOL 1, Item 20, asks: To what extent are there regular activities spread throughout the course that support learning? You may feel that your provision for this is Good so you tick the relevant box.*

You should also provide specific *evidence* in the adjacent space. This statement of evidence has several purposes:

- It focuses your attention on specifics that you can attend to.
- It can make your assessment meaningful to others and opens it up to discussion and ideas for improvement.
- It demonstrates to external reviewers that you have gone beyond a judgement (*Good, Satisfactory, Unsatisfactory*) to potential causes (*evidence*).

In this instance, you might mention that, '*There is an activity in each session*', to support your judgement.

## Incorporating patient evaluations

You should collect evaluations (feedback) of your course from your patients. Some aspects of a course are invisible to patients so their responses cannot provide evidence relating to everything. Patients can, however, tell you something about the quality of the environment, the content, the quality of its delivery, and the effectiveness of the course. TOOL 4 suggests what you might ask. Three steps you can use to incorporate patient evaluations into your review are:

1. Complete your Self Review using TOOL 1.

2. Read the evaluation of each patient and add their responses to the copy of TOOL 1 you have just completed.
3. Contrast their responses with your own. Where there is a discrepancy, reflect on it. Consider whether your Self Review of it is justified. If appropriate, change your assessment and reconsider the evidence.

   *For example, if several patients complained that there was too much talk and not enough hands-on activity, this would be added to your response to Item 20 as a contradiction of your judgement.*

## Valid assessments

It must be acknowledged that what different people consider to be *Good*, *Satisfactory* or *Unsatisfactory* may not the same. Taking patients' evaluations into account, as described above, can be a useful check on judgements. Discussing what counts as *Good*, *Satisfactory* and *Unsatisfactory* (and what constitutes specific, concrete evidence) with other educators involved in delivering a course can also be useful. Organised sessions of educators in a region to compare experience may also be possible. With courses of this nature, other evidence is provided by past patients' willingness to recommend the course to others, to clinical evidence of change, and to patients' views on the extent to which the course changed their lives for the better.

## Acting on an assessment

The TOOLS are intended to help you carry out a Self Review of the quality of a course. They are, however, often detailed enough to indicate specific areas that could benefit from attention. If you provide specific, concrete evidence, this can help you decide what you could do to remedy a deficiency. Think in terms of clear, precise and concrete actions rather than vague, general statements of your intentions. Simply saying that you will try to do better next time leaves what you will do doubtful. You should state what you will do, rather than what you hope to achieve.

*For example, given the responses to Item 20, above, you may decide to break up your talk by increasing the number of activities in each session, by having question and answer sessions, and by having some short group discussions that pull together key matters.*

Having made changes, you will need further reviews to see if they were effective. Note also that courses, even those that are repeated without change, are never exactly the same. What you say may change, the patients are different and their responses will be different. Appendix E offers more detailed advice on the process of course improvement.

## Maintaining records of reviews

Completed Self Review forms are generally considered to belong to the person they refer to. You should consider keeping forms that apply to you as evidence that you have carried out regular Self Reviews. In addition, you should attach a note of changes you have made in response to a review. You may volunteer such records as evidence to an external reviewer.

# Section 4: External Review

## External review

TOOL 3 is a modified and extended version of TOOL 1 and is intended to be used by external reviewers. Generally, an external reviewer is someone with relevant experience other than those who plan and deliver the course. The role often involves gauging the quality of a course for some external body although the information and conclusions could also help educators to develop their courses. If you have the role of external reviewer, much of what applies to self reviewing is relevant. For that reason, you should be familiar with Section 3 and also consider the additional matters set out below.

## Judging the quality of a course and providing specific evidence

The difference between an External Review and a Self Review is usually one of purpose. Self Review is primarily intended to help an educator improve a course. An External Review, on the other hand, may be reported to others and much can depend on it. For this reason, it may be perceived as a threat and that can affect what you see. What you are particularly interested in is the quality of the course when you are not there. You need, therefore, to look for evidence of that (see also below).

Since much may depend on the outcome of your review, care is needed to note specific evidence that clearly leads to and supports your conclusions. Much will be available as course documents and future action documents but be aware that not everything that affects course quality is on paper. For example, considerate behaviour and enthusiasm are more what you see than what you read. You may not be able to observe every teaching session and may have to rely on your observations of a sample. You will need to consider the extent to which the observed sessions reflect the quality of the course as a whole. As you form conclusions, you must treat them as tentative and test them by looking for further evidence. This is especially important when much depends on a particular conclusion. For example, if you suspect that a course is so ineffective that it makes little difference to patients' lives, you should seek corroborative evidence. Also discuss your conclusions with the educators as you proceed; they may have the evidence you seek or correct or confirm your views through discussion.

## Evidence from Patient Course Evaluations

Educators may have Patient Course Evaluations to hand and these could add to your evidence. Nevertheless, try to talk to patients on the course at an appropriate time to add to the evidence. TOOL 4 illustrates the kind of question you might ask but you may need to pursue other matters.

## Evidence from educators

You will probably have access to course documentation and patient handouts. Self Reviews have the potential to improve the quality of a course. You may, therefore, want to know if those who deliver a course carry out such reviews, take patients' evaluations into account and respond to the outcomes. Educators may make their

Self Reviews and/or Future Actions developed from them available to you. Always talk with educators to test the views you are forming.

# TOOL 1: Self Review

## Part 1: The foundations of the course

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 1. To what extent is the course well-founded (that is, based on good practice, known to be effective)? | | | | |
| 2. Is the course written down? | | | | |
| 3. To what extent are relevant characteristics of the patients known? | | | | |
| 4. Other (specify) | | | | |

## Part 2: The programme

*The mechanics*

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 5. To what extent have the aims and objectives of the course been clearly identified? | | | | |
| 6. To what extent has the knowledge (facts, understandings) that the patients should acquire been identified? | | | | |
| 7. To what extent have the skills (know-how) the patients should acquire been identified? | | | | |
| 8. To what extent is the course broken down into a manageable, sessions? | | | | |
| 9. To what extent has the order of presentation been identified? | | | | |

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 10. To what extent have suitable examples to make meaning clear been identified? | | | | |
| 11. Is it clear who will deliver the various parts of the course? | | | | |
| 12. Is it clear when and where the course will be held? | | | | |
| 13. To what extent is the environment where the course will be held conducive to learning? | | | | |
| 14. To what extent are the teaching resources available and appropriate (e.g. media, materials, handouts)? | | | | |
| 15. To what extent has provision been made for the health and safety of the patients while they are on the course? | | | | |
| 16. Other (specify) | | | | |

*Teaching and learning*

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 17. To what extent is your/the educator's knowledge of diabetes management adequate for the course? | | | | |
| 18. To what extent are your/the educator's skills in diabetes management adequate for the course? | | | | |
| 19. To what extent has the management of individual and group work to accommodate learning needs been planned? | | | | |

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 20. To what extent are there regular activities spread throughout the course that support learning? | | | | |
| 21. To what extent are there activities for patients that practise skills to an adequate level of competency? | | | | |
| 22. To what extent are the aims/objectives made clear to the patients? | | | | |
| 23. To what extent is the pacing of the presentations appropriate for the patients? | | | | |
| 24. To what extent are you/the educator succinct and clear and to the point in your presentations? | | | | |
| 25. To what extent do you/does the educator ask and answer questions that support learning appropriately? | | | | |
| 26. To what extent are you/is the educator successful in accommodating diversity amongst patients? | | | | |
| 27. To what extent do you/does the educator bring sessions to a successful conclusion? | | | | |
| 28. Other (specify) | | | | |

## Part 3: Outcomes of the course

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 29. To what extent was the programme delivered as specified? | | | | |

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 30. To what extent did the patients acquire the expected knowledge and skills and have relevant attitudes supported? | | | | |
| 31. Is there a procedure for those who do not acquire the knowledge and skills or who do not complete the course? | | | | |
| 32. Based on follow-up of the patients' progress, to what extent do the patients manage their condition effectively? | | | | |
| 33. Based on follow-up of the patients' progress: to what extent does the patients' quality of life improve? | | | | |
| 34. Would the patients recommend the course to others? | | | | |
| 35. Other (specify) | | | | |

# TOOL 2: Quick Review

This Tool is to help you carry out a quick review of a teaching session. It does **not** evaluate all aspects of a course but focuses on what has happened during one teaching session. It is **not** intended to replace TOOL 1 which relates to the quality of the programme more broadly. The Quick Review Tool is to help you plan for more effective teaching **during** an on-going course.

| | | |
|---|---|---|
| **Resources and environment**<br>Were there any difficulties with the resources or the room? | What were they? | What will you do about it? |
| **The session**<br>What worked well? | Why did this/these work well? | Applicable elsewhere? |
| What did not work well? | Why not? | What will you do about it? |
| **Participation**<br>Did all the patients participate? | If no, why not? | What will you do about it? |

# TOOL 3: External Review

## Part 1: The foundations of the course

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 1. To what extent is the course well-founded (that is, based on good practice, known to be effective)? | | | | |
| 2. Is the course written down? | | | | |
| 3. To what extent does the educator/team know relevant characteristics of the patients? | | | | |
| 4. Other (specify) | | | | |

## Part 2: The programme

*The mechanics*

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 5. To what extent has the educator/team clearly identified the aims and objectives of the course? | | | | |
| 6. To what extent has the educator/team identified knowledge (facts, understandings) the patients should acquire? | | | | |
| 7. To what extent has the educator/team identified the skills (know-how) the patients should acquire? | | | | |
| 8. To what extent is the course broken down into manageable sessions? | | | | |
| 9. To what extent has the order of presentation been identified? | | | | |

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 10. To what extent are there suitable examples to make meaning clear? | | | | |
| 11. Is it clear who will deliver the various parts of the course? | | | | |
| 12. Is it clear when and where the course will be held? | | | | |
| 13. To what extent is the environment where the course will be held conducive to learning? | | | | |
| 14. To what extent are the relevant teaching resources available and appropriate (e.g. media, materials, handouts)? | | | | |
| 15. To what extent has the educator/team prepared for the health and safety of the patients while they are on the course? | | | | |
| 16. Other (specify) | | | | |

*Teaching and learning*

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 17. To what extent is the educator/team's knowledge of diabetes management adequate for the course? | | | | |
| 18. To what extent is the educator/team's skills in diabetes management adequate for the course? | | | | |
| 19. To what extent has the educator/team planned for individual and group work to accommodate learning needs? | | | | |

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 20. To what extent are there regular activities spread throughout the course that support learning? | | | | |
| 21. To what extent are there activities for patients that practise skills to an adequate level of competency? | | | | |
| 22. To what extent did the educator/team make aims and objectives clear for the patients? | | | | |
| 23. To what extent is the pacing of the presentations appropriate for the patients? | | | | |
| 24. To what extent is the educator/team succinct and clear and to the point in their presentations? | | | | |
| 25. To what extent does the educator/team ask and answer questions that support learning appropriately? | | | | |
| 26. To what extent is the educator/team successful in accommodating diversity amongst patients? | | | | |
| 27. To what extent does the educator/team bring sessions to a successful conclusion. | | | | |
| 28. Other (specify) | | | | |

## Part 3: Outcomes of the course

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 29. To what extent does the educator/team deliver what the programme specifies? | | | | |

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 30. To what extent do the patients acquire the expected knowledge and skills and have relevant attitudes supported? | | | | |
| 31. Is there a procedure for those who do not acquire knowledge and skills or who do not complete the course? | | | | |
| 32. Based on any follow-up of the patients' progress, to what extent do the patients manage their condition effectively? | | | | |
| 33. Based on any follow-up of the patients' progress, to what extent does the patients' quality of life improve? | | | | |
| 34. Would the patients recommend the course to others? | | | | |
| 35. Other (specify) | | | | |

## Part 4: Further matters

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 36. Does the educator/team carry out effective Self Reviews? | | | | |
| 37. To what extent does the educator/team incorporate the patients' evaluations in their Self Review? | | | | |
| 38. To what extent does the educator/team identify strengths and weaknesses of the course? | | | | |
| 39. To what extent does the educator/team identify productive ways of addressing weaknesses in the course? | | | | |

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 40. To what extent is the educator/team able to improve the quality of the course in response to reviews and evaluations? | | | | |
| 41. Other (specify) | | | | |

# TOOL 4: Patient Course Evaluation

(The numbers in brackets at the end of the lines indicate the items in TOOLS 1 and 3 that the responses are likely to relate to.)

| | |
|---|---|
| 1. To what extent did you understand what the course might do for you? | (22) |
| 2. To what extent were the dates of the course convenient for you? | (12) |
| 3. To what extent was the place where the course was held comfortable? | (12) |
| 4. To what extent could you see and hear well enough? | (13) |
| 5. What about health and safety? Were you happy about that? | (15) |
| 6. How did you find the sessions? Was there too much in them? Was the order right for you? Was the information presented too quickly, too slowly or just about right for you? | (8, 9, 23, 24) |
| 7. To what extent did you understand what you had to do? | (10, 19, 20-27) |
| 8. Did you find the activities helpful? | (20, 21) |
| 9. Did you get enough practice? | (21) |
| 10. Did you find that the educator could answer your questions for you? | (25) |
| 11. Do you feel confident enough to give your new skills a try? | (30) |

| | |
|---|---|
| 12. Do you think it might make a difference to the quality of your life? | (33) |
| 13. Did you enjoy the course overall? | (34) |
| 14. Would you recommend the course to others? | (34) |
| 15. Any other comments e.g. suggestions for improving the course? | |

# Appendix A: Key criteria that a structured education programme would meet to fulfil the NICE requirements

Diabetes UK, National Diabetes Support Team, Department of Health

(The numbers in brackets refer to the questions in TOOLS 1 & 3.)

## Philosophy

The programme will be evidence based (1), flexible to the needs of the individual (3) and dynamic (19, 20): users should be involved in its on-going development (37). The programme should have a specific aim and learning objectives (5) which are shared with patients (22), carers and family. The programme should support self management attitudes, beliefs, knowledge and skills for the learner, their family and their carers (20, 21, 30, 31).

## A structured curriculum

The curriculum needs to:

1. be person centred incorporating the assessment of individual learning needs (3, 15, 19, 26, 32, 33);
2. be reliable, valid, relevant and comprehensive (1);
3. be theory driven and evidence based (1);
4. be flexible and able to cope with diversity (3, 26);
5. be able to use different teaching media (14);
6. be resource effective and have supporting materials (14);
7. be written down (2).

## Trained educators

Trained educators need to:

1. have an understanding of education theory appropriate to the age and needs of the programme learners (5-11);
2. be trained and competent in the delivery of the education theory of the programme they are offering (22-27);
3. be trained and competent in the delivery of the principles and content of the specific programme they are offering (17-18).

## Be quality assured

A Quality Assurance programme needs to be in place. The programme needs to be reviewed by trained, competent independent assessors who assess against agreed criteria (36-40):

1. environment (12, 13);
2. structure (6-11);

3. process (5-15);
4. content (1, 6-10, 17, 18);
5. use of materials (14); 6. whether the programme has actually been delivered (29); 7. evaluation and outcome information (29-34).

## Be audited

The outcomes from the programme need to be audited. The outcomes might include:

1. biomedical (32);
2. quality of life (33);
3. patient experience (34, 37);
4. the degree of self management achieved as a result of the programme (32-34).

# Appendix B: TOOL 5

## Patient Profiles

The Patient Profile describes those who will take your course. You should use the information to help you plan your course to suit diverse patients' needs. Each new cohort of patients can be very different. For instance, patients can differ in what they expect a course will do for them and, when they are on the course, in their preferred ways of learning. You should build a picture of what a group is like and respond to it, otherwise a successful course may fail to achieve its goals.

Questions to help you build a picture of the patients who will attend your course are listed below. You could present this as a questionnaire and have patients respond in writing. Some patients may, however, prefer to respond orally, face-to-face or by telephone. Whichever approach you use, try to put the patients at ease and assure them that their responses will be treated in confidence.

### Questions to contribute information to a patient profile

*About your medical condition and your lifestyle*

1. Do you have Type 1 or Type 2 diabetes?
2. How long have you had this condition?
3. How is your diabetes controlled at present?
4. Can you tell me if your are having treatment for any other condition?
5. Would you describe yourself as an active person? (e.g. Are you actively involved in walking or in sports or some other physical activity?)
6. How does diabetes affect what you do?
7. What would you like to be able to do?
8. Does diabetes affect your family/social life?
   If it does, in what way?

*Expectations*

9. What do you think the course might do for you? What do you hope to gain from the course?

*Learning preferences*

10. How do you prefer to learn?
11. Do you like working with others in groups?
    *(Tick the one on the list which you prefer.)*

No  Some of the time  Most of the time  No preference how I work

12. Do you prefer to learn by doing?
    If yes, how much hands-on learning activity do you like?
13. When you have to absorb new information, do you prefer to absorb it from:
    *(Tick those you prefer on the list below - you may tick more than one.)*

written words spoken words
words and pictures words and numbers

14. Are there any concerns or special matters you feel you should bring to our attention? *(for example, hearing problems, vision/sight problems, additional medical conditions)*

# Appendix C: Examples of entries in TOOL 1: Self Review

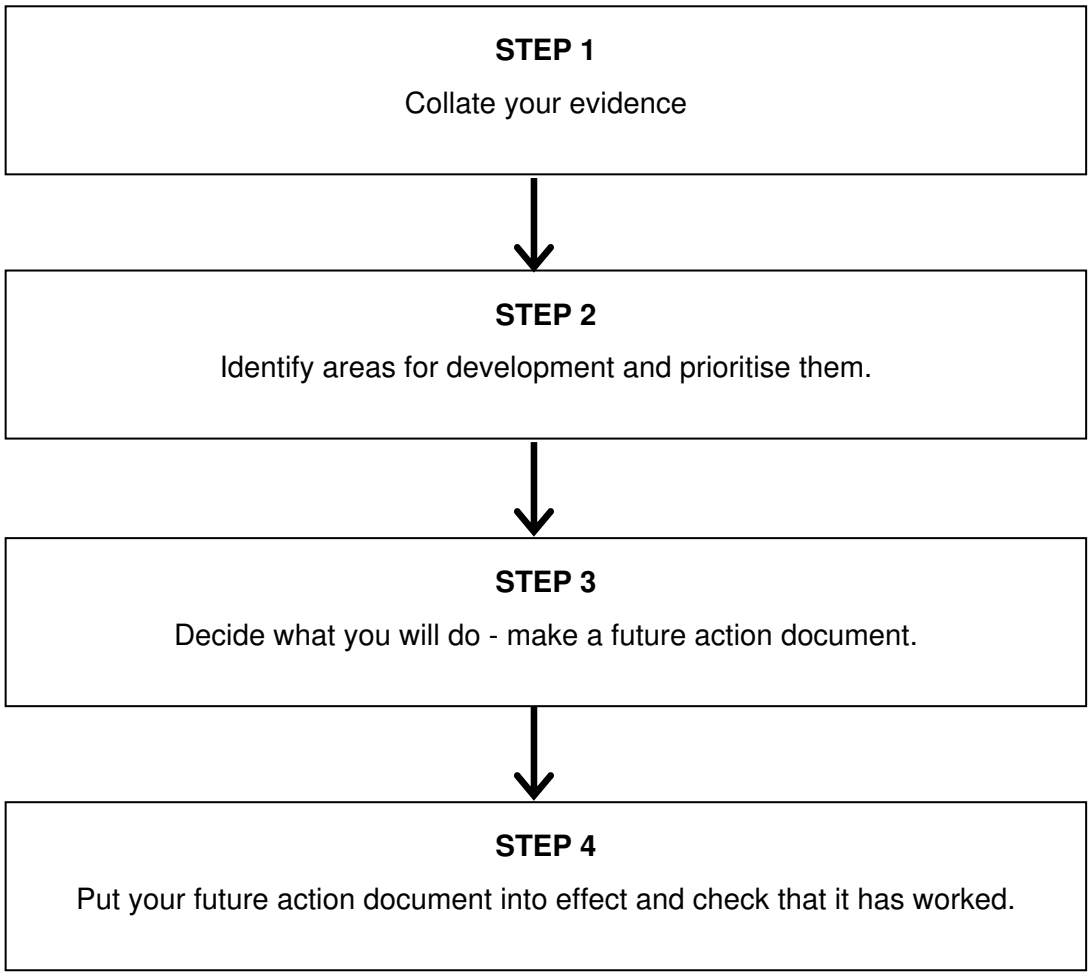
| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 3. To what extent are relevant characteristics of the patients known? | ✓ | | | Data collected prior to course. This indicated that pictures with explanations and hands- on activity could be a productive way of working. |
| 10. To what extent have suitable examples to make meaning clear been identified? | | ✓ | | Examples were OK but more needed and need to be better tuned to patients' interests. Use fewer graphs. |
| 18. To what extent are your/the educator's skills in diabetes management adequate for the course? | | | ✓ | I need to practise doing X until I can do it without thinking - cannot do and explain at same time yet. |
| 31. Is there a procedure for those who do not acquire and the knowledge and skills or who do not complete the course? | | | ✓ | Nothing in place. Need to get together as a team and work out future action. |

# Appendix D: Examples of entries in TOOL 3: External Review

| | Good | Satis | Unsat | Evidence |
|---|---|---|---|---|
| 1. To what extent is the course well-founded (i.e. based on good practice, known to be effective?) | ✓ | | | Course based on established and tested programmes. |
| 2. Is the course written down? | ✓ | | | Yes - details in files, course handbooks and support materials. |
| 5. To what extent has the educator/team clearly identified the aims and objectives of the course? | | ✓ | | Generally yes but vague about the aims of some parts of sessions. |
| 14. To what extent are the relevant teaching resources available and appropriate (e.g. media, materials, handouts)? | | | ✓ | Full range mentioned in planning but not seen in sessions. Handouts were not always available when needed. |
| 38. To what extent does the educator/team identify strengths and weaknesses of the course? | | ✓ | | Future action documents show team aware of weaknesses but they ignored strengths which may have been useful for overcoming some weaknesses. |

# Appendix E: TOOL 6 Using a Review for Course Development

Few courses are perfect and, after a Review, you will be in a position to improve your course. You can do this step-by-step. A set of steps is set out below and is then expanded upon.




(In the following, the numbers in brackets identify the relevant items in TOOL 1 and TOOL 3.)

## STEP 1 Collate your evidence

Take a completed version of TOOL 1. If you have not already done so, include in it the evidence collected from patient evaluations.

Does your judgement agree with the patients' judgements? Where they do not, compare your response and the patient responses. If several patients disagree with you, adjust your response accordingly unless there is good reason not to do so.

*For example: You may have felt that the course was divided into manageable units (8) and you endorsed this item as Good. However, a number of patients identified two of the sessions as being too long, tiring, and demanding. You had not expected this but, on reflection, feel their views are valid so you downgrade your response from Good to Satisfactory. At the same time, you add a note in the evidence box about the need to improve these two sessions.*

If there is a good reason for a difference in evaluation between yourself and the patients, record it on the sheet as a footnote.

*For example: The person taking the session stepped in at short notice to cover for an ill colleague.*

(You could, of course, begin with a completed version of TOOL 3 or some similar document, provided by an external reviewer, if that is available.)

## STEP 2 Identify areas for development

Those aspects of the programme identified in STEP 1 as deficient need your attention. In addition, you may feel that you can do better on some other aspects. You may need to go back to the original course aims or objectives.

*For example: You may feel that the pacing of the session was Satisfactory but could be improved, (see 23).*

List these areas for development. Group together those that have a similar theme.

*For example: Management of groups, spread of activities and skills practice, (19-21).*

Prioritise the areas, starting with the most urgent. These are likely to be those areas that have a greater impact on learning.

*For example: Priority 1. Density of information on handouts too great. Simplify and present as a flow diagram (14, 24).*

## STEP 3 Construct a future action document

Look at each item and identify the cause of the problem. Decide what specific course of action you should take to improve matters. This could include improving the knowledge and presentation skills of the educator or improving resources.

*For example: If the group work (four patients in each) had not been as successful as you had anticipated, the reason may have been that some patients did not participate well in the groups. They tended to be observers and did not take the opportunity to acquire skills. The next time you give the course, you could decide to have them work in pairs on certain activities and supervise these more closely (19-21).*

## STEP 4 Implement and follow up your future action document

Having decided on courses of action for each issue, you now try out your future action document and monitor its success. Do not expect complete success for every point in the document. Also remember that what worked well previously may not work as well again because the group of patients will be different and have different expectations, abilities and needs.

The table below is one way of organising your thoughts about course development and improvement.

| What needs to be improved? | Priority | Cause of the problem | Action needed to remedy the matter | Who will do it? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

# Glossary of terms

| | |
|---|---|
| **aims and objectives** | These are what a course is expected to achieve. It generally supports teaching if they are specific. When learners know the aims and objectives of a course, it can direct their attention to what matters. |
| **assessment** | A process by which evidence is gathered and used to make judgements about the quality of a course. |
| **collating evidence** | The bringing together and combining of evidence to produce an overall judgement of some aspect of a course. |
| **diversity** | Adults vary in many ways, such as, interests, experience and preferred ways of learning. Teaching needs to take this diversity into account. |
| **environment** | This generally refers to the place where the course is given and includes, for instance, size of room, appearance, level of comfort, ventilation, lighting, acoustics, space, and proximity of toilets. |
| **evidence** | A brief note pointing to support for a judgement of an aspect of teaching considered to be good, satisfactory or unsatisfactory. |
| **examples** | Concrete examples can clarify meaning. At the same time, they can also make things more memorable. |
| **external review** | Here, this refers to the review of a course by someone not closely involved in its design or teaching. |
| **future action document** | What will be done to make a course more effective and/or comply with requirements. |
| **group work** | Collaborative learning is facilitated by group work but the optimum size of a group depends on the task. Having adults work in twos and fours is a common practice but, on occasions, larger groups can be productive for some tasks, such as discussion or generating ideas. The danger with large groups is that some members tend to observe rather than contribute. |
| **health and safety** | This refers both to matters arising from a patient's condition and to general matters relevant to people attending a course. |
| **knowledge** | This refers to those facts and understandings (knowing the reasons for things) that patients should acquire to help them manage their condition successfully. |
| **patient course evaluation** | This refers to the views of patients regarding the quality of a course. As patients generally experience pre-course contact, the course itself, and post-course follow-up, they may comment usefully on these. As well as commenting on specifics, they may make broader suggestions for future courses for your consideration. |
| **patient profile** | A collection of information about a patient which is used to shape or |

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| | tune a course. Confidentiality is important. The information may be digested to produce an overall, anonymised profile of a cohort. |
| **peer review** | A term sometimes used when a member of a teaching team reviews the teaching of another member. |
| **quick review** | This is a brief self-review (see below) of a part of a course in order to improve subsequent sessions more or less immediately. |
| **resources** | This refers to the devices used to give a presentation and to accompany it. It includes printed and other materials for patients. Materials which may be shown to others not on the course (e.g. family, friends, GP) can shape beliefs and attitudes of those who see them. |
| **self review** | Here, this refers to the review of a course carried out by those closely involved in its design and/or teaching. Some such person may review his or her own contribution or a colleague may review it for him or her. |
| **skills** | This refers to what patients should be able to do to manage their condition successfully. |
| **valid assessment** | What counts as Good, Satisfactory and Unsatisfactory generally varies from person to person. Taking the views of others into account, such as those of patients, can help to make such judgements less variable. |

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## Additional Information and Support

There are a number of ways to get support to complete the Structured Diabetes Education Tools:

1. **Using the National Diabetes Support Team Discussion Forum:**
   If you have any queries when working through the sections you may find it useful to post your questions on the National Diabetes Support Team Patient Education Discussion Forum: www.diabetes.nhs.uk or on the Diabetes UK website: www.diabetes.org.uk/sharedpractice

2. **Sharing Completed Assessments:**
   If you are happy to share your completed tools on the National Diabetes Support Team website, please send them to: Bill.OLeary@diabetes.nhs.uk or the Diabetes UK website: goodpractice@diabetes.org.uk

3. **Contacting Local Regional Programme Managers:**
   Your local Regional Programme Managers for the National Diabetes Support Team and Diabetes UK would be happy to help with any queries

4. **Contacting National Structured Patient Education Programmes:**
   In addition, support to complete sections for those participating in the national programmes is available from:

   **DAFNE:**

   Gillian Thompson
   DAFNE Project Manager, Diabetes Resource Centre, North Tyneside General Hospital, Rake Lane, North Shields, Tyne & Wear, NE29 8NH

   0191 293 4115

   dafne@northumbria-healthcare.nhs.uk

www.dafne.uk.com

**DESMOND:**

Marian Carey
DESMOND Project Manager, Diabetes Research Team, Level 1, Victoria Building, Leicester Royal Infirmary, Leicester, LE1 5WW

0116 258 7757 or 0116 258 5881

desmondweb@uhl-tr.nhs.uk

www.desmond-project.co.uk

**XPERT:**

Trudi Deakin
Chief Dietitian and Clinical Champion, BPR PCT, Nutrition & Dietetic Department, Burnley General Hospital, Casterton Avenue, Burnley, Lancashire, BB10 2PQ

Tel: 01282 474631

Fax: 01282 474125

trudi.deakin@nhs.net

www.xpert-diabetes.org.uk

5. **Contacting the Type 1 Education Network:**

Helen.Loughnane@elht.nhs.uk

http://www.diabetes.nhs.uk/downloads/Type_1_Education_Network.pdf



Send form by email | Print completed form