Using Conversation Maps in practice: The UK experience

Sue Cradock, Sharon Allard, Sarah Moutter, Heather Daly, Elizabeth Gilbert, Debbie Hicks, Caroline Butler, Jemma Edwards

Article points

1. Conversation Maps are a series of educational tools that aim to enable people with type 2 diabetes to learn about behaviour change and improved self-management with regard to their condition.
2. The initial drafts of the tools were piloted by Diabetes UK in February 2008 in 56 people with type 2 diabetes of differing durations.
3. Following the results from the pilot phase, roll-out of the tools to diabetes specialist healthcare professionals in the UK was undertaken.
4. The Conversation Map tools are a useful addition, but not replacement, to the range of structured education programmes now available in the UK.

Key words

- Conversation Maps
- Self-management
- Structured education

Authors' details can be found at the end of the article.

Group education programmes are a useful tool in modern-day diabetes care. Their aim is to provide people with diabetes with the information they need to be able to make informed decisions regarding their diabetes care, thereby promoting empowerment and self-management. A range of education interventions for people type 2 diabetes exist in the UK, one of which is Conversation Maps, a range of tools that focus on promoting and facilitating behaviour change. This article describes the tools and outlines a pilot study to evaluate their content.

Type 2 diabetes is a metabolic condition characterised by insulin resistance and progressive beta-cell dysfunction. If not managed correctly, people with the condition are at an increased risk of microvascular and macrovascular damage (Holman et al, 2008).

To be able to effectively self-manage this long-term condition, individuals type 2 diabetes require appropriate education and information from healthcare professionals regarding issues such as diet, medication and blood glucose monitoring. With this knowledge and understanding – and ongoing support – these individuals can make informed decisions, in tandem with their healthcare professionals, regarding lifestyle choices and their diabetes care.

Structured education programmes are now are an integral part of diabetes care, and an intervention that should be "made available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis" (NICE, 2003). In 2005 the Department of Health and Diabetes UK identified key criteria that such programmes should meet to fulfil the NICE requirements, which comprise: a structured curriculum; provision of trained educators; quality assurance; audit.

A variety of group education initiatives currently exist for people with type 2 diabetes, such as X-PERT (Deakin et al, 2006) and DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed; Davies et al, 2008). One such group education programme is Conversation Maps. This article describes this range of education tools, outlining a pilot study that evaluated their content, and discusses the challenges to supporting access to these tools for people with type 2 diabetes.

Background

Conversation Maps are a series of educational tools that aim to enable people with

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1. A pilot phase was undertaken to test the content of the Conversation Map tools and to gain insight into how people with type 2 diabetes viewed them as a method of learning.
2. The Map tools were developed in partnership with Diabetes UK, which is responsible for the content represented on the Maps and in the facilitator guide. The initial drafts were piloted by Diabetes UK in February 2008 in 56 people with type 2 diabetes of differing durations.
3. Seventy per cent rated the session as very effective in helping them find something they could do better to control their diabetes, 100% would recommend this learning experience to someone they knew who had just been diagnosed with type 2 diabetes, and 98% wanted to learn more about the tools.

diabetes to learn about behaviour change and improved self-management with regard to their condition, created by Healthy Interactions (Chicago, USA) in collaboration with Diabetes UK and sponsored by Eli Lilly and Co. (Basingstoke).

There are four UK Map tools, each with a detailed facilitation guide and activity cards, covering the following topics: diabetes management; lifestyle; insulin initiation; and experiencing life with diabetes. Each Map is a large piece of laminated paper with colourful images and text that participants can gather round, view and discuss (*Figure 1*). Each Map includes a section on thoughts and feelings about diabetes, or on identifying support networks, and each Map ends with engaging the participant in goal-setting.

The tools are designed for use in groups of 3–10 people, with the aim of stimulating dialogue between participants and healthcare professionals. They have been developed to be as flexible as possible so that the facilitator may use the Maps according to local need. They can be used in any sequence or each Map can be used independently, or as part of other current education programmes. *Box 1* gives an outline of a common Conversation Maps session.

Pilot phase

Aim

A pilot phase was undertaken to test the content of the Conversation Map tools and to gain insight into how people with type 2 diabetes viewed the tools as a method of learning.

Method

The Map tools were developed in partnership with Diabetes UK, which is responsible for the content represented on the Maps and in the facilitator guide. The initial drafts were piloted by Diabetes UK in February 2008 in 56 people with type 2 diabetes of differing durations.

Figure 1. Participants and their facilitator during a Conversation Maps session.

Participants were recruited by Diabetes UK from its membership. Each person attended one session with the Map tool entitled "Managing my diabetes". Participants were given questionnaires at the end of the session, which were completed before leaving; percentages given below are representative of the entire group. Participant demographics were not collected.

Results

Eighty-four per cent of participants rated the way of learning using the tool as very effective, and 81% said that the experience was very effective compared with other ways of learning.

Seventy per cent rated the session as very effective in helping them find something they could do better to control their diabetes, 100% would recommend this learning experience to someone they knew who had just been diagnosed with type 2 diabetes, and 98% wanted to learn more about the tools.

The UK experience

Following the results from the pilot phase, a roll-out strategy of the tools to diabetes specialist healthcare professionals in the UK was developed. Roll-out used existing diabetes educators, with nine lead facilitators (specialist nurses and dietitians) who were trained in the UK in the use of the Map tools. The selection of the lead facilitators was based on their experience as facilitators of structured group education (most were trained X-PERT or DESMOND educators; all authors of this article were lead facilitators).

By the end of August 2010, 99 training sessions had taken place, with 1542 healthcare professionals trained in the use of the Map tools. A further 10 sessions are planned to run until the end of 2010, which will include up to 20 delegates per session, which could mean another 200 healthcare professionals being trained.

Integrating the use of Conversation Maps into UK practice

The Map tools are flexible in the way they can be delivered, either as a stand-alone

Box 1. A common Conversation Maps session.

Each session lasts approximately 1–2 hours depending on the needs of the group and the time availability. A group of 3–10 people is recommended and the role of facilitator is clearly outlined in the facilitator guide.

- The facilitator uses probing questions to explore thoughts, feelings and beliefs and enables myths to be dispelled, so that the participants leave with accurate information.
- The group does most of the talking.
- The facilitator asks mostly open questions.
- Participants come up with their own solutions.
- The facilitator demonstrates active listening.
- The group is kept focused by the facilitator.
- Everyone is involved so that no one participant is dominating the session.
- Participants leave having had an opportunity to set a goal for themselves.

programme or integrated into current local structured education. But, as with any group education programme, there are challenges and opportunities to establishing them within mainstream health care.

The challenges

Changing the way that healthcare professionals in the NHS work, to include either new group sessions or new tools into existing group sessions, can be challenging. Anecdotal experiences gathered from the training sessions have highlighted a few barriers to be overcome:

- Many healthcare professionals are not convinced of the value of group education.
- Robust research data are essential to meet the NICE requirements for structured education. In addition, the need for a sound audit or research programme to establish the effects of the Map tools on knowledge, metabolic and psychological outcomes has been identified. Two randomised controlled trials are currently being undertaken in the USA and Europe to assess the impact and effectiveness of group education using the Conversation Map tools, discussed in more detail later in this article.
- There is debate about who should facilitate the sessions – should it be specialist healthcare professionals or could it be lay facilitators? Where healthcare professionals are not used to working with and facilitating groups of people with diabetes, they might not have the confidence to use the tools.
- Some diabetes centres do not have the space for group education, but many primary care settings are now developing small group education rooms.
- Some healthcare professionals appear to be concerned that the Conversation Maps curriculum will not get covered and that subjects will get missed.
- It has been perceived that the healthcare professional is reluctant to relinquish control over the content of the session – there is still a focus on provision of knowledge as the priority.

The opportunities

The Map tools provide an opportunity for helping people identify their own learning needs – once someone wants to learn, they will find their own answers. In the authors' view, the value of education using the tools is that the process allows the individual to engage in a conversation rather than be passive learner. Anecdotal feedback gathered during Map training sessions suggests that if healthcare professionals are already using group education as part of their services for people with type 2 diabetes then integrating the Map tools would be easy to achieve:

"As I already run groups, these would be an easy addition and would add something special!"

"The maps would be great for starting insulin groups."

"I have used them as training sessions for healthcare support workers and carers in nursing homes – very successful! So the use of them as education tools for those who care for people with diabetes should not be underestimated."

Meeting the criteria for structured education: Evidence and theory

One of the challenges for developing and delivering structured education programmes in the UK is the need to fulfil the criteria identified by the DH and Diabetes UK (2005) based on NICE (2003) guidance (DH et al, 2006), and underpinned by the philosophy that the programme will be evidence based (DH and Diabetes UK, 2005).

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3. Anecdotal feedback gathered during Map training sessions suggests that if healthcare professionals are already using group education as part of their services for people with type 2 diabetes then integrating the Map tools would be easy to achieve.

The lead facilitators, all of whom believe in the value of the national criteria, have sought below to consider how far the Map tools currently fit the criteria, the evidence base underpinning their use, and what needs to be done to develop them further.

Evidence base

While there is no evidence base for the use of the Map tools at present, two studies are in progress. A USA-based study entitled "IDEA" (Interactive Dialogue to Educate and Activate) is currently recruiting participants to a randomised controlled trial that aims to understand the short- and long-term impacts of a group-based interactive approach to diabetes self-management education, using Conversation Map tools, on patient outcomes. Interim results from are expected in the summer of 2011.

A second study, being carried out in Germany and Spain, is recruiting 650 people to assess the effectiveness of the Map tools on knowledge and biomedical outcomes compared with usual care. This study is due to report in 2011.

Theoretical base

The theoretical basis for the Map tools is: "When we discuss with others what we're learning, we retain that new knowledge much better than when we just passively engage with the new information." This "conversation theory" was developed by Pask (1975) and outlines a scientific basis to explain how such interactions lead to "construction of knowledge" or "knowing".

The fundamental idea of this theory is that learning occurs through conversations about a subject matter, which serves to make knowledge explicit; this is exemplified by the use of activity cards. To facilitate learning, Pask argued that subject matter should be represented in the form of structures that show what is to be learnt – the Map tools seek to achieve this by showing the participants what the subjects are that will be discussed.

The Conversation Map tools, like many recent structured education programmes, are also underpinned by Bandura's (1997) self-efficacy theory (also known as social learning theory), which proposes that people learn from one another, via observation, imitation, and modelling. Such learning results in increased confidence and competence to undertake new skills in life.

Such theories have highlighted that certain educator behaviours are key to the delivery of a Conversation Maps session.

Educator training

A 4-hour training session, as used in the UK roll-out, is provided and led by a lead facilitator experienced in both group self-management education and diabetes. Training supports educators to understand how to use the Map tools and to observe "desired" practice in action (modelled by the lead trainer), but assumes that trainers have the essential skills and behaviours to deliver structured group education that supports self-management.

How well this prepares educators for delivering the programmes is unclear but there is now an educator self-reflection tool available to support development of practice by those attending training. There is a plan to develop follow-up sessions to support those wishing to develop their practice in using the Map tools.

Quality assurance

There are no current plans for an external process of assessing educator quality. External quality assurance (QA) is an expensive process, and the use of the Maps is very flexible – there is not one consistent approach to their use, which makes QA very difficult. However, a pragmatic approach to support teams using the tools in the UK has been developed to meet some of the criteria for structured education set out by the DH and Diabetes UK (2005). The Conversation Maps NICE Toolkit includes individual structured peer/personal review and self-reflection tools, which are available to all healthcare professionals trained in the use of the Map tools.

Audit

There is no centrally led audit of the impact of the Map tools but, as with the QA tools, a range of audit tools are provided with the Conversation Maps NICE Toolkit for those

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teams who wish to develop their own audit programme.

Comparisons with other programmes

In the authors' view, the Map tools are a useful addition, but not replacement, to the range of structured education programmes now available within the UK. In addition, given that many of the Map tools trainer facilitators and educators are either DESMOND or X-PERT educators, they are well placed to consider how the tools may fit with such programmes.

In the authors' opinion, the tools provide an innovative, easy-to-use, additional resource to a system of care that values the role of education as part of high-quality care to people living with type 2 diabetes.

Conclusion and closing remarks

The Conversation Map tools may be seen as an stand-alone resource that can be integrated into, or to complement, nationally recognised structured education programmes. Getting them used well in practice, however, will require practitioners to find the time and space within their current working lives to integrate them. This may be easier for those used to running group sessions and who already have access to required space.

During educator training, some practice nurses have considered the Map tools as a "more accessible" introduction to facilitating groups than other programmes, but still have voiced the need for ongoing support as they start to roll them out to people with diabetes within their practices.

Structured education in the UK has developed enormously over the past 3–5 years. As a result, a number of healthcare professionals have reflected on the education provided, and have developed programmes or bought into national initiatives for their localities. Consequently, the use of the Map tools may be limited unless healthcare professionals can visualise how they can be incorporated into their existing programme or service as a whole.

To prevent the tools becoming an expensive but unused initiative, there is a need to follow-up on how they are used in practice and the possible impact on people with diabetes. A newsletter is distributed to all healthcare professionals who have been trained in the use of the Map tools; the newsletter contains best-practice articles, ask-the-expert questions, and examples of the Map tools' integration into clinical practice.

In the absence of a current evidence base, the use of the Map tools needs to be developed with the criteria for structured education programmes in mind. A UK Conversation Map NICE Toolkit to support local teams in meeting these criteria has been developed by the UK lead facilitators and is available to all people who have attended the Conversation Map training. ■

Authors
Sue Cradock is Honorary Nurse Consultant, Sharon Allard and Sarah Moutter are Diabetes Specialist Nurses, Diabetes Centre, Queen Alexandra Hospital, Portsmouth; Heather Daly is Nurse Consultant – Diabetes, Diabetes Centre, Leicester Royal Infirmary, University Hospitals of Leicester NHS Trust; Elizabeth Gilbert is Community Diabetes Specialist Nurse, Surrey Community Health Services; Debbie Hicks is Nurse Consultant – Diabetes, NHS Enfield Community Services, Enfield; Caroline Butler and Jemma Edwards [at the time of writing] were Care Advisors, Diabetes UK, London.

Declaration of interest
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