The Case for Health Coaching
Lessons learned from implementing a training and development intervention for clinicians across the East of England
Carter A, Tamkin P, Wilson S, Miller L
Institute for Employment Studies

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Institute for Employment Studies
City Gate
185 Dyke Road
Brighton
BN3 1TL
UK

Telephone: +44 (0)1273 763400
Email: askies@employment-studies.co.uk
Website: www.employment-studies.co.uk

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Introduction

The subject of this report is the IES evaluation of an education initiative/development intervention consisting of a two-day health coaching programme for 777 clinicians and a further four-day programme for 25 of the clinicians to become in-house NHS clinician trainers in health coaching for skills transfer and sustainability. The intervention was commissioned by Health Education East of England during 2013/2014.

The aims of the evaluation were:

- To explore views on whether health coaching has been a useful approach for clinicians and their patients; and whether it has resulted in any changes to their thinking and practice.
- To describe the health coaching intervention within each pilot organisation; contextualise it within local strategies on long term conditions (LTC), engagement and patient experience, and the process of implementation.
- To liaise and support local representatives in identifying outcome data relevant to their unique context and examine evidence of impact.

How the evaluation was conducted

The IES evaluation was in addition to three post-training participant surveys conducted by Health Education East of England which indicated high levels of clinician satisfaction with 96% of survey respondents rating programme content, delivery and application to their work as good/very good. The HEEoE surveys also indicated a positive early picture of health coaching challenging clinician mind-sets as well as changing patient mind-sets.

The purpose of the IES evaluation was to elicit subjective clinician views about the outcomes from using health coaching and identify lessons learned from implementing health coaching in a range of clinical and organisational settings. The evaluation used a qualitative ‘deep dive’ case study approach in five NHS organisations.

Data collection methods included desk research; expert interviews; focus groups with clinicians; interviews with clinicians, team leaders, local stakeholders and site co-ordinators; and (in one organisation) analysis of local departmental records and cost data. For the design, conduct and compositional phases of the case study reporting IES drew heavily on guidance from Yin (2009). Following an initial scoping phase, we conducted five focus groups (comprising 42 clinicians) and 33 follow-up interviews.

In total 56 different NHS staff members from five organisations were involved in the evaluation.

What the evaluation found out

Clinician views on usefulness of health coaching

More than two thirds of the clinicians IES encountered (up to one year after their two-day training) were continuing to use their health coaching skills. This is a high percentage when compared to other soft skills training interventions.

Health coaching was being used with a wide range of patients and conditions and being found useful. Conditions included depression, weight management, smoking cessation, foot ulcers, pain management, anxiety, coronary heart disease, poor kidney function and hypertension. Clinicians reported benefits to their patients including increased confidence and empowerment, increased satisfaction, reduced dependency, more personalised advice and less medication.

In addition to presenting a positive picture of health coaching as an effective solution to the patient-centred care and self-management agendas, a picture of health coaching as an efficient way of working also emerged. Benefits to the NHS from health coaching reported by clinicians included higher patient compliance, reductions in episodes of care, reductions in appointments per patient, improved care quality and consistency, quicker discharge off caseload, potential to cut waiting times and less waste from unnecessary medication. Specific comments included:

2 Yin R (2009), Case Study Research Methods, Fourth Edition, SAGE
‘Currently there are on average over four appointments per patient per year. Within that overall figure LTC or elderly patient groups have on average nine to ten appointments per patient per year. This is a cause for concern. Since self-managed patients don’t need to see their GPs so often, more self-management is what primary care needs. Health coaching is ideal to support this.’

Health coaching site co-ordinator (General Practice setting)

‘It [health coaching] is indeed excellent… in particular as it focusses on a ten-minute conversation rather than a lengthy session.’

National Recovery Lead (mental health setting)

‘A normal caseload for me since 2005 has been 60 to 67 patients with 12 to 13 new patients per month. That all changed after I did my two-day health coaching training. Within one month my caseload was down to 35. Two months later it was under 30. I was dealing with the issues quicker and was able to discharge them back to their own management. It was partly that I didn’t feel so responsible for them and was able to let go but mainly it was that the patients felt confident to carry on without me, knowing they could come back to me if they needed to. It is now eight months since my training and I have 27 on my caseload… If everyone in the team was using this approach think of the impact this could make on our waiting list.’

Physiotherapist (community setting)

‘Very useful in teaching people how to self-manage chronic conditions, especially those who were having multiple hospital appointments trying to seek a cure. [Health coaching] taught me how to help people feel like they were part of their cure and take ownership of it. It was helpful to have the techniques to engage passive patients and help them make positive changes.’

Renal nurse (acute setting)

‘I have always listened to patients but it is in a different way now. The reaction from patients has been good. A lot more patients are coming back saying “Thank you. I’ve sorted it [e.g. weight loss]. I’m back to me”.’

General Practitioner

Organisation experiences of implementing health coaching

IES found that impact from health coaching at the organisation level was dependent on many factors including: the degree of commitment of the most influential staff within the practice/organisation; the time devoted to health coaching; the number of patients coached in self-care; recording of relevant activity and outcome data; having processes for assessing the readiness of individual patients to change; and the context in which the clinicians are operating. It is not just about the quality of the training provided.

IES noted that health coaching became a catalyst for organisation change. Whilst it was promoted as an innovative educational intervention, it was managed by HEEoE as an OD and change intervention. The two are not mutually exclusive. Training can often be seen as a first step leading to new ways of working which in turn can lead to major changes in the way organisations operate.

Health coaching effectiveness and widespread adoption within a clinical setting seemed primarily dependent on high organisational support. IES found that a wider coaching culture and having management support systems in place led to more success in targeting and embedding the health coaching (e.g. at the community case study organisation). Although some GPs and acute clinicians found health coaching useful for their own practice, there were more barriers to implementation and adoption within their teams, e.g. organisational and professional culture, time pressure, difficulty releasing staff for training in small teams/organisations, and lack of privacy for coaching conversations in busy ward environments.
A summary of approach taken by the organisations and lessons learnt from the five case studies is presented in the table below.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Approach taken</th>
<th>Lessons learned</th>
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<tbody>
<tr>
<td>Community Services</td>
<td>95 clinicians trained + 6 clinician-trainers</td>
<td>Managed as an organisation-wide long-term ‘culture change’ initiative</td>
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<tr>
<td></td>
<td>1. Casting the net widely at the outset</td>
<td>• A health coaching-friendly organisation culture was an enabling factor for success.</td>
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<tr>
<td></td>
<td>2. Clinicians selling the approach to peers</td>
<td>• Concept sold successfully as a new way of relating to old problems.</td>
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<td></td>
<td>3. Getting support from senior stakeholders</td>
<td>• A group of internal clinician-trainers provided opportunities for mutual support and momentum to inform further roll-out.</td>
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<td></td>
<td>4. Rolling out training internally at scale and pace</td>
<td>• A cadre of internal trainers requires ongoing investment of local resources to release clinicians to deliver training and ongoing support/CPD.</td>
</tr>
<tr>
<td></td>
<td>5. Documenting the evidence</td>
<td>• Engaging the Chief Executive and other leaders early proved extremely helpful in making the necessary resources available for roll-out.</td>
</tr>
<tr>
<td>CCG Commissioner</td>
<td>27 clinicians trained + 1 clinician-trainer</td>
<td>Managed as a project supporting a commissioning priority</td>
</tr>
<tr>
<td></td>
<td>1. Targeting the ‘right’ individuals to support Integrated Care Agenda</td>
<td>• Promotion from a CCG linked to a commissioning priority resulted in take-up of training across all 20 practices.</td>
</tr>
<tr>
<td></td>
<td>2. Tapping into local resources and persuading people to participate</td>
<td>• Impact data is needed to support the spread.</td>
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<td></td>
<td>3. Focussing on outcome measures</td>
<td>• Despite the constraints of ten-minute appointment slots, some are using health coaching successfully.</td>
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<tr>
<td>Mental Health Services</td>
<td>33 clinicians trained + 1 clinician-trainer</td>
<td>• Refresher training will help hone confidence and skill.</td>
</tr>
<tr>
<td></td>
<td>1. Clear link to new ways of working and National Recovery Model</td>
<td>• Awareness training for senior clinicians who do not need the full skillset would be helpful.</td>
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<tr>
<td></td>
<td>2. Targeting nurses and Improving Access to Psychological Therapies (IAPT) practitioners</td>
<td>• Support for isolated local trainers required so that the investment made will reap the benefits.</td>
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<td></td>
<td>3. Rolling out through HR Strategy</td>
<td>Managed as ‘skills acquisition’ training to support new ways of working</td>
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<tr>
<td></td>
<td></td>
<td>• Quality of training praised.</td>
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<td></td>
<td></td>
<td>• Training attendance should be voluntary.</td>
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<td></td>
<td></td>
<td>• Some difficulties with transferring learning into clinicians’ everyday routines; support locally after training may help.</td>
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<tr>
<td></td>
<td></td>
<td>• Refresher training would be welcomed if made available.</td>
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<tr>
<td></td>
<td></td>
<td>• Demand exists for more ‘Train the Trainer’ places if made available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Difficult organisational context (e.g. reorganisation, job insecurity) can have negative implications for learning.</td>
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<tr>
<td>Primary care (General practice)</td>
<td>0 clinicians trained ¹ + 0 clinician-trainers</td>
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<tr>
<td>1. Designing a test pilot</td>
<td>2. Clinicians to receive training</td>
<td></td>
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<td>3. Support requested from CCG</td>
<td>4. Reviewing results</td>
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<thead>
<tr>
<th>Acute services</th>
<th>32 clinicians trained + 1 clinician-trainer</th>
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<tbody>
<tr>
<td>1. Testing health coaching (HC) as tools to support patient self-management</td>
<td></td>
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<tr>
<td>2. Targeting specialties with longer interactions with patients</td>
<td></td>
</tr>
<tr>
<td>3. Booking onto training courses</td>
<td></td>
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<tr>
<td>4. Team leaders reviewing whether to adopt</td>
<td></td>
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<td>5. No plans for roll-out</td>
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<th>Planned (but not implemented) as a ‘research’ project</th>
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<tr>
<td>• Selling the concept and value of HC to GPs needs resource.</td>
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<tr>
<td>• Accessing two full days of training can be difficult especially for clinicians in small practices. Roll-out may need alternative training delivery model(s).</td>
</tr>
<tr>
<td>• Highly valued by some individual clinicians as an easy to use ‘mind-set’ within ten-minute appointment slots.²</td>
</tr>
<tr>
<td>• Many examples given of successes with patients.³</td>
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<tr>
<td>• Little evidence as yet of practices thinking strategically about where and how best to target health coaching.⁶</td>
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<tr>
<th>Introduced as a ‘new training intervention’ to be tested</th>
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<tr>
<td>• Major difficulties in transferring learning from the training to daily roles.</td>
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<tr>
<td>• Some clinicians using HC successfully especially those with high job autonomy and/or specialist roles.</td>
</tr>
<tr>
<td>• Local mentoring, championing or line management support needed for individual clinicians.</td>
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<tr>
<td>• Concern over lack of privacy for coaching conversations in busy acute wards.</td>
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<tr>
<td>• A view of health coaching as a set of tools that has to be explicitly ‘done’ to patients.</td>
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¹ No-one from this pilot site was trained within our evaluation timescale although many clinicians from within other primary care settings were trained. IES therefore selected three GPs and two practice nurses (from five different general practices) for interview to hear their experiences of using health coaching and their views on how useful it was.
² Not from case study - lessons learned from interviews with GPs and nurses in range of other practices
³ As above
⁴ As above
Cost effectiveness

IES explored with two clinicians in one case study organisation the claims they made about measurable financial benefits to the wider healthcare system. Using audited departmental records on activity and local management data on costs provided by team leaders and the finance department we found:

1. Fifty-one per cent actual increase in new patients onto one clinician’s caseload following adoption of the health coaching approach.

2. Sixty-three per cent indicative cost saving (through reduced clinician time) in using a health coaching approach when compared to using the usual approach in one patient case.

3. Potential saving of £12,438 per year full-time equivalent for one Grade 6 physiotherapist in reduced clinical time to treat existing patient numbers (assuming reduction in clinical time is replicable over time and across all patients).

4. Potential saving of hundreds of thousands of pounds per year per team/service (assuming reduction in clinical time per patient is achieved by all team members following health coaching training).

The view at the community services case study site is summed up thus:

‘The maths stacks up. Training one clinician alone costs about £400. Training one clinician-trainer costs about £2,000. Each clinician trained in health coaching sees armies of patients.’

(Chief Executive, community setting)

Summary of recommendations

- Future roll out should prioritise clinicians in primary care and community care settings where future investment in health coaching training may see the quickest returns.

- Local NHS organisations should think more strategically about where and how best to target health coaching (so that it aligns and supports their wider strategies). This will help determine which clinical services and which patients to select.

- Explore future funding options and business models. There is demand for more training from clinicians and organisations within the East of England. It would be helpful if training was provided at no cost to individual clinicians.

- Consider additional training delivery models. An alternative to the tried and tested two full days of training is particularly important for GPs and practice nurses.

- More local support is needed to help individual clinicians to overcome perceived barriers to using health coaching in some daily roles. Local mentors, champions, lead health coaches or line managers are potentially all suitable support options.

- Organisational support systems need to be in place to enable health coaching skills to be widely adopted and embedded, e.g. an organisation culture that values innovation and learning and support for health coaching from leaders.

- NHS organisations should be clearer about what they hope to gain, what their success criteria is and how it will be measured and whether any adjustments to the clinical environment might be needed.

- NHS clinician-trainers should primarily focus on providing training in health coaching within their own organisations where their credibility, knowledge of the clinical settings and experience in applying health coaching is greatest.

- Refresher training and support for newly trained clinicians could be provided locally by clinician-trainers.

- Local clinician-trainers need ongoing support and an operational infrastructure to be effective. Continuing professional development and training (as a trainer) and access to materials and external supervision will still be required by all clinician-trainers on an ongoing basis.

- Quantitative research is now needed on clinical outcomes and costs from health coaching in UK settings to add to the improvements in patient self-efficacy seen in the ‘proof of concept’ UCS evaluation and the positive clinician views explored in the present qualitative IES evaluation of the ‘large scale pilot’.

- It would be useful for future local research projects or evaluations to compare actual number of patients, throughput and costs at the whole team level, ideally covering multiple teams and over a significant period.
1. Introduction

With over 70 per cent of the NHS’ budget currently spent on managing chronic conditions, there is a clear need to develop and implement new interventions that can help the millions of individuals with these conditions to better manage them and so reduce the cost burden on the health system itself.

Health coaching integrates a coaching relationship with behaviour change assistance and core clinical skills to provide a consultation tailored to different patients’ needs to promote self-care, motivation and responsibility in patients.

1.1 The pilot health coaching programme - ‘the intervention’

A training delivery intervention was commissioned in April 2013 by The NHS Midlands and East from The Performance Coach (TPC) to support the roll-out of health coaching ‘at scale and pace’ to all organisations across the East of England including Norfolk, Suffolk, Cambridgeshire, Peterborough, Essex, Bedfordshire and Hertfordshire. It was described as a ‘large-scale pilot’ since it built on previous small-scale pilots targeted at specific professional groups. The programme was funded primarily by Norfolk and Suffolk Workforce Partnership so the majority of activity (and evaluation) is based on organisations within Norfolk and Suffolk.

The intervention consisted primarily of a core two-day training programme for clinicians to enable them to acquire and practice using health coaching tools and techniques. It was referred to as the ‘Health Coaching programme’. In addition, a further four-day training programme for suitably qualified clinicians was included for skills transfer so that future training might be possible from in-house NHS clinician-trainers beyond the contract period. The latter was referred to as the ‘Train the Trainer programme’. To maintain their skills after attendance on the programme participants have access to: regular health coaching email ‘shots’ which enable further integration of the skills and learning; access to an online learning resource (MyTPC); and occasional one-day CPD workshops.

Up to the end of March 2015, 777 clinicians (from 46 organisations) had been trained on the core two-day programme and 25 clinician-trainers trained (with 18 of those shortly to be accredited).

The official brochure marketing the intervention stated that the core programme was open to doctors, nurses, and allied health professionals in teams, within or across organisations. The brochure defined health coaching as:

‘Talking to people with long term conditions in a way that supports and empowers them to better manage their own care, fulfil their self-identified health goals and improve their quality of their life.’

The Invitation to Tender documentation in 2012 placed the intervention within the following context:

- A regional vision for delivering a revolution in patient and customer experience which is dependent upon embedding personalisation and shared decision making and a move towards a ‘co-productive’ style of relationship which involves the patient being engaged in decisions about their care and supported to look after themselves (self-care).

- A recognition of the crucial importance of both clinician and patient activation working in tandem, supported by system change.

- Demand for ways that motivate patients to self-care and incorporate prevention and management of multi-morbidity rather than of single diseases.

- About 15 million people in England have a long-term condition, more prevalent in older people and deprived groups. Multi-morbidity (especially when including a mental health problem) is becoming increasingly common and has a significant impact on health and social care.

- Current lifestyles present a serious threat to population health, particularly for more disadvantaged groups. Inactivity, smoking, alcohol and poor diet significantly increase the risk of chronic disease, including cancer, and reduce life expectancy.

- More than 60 per cent of the population have a negative or fatalistic attitude towards their own health, particularly in more disadvantaged groups.

- The suggestion that professional medical education has not kept pace with the complexity of system and population needs. Behavioural change techniques are not fully integrated into curricula and shared decision making can be seen as placing additional demands on time-poor clinicians.

1.2 Results from evaluation of the ‘proof of concept’ and previous pilot programmes

In 2010 the East of England Regional Innovation Fund supported a pilot health coaching programme for practice nurses in NHS Suffolk co-designed by Dr Penny Newman, Clinical Lead for Health Coaching and Dr Andrew McDowell, Director and Lead Trainer, The Performance Coach. Over the course of six months 13 nurses from seven practices attended a four-day health coaching training session. Approximately 199 patients were recruited and over 360 coaching appointments completed. An independent evaluation was carried out by University Campus Suffolk (UCS, 2011) with patient questionnaires using the Stanford self-efficacy outcome measure and administered before and after health coaching. Staff and patient feedback showed: significant improvements in self-efficacy which mirrored patients’ and nurses’ stories; very high or high levels of patient satisfaction (98 per cent); high levels of recommendation to other patients (86 per cent); greater patient understanding of their conditions (74 per cent) and greater understanding of their tests and treatments (61 per cent).

In a small subsequent pilot programme for GPs across East of England, 100 per cent were ‘extremely likely’ to recommend this training to other GPs and to other health professionals. Four subsequent programmes were commissioned for CCGs with the National Long Term Conditions (LTC) programme. CCGs brought multidisciplinary teams together for the two-day training. The feedback from participants was said to have been very positive.

In addition to the ‘proof of concept’ pilots within East of England itself, health coaching has been rolled out to hundreds of clinicians through the London Deanery following a Department of Health funded pilot with GP trainees. The evaluation of the pilot indicated there were benefits of a shift in mind-set, confidence and attitude, practical skills to help empower people, and tools to support patients with long-term conditions. Patients receiving coaching even reported benefits over a short follow-up period, including weight loss, smoking cessation and changes to medication and adherence.

1.3 Results from in-house evaluation surveys of the intervention

Following the two-day programmes all participating clinicians were sent a SurveyMonkey evaluation survey in June 2014 to identify satisfaction with the training; perceptions of the health coaching approach, health coaching activity and early results; and areas for programme improvement (response rate 45 per cent). In addition, in September 2014 all participants were sent a second survey to assess ongoing application of their learning and indications of impact (response rate 32 per cent). Both these surveys used mainly quantitative questions with free text boxes for additional comments. Finally a survey on health coaching competencies was sent to all clinicians undergoing the ‘train the-trainers’ programme (response rate 86 per cent).

The results of the three surveys were analysed by Health Education East of England (HEEoE) and reported in the project’s interim report. The findings overall demonstrate: very high levels of clinician satisfaction with the content, style of delivery and applicability of the content to clinical settings; high usage of the skills learned; and a generally very positive picture of the impact of health coaching on changing clinicians’ own mind-sets as well as patient mind-sets. In particular the findings showed:

- Some three months after the training, over 95 per cent of clinicians reported still using the skills they had learned.
- Clinicians reported applying their health coaching skills with a wide variety of patients, mostly those with long term conditions, for lifestyle and behavioural change and with ‘heart sink’ patients.
- The vast majority of participants perceived the health coaching skills to be of benefit to most clinicians and applicable to most consultations.
- Over 70 per cent of respondents to the second (impact) survey felt that there had been benefits to their patients which were measurable, e.g. weight reduction or blood sugar control.
- Sixty-seven per cent of respondents felt that there had been financial benefits to the NHS arising from their health coaching. No-one offered any figures and many respondents cautioned that it was difficult to measure the financial impact, it was too early to say and it was difficult to say that it was health coaching alone that resulted in the change. Nevertheless the open text comment boxes pointed to actual or future savings likely to arise from: fewer tests and inappropriate activities needed, fewer follow-up appointments needed by self-managing patients, reduced pharmacy costs and wastage through improved compliance, reduced demand from patients making healthier choices, and reduced supplier-led demand.
1.4 Literature Review

1.4.1 Health Coaching

Research on coaching programmes in a range of its main contexts (health, sports, and organisational) is no longer ‘new’ territory. The literature, principally from the USA, indicates a growing evidence base on the benefit of health coaching. In particular, there is a growing medical literature identifying outcomes directly from health coaching (e.g. Frates et al., 2011) and from improved clinician communication skills (e.g. Pollak et al., 2010; Hojat et al., 2011).

Health Coaching is used throughout the USA, Australia and elsewhere and benefits have been reported when used for many conditions such as: diabetes, asthma, smoking cessation, obesity, cardiovascular disease, mental health and medication adherence. Coaching is identified as an effective intervention in reviews of self-care support from both the Kings Fund and Health Foundation.

A literature review into best practice for behavioural change interventions, which included motivational interviewing (Powell and Thurston, 2008), found that the manner in which interventions are delivered and the training can both impact on the effectiveness of interventions.

An unpublished evaluation in 2011 of a randomised controlled trial of a telephone health coaching initiative (by NHS West Kent & BUPA Health Dialog CareCall) showed there were measurable benefits in reducing admissions and re-admissions, together with a 93 per cent patient satisfaction rate. The activity trends were not translated into cost savings, thought to be due to more costly type of admissions, although it could be argued that perhaps it might have resulted in rising costs otherwise.

However there is a paucity of evidence on the necessary skills, techniques and behaviours, i.e. competencies, required to achieve this. This knowledge gap has been highlighted by a systematic review of health and wellness coaching in the US (Wolever et al., 2011).

Authors point out that studies on the effectiveness of health coaching are difficult to compare due to multiple ill-defined variables. These include the use of different definitions of health coaching, a range of applications, e.g. to different populations, differing clinical conditions and health systems, and delivery by a diversity of professionals through both face to face and via telephone coaching. The methodology of these studies is often insufficiently rigorous (Olsen et al., 2010) and often the exact nature of the skills being applied is inadequately described, for example whether motivational interviewing or health coaching (Linden et al., 2010).

According to an independent rapid review of the health coaching literature commissioned by HEEoE, which included 275 studies about health coaching, most existing studies relate to stand alone coaching services in the US whereas the East of England initiative assumes that a health coaching mind-set can be used as part of a person’s usual care (The Evidence Centre, 2014). Thus the East of England initiative provides researchers with an opportunity to contribute to under-researched areas within the literature, both in terms of context within the UK health system and its application within routine practice. According The Evidence Centre review (2014):

- There is some evidence that health coaching can support people's motivation to self-manage or to change their behaviours, and their confidence in their ability to do so.
- There is some evidence that health coaching can support people to adopt healthy behaviours and lifestyle choices. Research has most commonly cited benefits in increasing physical activity, eating more healthily and reducing smoking.
- There is mixed evidence about the impact of health coaching on physical outcomes such as cholesterol, blood pressure, blood sugar control and weight loss.
- There is insufficient evidence to conclude whether health coaching reduces healthcare use or costs. Most studies are from outside the UK, making generalisation difficult.

1.4.2 Training Evaluation

A literature review into best practice for behavioural change interventions, which included motivational interviewing (Powell and Thurston, 2008), found that the manner in which interventions are delivered and aspects of the training can both impact on the effectiveness of interventions. Like other behavioural change interventions health coaching takes place in a context with a multitude of stakeholders with different priorities, needs and expectations. Achieving impact at organisation level can be dependent on the degree of commitment of the most influential staff within the practice/team, the time devoted to health coaching, the number of patients coached in self-care, the accuracy of data recording, the readiness of patients to change and the context in which the clinicians are operating, as well as the quality of the training itself.
From the wider literature into training evaluation, research has shown that there is relatively little correlation between learner reactions and measures of learning, or subsequent measures of changed behaviour (e.g. Warr et al., 1999; Alliger and Janak, 1989; Holton, 1996). It has been suggested that participant ‘satisfaction’ is not necessarily related to good learning and sometimes discomfort is essential. So, whilst participant surveys may prove very helpful for ongoing training delivery quality assurance purposes, our research needs to look deeper than the delegate satisfaction or reaction questionnaires which the training providers and programme management conduct.

An IES study (Tamkin et al., 2002) found a wealth of studies that commented on the failure of training to transfer into the workplace and which identified a range of organisational factors that inhibit success in evaluating behaviour change in training participants. The authors quoted Warr et al. (1999) as having identified the importance of organisational culture and learning confidence. The more difficult an individual found the training, the less likely they were to be able to apply it; the more supportive line managers were, the more likely the application of learning. Other important factors are perceived usefulness, job autonomy and commitment (Holton, 1996). Similarly, there are a number of individual factors that influence transfer and application of learning: self-efficacy, motivation to learn, and general intelligence have all been associated with this (Salas and Cannon-Powers, 2001). Thus our research will need to consider contextual and organisational factors, as well as training and clinician-related factors.

Whilst measuring organisational outcomes is probably the most difficult level of evaluation, many writers have expounded the view that training must be evaluated using hard outcome data (e.g. Levin, 1983; Phillips, 1996). The difficulties of doing so tend to be dismissed by these researchers. Others, however, express caution, pointing out the many assumptions that are made (Bee and Bee, 1994) or the inherent difficulties in linking soft skills training to hard results (Abernathy, 1999), the time delays that are rarely taken into account (Newby, 1992) and that hard measures miss much that is of value (Kaplan and Norton, 1996). Thus our research approach needs to avoid making narrow assumptions about where evidence of effectiveness and return on investment (ROI) may be found in the health system. The aim of this evaluation as we envisage it will be to capture credible evidence of impact as far as is practically possible, given the time and budget constraints.

2. Methodology

Unlike in academic research, in a programme evaluation the researchers do not determine the patient selection criteria. At the outset IES assumed that the patients chosen by the clinicians were likely to have a range of chronic conditions with a range of clinical indicators appropriate for each individual. It would not be practical for the evaluation to consider all these. Our original intention was to discuss the breadth of patient outcome measures potentially available with some of the clinicians being trained and agree with them the three to four outcome measures they felt were most credible and relevant to a range of patient conditions and which they would ‘sign-up’ to. We would check that the data was already captured and in the same way. We would have agreed a common reporting framework and designed the relevant research tools which would then be incorporated into their coaching documentation. We expected that this positivistic approach would minimise clinician time overall, plus ensure that clinicians would see data collection for the evaluation as part of their pre- and post-coaching routine and not as an additional ‘burden’.

The short time period of the project was an expected challenge for the evaluation - changes in patient behaviour may be observed sooner than changes in organisational indicators - there may not be long enough for a significant effect to be seen. Hence we suggested addressing organisational outcome performance measures through some in-depth qualitative work to provide insights, in addition to reporting on Friends and Family Test scores.

In the event it did not prove possible to implement our preferred pluralistic research approach, as reported below.

2.1 Purpose of the evaluation

The Invitation to Tender from NHS Midlands and East for a training provider asked for:

‘Robust impartial evaluation with an academic partner to demonstrate ROI, particularly in terms of quality, patient experience and patient outcomes.’

IES agreed to be the academic partner. Although commissioned alongside The Performance Coach (for NHS Midlands and East administrative reasons) IES and TPC had never worked together before and therefore considered ourselves to be sufficiently impartial. Throughout the project we operated as entirely separate entities. IES’ originally proposed evaluation approach was underpinned by four theoretical models:
• **Training evaluation model**, i.e. did the training work?

• **Coaching Evaluation model**, i.e. did the coaching for self-care work?

• **Systemic Evaluation model**, i.e. what is the impact and value locally and for the wider health system?

• **Return on Investment calculation**, i.e. articulating the organisational benefits and assigning a monetary value to them.

In our tender bid, IES proposed using a mixed qualitative and quantitative approach to assessing impact, in summary:

• Three scoping focus groups with participating clinicians at early training workshops to assess the feasibility of the evaluation approach and agree three to four key patient outcome hard measures.

• Three short patient feedback surveys embedding standardised measures of self-efficacy and patient experience, delivered pre-coaching, post-coaching and three to six months later to see if changes had been sustained.

• An online clinician survey to gather perceptions of coaching for self-care and patient outcomes.

• In-depth qualitative work with three to four case study organisations in different parts of the health system to explore organisational outcomes and issues (interviews and data analysis).

• Additional stakeholder telephone interviews on costs and outcomes so that a thorough and credible ROI could be calculated.

However, following discussion at the Steering Group meeting in April 2013, and in particular the findings from the scoping focus groups in May-June 2013, it was determined that the quantitative aspects of the evaluation approach focusing on clinical outcomes and cost that we had initially hoped to conduct were not possible/practical. This is discussed in more detail in the following section describing the scoping stage. Instead it was agreed with the evaluation commissioners from Health Education East of England that it would be more helpful to take a qualitative evaluation approach focusing on the organisation’s ‘experiences/stories’ and clinician and patient views. Since the success of health coaching is about changing the mind-set of patients, case studies were thought to be the best way to capture this within the budget available. The overall aims of the case study approach were re-specified and described in the widely circulated Evaluation Information Sheet as follows:

• To explore views on whether health coaching has been a useful approach for clinicians and their patients; and whether it has resulted in any changes to their thinking and practice.

• To describe the health coaching intervention within each organisation; and contextualise it within local strategies on LTC, engagement and patient experience, and the process of implementation.

• To liaise and support local representatives in identifying outcome data relevant to their unique context and examine evidence of impact in terms of health outcome improvements, changes to practice or culture, and consequences for organisations.

Summary of data collection methods actually used:

• Desk research.
• Scoping focus groups with clinicians.
• Expert interviews.
• Case studies in five organisations.
• Focus groups with clinicians.
• Interviews with clinicians, team leaders, stakeholders and site co-ordinators.
• Analysis of management data.

In the following paragraphs we describe the sequence of activity in the conduct of the evaluation.

### 2.2 Scoping stage

Three telephone interviews with health coaching experts/academics and two face to face focus groups (comprising 18 clinicians from among the earliest participants) were conducted during May-June 2013. These were extremely valuable in the sense they allowed us to determine that the quantitative evaluation approach focusing on clinical outcomes and cost that we had initially hoped to conduct wasn’t possible/practical. This was because some clinicians were ‘early-adopters’ attending more for personal interest, or ‘scouts’ attending to check out whether the training was of merit before their organisation committed to sending large numbers through, rather than as part of planned local interventions using specific professional groups.

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8 See Moore’s Technology Adoption Life Cycle, *Crossing the Chasm*, 2006
to target patients with specific conditions. It was also apparent at the scoping stage that many participating clinicians were operating relatively autonomously and intended to use health coaching as part of their routine practice with all their patients and not as a targeted separate intervention, which meant that targeting clinical outcomes was difficult. They also gave us some insight into the types of departments and clinics we might want to consider for case studies; in particular that we should try to capture the widest range of areas of medicine where the health coaching training has potential to make an impact.

At the end of the scoping stage IES consulted with Health Education East of England who agreed on 25 June 2014 that we should move away from a primarily quantitative approach (including clinical measures, behavioural change and ROI) to a primarily qualitative approach (deep dive/in-depth organisation-based case studies of implementations). As the Health Coaching Programme Co-Director later explained (Newman, 2014):

> ‘The training is an educational initiative aimed to reach optimal numbers of clinicians and not a research programme (as a randomised control trial would be).’

The only requirement was that we did not focus exclusively on primary care (since that had been the subject of the first pilot). They wanted to hear ‘stories’ about implementing health coaching from a variety of contexts. It was decided that the most useful approach to the programme evaluation would be in trying to elicit subjective views about the value of health coaching to clinicians and their patients using a qualitative ‘deep dive’ case study approach.

2.3 Evaluation logic model

In September 2013 IES completed an evaluation logic model which outlined our understanding of how the training in health coaching might be expected to lead to outcomes through a chain from changed clinician behaviour, through to changed patients’ mind-sets and resultant patient behaviour change, resulting in improved clinical and NHS outcomes.

Figure 2.1 of the evaluation model shows the methods by which we determined to capture relevant data.
Problem/Issue - promoting health coaching as a route to better health; overcoming practitioner reluctance to coach; better management of long term health conditions; changing behaviours that contribute to ill health, improving health outcomes.

Figure 2.1: IES Evaluation logic model for Health Coaching two-day training programme

Evidence?
Focus groups with clinicians.
Follow-on interviews with clinicians and stakeholders.

Evidence?
Patient surveys.

Evidence?
Management/clinical information.
2.4 Case studies

The core part of the study was detailed case studies in five organisations.

2.4.1 Qualitative methods

Using semi-structured discussion guides, we interviewed and conducted focus groups with key informants within five NHS organisations – from health coaching co-ordinators, clinical team leaders, clinicians who had been trained and stakeholders. Cases were selected based on achieving one in each NHS sector, i.e. acute, primary care (General Practice), community care, mental health and CCG. Initially we hoped to select all the case study settings from within one geographical location so that connections and collaborations within a local health economy might also be seen. However this did not prove possible due to the pattern of training programme take-up: some organisations had not made their mind up about whether to send staff for training by the start of the evaluation period. In the event a wider geographical coverage of cases proved helpful as it provided us with exposure to a wider variety of local contexts.

Each interview lasted between 30 and 60 minutes while each focus group lasted between one hour and two hours. Key informants – co-ordinators and some team leaders – were interviewed on two occasions with a six-month gap between interviews. Some clinicians involved in focus groups were subsequently interviewed with a six-month gap between the initial focus group and follow-up interview. In total during the case study stage we conducted five focus groups (comprising 42 clinicians) and 33 interviews involving 56 different individuals. Five of the clinician interviews were conducted with clinicians from different General Practice settings (outside of our case study) since it did not prove possible to interview clinicians from within the General Practice case study organisation.

The implications arising from findings from one set of interviews were used to inform the questioning in the subsequent interviews and in the other cases. The pattern of repeat interviews used in the research design was especially valuable because of this research technique.

The interview and focus group write-ups from each site were analysed by different members of the research team. Through comparative work among team members, selections were made about which examples and direct quotations would be used in order to illustrate perspectives in this report. For the design, conduct and compositional phases of the case study reporting we drew heavily on guidance from Yin (2009). In particular we adopted one of Yin’s strategies for qualitative data analysis: we produced individual rich case descriptions based on multiple interview transcripts from the same case site. These accounts of the organisation ‘case story’ were shared between two researchers within the evaluation team and consensus was sought concerning their meaning and their contribution. Simultaneously one of the research team used the data to produce vignettes of individual practice.

2.4.2 Quantitative methods

In two of these case studies the work also included some quantitative elements. In the first case we collaborated on management costing figures. In a second case study organisation we designed and developed two survey instruments to assess patient experience for one organisation.

Subject to local agreement, IES had hoped to also access the perspective of patients at all case study sites. We produced template patient experience surveys developed with assistance from Steering Group members and other stakeholders which we hoped would be administered by key staff locally. Three out of five case study sites initially expressed willingness but subsequently just one site agreed and we produced a version tailored for their unique context. However, in the event it was not possible to implement either of these surveys within our evaluation timescale. Reasons given by the sites for not implementing a patient experience survey included staff workload, clinicians not released for training in health coaching within our time frame and duplication of their own patient feedback process. This left the evaluation without direct access to patients’ views, which is a major limitation in the research design. The surveys developed have been put on the programme website pages and promoted as a useful product from the evaluation which can be adapted and used by any NHS organisation as part of their future local evaluations.

2.4.3 Sequence of activity for case studies

1. Organisations of particular interest were selected by IES in collaboration with HEEoE during September 2013.

2. Initial telephone interviews were carried out with five site co-ordinators and four team leaders during October–December 2013 to explore their plans for implementing health coaching, agreeing which professional teams/patient groups it would be best for us to follow and consulting on administering patient experience questionnaires and identifying/obtaining obtain suitable anonymised outcome data regarding patient outcomes.
3. **Clinician views on the usefulness of a health coaching approach**

The first aim for the evaluation was to explore views on whether health coaching has been a useful approach for clinicians and their patients; and whether it has resulted in any changes to their thinking and practice.

In this chapter we present the views from the perspective of clinicians. This is based on the self-reported data captured through our five focus groups and 33 in-depth interviews. In total 56 different clinicians gave us their views. For detailed examples of specific uses of a health coaching approach in practice, please see the following chapter.

In this chapter we start by presenting the range of views on a number of aspects relevant to health coaching, using direct quotes from clinicians to illustrate the issues:

- Overall usefulness, especially in relation to improving patient self-management.
- What clinicians actually do that’s different from their normal clinical practice.
- Which patients the approach worked best/less well with.
- Which clinicians found the approach worked best/less well for them.
- Barriers to using the approach in practice.

We then move on to consider the benefits reported by clinicians, once again using direct quotes to illustrate the following topics:

- Benefits for clinicians.
- Benefits for patients.
- Benefits for the NHS.

**3.1 Overall usefulness**

Over two-thirds of the clinicians we spoke to said they found health coaching useful and would recommend it to their peers within the wider NHS. The remaining clinicians either had not used the approach (yet) or felt it was not useful to their context, although all said they could see how it could be useful in other clinical contexts. The ‘person-centred’ approach that health coaching offers was valued particularly highly by most of those who had used it.

There were a several commonalities in the way that coaching was described. There was general agreement that coaching techniques provide a way of structuring (difficult) conversations and offer a means of going about things in a more ‘user friendly’ or ‘person-
centred’ way. There was a view that health coaching facilitated ‘better conversations’ and ‘more open discussions’:

‘Very useful in teaching people how to self-manage chronic conditions, especially those who were having multiple hospital appointments trying to seek a cure. It taught [me] how to help people feel like they were part of their cure and take ownership of it. It was helpful to have the techniques to engage passive patients and help them make positive changes.’

Renal Nurse, acute sector

The potential of the approach to enable more effective goal-setting was repeatedly highlighted (SMART objectives were cited as a particularly useful).

‘It’s good for establishing, “What do we want to gain?” and helpful for coming up with plans to change behaviour.’

Psychiatric Support Worker

The focus group of community care participants strongly identified with the values of health coaching, thought self-help would provide for a longer lasting change in behaviour and provide the opposite of fostering dependency in a humane way. They also liked the process of changing mind-sets - they were aware that they had previously tended to talk at patients whilst nothing changed. There was agreement that they needed a fresh approach. They were also aware of the increasing pressures on colleagues too and a general desire for a more holistic way of tackling these issues.

One of the community-based interviewees explained how health coaching enabled her to take full advantage of the patient’s stage (in their recovery) providing an opportunity for health coaching to shed a light on what has happened to them and what they can do for themselves in moving forward. As she explained:

‘Patients in the coronary heart disease service are perfect for health coaching. They have all had a cardiac event and are in a psychologically vulnerable place when we see them. Many seek to defend their previous lifestyle/behaviours and put barriers up as to why they can’t change now. Most want to reflect on their admission and are grateful for any education, information and support on offer. All our work as nurses is evidence-based to prevent re-admission. We use the heart manual written by a psychologist which has an element of Motivational Interviewing in it. Health coaching has given me some additional tools, especially around goal-setting which puts the patient at the centre of the conversation. It puts the focus on what they feel they can do right now.’

Nurse, coronary heart service

Among practitioners of psychological therapies in particular health coaching was felt to complement and strengthen their existing communications skills base. Some professionals viewed that the approach could be ‘mixed in’ with Cognitive Behavioural Therapy (CBT) to good effect while others saw it as an alternative when CBT could not be used.

One of the GPs said:

‘Health coaching has a huge role in general practice with health behaviour change and chronic disease review. We are taught as clinicians that we are the experts. We have to go away and tell people how to put it right. I am more aware now of not being in charge. But patients still perceive me as the expert. I need to challenge that. I am not as paternalistic now as I would have been [before health coaching].’

General Practitioner

The GP trainee felt that patients tended to respond positively to the techniques she used and were engaged with the idea of their own involvement and responsibility. She told of how she used coaching on a man who was in the middle of a heart attack. She had started using the process as he and his wife were quite anxious and she wanted to talk to them. He had high blood pressure and had stopped taking his medication as he didn’t like how it made him feel and he had also

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9 Specific, measurable, achievable, realistic, timely.
continued to smoke. So she asked him what he felt the heart attack was saying to him.

‘… and he was lying there agreeing that he hadn’t taken care of himself; if I can coach someone who is having a heart attack then you can coach anyone!’

GP trainee

She spoke of another young woman who had been lonely since childhood and who was seen frequently at the surgery. This patient was difficult in consultations, rarely saying anything very much and being very quiet. She had problems with anxiety and anger issues and had been unable to keep a job as she would inevitably lose her temper with someone. She had been using health coaching on this patient with no real expectations of impact, but had then noticed a change when she last came in. She had kept her job, had formed friendships and was now going to the gym with a friend. These were all unexpected results as she hadn’t even thought her approach was having an impact.

When describing the benefits of coaching, the phrase ‘additional/extra tool’ was used by several clinician interviewees. In general these were individuals already highly trained in communication skills and/or whose job centred on communicating.

The majority of nurses at the initial mental health setting focus group agreed that the training they had received had influenced the way they carried out their roles since they had completed their training. They felt this had affected almost every aspect of their communication with patients, i.e. they had not just applied their new skills to a subgroup of their patients or in specific types of situation (although one-to-one situations were highlighted). It had helped them think about the way they communicated in general and how they could do so in a way that helped their patients feel empowered to make changes ‘showing not telling’. However it is not clear if this initial enthusiasm was sustained over time and it is hard to make judgements about the impact since it proved difficult to recruit nurses for the follow-up interview phase of the evaluation.

Overall there were mixed views from primary care clinicians sponsored by the CCG with some mainly positive and others mainly negative. A follow-up conversation with two GPs who had previously been interviewed whilst on their training course, explored their view that the techniques had limited applicability within the GP appointment. One felt that in the training programme there were several scenarios based on a patient identifying the change they wished to make, but in her experience most of the patients she sees had not got to that point yet. She commented that her Nurse Practitioner used health coaching in weight management discussions and had found it useful ‘but not revolutionary’. The other GP felt it hadn’t worked well with chronic pain patients or those who had very embedded behaviour. They had not had much success with those with chronic fatigue syndrome.

In contrast the trainer GP had come to a very different conclusion from a similar starting place. She commented that on the training programme several people were questioning if the techniques could be applied in a clinical setting. She described how her thinking dramatically changed.

‘I just had a light bulb moment and thought, oh my god, this is genius. It just turned round my thinking and my own practice to get patients to own their own health, and I thought this could work.’

One Nurse Practitioner made only modest claims for health coaching. She felt patients could be a bit surprised when they came up with ideas and were able to resolve their own issues. She felt there had been a shift in attitudes as she was pushing patients more, but that any change could only be described as moderate. The other Nurse Practitioner was more positive. She had seen the techniques work well with several patients and so felt that they could prompt people to lifestyle changes.

Two GPs at follow-up said they were using the techniques in their practice anyway regardless of the training. They noted some differences in how the technique is taught and the communication techniques that are used. They did not notice any difference in patient outcomes – they stressed that health coaching was only a minor part of the techniques they use and they hadn’t had time to use the more complex techniques (they specifically mentioned charting with people as to where they were).
3.2 What clinicians ‘do’ differently when they are health coaching

3.2.1 Mind-set changes in clinicians

One of the enthusiastic GPs said that she felt she listened more to people. She had always prided herself on being an empathic listener and had good feedback from patients in the past but still felt that was different now. She found the process of listening generatively was profound and was different. She was also very interested in the conduct of the consultation as an event and felt it needed to be considered important. The Trainer GP has gone on to use the technique in the majority of her consultations, at least using some flavour of it, and to also use the techniques in her external life. She was very clear on how health coaching had changed her mind-set to the consultation. It not only means that she seeks to get to the heart of the problem (which in some sense she always tried to do) but also now has specific tools to use with patients. She also ‘contracts’ with them and this is different. She felt that the training had given her more confidence and she now feels that she is more in control of the time she has with patients, and as a consequence she feels less stressed and overwhelmed.

One Nurse Practitioner felt that her use of health coaching depended on the consultation and the mind-set of the person she was working with. She stated that these were not new behaviours, rather techniques she had used before but with less skill previously. She highlighted how she might have had comments previously from patients such as ‘you should go into politics’ or ‘you’re making me do it’ and her own view was that it could sometimes feel quite ‘clunky’. In contrast the health coaching training has meant she feels a bit more natural, and she uses the behaviours more often. She didn’t think it had brought about a large change in her behaviour as she had never thought that she needed to try and fix the patients’ problems, but she does now explore what the patient can do for themselves more. In her view it seems to work well on all those that she sees, although she hasn’t conducted any kind of more detailed evaluation.

The other Nurse Practitioner interviewed had tended to stick with a coaching model known as TGROW as that worked for her although she said the course had also covered several other techniques. Generally she found that the techniques worked well with diabetic patients who wanted to change. She did however admit that when she came off the course she still did not feel wholly confident in applying the techniques. She was trying to change her behaviour and word things differently; for example she would have said ‘how can I help you today’ whereas now she says ‘what have you come in with today’. She found that the more she applied the techniques the easier it became. She has found that older patients or those from more rural areas expect to be told what to do whereas younger patients or those from urban environments were more open to discussion. She also found, interestingly, that whether or not she wore her uniform made a difference. When in uniform (her previous role) patients tended to look to her to tell them what to do. In her new role (same kind of role but no uniform), they were more open to the coaching. She also found that those with mental health difficulties, such as depression, needed to be chemically treated first, before they could listen to the counselling. She felt it was also important to understand that some chronic disease patients have got the point of desperation and they can’t look to the future easily.

Another of the practice nurses said health coaching had changed the way she approached patients. Instead of asking ‘how can I help you?’ she now asks ‘what can you do about your uncontrolled diabetes?’ She said she had been a bit stronger/harder with patients and waits for them to come up with solutions which she writes in their notes so she can follow-up at their next visit.

A Complementary Therapist reported delivering ‘coaching’ in some form ‘to around six to eight patients’ since she had been trained around four months previously. She reported that it was not possible to estimate ‘hours of coaching’ since like other clinicians she does not deliver ‘coaching sessions’ as such. Instead she had tried to apply it in parallel with her existing work (e.g. hand, head massage) which she conducts in a treatment room away from the ward.

Two community-based clinicians claimed that their whole approach as clinicians had changed now they were using health coaching approach, meaning they worked differently with all their patients. They said:

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[10] Generative listening describes a level of listening where the listener drops their own beliefs and no longer seeks to interpret what they hear through their own belief system but allows themselves to truly and deeply listen to what the other person is saying.
‘My conversations are different. I ask patients what their aims are. I used to say “this is what I’m going to do.” Now I’m a facilitator asking “what can you do?” and “how can you change it?” This has enabled me to get onto the clinical stuff much quicker.’

Physiotherapist, community

‘My approach to treating patients has completely changed. I used to sit at the bottom of the couch and tell the patients what they should do. Now I sit at the side of the couch and talk to them about what they can do. I used to hand out leaflets for them to take away. Now I am more selective about leaflets and highlight what is relevant to that person.’

Podiatrist, community

One also said:

‘I came away from my training totally convinced that health coaching is the way forward. It is a ‘perfect approach’ for some of our patients with diabetes. In a ten-minute appointment per patient we can only use the basics of questioning and being mindful, getting them to identify where to improve. I have to rush through any medication changes etc. in order to have time for lifestyle issues… Not all patients get it or are ready to take responsibility but with about 50 per cent of patients where I have tried the approach I have seen good results in terms of weight loss and blood sugar control.’

General Practitioner

‘What’s different for me is that from day one health coaching has become part of my consultations. It taught me to listen to patients, respect the patient’s resourcefulness and help them discover the best they can do. I can enable them to change.

‘I have always listened to patients but it is in a different way now. The reaction from patients has been good. A lot more patients are coming back saying “Thank you. I’ve sorted it [e.g. weight loss]. I’m back to me”’.

3.3 Which patients?

There was a general view among both focus group participants and interviewees that health coaching could be more useful for some patients than others. For example, it was seen as less applicable to those with mental health conditions at the severe end of the spectrum, such as those involving psychotic symptoms. It was suggested that empowering patients when their thoughts are distorted might not be appropriate (although with the right ‘support and planning’ a support worker felt this could be possible). Advanced dementia was also viewed as a context where coaching would not work well, although some of the nurses stated that in these circumstances coaching techniques could be effective with carers/family members present (especially during home appointments). In general some ability of the patient to engage in structured conversation was seen as a basic requirement for health coaching.

A GP trainee gave a less positive example of when she used challenge on someone and underestimated their anxiety. This person had been on and off work for some time, and had come to see her because of recurrent anxiety but was also anxious about taking more time off and had been well for some time. Because of this the GP challenged her and suggested she tried continuing at work. The patient did go into work after the appointment but subsequently went off work. The GP wondered if she had underappreciated the level of anxiety that the patient was feeling and had pushed her too far. She concluded that sometimes you can’t work out who the techniques won’t work with until you’ve used them and seen that they don’t work.

The potential of coaching to improve patient self-management was also mentioned in regard to eating disorders, chronic pain and IBS. There was also evidence that coaching could work over the telephone.
An occupational therapist conducted a lot of her one-to-one counselling this way; interestingly she had been able to make coaching work in this context but commented that the impact of this was compromised somewhat by not being able to use visual cues and worksheets.

The training was seen as particularly useful in the context of encouraging social behaviours that people with mild to moderate psychological conditions could find difficult, such as dealing with family relationships and conflicts, mixing with others socially and (for outpatients) getting out of the house. It was noted that patients with anxiety had a tendency to be avoidant in this respect and coaching could be helpful in addressing that. For patients with post-traumatic stress disorder (PTSD) coaching was seen as useful for establishing which of their goals were realistic to achieve.

There was a general consensus from the nurses in the mental health setting focus group that health coaching could be applicable in a psychiatric nursing context and that there was scope for coaching to help patients self-manage both mental and physical aspects of their wellbeing. Some activities such as moving around, going outside more or socialising can facilitate both mental and physical health. It was also pointed out that many psychiatric patients do not have good social/family networks and may not receive the same informal support to manage their health conditions that people without mental health problems may have access to. Potentially coaching could make up for this somewhat.

A member of staff based in an acute ward felt it was not appropriate to coach patients in relation to lifestyle issues such as losing weight or doing more exercise. However she reported that patients differed significantly in their ability to ‘get up in the mornings and be active’ and she had tried to apply coaching with some degree of success in this area. More specifically coaching techniques had assisted her in helping a patient with depression to become better at setting goals: coaching had offered a way of challenging. ‘Decisional balance’ was specifically mentioned as a useful approach to the ‘all or nothing thinking’ that is characteristic of chronic depression.

‘Assessing the pros and cons showed him where he was getting stuck. He was able to make statements “this has been difficult for me”.’

Complementary Therapist Support Worker

A community-based Podiatrist said she hadn’t identified specific patients and had a dedicated health coaching session with them. Rather she said:

‘A 30-minute in clinic appointment isn’t really long enough to use the health coaching tools when you have got lots of other things to do in that time. So I use the questioning techniques to get patients to reflect and I tend to use the tools more with colleagues and in supervision.’

An occupational therapist who worked to support the psychological health of IBS (Irritable Bowel Syndrome) outpatients had found coaching could be particularly effective for patients who were not responsive to CBT. She highlighted Motivational Interviewing as an area where it was very effective especially when goal-setting. For her, coaching offered a way of improving the quality of the conversation that took place between herself and the service user, encouraging them to come up with their own solutions (in her area of work goals often centred on social events and outings as IBS patients can often feel their condition holds them back in this area). She felt that coaching techniques were especially useful for ‘troubleshooting difficulties’, and ‘focusing on the person’ and more generally improving patient engagement. When goals could not be achieved or patients did not comply with advice, coaching enabled her to deal with this in a way that was ‘less punitive’.

Nurses from the acute sector focus group felt that there was more of a chance that coaching could be expected to be useful and effective with some patient populations than with others. This was both in terms of the nature of their health problem and the stage at which the practitioner first has contact with them. As one of the nurses said:

‘This is a patient population with chronic health needs and difficult health problems and so they are prime for coaching. It should help them manage their health in a more positive way. There is a long term nurse-patient relationship, close and trusting.’

Renal Nurse, acute

While there was some agreement with the choice of patient population with which to trial the approach within the acute sector focus group, there were questions about the utility of the coaching method for staff with different experience levels and in different settings, as the experience and level of the member of staff may impact on the extent to which individuals can
use coaching knowledge and skills effectively, so that
health coaching may work more for some staff than
others. One of the renal nurses explained it thus:

‘It might give a bit more structure to how people
talk to patients. It’s not necessarily useful for
everyone.’

Renal Nurse, acute

A trainee GP found it particularly helpful with patients
who are stressed or dissatisfied with their life or in
chronic pain, she had used it with those who are
generally unwell, tired, overweight etc., rather than
those who present with a specific disease. She felt the
general approach was applicable to everyone but that
some tools worked less well with those who had low
educational achievement.

More than one clinician mentioned the importance of
‘choosing your moment’ to apply coaching techniques.
It was typical for professionals to report that, rather
than applying any set ‘rules’, they would decide who
might benefit from a coaching approach and when on
a case by case basis. Clinicians felt it was important
to make a judgement based mainly on how receptive
the patient was at a particular point in time. The type
of circumstances seen as most appropriate to the
coaching style of communication were described as are
those when a patient seems ‘stuck’ in some way.

‘You have to work at rapport building - the
patient has to be at a stage where they are
comfortable with being challenged. Some just
don’t get it’ there is no point in trying.’

Complementary Therapist Support Worker

One community-based clinician talked about the need
to coach others within the patient’s support network:

‘There are glitches when implementing
something new. Two patient relatives returned
for reassurance so I am still learning - you need
to coach all the significant others as well as the
patients: they need to be on board too.’

Physiotherapist, community

3.4 Which clinicians?

Most of the nurses felt that all of their immediate
colleagues should have access to the health coaching
training, not simply because the training was viewed
positively, but because they thought consistency of
approach was important in their work environment,
both in operational terms and from the perspective
of patients and the consistency of approach they
experienced.

Related to this was a feeling that most were returning
to an environment where they could not share
experiences with others who had received the training
or benefit from any mutual support arising from that.
There was therefore no foreseeable opportunity for the
nurses to work as a team in implementing the coaching
once the training had finished or to support each other.

As well as benefitting their interactions with patients,
some interviewees felt that their new coaching
skills had had improved their communications with
other staff. For example it was felt that coaching
techniques could be useful in a supervisory context
(e.g. supporting trainees in one-to-one sessions) and
when working with team members (e.g. social workers
and nurses). One clinician felt that to some extent they
facilitated putting care plans together (in consultation
with service-users).

Apart from the Team Leaders, only one clinician
interviewee made specific reference to the contribution
of the training to meeting wider strategic objectives
such the Recovery Programme or the Integrated Care
Programme.

It was suggested that this type of programme might
be more beneficial to newer staff, although there was
also a view that the training would make established
staff feel more confident about their approach to
interactions with patients. That said, it appeared that
many recognised that the coaching approach could
be used within much clinician-patient interaction;
what was needed was an opportunity for clinicians to
practice, with feedback and guidance, both within and
following on from the formal training days.

Some felt that even though they were experienced
they could still learn and use such skills, perhaps more
in their conversations with staff rather than patients,
although they acknowledged that the initiative was
aimed mostly at improving patient outcomes. One
member of staff who had used the coaching approach
with staff said that they had:
‘… used the ideas of detaching oneself and having a bit of structure. If you had to teach a newcomer it gives you a bit more support and structure.’

Renal Nurse, acute

However, a rather more negative corollary of the suggestion that this training would be of more use to newer staff was the view that if a more established member of staff found the training to be of benefit then this would imply that they had been:

‘… doing it wrong all that time... some snippets were useful but not very much, the money’s not well spent, I felt a bit guilty [taking the place].’

Renal Nurse, acute

Clearly the message needs to be reinforced that there is room for development and improvement at all career stages to avoid people internalising negative ideas about learning opportunities.

3.5 Barriers

One practice nurse said that practice nurses were alerted to the health coaching programme through the Chief Nursing Officer, who was really backing health coaching. Three out of the four nurses at her practice had been trained with one of her colleagues also doing extra training to be a trainer. The remaining nurse was nearing retirement and declined to take part. She said:

‘We (the nurses) just decided it sounded important and we needed to go on the health coaching training. I don’t think the GPs really knew where we were going or what we were doing. This was a while ago. It definitely wouldn’t be possible to take two days out now as we are all too busy. In a ten-hour shift on one day I can see up to 50 patients. And there is a three-week wait for an appointment.'

‘The GPs prioritise nurses going on chronic disease courses (e.g. COPD, Asthma, and Diabetes & Family Planning at Essex, Anglia Ruskin or Warwick Universities) because that directly affects their funding. Nurses can only see these patients if you have been on the right course so they need us to go. They also release us for one-day study days (e.g. anatomy, latest NICE guidelines etc., also run by universities or EQUIP North Essex). If health coaching was mandated for nurses or run as a one-day course there is a chance more could go, but it all depends on the mind-set of the GPs.’

Practice Nurse

Teams/departments in which staff have significant longer-term interactions with patients had been targeted during the selection process, as these were viewed as being more likely to have an ongoing relationship with patients that would afford more opportunity for adoption of the coaching approach. However, as the renal team staff attending IES’ focus group pointed out, the coaching conversation also needs a degree of privacy.

One GP was alerted to the health coaching programme through an email sent to the practice manager. Regarding why more people from general practice haven’t got involved she said:

‘Not all GPs locally were reached. I only heard about the health coaching training from my practice manager who forwarded the email to me because of my staff training role. There was no central email about it to all GPs. Not that I saw. Not all practice managers will have cascaded it to all their GPs.

‘Two days out for training is a big chunk. We already have PDP days and go to clinical update days. Whole days out are fantastic and suit me as a part timer since I can go on my days off and concentrate on learning.’

The same GP identified that there is still demand for training places from her practice but no apparent means of fulfilling the demand. Since she has done the training, four-five more nurses and two GPs were booked to attend. By September [2014] one third of the practice were due to have been trained. She would also like to have sent the staff who do the health checks and two nursing assistants but it is unclear if and when more programmes will be forthcoming.
Another GP was keen on exploring anything that could lead to clinical or service innovation or improvements so she signed herself up for health coaching initially ‘out of professional curiosity’.

One practice has a virtual patient representation group and has conducted three surveys in recent years about clinical care experience, appointments and most recently patient satisfaction. Overall satisfaction with the practice has been good, they use the feedback information to look for areas for improvement. As one of their GPs said:

‘I haven’t got time to use the health coaching tools in my own practice. But I use the mind-set in all my consultations with patients to good effect.

‘I see myself as a supporter of health coaching within the medical community. But I don’t want to get more deeply involved, for instance as a trainer.’

Another GP described health coaching as:

‘A mind-set change for clinicians… to improve every consultation, allowing clinicians to become enablers as well as experts.’

It was also believed that in the relatively short time (typically ten minutes) that some clinicians spent with patients a coaching approach could help the clinician structure the conversation and therefore make more effective use of the time. That said, time was viewed as a major constraint in applying coaching skills in the healthcare setting. For example, one GP said:

‘I haven’t used the coaching tools in my general practice. There isn’t time even for an experienced GP. I get 12-13 minutes per patient – most GPs only get ten minutes. It is not cost-effective to give patients a double appointment…’

In addition, if the coaching approach is to be truly effective then arguably it needs to be woven throughout clinician training so that it becomes fully embedded within the culture of the health sector. More than one person suggested that coaching as a topic/skill needed to be incorporated into initial nurse training/other initial training and embedded across the healthcare system:

‘If you want something like this to be sustainable you need to factor it into undergraduate programmes or the CPD portfolio. For long term sustainability it needs to become part of the ethos around health promotion. In health and social care you can’t just implement in one bit of the system, it has to be across the system. E.g. if it’s diabetes, it needs to come in via the [diabetes] pathway approach, but not if it’s just one bit and it’s not reflected elsewhere – [that] isn’t sustainable. We each see our patients for a limited length of time, it has to start in primary care.’

The principles of coaching also need to be fully incorporated into the clinical review process, so that it becomes part of all clinician-patient interactions, not just some of them:

‘You can’t do it on an ad hoc basis. If you send them away with a couple of goals then we have to follow-up and we don’t have the opportunity to do that.’

The problems participants experienced are quite typical of the challenges seen in transferring new learning to the workplace. Models evaluating the effectiveness of training and development typically distinguish between the demonstration of skill in the training situation (‘learning’ or ‘acquisition’) and its use or application in the workplace (‘behaviour’ or ‘performance’). What is often required to make training fully effective is support for the use of new skills in the workplace. This is often in the form of mentoring or coaching to help people become more familiar with applying their skills at work, much as a newly-qualified nurse is assigned a preceptor or mentor for this purpose.
3.6 Benefits to clinicians

One clinician raised the issue of how changing thinking can help behaviour change in a more efficient way. She felt that clinicians needed to lift the patient into thinking ‘I can do it myself’. In part this is about self-protection for clinicians in that they need to recognise that they can’t solve everything and it is also about dispelling dependency. Comments at the focus group included:

‘I have different conversations with people; now I understand I can say no.’

‘I’m having difficult conversations with people; it gives me a whole other language.’

‘I started nervous and anxious and now use it. What a difference!’

‘I do sometimes slip back but have learnt self-awareness too so am aware of that. It has opened up a whole new way of being confident and having a resilient way of thinking.’

‘You have a shield. You know that heart sink stuff? If I do a coaching approach it doesn’t get to you, you don’t take that crap on.’

Two clinicians pointed to reductions in their caseload. At the focus group in January one participant described that she was on leave for February and wanted to return with a blank slate.

‘It’s really demoralising in the NHS at the moment. I can’t think of a worse time. Health coaching feels like getting thrown a lifebelt to hang on to. This gives me hope that the NHS might persist.’

‘In a time of negativity, this is the most positive thing that has happened.’

‘The use of goals has changed my mind-set and in terms of empowering patients sometimes giving them options helps realise people’s potential.’

One GP said ‘I can’t describe how wonderful it is’. She finds that patients are grateful for the help it gives them. She has also noticed that more people say ‘thank you’ than before. The health coaching has also given her a way to listen to patients more and a desire to make things better for them; ‘health coaching is every which way I look’.

3.7 Benefits to patients

One community podiatrist commented on how health coaching could raise patient confidence:

‘You can visibly see power coming back to the person; they grow in confidence and create solutions for themselves.’

Podiatrist, community

A second podiatrist interviewed said there were many patients within the Diabetic Foot Complication Clinic who could benefit, especially the ‘Frequent flyers’, i.e. those who kept getting foot ulcers. A second group was those whose ulcers were not healing. Good outcomes might include preventing them coming back again, reducing the number of episodes of care patients required and preventing amputation. An ulcer can take between two weeks and 14 years to heal and a weekly clinic session is necessary throughout that period, so a healed ulcer would save patients and clinicians the time and cost of repeat clinic attendances.

A nurse in coronary heart disease service pointed to increased patient satisfaction. She explained that a patient’s family can benefit too. Very often the spouse is present and can be very surprised at some of the questions she asks and the responses given by their spouse. They say they realise they have not been asking the right questions and that they will copy the approach and questions to allow them to spot if the recovery is slowing down or encountering problems.

A podiatrist said her patients were more confident in their own abilities. She used to get lots of phone calls asking ‘what do I do next?’ so patients were acting in a very dependent way. Now she finds that they are more likely to have written down what they need to do and have identified friends or relatives who can help them if they forget what they need to do. She acknowledged
that each patient was different but benefits she had observed included:

- more activity and mobility benefitting their overall health
- more realistic idea of what’s possible for them to achieve, given their condition
- more motivation to do exercises because they suggested them
- better support systems - other people to prompt and support them in doing their exercises
- great sense of achievement at having met their personal goal which was valuable to them.

The focus group participants for the community care sector felt health coaching was enabling people to enjoy life more and to feel empowered. It gave an element of control and helped the client identify that they were not in the right place. The tendency was to ‘cradle the patient’ which let them off taking responsibility. They anticipated health coaching would get patients to take responsibility and change their behaviour which would in turn prevent recurrence of problems and reduce demand.

One nurse practitioner recently saw a man with Chronic Obstructive Pulmonary Disease (COPD) who was still smoking. This was someone that she knew well as he had recurrent chest infections during which he became quite poorly. She asked him if he felt there was anything that might be adding to his chest infections, he mentioned that smoking was probably not helping and they discussed this. At the end of the session, he volunteered; ‘I have got to give up smoking haven’t I?’ She believed that before the training she probably wouldn’t have tackled the issue of his smoking as she didn’t want to put people off and felt telling people what they should do probably didn’t help move them on. However the way she now approached it enabled people to take ownership.

In thinking through what particularly had an impact on this patient, the nurse felt it was important not to have told him what he should do but to have explored together what factors might be exacerbating his condition. That way he came to the conclusion that smoking was an issue himself. She was certain that she must have told him many times previously that he should stop smoking and probably other professionals had told him the same thing and he was saturated with it. This time a combination of timing and a different approach worked.

Another nurse practitioner gave the example of a patient who developed type II diabetes. This lady had gained a lot of weight, ate mostly junk foods and didn’t exercise and her diabetes was discovered when she came in for a routine check-up. She was told that she had to go on to oral medication which she was very unhappy about. The nurse went through with her lifestyle and diet and asked if she thought there was any reason she had put on weight. At that point the patient could not think of anything and so the nurse practitioner suggested that she keep a food diary of everything she was eating. When she came back with that it was clear why she was overweight. So they were then able to explore what she might do about it. She has since lost 1.5 stone, exercises regularly and has come off the medication. The nurse felt that the change was because the lady felt empowered to make lifestyle changes. The nurse practitioner had also had very negative experiences and gave the example of a lady who desperately needed to lose weight, but everything she tried in health coaching terms was answered negatively. The patient didn’t feel that there was anything she could do to manage her own health. She would respond with a ‘no, it’s not worth it’ to every suggestion. The nurse practitioner concluded that there are some occasions when you have done everything you can do, and you have to stop and move on.

A GP commented more generally on a number of success stories of people exercising regularly, losing weight, making more of their day to day lives and managing their limitations better. People often come to her looking for a prescription and she tries to increase their awareness and get them to realise that a prescription is not what they need.

3.8 Benefits to the NHS

One clinician commented that the health coaching had re-invigorated her desire to make things better for patients. Another clinician identified greater productivity as a benefit:

> ‘In May 2014 I reduced my hours from 30 to 25 hours a week. I have dropped someone I used to supervise but have managed to keep the same caseload and same number of new patients a month. This is more patients than recommended. Health coaching challenges our old values and the ways we used to manage our patients in the past. Health coaching gives us the potential to manage our patients not just in a better way but also a quicker way.’

Physiotherapist, community

Specific organisation outcomes were identified in the community care focus group discussion. Having a health coaching capability in the team could be a nice selling point for the teams when tendering their services. It will enable therapy service teams to be
more timely and effective through slimming down the waiting list and giving more time to those who need more time. This was thought particularly important for teams that are not currently keeping up with new referrals.

The difficulty of isolating any apparent impact from the intervention was raised repeatedly in many of the focus groups and interviews, i.e. that it would not be possible to determine the extent to which coaching brought about positive improvement.

One clinician felt the coaching (or at least her approach to it) had not worked well in an example where a patient came from an ethnic minority with a strong belief in teachings of the Koran. She felt this made him ‘hard on himself’; he wasn’t able to show himself the compassion that this approach requires to be truly effective. She commented that a male link worker who had a different communication style (described as ‘less emotion-focused’) was more successful with this patient.

**Summary of lessons learnt**

- Over two-thirds of the clinicians IES spoke to said they found health coaching useful and were still using the approach six months after their training and would recommend it to the wider NHS. The minority (just under one-third) are not ‘sold’ into the concept and/or do not intend to coach their patients in the immediate future.

- There is a wide spectrum of reactions among those who find health coaching useful. For many clinicians using health coaching has been revolutionary involving ‘light bulb’ moments leading to fundamental changes in their own mind-set and practice, and major improvements in the health behaviours of their patients. For others the claims are more modest: it is useful for supplementing what they already do for greater impact.

- Health coaching techniques are thought to provide a way of structuring (difficult) conversations, a means of going about things in a more ‘person-centred’ way and enabling effective goal-setting.

- Health coaching had been used during the pilot phase on patients involving: chronic depression, weight management, smoking cessation, foot ulcers, chronic pain, diabetes, COPD, poor kidney function, PTSD, anxiety, coronary heart disease, chronic fatigue syndrome and hypertension. It is also likely to be used for patients with eating disorders, IBS and more generally with those who are presenting unwell, tired and overweight or with very embedded behaviour.

- Benefits for clinicians reported included: greater confidence and resilience, a more sustainable way of working in the face of growing workload pressures, an approach for difficult conversations and ‘heart sink’ patients, reductions in caseload, less ‘what do I do next?’ phone calls and patients say thank you more.

- Benefits for patients reported by clinicians included: more confidence in their own abilities, more realistic idea of what’s possible for them to achieve (given their condition), better support systems (can engage the whole family in helping), greater patient satisfaction, saves time and cost of coming back again, more activity and mobility, more motivation, and a greater sense of achievement.

- Benefits for the wider NHS reported by clinicians include: dealing with patients more effectively and efficiently, greater productivity, a reduction in the number of episodes of care, and the potential for getting through waiting lists quicker.

- Health coaching was thought to have a potentially major role in general practice with health behaviour change and chronic disease review.
IES was interested in the claims made by clinicians about outcomes during our follow-up interviews with them. A selection of vignettes is presented in this chapter which are based on self-reported data by clinicians from across the East of England. We asked all our interviewees to recall at least one specific ‘incident’ where they had used a health coaching approach with an individual patient. We also asked for their reflections on the outcomes of using the approach with that patient: for the patient, for him/herself as a clinician and for the NHS.

In total we present five vignettes, chosen from the many stories we heard because they reflect a range of ways of using health coaching skills that have been identified in the literature. With average lifestyle changes below ten per cent, this was a particular priority for many of our interviewees and there were many examples we might have presented.

The vignettes cover the following clinical contexts:

- Weight loss.
- Lifestyle change.
- Recovery and rehabilitation.
- Prescribing.
- Mobility.

### 4.1 Weight Loss

**The clinician**  
Practice Nurse, Essex

**The patient**  
The practice nurse has been seeing a very large diabetic gentleman for many years and throughout this time she feels he has been sulky and moping during appointments about not being able to lose weight. He has always had a list of credible excuses why nothing has worked. She decided to change her approach and use a health coaching approach.

**Using health coaching**

‘Timing is everything. Health coaching is a relationship and a partnership. It is not all down to me: I sensed he was ready too.’

The practice nurse said she was very firm in not listening to his excuses. She used questioning to empower him including ‘What are you going to do about this? What is your plan?’ She asked him to come back in one month and report on what action he had taken, which he did.

**Outcomes**

For the patient - The nurse reported that in the first month the patient lost half a stone which was his first time losing weight in many years, and was really thrilled with himself. His blood sugar control was also improved. He is carrying on which can help prevent complications further down the line.

For the professional - The nurse reported feeling so happy for him that he was able to take control in this way.

For the NHS - The practice nurse says that this is about achieving better clinical outcomes for the patient down the line by slowing down progression of his diabetes and therefore less use of NHS resources in the future.

Source: IES interview, 2014
4.2 Lifestyle Change

The clinician
Sara Hill, Podiatry Business Manager/Clinical Lead

The patient
A male prisoner with diabetes. He was also obese and a smoker. He seemed angry when the podiatrist arrived not least because he felt his prison environment made his access to exercise equipment and good food challenging.

Using health coaching
It was his annual diabetic foot review and the clinician took the opportunity to use the health coaching T-GROW model with him to get him thinking about and committing to changes he might be able to make to his diet and exercise which would help his health. The clinician sat beside him and listened to his concerns and worries. Before her health coaching training she used to sit at the foot of the couch during consultations and though she was listening it wasn't active as she was treating at the same time. One of the patient's frustrations was that he couldn’t get into the prison gym but through talking he remembered that he had seen some friends do a workout together in another room and decided to join them instead. The podiatrist wrote the model down for him as he wanted to keep it to use himself in the future. At the end he said “Thank you. I can do something now. I was on a hamster wheel before”.

Outcomes
For the patient - The podiatrist reported that the patient walked out more relaxed and up-beat. The signs are very good but it will be a year before the next visit to see if he has changed his behaviour.

For the professional - She reported professional pride at having made a difference and empowered a patient to make changes.

For the NHS - The podiatrist believes this patient is the perfect target for health coaching because a mind-set change and behaviour change could make a big difference to his health and future use of NHS resources in terms of preventing costly diabetic complications. There are also the implications to prison society in that an activated engaged inmate is less likely to offend inside prison, which could also impact on his release date.

Source: IES interview, 2014

4.3 Recovery and rehabilitation

The clinician
Nurse in Coronary Heart Disease Service

The patient
Following a heart attack the patient had declined the cardiac rehabilitation group sessions and was categorised by the hospital as ‘disinterested’. However he did accept the offer of a home visit. His family were present and very involved in the conversation asking what they could do to help. The patient said: “Please don’t ask me to go to the hospital.”

Using health coaching
The clinician used the health coaching T-GROW model as it covers what is important and happening in a patient's life right now and helps in thinking about options. He said: ‘I want to get well. I want to extend my life. But I need to be at home so I can look after my wife as she has dementia. I don’t want to leave her. I need to do the equivalent from home instead.’ The clinician said that the model worked really well and improved the quality of the service she gave. Far from disinterested, the patient was focussed and positive about setting goals and making sure he didn’t do too little or too much too soon. As he lived on a farm meant it was easy for him to plan a daily walk. Moving the ‘goal posts’ was a feature of the follow-ups to ensure a return to normal and long term maintenance to reduce risk factors.

Outcomes
For the patient - Patient satisfaction was high. He appeared relieved that the clinician listened and didn’t try to persuade him to attend group sessions. Medically he got back to normal at the right pace and maintained his confidence
throughout. His family also got the support they needed to make sure they could spot any problems with his recovery.

For the professional - It felt good to take a quality service to the patient, especially when she realised why he had declined the group sessions. She felt emotional recalling how the patient expressed his love and concern for his wife.

For the NHS - Support in the early discharge stage and prevention of re-admission are aims of the community service. Home support is more expensive than a place in group sessions at hospital. This patient had two home visits plus two phone calls. However, because the patient would not have gone to the hospital sessions, using health coaching tools as part of his home support meant the patient has recovered well and an expensive re-admission was successfully prevented.

Source: IES interview, 2014

4.4 Prescribing

The clinician
Dr Penny Newman, in Locum GP role

The patient
A woman presented to a Locum GP who had never met her before asking for testosterone patches having already tried four types of HRT.

Using health coaching
The Locum GP felt unable to give a simple answer. Before health coaching training she says she would have recommended alternatives, and if that didn’t work checked the evidence on patches and offered a second appointment to discuss.

However, the GP decided she needed to get behind the issue and opted instead to ‘flip’ into ‘health coaching mode’ by sitting back, listening to the patient with compassion but without being scared that she might not be able to answer the problem and asking challenging questions in a supportive manner. The GP says this differs from her non-coaching mode which might be characterised as firing questions, writing

simultaneously on the computer to save time and quickly moving things along. Instead, she asked the patient why testosterone patches were important to her and what she wanted to achieve. The woman explained what a difficult life she had and how she was not currently coping with a sick husband. The GP and patient explored whether HRT would address the issues and by herself the patient realised they would not. The patient was put back onto the more common HRT she had tried originally and resolved to think of other ways she could solve her domestic concerns.

Outcomes

For the patient - She went away realising that patches were not the answer and that she needed to sort out her life instead.

For the clinician - This was a satisfactory encounter within a very busy session and took no longer than a standard appointment. She was moved by the patient’s stories. It felt good to have helped her patient realise what was within her own control to sort out. The GP reflected further on whether what she did wasn’t just being a good doctor. She said: ‘Sometimes we forget to be a good doctor. Health coaching builds on what we already do. It makes us an even better doctor by really listening and being interested in the whole patient and where they are in life so a joint approach can be tailored appropriately. Its scary not always having the answer and this way both me and my patient were responsible for finding out the best way forward.’

For the NHS - The patient is unlikely to return asking for costly testosterone patches as she has greater awareness of the cause of her symptoms.

Source: IES interview, 2014
4.5 Mobility

The clinician
Sara Hill, Podiatry Business Manager/Clinical Lead

The patient
A patient with poor vascular condition and bunions had been attending weekly clinic appointments. She lives alone and after two falls in the street stopped going out. A member of the rehabilitation team visited her, the family organised food deliveries and her GP asked podiatry for home visits. The patient was keen to stay in her house in the village where she has lots of friends. The issue was the patient’s loss of confidence as medically she didn’t meet the criteria for home visits and the podiatrist wouldn’t be able to come again.

Using health coaching
The podiatrist quickly realised that the rehabilitation professional who had visited before must have used a health coaching approach as the patient was using health coaching ‘language’. She said: ‘I have a goal now. I know what I need to do. My goal is to get out to the village post office.’ The podiatrist jumped at the chance to build on the goal-setting groundwork already done by helping the patient explore her options in what she could do for herself in achieving her goal. The patient identified that she could use a frame and that it would be easier for her to exit the house via the garage.

In asking how the podiatry service could help her achieve her goal the discussion broadened to new shoes and the concerns she had over being able to manage without her aids during her upcoming holiday. The podiatrist used her health coaching skills to explore options. Not all the topics were strictly within a podiatry remit but they were all related to her confidence in getting out.

Outcomes
For the patient - Quality of life improvements from getting her confidence back. She is happier now she is back on her feet and is walking to the post office. She has booked a holiday with family.

For the professional - It was a nice experience and the health coaching approach worked well.

The patient had wanted to get out and was very grateful that through the conversation she identified ways of overcoming all the practical problems.

For the NHS - Cost-reduction. The patient is coming back into clinic instead of asking for home visits. This saves time for a busy service and is cheaper (a clinic session is half the cost of a home visit).

Source: IES interview, 2014

Summary of lessons learnt

• Early-adopter clinicians have reported success in using health coaching with a range of patients within a variety of contexts.

• Health coaching seems to have been adopted by some clinicians as a ‘mind-set’ which has been fully integrated into their daily practice; for others it is a set of basic skills, ‘tools’ or a mode of working to use selectively in specific practice situations. These distinct differences in perceptions about what health coaching is and how it should be used in practice may not matter. It seems, either way, that these early-adopters perceive health coaching as an enabler or solution in advancing the overall aim of patient self-management.
The second aim of the evaluation was to describe the health coaching intervention within each case study organisation; contextualise it within local strategies and explore the process of implementation.

In this chapter we present five case studies, one organisation from each of the following sectors:

- Community Services.
- Mental Health Service.
- CCG/Commissioner.
- General Practice/Primary Care.
- Acute Service.

We then present a summary of approaches to health coaching and a summary of the lessons learnt from the case study sites.

Please note that the views of clinicians from the sites about the usefulness of a health coaching approach and detailed examples from using the approach with specific patients were also collected but these were presented separately in the previous chapters.

### 5.1 Health coaching in a community services setting

The following case study is based on:

- One focus group involving six clinicians.
- Seven in-depth telephone interviews with five clinician-trainers.
- Two interviews with health coaching site coordinators.
- A discussion group involving four clinician-trainers from within the local Workforce Partnership area.

#### 5.1.1 Profile of the Case study organisation

Cambridgeshire Community Services NHS Trust (CCS) had 3,700 staff in July 2014. Services provided by the Trust during 2013-14 operated over a wide geographical area and included: a range of health services; adult and children's services, community dental and unscheduled care services and sexual health services. In September 2014 the Trust was shortlisted for the Health Service Journal 'Provider Trust of the Year' award category. The Trust’s vision is described thus:

> ‘Our aim is simple; we want to provide high quality, innovative services that improve the lives of the people we serve. Our vision is to transform services, wherever possible providing these in the community closer to people’s homes.’

The Trust’s 2013-14 Quality Account highlights patient satisfaction in excess of 91 per cent (based on 5,000 patients surveyed), an operating surplus of 0.5 per cent and recognition for quality from NHS England’s Chief Nurse, who awarded the Trust the National 6Cs Story of the Month twice in six months.

Innovation is an important part of the stated organisational culture and the Trust has its own Staff Excellence and Innovation Awards scheme. Recent service innovations include new one stop clinics offering integrated contraception and sexual health services and offering Preparing for Parenthood sessions with an interpreter through an innovative partnership between midwives, health visitors and Children’s Centre staff to offer support to new parents without English as a first language.

The Trust was recognised in September 2014 as a ‘Top 100’ NHS organisation to work for in England. This follows on from good feedback from staff via the annual NHS staff survey, published by NHS England. When compared to other community trusts across the country, CCS claims its rating for staff motivation was the most positive and the prevalence of staff experiencing work-related pressure was the lowest.

During the period we were following the health coaching initiative at the Trust (September 2013 - September 2014) the organisation was preparing for major change with Adult Services being subject to procurement processes. Many of the early adopter staff trained in health coaching are located within Adult Services and the deadline of April 2015 to successfully transfer approximately 1,000 staff to another provider meant the need for focussed activity to establish a local

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infrastructure to ensure health coaching could be spread into other service areas.

By end of September 2014, all five clinicians interviewed at CCS have been through an additional four days training to become internal trainers of health coaching, accounting for 20 per cent of the total clinician-trainers. Adult and older people’s services are where the take-up has been greatest within CCS. The podiatry team is believed to be the only service where all team members have been trained.

5.1.2 Clinicians involved to date

Health Education East of England records show that by the end of September 2014, 95 clinicians from CCS had participated in two-day health coaching training. This is the highest number of participants from one organisation and accounts for 15 per cent of the total clinician numbers trained through the centrally managed programme. The professional categories making up this population are shown in the table. Note that the largest group are nurses with 13 trained.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist</td>
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</tr>
<tr>
<td>Not recorded</td>
<td>9</td>
</tr>
<tr>
<td>Team Leaders</td>
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<tr>
<td>Occupational Therapist</td>
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<td>Podiatrists</td>
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<td>Nurse</td>
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<tr>
<td>Specialist Respiratory Nurses</td>
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<tr>
<td>Community Rehabilitation Nurses</td>
<td>4</td>
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<tr>
<td>Community Cardiac/Heart Disease Specialist Nurses</td>
<td>3</td>
</tr>
<tr>
<td>Community Pharmacy Technicians</td>
<td>3</td>
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<tr>
<td>Support Workers</td>
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</tr>
<tr>
<td>Dietician</td>
<td>3</td>
</tr>
<tr>
<td>Therapy Assistant Practitioners</td>
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</tr>
<tr>
<td>Community Rehabilitation Nurse</td>
<td>2</td>
</tr>
<tr>
<td>Cancer Nurse Specialists</td>
<td>2</td>
</tr>
<tr>
<td>Weight Management Practitioners</td>
<td>2</td>
</tr>
<tr>
<td>Nursing Sister</td>
<td>2</td>
</tr>
<tr>
<td>Health Promotion Advisors</td>
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</tr>
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<td>Children’s Services Manager</td>
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<tr>
<td>Clinical Exercise Specialist</td>
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<tr>
<td>Falls Prevention Co-ordinator</td>
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</tr>
<tr>
<td>End of Life Care Co-ordinator</td>
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<tr>
<td>Practice Nurse</td>
<td>1</td>
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<tr>
<td>PALS and Public Engagement Co-ordinator</td>
<td>1</td>
</tr>
<tr>
<td>Stroke Family Support Organiser</td>
<td>1</td>
</tr>
<tr>
<td>Community Cancer Nurse Specialist</td>
<td>1</td>
</tr>
<tr>
<td>Family Nurse FNP/Health Visitor</td>
<td>1</td>
</tr>
<tr>
<td>School Nurse NCMP Lead</td>
<td>1</td>
</tr>
<tr>
<td>Multiple Sclerosis Nurse</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: HEEoE records, 2014

5.1.3 The approach the organisation took to health coaching

IES would characterise the approach as comprising the following key activities:

1. Casting the net quickly and widely within the Trust.
2. Clinicians selling the approach to other clinicians.
3. Getting support from senior stakeholders.
4. Reviewing and rolling out health coaching training internally.
5. Documenting the evidence.

Step 1: Cast the net quickly and widely within the Trust

The Training Lead/Health Coaching Site Co-ordinator first heard about the training available in health coaching from HEEoE in May 2013 when she was asked to advertise and co-ordinate bookings for the training places on programmes being made available. She assumed that many staff could benefit from using the approach in their everyday treatment of all their patients and carers and so, from the outset, there was no targeting or prioritising of particular services or professional groups. The intention was to cast the net as widely as possible. By October 2014 32 clinicians had participated in health coaching programmes with 20 more clinicians booked to attend.

During an interview in October 2013 the Training Lead at the Trust said:

‘I am a Level 7 ILM Accredited Executive Coach so I saw the potential value of health coaching to make huge shifts in patients and be empowering for staff. I sought to get as many of the places on offer as possible by moving quickly. I advertised the training widely within the Trust but left it entirely up to the clinical teams to decide who to send. There was loads of interest initially with 60-70 people expressing an interest.’

‘By moving quickly and matching up all the dates, we have got people trained already… All job roles are represented. For instance podiatry, physios, OTs all of whom work with patients with LTCs, diabetes and heart failure.’
‘We asked for trainer places as well. In IT terms I see these as the ‘super-users’ who can support this locally. We have six trainers in training currently. I expect to see them delivering at least two two-day programmes a year each. Allowing two days for preparation that will be six days a year commitment a year from them. With 20 places per programme that’s potentially 240 staff we can train per year. By setting up a unit of internal trainers we should be able to perpetuate this locally and create some sustainability.’

‘Although I have used health coaching in my own clinical practice for over six months, health coaching didn’t really take off within our team until recently when two of the assistants came back from their two-day training programme and were also very enthusiastic. The general profile of health coaching was also higher within the Trust by then and our team leaders are now on board.’

‘Everyone in the team having the same skillset is really useful in terms of quality and consistency of the service. For instance if we all set goals then when a patient rings for advice about something, no matter who answered the phone, we would all ask how they are getting on with their goals.’

‘There is a demographic time bomb which could cause the NHS to crumble… For us health coaching is all about survival, the NHS changing its USP and thinking what we can do differently. The potential for a win-win is fabulous.’

Step 2:
Clinicians selling the approach to other clinicians

Having been trained and experienced using their health coaching skills in their daily practice, a group of six clinicians (all in training to become internal clinician-trainers) had a series of meetings with the Training Lead to decide how to take health coaching forward within CCS. At a focus group discussion in January 2014 one of the clinician-trainers recalled a general agreement that health coaching is right for the particular challenges that the NHS is facing now.

Another of the clinician-trainers at the January 2014 focus group described the need to demonstrate the value of health coaching to colleagues. She said they had begun to plan a roadshow and started attending team meetings to explain and sell the approach. Some of the group’s own patients who have made a behaviour change had been identified and case studies were being created.

The main argument in favour of health coaching presented to other clinicians was that health coaching is an effective solution to securing behaviour change in patients, with the added benefit for clinicians from increased patient self-management of reduced feelings of work pressure. The intention expressed was to cascade out to relevant clinicians and get as many trained as possible.

In the follow-up telephone interviews in July 2014 the benefits of so many clinicians being trained were described by two of the clinician-trainers:

‘The organisational culture is open and fast-paced with high enthusiasm and an accessible executive team. A recent Care Quality Commission [CQC] visit was very positive. The executive team are advocates of coaching and other development things. They see a direct correlation with development underpinning the endeavour.’

Step 3:
Getting support from senior stakeholders

By the time of the follow-up telephone interviews in July 2014, 76 clinicians had been trained or were booked onto health coaching training programmes which the (new) Health Coaching Site Co-ordinator acknowledged as a ‘considerable investment in time and effort by the Trust’. In addition the six clinicians being trained as internal trainers were nearing the end of their additional four days’ training and accreditation requirements and the focus had shifted away from booking onto centrally run programmes to rolling out training programmes internally within the Trust. To do that senior support was needed.

Also speaking in July 2014 one clinician-trainer described how she had spoken to the Trust Chief Executive about getting support and he had seemed interested. She had also written a two-page document for the HR Director who she hoped would help her with planning to free up staff to attend internal programmes. The Site Co-ordinator meanwhile had arranged to meet with the Deputy Chief Executive and one of the trainers to pull together a roll-out plan. She said:

‘The organisational culture is open and fast-paced with high enthusiasm and an accessible executive team. A recent Care Quality Commission [CQC] visit was very positive. The executive team are advocates of coaching and other development things. They see a direct correlation with development underpinning the endeavour.’
In addition to presenting a positive picture of health coaching as an effective solution to the patient-centred care and self-management agendas, for the senior stakeholders a picture of health coaching as an efficient way of working was also presented. One of the Trust’s physiotherapists highlighted the expediting of discharge and reduction in caseload.

‘A normal caseload for me since 2005 has been 60-67 patients with 12-13 new patients per month. That all changed after I did my two-day health coaching training. Within one month my caseload was down to 35. Two months later it was under 30. I was dealing with the issues quicker and was able to discharge them back to their own management. It was partly that I didn’t feel so responsible for them and was able to let go but mainly it was that the patients felt confident to carry on without me, knowing they could come back to me if they needed to. It is now eight months since my training and I have 27 on my caseload… If everyone in the team was using this approach think of the impact this could make on our waiting list.’

Community-based Physiotherapist

In the context of reflecting on what had helped in implementing health coaching at CCS, one of the clinician-trainers explained her positive expectations for the future of health coaching at the Trust:

‘Within the last month our Trust Chief Executive has publically supported the approach, my direct boss has offered me more time off to train others in the organisation, my boss’s boss has done leadership coaching so ‘gets’ the idea, and our Director is enquiring about what support we all need to roll this out.’

IES has observed that the drive and determination of the clinician ‘super-users’ or champions of health coaching and their collaboration with the in-house training specialists has been a key feature of the CCS future planning. One of the trainers explained the current position in July 2014:

‘The trainers are currently putting a proposal together for rolling this out. There are six internal trainers within our organisation and the Trust wants us to train 300 clinicians during September 2014-April 2015. Each programme lasts two days with up to 20 participants. That equates to 30 days or 225 delivery hours. That’s five hours a week when training *excluding preparation time*. So we have worked out that’s going to be a back-fill requirement of 0.8 WTE across the whole of CCS over six months. But we might not need to back-fill for everyone. Practically it is possible for us to do this. The key thing for our proposal is to spell out the benefits of health coaching.’

A final update on progress was provided during the discussion group at a September 2014 event.14 Further activities to raise awareness of health coaching and support roll-out include:

Step 4:
Review and rolling out health coaching training internally

Joining CCS in May 2014, the (new) Site Co-ordinator took the opportunity to review the experience of staff who were already trained. In July 2014 she told IES:

‘Feedback from individual clinicians has been very good. Health coaching is an extension of what we believe in as an organisation. It is an opportunity to further develop our clinical culture. Health coaching in our organisation has grown from the bottom up. We now need to pick it up and rein it into a strategic framework. That includes deciding where it will be most beneficial. We can focus on specific services or continue to go for a blanket approach across the organisation.

‘We have a valuable resource in the trainers but we need an infrastructure behind it and a proper plan. We won’t develop the culture without giving it a proper steer. Without us now putting some time and effort behind it, health coaching will wither away.’

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A presentation about health coaching to the CCS Leadership Team at which the Chief Executive had suggested a focus for the roll-out on integrated care pathways and the need to work across boundaries with other organisations, e.g. children’s services.

CCS trainers have planned a one-day event to support the practice of CCS staff who have already been trained. They have also committed to go to other organisations without their own trainers to provide something similar.

Creation of an internet site where clinicians can share stories about using health coaching.

Talking to the Huntingdon LTC group to raise awareness of health coaching.

Through meeting with their local Head of Workforce Partnership for the Local Commissioning Group, the trainers have learnt about non-medical tariffs for CPD funding and support for non-medical infrastructure. They will explore the possibility with Trust colleagues of some support for health coaching to be included in this for 2015/6 (perhaps to back-fill trainers time to train other colleagues).

Step 5: Documenting the evidence

An organisation-wide evaluation is not considered a priority. However, the clinician-trainers (super-users) are using their own clinical practice and service development to plan research projects and pilot studies in conjunction with local public health or other evaluation partners. As one of the clinician-trainers said during the discussion group in September 2014:

“We need to back up our arguments to take us from a leap of faith to an evidence-based practice.”

One potential project being considered is to test the potential benefits of a small health coaching intervention of one 30-35 minute dedicated health coaching appointment for patients with diabetic foot complications which is a result of both their condition (poor potential for healing if their vascular system is not working well) and their lifestyle (including poor compliance with non-weight bearing instructions). The podiatrist believes that the current 30 minutes doesn’t allow long enough to fully incorporate health coaching and she feels a separate additional 30-35 minute health coaching appointment could make a real difference to outcomes. But there is a cost for an extra appointment so she feels they will have to conduct a small scale pilot to justify this. Current thinking is to target a minimum of 60 diabetic foot complication clinic patients across the team’s four clinic locations for which good records over the preceding years are available for recurrent problems. This would be followed by studying their health records over the same period of years after the intervention. The scope of the research is still under discussion but, as well as health outcomes, it would also include compared costs of treatments, e.g. amputations, hospital admissions and weekly sessions if patients come back again, versus the cost of the one extra health coaching intervention session.

5.1.4 Challenges and lessons learnt

Sustainability

Ensuring sustainability locally is the immediate challenge. One of the clinician-trainers felt that to be sustainable in the long term the health coaching message needed to get into universities. She had met the Workforce Manager in Cambridge and suggested that the technique goes into the curriculum for the degrees that they are doing. She was also going to Papworth Hospital to get the buy-in from undergraduates.

Having the right champions for health coaching is also very important. She said she would fight to keep health coaching embedded in her service but it was difficult to show increases in patient satisfaction as their survey scores were already 98 per cent before they introduced health coaching. Quality EQ5 is on their dashboard and they could explore picking that up in some way.

The potential for joining up services through health coaching is good.

A second clinician thought that a local pilot project would be a good way forward and, if they could show real benefit for patients and the Trust, then that would be a big help in keeping the health coaching programme sustainable in their service.

A third clinician said:

“Health coaching is an exciting and commendable approach but it could take 20 years to embed. All registrations should include health coaching. Otherwise we are not role-modelling problem-solving or resilience. Acute care might be different but for the rest of us we can’t keep letting patients think we are the experts and we can tell them how to solve their problems. We need a big shift away from clinicians as expert. We shouldn’t be “tell, tell, tell” we should be “what do you feel you can do right now?” Health coaching helps us do this.”
According to a fourth clinician, the biggest barrier to implementation beyond individual practitioners to date had been the poor communication and understanding about health coaching. But that is better now. People are starting to use the health coaching language within the Trust and understand the benefits.

Barriers and enablers

A potential barrier looming ahead at the time of the evaluation was that many of CCS services were up for tender. A new provider was due to be announced in September 2014 and might take over from CCS by the end of March 2015. All six current trainers at the time of the evaluation were in services which were due to move over. The agenda of the new provider was totally unknown. They might or might not support the use of health coaching. They might or might not support the trainers in training people from other organisations. In the meantime IES was told that the best shot at sustainability might mean:

- A rush to train as many of the 300 clinicians as possible before end of March takeover.
- The Performance Coach/Health Education East of England needed to confirm as soon as possible the accreditation of the trainers. The trainers needed their licences to practice/train by September 2014 or the roll-out would be threatened.
- In order to access the trainers in future the NHS might need a proportion of their time to be under the financial umbrella of Health Education East of England or other organisation.

Regarding enablers, one of the clinicians said:

> ‘The biggest enabler has been getting the Chief Executive on side. This was key for us. We [the trainers] sold it to him. The story about my reduced caseload ticked his boxes. At a talk in July in front of people from Health Education East of England he publically supported us.’

The Site Co-ordinator thought it would help if health coaching became a formal ‘programme’ within the Trust starting in October (when the other programmes mostly started too). This way the normal infrastructure of a post-registration programme for individual clinicians supported by the training team could be put behind it, especially in terms of profile, credibility, marketing, management, administration and (in the very short-term) possibly some funding. Speaking in July 2014 she said there were a number of issues to be resolved quickly and, if they were not, they would get in the way.

These issues included:

- It was essential that managers were persuaded to release their staff as trainers if the organisation were to train more people locally. So the case for back-filling needed to be discussed, resolved and funding agreed internally.
- It was essential that final accreditation for internal trainers came through quickly from The Performance Coach/Health Education East of England. Otherwise a delay would mean the initiative would lose momentum.
- It was desirable that the Chief Nurse and Lead Clinicians be involved as well and give their support if participants were to be released for training. She expected this would be forthcoming it was just that the conversations were scheduled but hadn’t happened at that time.
- Finally, East of England needed to be clear if further funding would be attached to the programme and when it would come, e.g. CPD for trainers, more Train the Trainer programmes, or to provide more programmes if internal trainers were not yet accredited.

Summary of lessons learnt

The feedback from the clinician-trainers at CCS was overwhelmingly positive. Particular lessons learnt were:

- Organisation readiness for health coaching seems important. Where the organisation culture places a value on learning, innovation and continuous improvement, this provides a health coaching–friendly context within which health coaching is seen positively by clinicians and implemented as such.
- Health coaching shouldn’t need to create more work and doesn’t seem to need planning: it can be used as part of routine practice. In most cases in a community setting we heard it can be used with almost all of a clinician’s patients.
- Health coaching seemed to have been successfully ‘sold’ by clinicians to other clinicians as a new way of relating to old problems.
• The ‘Train the Trainer’ model to build internal NHS training capability in health coaching shows promising signs of potential success at CCS. It may be that having a group of six internal trainers (as opposed to one or no trainers as in our other case study sites) provides opportunities for mutual support and helps generate additional enthusiasm and momentum to inform the development of organisation-wide roll-out.

• The training of internal clinician-trainers does however require considerable investment of local resources to release clinicians from their day jobs to be trained and accredited in the first place, and then to release them to deliver training on an ongoing basis. The internal trainer role will also require ongoing support and continuous professional development. Initially the clinician-trainers and their managers did not seem to fully appreciate the time commitment that would ultimately be needed.

• Educating and involving the organisation’s leaders and HR/training specialists into the process as early as possible has been extremely helpful in making the necessary resources available for roll-out. The challenge now will be maintaining that level of support over time and with the leadership changes anticipated.

5.2 Health coaching in a Mental Health setting

The following case study is based on:

• One focus group comprising 15 clinicians (predominantly nurses) with diverse roles and caseloads working across 14 different outpatient locations.

• In-depth interviews with five clinicians (Clinical Psychologist, Complementary Therapist Support Worker, Psychiatric Support Worker, Occupational Therapist and Psychological Wellbeing Practitioner).

• Two in-depth interviews with the Implementing Recovery Team Lead (who was also the Health Coaching Site Co-ordinator) and ongoing telephone and email contact.

5.2.1 Profile of the Case Study Organisation

Norfolk and Suffolk NHS Foundation Trust (NSFT) provides mental health, substance misuse and learning disability services across Norfolk and Suffolk. This encompasses: community services; acute services; assessment services; inpatient services; learning disability; secure services; and substance misuse. The Trust employs more than 4,000 staff at more than 50 locations across Norfolk and Suffolk.15

The Trust was formed in January 2012 by the merger of Norfolk and Waveney Mental Health Trust and Suffolk Mental Health Partnership. According to their 2012-3 annual report16, as at 31 March 2013, the Trust had delivered the following performance:

• Surplus of £1.3m (before exceptional items).
• Financial risk rating of ‘3’.
• A cash balance of £19.4m.

In October 2012, NSFT revealed that up to 500 jobs could be lost as part of its ‘radical redesign’ of services, aimed at saving £40m over four years.17 The pace and scale of recent organisational change is therefore an important factor to recognise when considering the potential and actual impact of health coaching at the Trust. The redesign was reported as meaning a ‘doubling’ of caseloads for many nursing participants in our initial focus group. Low morale was apparent at the focus group; this seemed unconnected to the training they had just received, which was viewed enthusiastically.

5.2.2 Drivers for health coaching and link to wider strategies

The Trust is committed to the Recovery model of care and has adopted ‘a strong cultural commitment to the recovery model in all services through organisational change’. This involves the development of Recovery Colleges and forms part of the national Implementing Recovery through Organisational Change (ImROC) initiative.18 According to the Mental Health Foundation website:19

15 http://www.nsft.nhs.uk/Pages/Search-Results.aspx?k=population, accessed 30/09/14
18 http://www.imroc.org/, accessed 13/10/14
19 http://www.mentalhealth.org.uk/help-information/mental-health-a-z/R/recovery/, accessed 13/10/14
'The recovery model aims to help people with mental health problems to look beyond mere survival and existence. It encourages them to move forward, set new goals and do things and develop relationships that give their lives meaning. Recovery emphasises that, while people may not have full control over their symptoms, they can have full control over their lives.'

Implementing Recovery Project Lead

Another relevant policy driver is that of Transforming the Workforce. This involves employing users into peer support worker roles with the aim of changing the power imbalances between providers and service users. This builds on the Expert by Experience programme (which emphasises lived experience of mental health issues) and recognises that service users should have a say not only in their own care but also in development and delivery of services. It could be said this represents a move away from a traditional ‘therapy’ approach towards more of a ‘coaching’ model.

Furthermore, NICE recommendations for strengthening existing links between primary and secondary care are consistent with the potential application of coaching to help people with mental health conditions manage their physical health (which tends to be poorer than the general population). Previously there was an expectation that ‘GPs would do that’. The Trust now has a Lead for physical health to reflect this change in priorities.

Note also that a CQUIN20 sets out a requirement to demonstrate that routine physical health checks are being provided in secondary mental health care.

‘Because of NICE guidelines the Trust has a much clearer imperative on how we work with primary healthcare. And to ensure people with long term conditions, as well as mental health conditions, are encouraged to seek appropriate treatment and interventions to support their physical health as well as mental health... so of course coaching is compatible with this too.’

Implementing Recovery Project Lead

5.2.3 Approach the organisation took to health coaching

The Project Lead felt that the coaching model seemed to be designed for implementation in a structured one to one session: not a scenario in which many NSFT training participants conduct their work. Nevertheless she felt that the training could be used to equip NSFT staff with new communication techniques and in doing so would ‘build their confidence and skills and encourage *service-users] to take ownership of their situation and encourage self-management’. The overall hope was to embed new ways of communicating with patients and in doing so entrench an approach consistent with the wider organisational drivers described above. As the Implementing Recovery Team Lead explained:

‘We need to get staff to think about having different kind of conversations with patients.’

Among the participants interviewed, the majority had opted to receive health coaching training after hearing positive reports from others and/or reading a description of the training and feeling that it would enrich their existing skills base.

‘My manager had been on the course. She said it was brilliant. I wasn’t sure how good it was actually going to be but I was really impressed.’

Occupational Therapist

The extent to which staff not interviewed had opted for training or been sent is unclear, although views provided during focus group discussion at the time of the training, suggested that many had been ‘volunteered’ by their managers.

The training was offered initially to the physical health nurses, however the timing of the first training sessions meant that a small group of people were unable to attend.

It was then offered more widely including to Improving Access to Psychological Therapies (IAPT) practitioners who feed back that the training was ‘excellent’ that but that coaching would probably not be useful for people with severe and enduring mental health conditions.

20 The key aim of the Commissioning for Quality and Innovation (CQUIN) framework for 2013/14 is to secure improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management.
This was viewed by the Lead as a little disappointing because those patients ‘have the highest morbidity rate’ in terms of their physical health. However subsequent training participants were more optimistic; it was felt that perhaps IAPT practitioners’ pessimistic perspective arose from them coming from ‘more of a mental health background’ and possibly they weren’t able to easily ‘see beyond the mental illness’. There was a view that having a ‘stereotypical view’ of a mental health patient possibly presented a barrier to using the technique.

The Trust delivers its services within a range of environments including the outpatient clinics at hospital wards (with varying levels of security) and in the community. Therefore there was potential for coaching principles to be introduced into all these environments. A key point to note is that, as far as could be determined from the evaluation fieldwork, application of the training did not manifest in the introduction of new ‘coaching sessions’ for service-users. Instead the training was implemented within the context of existing models of service delivery in the environments described.

Generally clinicians reported applying coaching techniques in quite a sporadic way rather than regularly (although the Clinical Psychologist reported using it ‘all the time’). They found it difficult to estimate numbers or percentages of patients who they felt had benefited from coaching.

One clinician put herself forward for the additional four days training to become an in-house clinician-trainer of health coaching. She successfully completed this in October 2014.

Finally, the Recovery Lead (health coaching co-ordinator) herself attended the two-day coaching towards the end of our period following the site. She told IES:

“It was indeed excellent, and I thought very easy to put into nurses’ toolkit, particular as it focuses on a ten-minute conversation rather than a lengthy session, something that didn’t come out in your meetings with the other NSFT [attendees].”

Although the Lead was keen for the evaluation to include a patient experience survey to secure some patient perspective on health coaching, it proved difficult to secure the agreement of staff within the timescale of our evaluation. This seemed mainly due to the timing of our request just after the re-design of services and possible job losses had been announced.

5.2.4 Clinicians involved to date

Health Education East of England records show that 33 clinicians from the Trust attended health coaching training. The professional categories making up this population are shown in the table. Note that the largest group are nurses.

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<thead>
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<th>Profession</th>
<th>Total</th>
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<td>Nurse</td>
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<td>Charge Nurse</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health Nurse</td>
<td>3</td>
</tr>
<tr>
<td>Crisis Resolution &amp; Home Treatment</td>
<td>3</td>
</tr>
<tr>
<td>Support Workers</td>
<td>3</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Team Leader</td>
<td>2</td>
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<tr>
<td>Clinical Psychologist</td>
<td>2</td>
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<tr>
<td>Norfolk Recovery Partnership</td>
<td>2</td>
</tr>
<tr>
<td>Technical Instructor</td>
<td>1</td>
</tr>
<tr>
<td>Complementary Therapist</td>
<td>1</td>
</tr>
<tr>
<td>Psychological Wellbeing Practitioner</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
</tr>
<tr>
<td>Modern Matron</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: HEEoE records, 2014

5.2.5 Future intentions with health coaching

At our last contact with the Health Coaching Co-ordinator in October 2014 she had met with the one staff member trained as a clinician-trainer to discuss a possible business proposal to the Executive Team to develop the training in-house, to link it into the HR strategy to develop personal development coaching in the organisation and to use the health coaching model in the physical health course that is being developed in the Recovery College.

There were no formal plans (as yet) for an organisation-wide approach regarding training implementation, the numbers of staff who would be trained in future or the extent to which a ‘Train the Trainer’ model would be extended to disseminate learning further. However a number of participants viewed the ‘Train the Trainer’ approach favourably and were willing in principle to train other staff themselves.

No plans for a local evaluation were disclosed.

A number of interviewees recognised that a key issue will be sustaining the positive effects of training they received. In general the prospect of refresher training, if made available, would be welcomed. One participant mentioned that she hadn’t had time to look at emailed training updates/briefings from TPC and didn’t think this was probably the best means of reinforcing training messages for busy professionals. She suggested
that face to face in-house refreshers may be a more effective alternative.

One member of staff felt she would benefit from further support to help her implement what she had learned. She felt that the presence of visual cues in her treatment room (e.g. key phrases from the training) would help jog her memory and remind her to apply various coaching techniques and possibly also stimulate interest in patients. She had requested a white board for this purpose.

5.2.6 Challenges and lessons learnt

What has helped/hindered local implementation?

Organisational change and reduction in staff numbers was felt to have impacted on implementation at this organisation: there was a view that training was more likely to have been implemented by staff not working at full capacity ‘when you just do what’s necessary’. One participant predicted these factors were behind a lack of participation in the evaluation among nurses who had attended the same TPC training sessions as herself. She felt that their ‘increased workloads’ and ‘competing priorities’ may have hindered them from applying their coaching training in any substantive way: ‘people were enthused but there is so much pressure’. She talked about the environment being ‘volatile’ and a potential lack of the necessary support to be flexible about the way they do their job.

A comment was made that the training may have been ‘sold’ to them via ‘one email among many’. Comments were made about a lack of formal support to use the training and a lack of follow-up, although it was not possible to confirm the extent of this issue.

A Clinical Psychologist suggested that a potential barrier to implementation was the lack of tailored training for a mental health (as opposed to physical health) care setting, although she had not felt this was a barrier personally.

Having a ‘stereotypical view’ of a mental health patient was raised by the Lead as a potential barrier to using the technique.

Enablers for change

A key enabler was felt to be the quality of the training and the fact that it was ‘pitched at the right level’. The approach was felt to be ‘realistic not wild and wacky’ and ‘person-centred’. The interactive nature of the training was praised.

Those who would like to see the training rolled out further in their specialism felt that the ‘Train the Trainer’ model would work well. Some noted that this model had worked well with other types of professional development in the past.

It was noted that that a greater proportion of staff would need to be trained to increase the potential for a measurable positive impact. It was also suggested that the training should be better tailored to mental health (although this was by no means a unanimous view). Staff should be helped to understand the positive benefits of coaching before being ‘sent’ on the training course. The training appeared to be better appreciated and more successfully implemented by professionals who had volunteered for the training and had understood the potential benefits before they attended.

More specifically this case study suggests that staff who are trained in counselling/psychotherapy may be more receptive to the concept of health coaching than those who aren’t, especially if the benefits are not explained well.

Summary of lessons learnt

Those willing to participate in evaluation interviews for this case study site were, by and large, very positive about the health coaching training intervention and the improvement it offered to their skills set. Key lessons arising were:

- Staff should attend on a voluntary basis so the benefits need to be sold to staff before they attend; managers should have sufficient knowledge to let staff know in advance what to expect.

- Some clinicians may need to be shown more explicitly how coaching can be used in their roles, possibly illustrated by relevant examples in training materials or through support locally after training.

- Subsequent to training, support should be provided to encourage implementation (e.g. reviews of progress and opportunities for sharing good practice).

- Clinicians would welcome the prospect of refresher training if made available.

- More clinicians are willing to become internal trainers if another Train-the-Trainer programme is made available.
• There is a suggestion that coaching can be used in tandem with cognitive behavioural therapy (CBT) and/or used in place of it in circumstances when a patient is not receptive to CBT.

• Organisational context (e.g. reorganisation, job insecurity, increased caseloads) can have negative implications for implementing learning.

5.3 Health coaching in a CCG Commissioner setting

The following case study is based on:

• Two small focus groups (one of integrated care coordinators, one of GPs).

• Follow-up in-depth interviews with three GPs and two practice nurses.

• Two interviews, ongoing discussions and email contact with the local health coaching site co-ordinator.

5.3.1 Profile of the Organisation

North Norfolk Clinical Commissioning Group (NNCCG) is a local membership organisation led by GPs that is responsible for planning and paying for healthcare services. Formed in 2012 following the Health and Social Care Act 2012, NNCCG is made up of 20 GP practices in North Norfolk and rural Broadland. The commissioning group covers a population of some 167,000 people with an income budget of £206.3 million (in 2013/14).

The annual plan (2013-14) stated that the aim of the CCG is:

‘Working together for excellent healthcare in North Norfolk and rural Broadland. Delivering seamless health and social care for our patients by 2016.’

The aims are:

• To work with patients, staff and stakeholders to offer care that is high-quality, good value for money and delivered (where possible) closer to home.

• To maximise the potential of primary care to deliver excellent services for patients.

• To provide information to GPs to help inform work and planning.

• To involve patients in decision making.

• To reduce health inequalities.

• To aid educational opportunities for staff in GP surgeries to improve services.

The organisation has five priority areas:

1. Older people: including delivering patient-centred care, developing volunteering services, developing a pathway to prevent falls and promote bone health, and working with Norfolk County Council to maximise resources for the benefits of local patients.

2. Mental Health: including improving dementia diagnosis rate and developing local support services in partnership with patients and carers; working with the Norfolk and Suffolk NHS Foundation Trust to improve access to mental health services and assessments; implementing a new Eating Disorder pathway; and implementing a new wellbeing service in 2015 for those with depression and anxiety.

3. Planned Care: including reviewing and improving elective care pathways for patients in North Norfolk, in particular Ophthalmology and Orthopaedics; improving diabetes structured education in collaboration with patients and providers; introducing a new service for patients to receive intravenous therapies (IV) in the community; and developing robust systems for monitoring and following up patients in primary care.

4. Unplanned Care: including improving access to seven-day services for people with complex mental and physical care needs, working with Norwich and South Norfolk CCGs on ‘Project Domino’ to improve urgent care systems for the rural population to avoid people being admitted to hospital unnecessarily.

5. Children and Young People: including working with local authorities to promote active and healthy lifestyles in children and young people, improving access to Child and Adolescent Mental Health Services (CAMHS), working with Norfolk County Council’s Children’s Services Healthy Child Programme to modernise local services, ensuring services are available for Young Carers, Looked After Children and those with Special Educational Needs (SEN).
5.3.2 The approach the organisation took to health coaching

The approach was an attempt to align health coaching to a strategic priority. Key steps were:

- Targeting the ‘right’ person within each practice.
- Tapping into local resources and persuading people to participate.
- Focussing on outcome measures to evidence if health coaching was ‘working’.

Step 1: Targeting the ‘right’ person within each practice

In North Norfolk CCG the health coaching programme was seen as a potential enabler of integrated care. Their approach was to train one person from each of the 20 GP practices and to also train four or five as trainers who could then cascade train within surgeries. There was some nervousness initially about this approach as it depended on identifying the right individuals to deliver the training and getting funding to support it. Each of the 20 practices was taking their own approach, although there were plans to bring those trained together to help identify how to grow its application.

A networking session was held in February 2014, with the majority of attendees from the acute sector and with limited engagement from CCGs and GP practices. The difficulties of embedding health coaching was noted at this stage especially in reaching out to social care colleagues and finding volunteers for the ‘Train the Trainers’ programmes. At that stage only one person in North Norfolk had attended the Train the Trainer programme and various options were being explored on how other resources across the region might be tapped into.

The expectation of the co-ordinator was that although GPs were being offered the training, the group most likely to apply it would be nurse practitioners as they have day to day contact and see patients over eight to nine weeks. It was believed that health coaching would work best where practitioners and patients have a longer term relationship.

The conclusion of the Health Coaching Co-ordinator after the networking meeting was:

‘It is absolutely essential that we continue to invest in promoting a coaching culture to support integrated care. Prior to attending the day I thought we should target specific roles. I now think we just promote and train the people who ‘get’ this approach and want to share it with others. We will also continue to need professional training/coaching support to sustain this.’

5.3.3 Clinicians involved to date

Health Education East of England records show that by end September 2014, 27 clinicians put forward via the CCG had attended health coaching training, as shown in the table. This is in excess of the 20 places originally hoped for.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Nurse</td>
<td>22</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: HEEoE records, 2014

In addition one of the GPs had also participated in a four-day Train the Trainer programme to become an internal trainer of health coaching. This is less than the four/five internal trainers originally hoped for to secure ongoing sustainability locally.

Step 2: Tapping into local resources and persuading people to participate

At initial interviews in January 2014, three GPs were interviewed in the course of their two-day training programme. They were asked about their motivations for attending the course. One had decided to undertake the training as communication skills had been identified for improvement in her appraisal; one was a GP registrar and wanted to develop teaching communication skills and thought the health coaching approach might help; and a third was a GP trainer who delivered communication skills training. She had previously undertaken a session on life coaching and was very enthusiastic about it. She had, however, met some resistance from her colleagues. A later seminar had rekindled her interest and she had become increasingly involved in the management of long term diseases. They also noted that nurse practitioners were going through the training and they felt it would be useful. There was also a presentation at an annual GP trainers’ conference and an inspirational workshop.

Follow-up interviews involved a fourth GP who had gone on to undertake the Train the Trainer programme.
She had seen the flyers for the programme which had been cascaded through practice managers. The title captured her imagination as she was always looking for ways to improve her consultations. She was particularly frustrated by seeing the same people over and over again and thought this would be of interest. As it was, her practice would not release her so she did the training in her own time. A nurse practitioner was also primarily motivated by the struggle to get people to own their own health and so went on the course to see if it would help.

All the GPs were somewhat concerned over the applicability of health coaching to General Practice, especially the ability to use the techniques within a reasonably brief consultation. As two GPs commented:

‘It feels at the moment that there is no room for spending more time and this feels like it will take longer and we don’t have more time.’

‘Have to ask if this would reduce the attendances of those frequent attenders, such as those with chronic back pain. It is also possible that people will go and see another GP so everyone would need to use health coaching.’

Discussions with Integrated Care Co-ordinators (ICCs) highlighted that this group knew nothing about the approach but felt some knowhow would be useful so they could suggest it when discussing patients with a high number of needs and attempting to prevent acute problems developing. There were no plans however for ICCs to attend the health coaching training (quite appropriately as they do not see patients) but there were also no briefing sessions available for professionals who will not use the training themselves but would benefit from understanding the principles.

Step 3: Focus on outcome measures to evidence if health coaching is ‘working’

The Site Co-ordinator and Integrated Care Co-ordinators were sympathetic to trying to capture data around coaching. They included a coaching indicator on the ICC dataset and they had intended to share the results with the evaluation team. However they had not been able to collect any data on this within our evaluation timescale.

Individual clinicians felt it was very difficult to clearly define benefits. The nurse practitioner conjectured that there might be fewer prescriptions in the future and therefore cost benefits, or perhaps a reduction in hospitalisations, but this could only be seen at a macro level. When pushed on measures of change she commented that nurse practitioners were all doing different things and looking at different aspects of health and therefore it was difficult to identify changes. She wondered if diabetes nurses were using more consistent measures of either physical changes or lifestyle changes. Similarly she felt that smoking cessation nurses might be able to see tangible results more easily.

A GP felt that the region needed to be more proactive and think about what outcome measures might indicate success. She felt that people were using it in personal practice but it was not spread widely enough to be able to gather good evidence. She suggested choosing the outcome measures at a high level. Some suggested measures included untimed admissions, looking at pilot practices and seeing if admissions or referrals were reduced or the average number of consultations per patient over time. Specialist nurses could gather relevant data.

The main barrier was felt to be a ‘Catch 22; evidence is essential to get buy-in but you need buy-in to get evidence’.

At the time of our final email contact with the Site Co-ordinator in October 2014 she was optimistic saying:

‘We are about to go out to our integrated care teams to capture feedback and get our frontline workers involved in shaping integrated care… So thank you very much indeed for providing an external review of the work that we did which has reminded us about the contribution that coaching can play and provided fresh impetus to make sure that we continue to invest in this approach.

‘I think this approach is a culture change which, given time, will happen over a number of years. My conclusion is that we just now need to continue to offer out refresher training and build it into our systems change.’

The GP trainer had experienced some resistance to her involvement in health coaching. She did the initial training in her own time and also attended the Train the Trainer training by taking leave or swapping days off. She felt that she had to keep her involvement ‘under the radar’ as her colleagues had not been supportive.

‘At the moment it is some kind of weird hobby!’
She also described how it felt as if she was in a bit of a cult and had ‘seen the true light’ whilst others needed to catch up. She felt some data on ROI would help secure engagement across the wider organisation and get people discussing how the NHS will cope in the future with growing demand and constrained resources. She felt that whilst her confidence in using the techniques had grown enormously, she was still at the stage where she was learning and developing herself and getting to grips with the nuances of health coaching, and that she was not yet ready to challenge the wider system. There are lots of difficulties, not just for doctors but also practices as employers of nurse practitioners, in terms of facilitating the techniques and the training. There is generally resistance against change. She would welcome more support in what she is trying to do.

The fact the training was free was felt to be a significant enabler of attendance. One of the nurse practitioners did not feel that she would have been able to attend without that.

5.3.4 Sustainability

One nurse practitioner was positive about the sustainability of the techniques as they had become part of her consultation approach. However, she also acknowledged that there were aspects of the training that she didn’t use so it would probably be useful to have refresher training to maintain and deepen its application. The other nurse practitioner also felt she tended to only use one technique and refresher training would help remind her of others. She also felt it would be helpful to be able to talk with colleagues about their use of the techniques.

One GP had applied the techniques to her own practice meetings which were normally quite frustrating events. In the last two meetings she had asked colleagues how they were going to develop the practice and focused discussion on learning from success rather than failure.

The GP trainer felt there needed to be more investment to achieve sustainability.

‘There needs to be more support for evaluation and more trainers and co-ordinators. We need to think about how we are going to sell this and get the message across in terms of making changes.’

She had tried to gather people together to talk about some of the challenges but only three people attended. She felt clinicians were not good at working across organisational boundaries to identify problems and act on them. They tended to focus on investment rather than if the patient received better care. She felt engaging with those in patient experience roles would be helpful, as would setting the seeds for a TripAdvisor kind of culture where patients could vote with their feet (and the money they bring to a practice).

Two GPs interviewed together at follow-up felt that there was a role for health coaching but that it needed more time and to be applied to specific problems. For some practitioners with longer patient time slots, and who were dealing with very similar issues, they felt it had a place, but it was difficult to apply within a busy GP workload. They felt that refresher training would be helpful to those who are using it to help them keep their skills up to date and ensure they were doing the right thing. But time was a barrier as practices have to pay for the time that nurse practitioners are not there. They suggested that Health Education East of England should target the most essential practitioners for the training and back-fund their time. With a smaller group to train, greater investment per person should be possible.

5.3.5 Improvement ideas and advice

Integrating the techniques into the GP training programme was felt to be a good idea and would prevent trainees having to disrupt work, as well as giving them the opportunity to embed the techniques into General Practice.

The group also highlighted ideas of who they thought would most benefit from health coaching. They felt that certain patients could be targeted for the approach, e.g. diabetics or obese people and then nurses or nurse practitioners could be charged with following up this group and could also monitor if there was any shift in outcomes. Similarly smoking cessation advisers could adopt the techniques.

Another GP suggested health trainers could benefit as this approach would sit comfortably within their remit. This is a relatively new role funded by the County Council rather than the NHS. These practitioners work in the community, providing free, confidential support and guidance to people who want to make changes to their health.

One Nurse Practitioner suggested that training delivered very locally would be of benefit. She had had to travel for an hour and a half to attend the initial course and closer venues would have helped both attendance and sharing learning. On this point, bringing together people who worked closely geographically would have helped them think through how they might implement it locally. Another Nurse Practitioner would have liked to attend other courses and thought assertiveness training would help her deal with those patients who came in demanding a prescription.
One GP highlighted the importance of getting people at the top involved and interested in what health coaching is and why it is so important, as it needs intent and systemic challenge to promote it.

Summary of lessons learnt

Feedback from the GPs and practice nurses put forward by the CCG for training and who participated in the evaluation varied. Particular lessons learnt were:

- Coaching is not a discrete activity but an approach that enables conversations which is applied when appropriate.

- Promotion and support for the training from a CCG linked to commissioning priorities resulted in higher take-up of training places across practices than the direct invitation approach used in other geographical areas.

- Free training is an enabler.

- GPs perceive that lack of time is a barrier to using health coaching ‘models’. However we found some GPs who are using health coaching very successfully within existing ten-minute appointment slots as a ‘mind-set’. Suggestions from GPs included more discussion within the training of how it fits within the ten-minute slot and possibly, separate training of GPs with relevant scenarios and sharing of best practice would help overcome these perceptions.

- Awareness training or briefing sessions would be helpful for professionals who will not use the training themselves but would benefit from understanding the principles.

- Refresher training will help hone confidence and skill.

- Focusing on key roles could free up resources to allow more time for training and support and to bring training closer to the trainees.

- Data is needed to support the spread - identifying fewer key roles to focus on would make this easier.

- More support is needed to help GP trainers embed the training as there is a real danger that the investment made will not reap benefits.

5.4 Health coaching in primary care (General Practice)

This case is based on one face to face interview, two telephone interviews and email exchanges with the Health Coaching Site Co-ordinator.

5.4.1 Profile of the Case Study Organisation

The case study surgery is a small GP practice on the outskirts of a town with a patient population of just under 8,000. At the time of IES’ first contact with the site in October 2013 the partnership was still relatively new with two GP partners and a Nurse Practitioner partner. They were supported by two long-term locum GPs, a Practice Manager, reception staff and a Nurse and Health Care Assistants.

All the patients lived within 1.5 miles in a close-knit urban community and most staff also lived locally. The practice profile indicates high levels of deprivation and unemployment in the area, alongside an elderly population with several care homes in the vicinity. There are low levels of self-care with frequent A&E attendees, falls and also issues of substance dependency and mental health support for patients. The number of patients with Long Term Conditions and co-morbidities are in line with national percentages.

The Practice vision is:

‘We strive to deliver a first class medical service to the community we serve and to enjoy our work as a team.’

There have been challenges in the recent past including a below average patient recommendation score (as calculated from 2001 and 2012/3 national GP patient survey data) and problems recruiting GPs. However by October 2013 the practice reported that it had had a successful CQC visit in July 2013, had established a patient participation group (which had been pro-active in engaging patients in two patient surveys) and was addressing issues of quality and productivity through a focus on innovation and ill-health prevention. A particular focus for the immediate future was patient partnership and self-management for patients with LTCs.

21 Unpublished Draft Practice Development Strategy 2013-16 (version 1)
23 Unpublished Draft Practice Development Strategy 2013-16 (version 1)
5.4.2 The approach the organisation took to health coaching

The approach planned by the practice IES would characterise as akin to a research project approach, as follows:

- Designing and setting up a test pilot.
- Clinicians to receive health coaching training.
- Getting support from CCG.
- Reviewing results (to make sure health coaching is working).

Unfortunately no clinicians from the practice were released for training within the timescale of our evaluation, so the planned approach has not (yet) been implemented.

Step 1: Designing and setting up a test pilot

In October 2013 the practice was planning to become a demonstrator practice to educate people to work in a partnership way with patients. Health coaching seemed a perfect fit with a number of local strategies, in particular by giving clinicians the skills to work differently and to personalise their consultation conversations, which was expected to complement existing work with patients to prepare them for partnership working with their clinicians.

The co-ordinator perceived that there was quite a lot of knowledge out there about self-management for patients and there are four platforms of help for patients: support (e.g. self-management courses for people run by voluntary organisations); information; access to tools (e.g. Tele health and telephone apps); and education. However she felt that clinicians also needed to be supported in using the four platforms. That is where she felt health coaching training could really help in primary care to give clinicians the support, information (e.g. website, DVD demo of a health coaching approach), access to tools (e.g. initial training and ongoing support through an updated resource guide) and education/training (i.e. skills acquisition) that they needed. She said:

‘Getting buy-in to health coaching is the issue. We need to set the context of what’s coming up for GPs, but most importantly the benefits to GPs and practices and to consultants needs to be spelled out in terms of the economics - money, time and quality.’

She expected that, once trained, clinicians at the practice would wish to use a health coaching approach on many or all patients. However for the purposes of being a pilot site for the evaluation the Co-ordinator decided to collect data focusing on diabetic patients since this is a particular area of interest within the practice. A postal survey of diabetic patients was being analysed in October 2013, designed to test patients’ understanding of their conditions. The response rate was 60 per cent with 50 patients having completed and returned their surveys.

‘Not all the diabetics are managed effectively at present - in part this is lack of knowledge by patients. Diabetics also tend to have a long term relationship with their health care professionals. They have annual reviews October, March each year so that could be a good time to get some data before and after staff have been trained in using health coaching. These patients are also likely to have other appointments too during the study period.’

Key patient measures at the practice included complaints, patient satisfaction and registration list size. There was also a regular management audit of appointments per patient. It was decided that two bespoke patient experience questionnaires would be designed to be administered to the same patients before and after the test pilot, as well as clinical outcome measures (e.g. HbA1c). As the co-ordinator explained:

‘Currently there are on average over four appointments per patient per year. Within that overall figure LTC or elderly patient groups have on average nine-ten appointments per patient per year. This is a cause for concern. Since self-managed patients don’t need to see their GPs so often, more self-management is what primary care needs.’

A period of development work was undertaken jointly by IES and the practice. Outputs included a research protocol for the pilot and a pair of draft patient experience surveys (for pre- and post-training use) for adult patients with diabetes. The surveys were peer reviewed by researchers and commented on by regional experts and Health Coaching Programme Steering Group members to ensure best practice. Comments were also received from administrative and reception staff at the practice to ensure they understood the questions and were comfortable in helping people fill the form (if necessary). A box of 120 surveys (pre-coaching surveys) and reply paid enveloped were sent to the practice in November 2013.
It was intended that during the test pilot the first 100 diabetic patients to come into the practice for a consultation or annual review during November 2013-January 2014 would be asked to complete the first survey (pre-training) and post it directly to IES. Training places for four clinicians were not secured at that time but it was thought likely the training would happen during January-February 2014. The plan was that the second (post-training) survey would then be given to all/any of the 100 who came back for a consultation and any subsequent consultations (whether related to their diabetes or not) during March-July 2014. Analysis was to have been undertaken independently of the practice by IES.

**Step 2:**
**Clinicians to receive training in health coaching**

By March 2014 patient participation work had been put on hold and no GPs or Nurse Practitioners had participated in the health coaching training. The Co-ordinator explained that there had been staffing problems with GPs for the last four months and they had been using locums. One new permanent GP had been recruited and was due to start in April after which it should be possible to consider booking two GPs and two nurses onto the health coaching training courses. This gap meant everyone else had been too busy to be released for the training:

> ‘Issues of cover are very difficult in a small practice: it is always a fine line. Primary care is the same everywhere with a high demand for face to face GP time. And with no back-fill support on offer we would have to juggle to cover anyway, but when a GP short it is just not possible.’

> ‘Taking two whole days out is difficult in primary care. Could we have different models which better suit different sectors? Maybe four half-days would help in primary care especially if it was delivered locally. Around here we have specific shut down days - half a day a month - when we do training locally. I could have had all mine trained by now if the programmes had coincided with shut down days.’

**Step 3:**
**Getting support from CCG**

During March 2014 the Site Co-ordinator met with the Pain Lead at the local acute unit partner of the practice, to talk about self-management and patient partnership. They felt that it needed the local CCG to offer more encouragement to practices and they understood that the Patient Group Lead at the hospital was also asking the CCG Board for support. As the Site Co-ordinator explained in March 2014:

> ‘Care Pathways are the CCGs’ responsibility and they have a legal requirement to support self-management and support clinicians to have patient partnerships. The problem is CCGs are new and don’t all know how to do it yet so the providers like us have to do everything on our own. We are finding it difficult without CCG support.’

By June 2014 it still had not been possible to release anyone from the practice to undertake training in health coaching. The Co-ordinator summarised her reflections about the health coaching programme and the issues arising as follows:

> ‘With the ongoing need to find a more productive and effective means of delivery of primary care services, it seemed a good opportunity to encourage and support staff to adopt a more partnership approach to working with patients. Encouraging patients to become part of the team and empowering them to make informed choices. Everyone within the team was ‘on board’ with this change in behaviour; however issues that may particularly pertain to primary care came to light very early on in the process and still continue.’

> ‘Primary care staffing levels are very finely balanced and any slight change can cause a ripple effect throughout the organisation. The practice encountered problems with staff sickness and ongoing alterations in health care professional and partnership staffing levels, which affected our ability to continue to provide services whilst attempting to change the way in which we work.’

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24 Reproduced in full from an email to Co-Director of Health Coaching programme, HEEoE.
‘It also became apparent that patients were not necessarily in a position to understand this new approach as they were accustomed to receiving instructions from their GP.’

‘The format of the training required the loss of too much clinical time in one go for the practice to be able to actively participate.’

5.4.3 Challenges and lessons learnt

Since IES was not able to meet clinicians in a focus group or conduct any interviews (as no-one had undertaken the training within our timescale), we interviewed five clinicians (three GPs and two nurses) from five different general practices to hear their experiences of using health coaching and their views on how useful it was. Their views are mainly incorporated into the next chapter. However they have also informed this section on challenges arising in implementing health coaching in general practice, in addition to the challenges experienced and lessons learnt by our case study practice.

Lack of time was the biggest challenge mentioned by all our interviewees from General Practice settings. As an illustration, all five of our General Practice interviewees spoke to IES outside their normal working hours since their work days were too busy. Four of our interviewees had also attended the training in their own time. Time pressure limits the adoption of health coaching both in terms of finding two days to attend the training and in using the coaching models within ten-minute appointment slots.

Looking at the HEEoE figures for uptake of programmes in general practice it seems that in areas where the local CCG had identified health coaching as clearly aligned with their wider health strategies and had been pro-active in their support for training in health coaching (e.g. encouraging emails from the Chief Nurse), the uptake had been higher. One of the GPs interviewed suggested taking GPs out separately from other staff for local training, for shorter sessions of two hours or half a day at a time. IES suggests reflecting on the feasibility of alternative training delivery models, perhaps in conjunction with CCGs, and in utilising those NHS clinician-trainers who will be operating locally as part of the cascading process.

One Practice Nurse intends to use health coaching techniques with diabetic patients at her new practice and will encourage her new colleagues to embrace the approach and seek training (if it becomes available locally). But she says that with ten-minute appointments you cannot use all the models that are taught. At her current practice it is out of the question to have a longer appointment slot for health coaching and she suspects most other practices would be the same. Ultimately she says it all depends on whether the employers (GP partners) see the benefit.

One GP suggested it would be good to:

- Offer the training to all GPs directly.
- Cascade it from the ground level through medical schools.
- Market the approach to GPs by targeting patient niches e.g. ‘Come and learn about how to deal with… heart sink patients (extremely chronic difficult patients)… chronic pain… medically unexplained symptoms (e.g. ME) etc.’

Despite the constraints of ten-minute appointment slots, our interviews with clinicians suggests that some clinicians in primary care settings are finding it easier to use a health coaching approach in their patient consultations than those in other settings. There are clear indications that health coaching is finding its place in some practices as a valued tool for individual clinicians who are able to provide examples of successes with their patients. This makes it all the more important to find ways for more clinicians in primary care to access training in health coaching and to be persuaded of its potential application.

Summary of lessons learnt

- There are clear indications that health coaching is finding its place in some practices as a highly valued tool for individual clinicians who are able to provide examples of successes with their patients.
- Clinicians in primary care seem to have experienced particular difficulty in accessing the training in health coaching.
- Alternative training delivery models (not two full days) may need to be considered in utilising those NHS clinician-trainers who will be operating locally as part of the cascading process.
- Health coaching has been seen as about skills or a mind-set for individual practitioners only.
There is little evidence of practices thinking strategically about where and how best to target health coaching (so that it aligns and supports wider strategies).

Despite the constraints of ten-minute appointment slots, from our interviews it seems that clinicians in primary care settings are finding it easier to use a health coaching approach in all their patient consultations than those in some other settings.

5.5 Health coaching in an acute setting

This case study is based on:

- One focus group with 13 staff from renal medicine.
- Interviews with two team leaders - Research Nurse Team Leader and Renal Team Leader.
- Two interviews with the Training Lead (also the Health Coaching Site Co-ordinator).

5.5.1 Profile of the Organisation

Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) consists of three hospitals: the Norfolk and Norwich University Hospital; Cromer and District Hospital; and the Jenny Lind Children's Hospital. NNUH was the first new NHS teaching hospital built in England for more than 30 years and the hospital trust is a joint venture partner in the University of East Anglia School of Medicine, Health Policy and Practice. According to the Trust's website turnover for the Trust for the year 2013-14 was £480 million with a surplus of £4.7 million. The Norfolk and Norwich University Hospital employs over 6,500 staff and in 2013-14 treated over 825,000 patients. Cromer and District Hospital deals with minor injuries, day cases and outpatients and during 2013-14 treated 51,380 patients. In September 2014 the hospital was shortlisted for the Health Service Journal's 'award for innovative approaches to workforce development' for its apprenticeship project.

At NNUH A&E admissions rose by six per cent in the first half of 2014/15, compared with the same period the year before. In line with other acute hospitals particular challenges and priorities are to:

- Reduce admissions.
- Reduce admissions to A&E.
- Reduce multiple attendances.

According to the Trust’s Quality Report for 2013/14 other priorities include:

- Expediting discharge.
- Increasing the number of patients given the opportunity to self-administer their medication.
- Improving patient experience.

There is also a specific goal in both 2013/14 and 2014/15 of improving the Trust’s score in relation to the Friends and Family Net Promoter Score.

5.5.2 The approach the organisation took to health coaching

IES would describe the organisation’s approach as a ‘dipping a toe in the water’. Key steps were:

- Targeting nurses and therapists in clinical specialties who tend to have longer interactions with patients.
- Booking onto training courses.
- Team leaders reviewing whether to adopt.

Step 1: Targeting staff for training

According to the Site Co-ordinator, there was a growing interest in the Trust around tools to help deliver more active patient engagement in the management of their health conditions and self-care. Health coaching was viewed favourably at the outset and seen as a potential contributor to all those aims, fitting in with other initiatives such as Making Every Contact Count. Speaking in November 2013 she said:

‘The outcome would be the patient taking responsibility for controlling their weight, phosphate levels etc. and how the patients feel about their care and treatment… there is a new CQUIN coming out and we will have to offer the option to self-care on 15 points. Some are already doing it… So it could be very useful in terms of self-care, for the band 5 nurses… it would be helpful to get coaching to those people.’

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25 http://www.nnuh.nhs.uk/page.asp?id=14, accessed 15/10/14
26 http://www.nhs.uk/services/trusts/overview/defaultview.aspx?id=1102, accessed 15/10/14
While the health coaching training offer had been essentially open to all clinical staff, the Co-ordinator had tried to target those teams/individuals that had lengthier interactions with patients. The focus was on clinical specialties where staff typically spend more time with patients, such as outpatient clinics and day care wards. This seemed to have been based on the assumption that these staff would have longer term relationships with individual patients and more time in which to practice/use their new ‘skills’. Hence the final list of staff put forward for health coaching training had been drawn from four main groups:

**Research nurses** (who co-ordinate and administer research trials): the Trust is one of just 15 NHS Trusts/Foundation Trusts in England that have been appointed to run a local branch of the National Institute for Health Research (NIHR) Clinical Research Network, which carries out clinical research and gives patients access to cutting edge clinical care.

**Hand care specialists**: clinicians who work in the Hand Therapy Unit and whose role is to help guide patients’ recovery so that they regain as much hand function as possible following a hand injury or elective operation. This involves significant one-to-one communication with patients and advice-giving.

**Pain management specialists**: clinicians who work with patients offering advice on pain control, again involving significant one-to-one communication with patients.

**Renal medicine department staff**: staff in the renal medicine department include generalists and specialists and the role includes giving advice on diet and lifestyle as well as helping patients understand the dialysis procedures and options. These staff tend to have long term relationships with patients, some of whom are seen three times a week for outpatient dialysis.

In addition, one department had been nominated to adopt an inter-professional approach that would see all members of a multidisciplinary team sent together to the coaching. Unfortunately, this did not happen.

A range of clinicians attended six training programmes held during the period July 2013-July 2014. Health Education East of England records show that 37 participants from NNUH had attended health coaching training by the end of September 2014. The job titles recorded making up this population are shown in the table below. Note that the largest professional group trained are nurses with 25 trained.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>9</td>
</tr>
<tr>
<td>Research Nurses</td>
<td>6</td>
</tr>
<tr>
<td>Junior/Senior/Deputy Sister</td>
<td>5</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>4</td>
</tr>
<tr>
<td>Occupational Therapist Hand Therapy</td>
<td>3</td>
</tr>
<tr>
<td>Clinical Team Leader</td>
<td>2</td>
</tr>
<tr>
<td>Renal Education Sister</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
</tr>
<tr>
<td>Senior Research Nurse Manager</td>
<td>1</td>
</tr>
<tr>
<td>Assistant Practitioner Hand Therapy</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Nurse Manager</td>
<td>1</td>
</tr>
<tr>
<td>Iron Therapy Specialist Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Dermatology Research Nurse</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: HEEoE records, 2014

**Step 2: Booking staff onto training programmes**

From the outset, implementation within the Trust was said to have been hampered by problems with arrangements for the training. In the start-up phase of the programme, the training dates appeared to keep changing and a particular problem at NNUH had been late notification of the training dates and of cancellations.

‘First there was going to be one day, then two days, then Train the Trainer. Then the one-day [option] got dropped.

‘The notification was very late in coming - if you have to cancel clinics you can’t keep doing that. One of [my colleagues] said “The biggest issue was the course being cancelled at the last minute. We were closing off clinic slots in order to attend.” You can’t do that. So that’s a barrier. And not everyone who wanted to attend could attend. We roster people 8-12 weeks in advance - so three weeks for a date [i.e. three weeks advance notice of the date of a workshop] is too late. We need to have as much notice as possible.’

There had been a lack of flexibility regarding scheduling of the ‘Train the Trainer’ training. One person had wanted to attend this more advanced training but inflexibility regarding the dates meant that she could not fit it around her clinical duties.

Among our focus group attendees there were diametrically opposed experiences and views of the training itself. Clinicians within the focus group who
attended together on one programme had found their training programme to be very good, whilst those who attended together on a different programme described a poor experience which had not convinced or inspired them that health coaching was for them. A particular ‘bug-bear’ had been poor attendance control - several people turned up who were not booked but were allowed to attend, meaning that the room was too small for the ultimate size of group and the practice/feedback sessions were compromised.

In the second session participants had been asked to discuss different types of scenarios. Some had not been comfortable doing so in front of their colleagues – the number attending the session, along with the fact that they had been required to work in trios had meant they were working with people they knew. Some nurses commented on the ‘personal’ nature of the issues they had been required to discuss in the second day:

‘I felt it was almost like a counselling session and we had been asked to discuss things that were too personal. I did not feel comfortable doing so in front of my colleagues.’

There were several suggestions for how future sessions could be improved: restrict the number attending a session from any one unit to a maximum of four; ask participants to deal with a hypothetical scenario or issue (rather than suggest one); and/or have actors acting out pre-designed scenarios.

**Step 3:**
**Team leaders to review and decide whether to adopt health coaching within their team**

There were mixed views on the usefulness of both the training and the value of the health coaching initiative itself.

Teams/departments in which staff have longer term interactions with patients had been targeted during the selection process, as these were viewed as likely to have an ongoing relationship that would afford more opportunity for adoption of the coaching approach. However, many of the renal team staff attending IES’ focus group felt that, irrespective of long term relationship, a busy ward environment was not conducive to these types of conversation. Privacy was viewed as a key issue when attempting a health coaching intervention, but many interactions took place in busy public wards where people can overhear the conversation.

As one of the renal nurses said:

‘Ideally it [the coaching approach] needs a clinic, a one-to-one environment, in primary or secondary care perhaps, but not in a busy acute ward.’

Focus group participants felt that there was more of a chance that coaching could be expected to be useful and effective with some patient populations than with others. This was both in terms of the nature of their health problem and the stage at which the practitioner first has contact with them. Three of the renal team nurses mentioned population issues:

‘This is a patient population with chronic health needs and difficult health problems and so they are prime for coaching. It should help them manage their health in a more positive way. There is a long term nurse-patient relationship, close and trusting.’

‘While I found the course very interesting and informative and thought a lot of people could learn from it, what limits our ability to use a coaching approach is the nature of the populations with which many of us are working.’

‘I find it (health coaching) useful. I visit people at the beginning, when it is starting to impact their lives. A huge array of lifestyle adaptations are encouraged. How you cope, and the adaptations you make, impacts on how long you live. It’s very scary and new for people so it’s a perfect place to start.’

While there was some agreement about the choice of the renal patient population to trial the approach, there were questions about the utility of the coaching method for staff with different experience levels and in different settings. These may impact on the extent to which individuals can use coaching knowledge and skills effectively. Two of the renal nurses explained it thus:

‘Health coaching may work more for some staff than others. It might give a bit more structure to how people talk to patients. It’s not necessarily useful for everyone.’
‘Very useful in teaching people how to self-manage chronic conditions, especially those who were having multiple hospital appointments trying to seek a cure. It taught [me] how to help people feel like they were part of their cure and take ownership of it. It was helpful to have the techniques to engage passive patients and help them make positive changes.’

The Site Co-ordinator was sure that most of the teams were able to use their health coaching skills to some extent:

‘…the problem is [not having] the time to use it. One Research Nurse said it was ‘excellent’ and has used the training a little but not in an ongoing way, the way you could if you saw the patients in an ongoing way over time. The research nurses see the right sort of patient population and have the time to talk to them but don’t see them over the long term, only for the duration of the trial. So the kind of view that’s coming through is that where there is time to use it [it’s good] but the big issue is in our consultations we do have only limited time to have the in-depth conversation that’s needed. So yes we are using it... [but]…’

Similarly, one of the focus group participants said:

‘It’s helpful but there’s the issue of time to talk to the patient and location. But it’s a help.’

It was suggested that this type of programme might be more beneficial to newer staff, although there was also a view that the training would make established staff feel more confident about their approach to interactions with patients.

There was general agreement in the focus group that people with more patient contact were more likely to be able to use their skills to the benefit of the patient. However it was also believed that in the relatively short time (typically ten minutes) that some clinicians spent with patients a coaching approach could help the clinician structure the conversation and therefore make more effective use of the time.

Those who felt they could not use the training in their own clinical setting felt that they had therefore ‘wasted’ both a place on the programme and the time spent away from the workplace. One suggestion was that there needed to be more careful consideration of how people are selected for a place in future. Ideally participants should be those who have a lot of patient contact, ideally in private settings.

That said, it appeared that many recognised that the coaching approach could be used within much clinician-patient interaction; what was needed was an opportunity for clinicians to practice, with feedback and guidance, both within and following on from the formal training days.

The problems participants experienced are quite typical of the challenges seen in transferring new learning to the workplace. Models evaluating the effectiveness of training and development typically distinguish between the demonstration of skill in the training situation (‘learning’ or ‘acquisition’) and its use or application in the workplace (‘behaviour’ or ‘performance’). What is often required to make training fully effective is support for the use of new skills in the workplace. This is often in the form of mentoring or coaching to help people become more familiar with applying their skills at work, much as a newly-qualified nurse is assigned a preceptor or mentor for this purpose.

5.5.3 The future

The training was still ongoing in late summer 2014. There was a view that the teams that had undergone the training might begin to share their practice and ideas for how to best use these skills, and then to give presentations on the approach to other colleagues, in order to promote the coaching approach and encourage more people to sign up for the training. However, there were no further plans beyond that other than to ensure the remaining staff who had signed up were able to undertake the training. Given the lack of any consensual view on these developments, or the suggestion that any impact had been seen in terms of improved clinical or behavioural outcomes, no decision had been taken regarding further dissemination to the wider staff group:

‘It’s been beneficial but not in a huge range of disparate people.’

The Trust had not reached any decision regarding the future development or implementation of health coaching in the Trust in September 2014 when IES had its final contact with the site.

There is a question regarding the extent to which busy staff can promote such initiatives and indeed the effectiveness of attempting to do so on a site by site basis. A co-ordinated approach that engaged with organisations at all levels across a region might have more impact:
‘I feel the value of these things but it’s not the highest priority. I had to find the time on top of everything else. If they really wanted something like this to stick they’d be better off putting some money into a regional co-ordinator post. I can only do the little bits I can do, if you want consistency you should use the money not to buy odd days but put it into one central post who can go around and talk to primary care and the CCGs.’

Summary of lessons learnt

- Any training that requires clinicians to be away from an acute services unit has to be arranged with recognition of the fact that staff rosters are fixed many weeks in advance. There has to be a significant period of notice for such events - and of any changes to arrangements.

- There was a request for training programmes to incorporate scenarios of clinician-patient interactions that were more contextualised to a busy ward-based environment to enable health coaching principles to be rehearsed in familiar contexts.

- Clinicians need to understand better how they might utilise the coaching approach when they return to the ward or clinic. Mentoring or coaching and shaping of behaviour from local managers or ‘lead health coaches’ would help clinicians transfer the training to their daily roles and interactions.

- Ideal health coaching participants were said to be those who have a lot of patient contact, ideally in private settings. Whilst the clinicians we spoke to did not avoid talking to patients about their health issues in situations lacking privacy, the thought of engaging in a health coaching conversation within that situation appeared to disturb them.

- There was an idea that the coaching approach could be seen by the patient as threatening or intrusive. Some clinicians feel it requires them to deal with more personal issues than they normally would in certain, perhaps most, acute clinical settings. So it is crucial that clinicians achieve and maintain a high level of confidence in their ability or they will not put their newly acquired health coaching skills into their daily work routines.

- Some of the clinicians had a view of health coaching as a set of tools that has to be explicitly ‘done’, with little sense emerging of coaching as a tool could be used more generally as part of routine practice in talking to patients.
### Table 5.1: Summary of issues arising from case study organisations

<table>
<thead>
<tr>
<th>Sector</th>
<th>Approach taken</th>
<th>Lessons learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services</td>
<td><strong>95 clinicians trained + 6 clinician-trainers</strong>&lt;br&gt;1. Casting the net widely at the outset  &lt;br&gt;2. Clinicians selling the approach to peers  &lt;br&gt;3. Getting support from senior stakeholders  &lt;br&gt;4. Rolling out training internally at scale and pace  &lt;br&gt;5. Documenting the evidence</td>
<td>Managed as an organisation-wide long-term ‘culture change’ initiative&lt;br&gt;• A health coaching-friendly organisation culture was an enabling factor for success.  &lt;br&gt;• Concept sold successfully as a new way of relating to old problems.  &lt;br&gt;• A group of internal clinician-trainers provided opportunities for mutual support and momentum to inform further roll-out.  &lt;br&gt;• A cadre of internal trainers requires ongoing investment of local resources to release clinicians to deliver training and ongoing support/CPD.  &lt;br&gt;• Engaging the Chief Executive and other leaders early proved extremely helpful in making the necessary resources available for roll-out.</td>
</tr>
<tr>
<td>CCG Commissioner</td>
<td><strong>27 clinicians trained + 1 clinician-trainer</strong>&lt;br&gt;1. Targeting the ‘right’ individuals to support Integrated Care Agenda  &lt;br&gt;2. Tapping into local resources and persuading people to participate  &lt;br&gt;3. Focussing on outcome measures</td>
<td>Managed as a project supporting a commissioning priority&lt;br&gt;• Promotion from a CCG linked to a commissioning priority resulted in take-up of training across all 20 practices.  &lt;br&gt;• Impact data is needed to support the spread.  &lt;br&gt;• Despite the constraints of ten-minute appointment slots, some are using health coaching successfully.  &lt;br&gt;• Refresher training will help hone confidence and skill.  &lt;br&gt;• Awareness training for senior clinicians who do not need the full skillset would be helpful.  &lt;br&gt;• Support for isolated local trainers required so that the investment made will reap the benefits.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td><strong>33 clinicians trained + 1 clinician-trainer</strong>&lt;br&gt;1. Clear link to new ways of working and National Recovery Model  &lt;br&gt;2. Targeting nurses and Improving Access to Psychological Therapies (IAPT) practitioners  &lt;br&gt;3. Rolling out through HR Strategy</td>
<td>Managed as ‘skills acquisition’ training to support new ways of working&lt;br&gt;• Quality of training praised.  &lt;br&gt;• Training attendance should be voluntary.  &lt;br&gt;• Some difficulties with transferring learning into clinicians’ everyday routines; support locally after training may help.  &lt;br&gt;• Refresher training would be welcomed if made available.  &lt;br&gt;• Demand exists for more ‘Train the Trainer’ places if made available.  &lt;br&gt;• Difficult organisational context (e.g. reorganisation, job insecurity) can have negative implications for learning.</td>
</tr>
</tbody>
</table>
### Primary care (General practice)

**0 clinicians trained**

1. Designing a test pilot
2. Clinicians to receive training
3. Support requested from CCG
4. Reviewing results

**Planned (but not implemented) as a ‘research’ project**

- Selling the concept and value of HC to GPs needs resource.
- Accessing two full days of training can be difficult especially for clinicians in small practices. Roll-out may need alternative training delivery model(s).
- Highly valued by some individual clinicians as an easy to use ‘mind-set’ within ten-minute appointment slots.
- Many examples given of successes with patients.
- Little evidence as yet of practices thinking strategically about where and how best to target health coaching.

### Acute services

**32 clinicians trained**

1. Testing health coaching (HC) as tools to support patient self-management
2. Targeting specialties with longer interactions with patients
3. Booking onto training courses
4. Team leaders reviewing whether to adopt
5. No plans for roll-out

**Introduced as a ‘new training intervention’ to be tested**

- Major difficulties in transferring learning from the training to daily roles.
- Some clinicians using HC successfully especially those with high job autonomy and/or specialist roles.
- Local mentoring, championing or line management support needed for individual clinicians.
- Concern over lack of privacy for coaching conversations in busy acute wards.
- A view of health coaching as a set of tools that has to be explicitly ‘done’ to patients.

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27 No-one from this pilot site was trained within our evaluation timescale although many clinicians from within other primary care settings were trained. IES therefore selected three GPs and two practice nurses (from five different general practices) for interview to hear their experiences of using health coaching and their views on how useful it was.

28 Not from case study - lessons learned from interviews with GPs and nurses in range of other practices

29 As above

30 As above
6 Management and financial implications

The third aim of the evaluation was to liaise with and support local representatives in identifying outcome data relevant to their unique context and examine evidence of impact in terms of health outcome improvements or consequences for organisations. As outlined in the case study reports, HEEoE did not in the end require sites to target their health coaching implementation at particular patient groups or conditions and neither did the sites set up their pilots to measure clinical data or health outcomes in any targeted manner. In that sense the pilot might be considered an uncontrolled pilot.

It would be useful for future local research projects or evaluations to compare actual number of patients, throughput and costs at the whole team level, ideally covering multiple teams and over a significant period. According to literature reviews of health coaching, healthcare costs is an area where the evidence base is currently ‘insufficient’ and more research is needed before a conclusion can be reached on whether health coaching assists health providers in handling increasing demand for services or in reducing healthcare costs. Whilst a number of studies have found reductions in hospital admissions, other studies have found increases in average cost per patient. Organisations within the East of England are ideal locations for researchers able to conduct research in service usage and costs.

IES was however able to explore with individual clinicians the claims they made about benefits to the wider healthcare system and in one case to compare numbers of patient appointments conducted pre-and post-training in health coaching.

In this chapter we reflect on the management and financial implications for NHS organisations. This approach was informed by the claims of two clinicians, who believed that health coaching had led to three types of benefit:

- Increase in new patient throughput.
- Cost saving from reduced clinical time.
- Potential cost saving from preventing secondary care admissions.

In order to examine the clinicians’ views regarding the management and financial implications for the case study organisation and the wider local healthcare system IES suggested auditing departmental records containing relevant data. Additional local management data were provided to IES by CCS and its partner organisations (e.g. on activity and costs) usually by team leaders and/or finance departments. We also referred to national tariffs on service charges.

6.1 Increase in new patient throughput by one community physiotherapist

IES had a series of discussions and email exchanges with the Senior Community Physiotherapist who provided us with the vignette below. She had claimed that by adopting a health coaching approach she had been able to reduce her existing caseload and (as a consequence of this) increased the number of new patients added to her caseload.

Example of reducing clinical time

Jo Wallis, Community Physiotherapist

The patient

A gentleman with Chronic Obstructive Pulmonary Disease (COPD) and some other issues was living downstairs in a two-storey dwelling with his wife (who had a failing memory).

Using health coaching

The patient had already had eight sessions (home visits) with an assistant practitioner using the regular approach of working towards 20 repetitions of exercises twice a day, which ‘got nowhere.’ When the Senior Community Physiotherapist inherited the patient it seemed like a good opportunity to try a different health coaching approach. She had two sessions with the patient. At the first session she asked him what he felt the benefits of exercise were, what he liked doing before his illness, what he didn’t used to like doing and what he felt he could do now. He realised that his condition had deteriorated a lot since then and that his expectation of being able to walk around the

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31 E.g. The Evidence Centre (2014)
32 E.g. Parry et al. (2009) and Coleman et al. (2006)
33 E.g. Steventon et al. (2013), Cate et al. (2014) and Turkstra et al. (2013)
village again was probably unrealistic. Instead he identified that he really wanted to climb the stairs so he could see photos of his grandchildren on the computer. He created options to achieve his goals. He renegotiated his exercise regime by saying ‘If I don’t do all my exercises I won’t be tired and I could climb the stairs instead.’ She agreed that was a good bargain because climbing the stairs would meet his current exercise need.

At the second session they reviewed what he had achieved. He was getting upstairs and it was working well getting other people to prompt and support him in his exercise, so the whole responsibility didn’t fall onto his wife. He was happy and there was no need to book a further session.

The patient died three months later.

Outcomes

For the patient - Improved quality of life. After a while he had got upstairs and down again once a day. Although he was finding it very tiring he was very happy to have achieved something so valuable to him as seeing images of his ‘beautiful grandchildren’ living abroad. The activity was helping his overall health although his COPD had become advanced.

For the professional - It felt ‘empowering.’ She said:

‘If patients weren’t getting anywhere we would discharge them. Instead we re-visited what could be done. In just two health coaching sessions we improved the quality of the remainder of his life. I feel my time with him was worthwhile.’

For the NHS - Reduction in clinical time.

The Physiotherapist said:

‘This case serves as a useful comparison between our usual clinical practice and what is possible taking a health coaching approach with COPD patients. This patient happened to live right on the edge of our patch so there was considerable travel time. He had six sessions using our normal approach which took on average 40 minutes each. That comes to four hours of clinical time plus five hours of travel time and in this case unfortunately the approach didn’t get results. The health coaching approach took two sessions of up to 40 minutes each. That comes to three hours and 20 minutes of clinical and travel time and resulted in an improved quality of life. In this case that’s a potential saving of five hours and 40 minutes demonstrating the possible benefits for each patient that we can use health coaching with.’

The clinician said she has four other COPD patients herself at present and among the team there are many more.

Source: IES interview, 2014

We asked the clinician to verify her claim through an audit of departmental records.

Then we asked for data on the total number of appointments over the six month period prior to her attending the health coaching training programme and again for the six month period following training.

These data are presented in Figure 6.1 below:

Figure 6.1: Comparison of one clinician’s number of appointments before and after using health coaching (part-time clinician working 30 hours per week)
Figure 6.1 shows reduction of 57 in the number of follow-up appointments and an increase of 28 new patient referrals between the comparison periods: from 55 patients in the six months before using a health coaching approach to 83 afterwards (51 per cent increase). The ability to take on more new referrals is likely to be helpful in reducing patient waiting times for high-demand therapy services.

Some academics warn that caseload data can be misleading.\(^{35}\) Health coaching might for instance have just been used on the less high risk or most straightforward patients to reduce the caseload. Whilst this would allow more time to treat the higher risk or more complex cases, targeting higher risk cases for health coaching might result in the same caseload but has more potential for longer term benefits for the NHS. In our example the clinician says she was using the health coaching mind-set with all her patients. Departmental records also show that the percentage of her patients who have LTCs is approximately 40 per cent and this has remained consistent in the periods both before and after health coaching training. However the key issue is what happens to the patients, not just what proportion of cases they constitute.

There are various ways of interpreting Figure 6.1 which also shows the total number of appointments worked (working 30 hours per week) has reduced from 332 to 303. This would seem to confirm the clinician’s comment\(^{36}\) to IES about the benefit to her as a clinician:

‘One thing that I have noticed in my diary is that I am no longer squeezing in patients into time I don’t have... I am also working in my contracted hours rather than doing extra as I used to.’

*Physiotherapist, community*

It could be argued that if the clinician was working more effectively, shouldn’t she be fitting in more patient appointments overall rather than less? A reduced number of total appointments may not on the surface seem like an increase in throughput. If you spend less time with a patient (because you are more effective) you would be more likely to see more new patients, as in this case. However the number of new patients is less than the fall in number of follow-up patient appointments. So without something to back up the reduced working hours claim, one could argue that the clinician might be spending more time on these fewer appointments?

It would be useful to see if this increase in throughput of new patient referrals is sustained over time with this one clinician. We need to see this exercise repeated with large numbers of clinicians and over a longer period of time. It may be that after an initial burst of post-training enthusiasm clinicians return to their previous non-health coaching approaches. Alternatively we can speculate that this may be a one-off dramatic benefit in terms of caseload reduction followed by period of reduced throughput (albeit it still at a higher level than pre-health coaching training). Without further research we do not know.

### 6.2 Cost saving from reduced clinical time

Several clinicians from primary and community settings claimed that health coaching enabled them to reduce total patient contact time. The reason given for this was mainly because more effective interactions with patients who self-manage meant that they did not come back so often. Using the reduced clinical time identified by the community physiotherapist in the COPD patient vignette described earlier in this previous chapter, IES used three steps to calculate the cost saving from her using a health coaching approach compared to the usual approach used by her colleague, as shown in Box 1 below.

**Box 1: Cost of usual approach versus cost of health coaching approach**

1. **Compare the actual time spent (in hours) using each approach**

The first clinician used 9 hours working time using the usual approach (which was unsuccessful in this case). The second clinician used 3 hours and 20 mins working time (3.33 hours) using a health coaching approach (which was successful in this case).

2. **Assign a monetary value/cost to the time spent (in pounds)**

Using the mid-point salary for each Grade plus on-costs:\(^{37}\)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Annual Full Time Salary</th>
<th>On-costs</th>
<th>Total Salary</th>
<th>Hours</th>
<th>Cost per Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>£24,846</td>
<td>£24,846</td>
<td>£49,692</td>
<td>9</td>
<td>£114.66</td>
</tr>
<tr>
<td>6</td>
<td>£36,193</td>
<td>£36,193</td>
<td>£72,386</td>
<td>3.33</td>
<td>£61.81</td>
</tr>
</tbody>
</table>

Annual full time salary for second clinician (Grade 6) plus on-costs of £36,193, divided by 1,950 hours paid for per year (52 x 37.5) multiplied by 3.33 hours = (36,193/1,950) x 3.33 = £61.81

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\(^{35}\) IES expert interviews, 2013. 
\(^{36}\) Email to IES lead researcher, 06/10/14. 
\(^{37}\) Salaries plus on-costs supplied by CSC 24/09/14.
3. Compare the costs and work out any cost savings of using the health coaching approach (in pounds)

The saving in this example had the patient received only the treatment from the second clinician using the health approach would have been £52.85 calculated by:

Cost of usual treatment £114.66 minus cost of treatment using health coaching £61.81 = 114.66 - 61.81 = £52.85.

The percentage saving of using health coaching in this example is 54 per cent calculated by:

Cost of health coaching treatment divided by cost of usual treatment = (61.81/114.66) x 100 = 54 per cent

Source: IES/CCS, 2014

As Box 1 shows the cost saving of reduced clinician time in this real-life example was 54 per cent. Health coaching training has been open to all clinicians whatever their grade so in practice both these clinicians could be working differently in the future and both might be expected to have achieved similar results in terms of reduced clinical time to achieve an outcome they considered successful. Therefore it would be more sensible to compare the costs of each clinician using the usual approach, compared to each using the quicker health coaching approach.

Potential cost saving for Grade 4 Physiotherapy practitioner is £(24,864/1,950) x 5.66 = £72.17 (63 per cent saving).

Potential cost saving for Grade 6 Senior Physiotherapist is £(36,193/1,950) x 5.66 = £105.05 (63 per cent saving).

6.3 Scaling up reductions in clinical time per patient

The third issue we wanted to explore with the Physiotherapist and local management was scaling up the reduction in clinical time example from the level of one patient to all the patients of that clinician. Assuming a conservative 80 new patients over 12 months (for a clinician working 25 hours a week) that is a potential saving in clinical time for our Grade 6 Physiotherapist equating to £8,404 per year (80 x £105.05). This equates to £12,438 per year for a full-time equivalent.

Note, though, that this assumes that the effect is sustained over time. It is also possible that some patients may be more receptive to a health coaching approach than others (which will tend to reduce average benefit) while the time taken for clinicians to reach patients in their homes will vary, so the actual clinical time saved (and cost equivalent) could be more or less than this. Nevertheless this provides an indication of what might be possible for an individual clinician to achieve in a community-based therapy service.

Ideally we would also like to have scaled up from the level of one clinician to the whole team level. As the physiotherapist commented:

‘Health coaching has created the potential to change how the whole team support patients. The potential cost saving in our modest team alone could be significant.’

The plan locally is for the whole ten-person South Cambridgeshire Therapy Team to be trained in health coaching. The team work a variety of contracted hours with most being part-time. Some team members have already been trained in health coaching while the others were booked on future programmes at the time of our evaluation. Therefore calculations based on actual savings for all the clinicians and assistants using pre-and post-training service/departmental data is not yet possible. Nevertheless it is clear that potentially there are considerable savings that might be made at the team/service level.

6.4 Cost savings from preventing acute outpatients admissions

Another way of looking at financial implications raised by the clinicians is in terms of preventing admissions or re-admissions to other parts of the health system. Potential cost savings from preventing admissions can be thought of as an anticipated future benefit to the health system. IES explored a little further a claim from another CCS clinician, the Podiatry Business Manager and Lead Podiatrist, relating to her efforts to prevent outpatients admissions following toe traumas. The Podiatrist started by explaining how using a health coaching approach fed through to the way she handles complaints:
Fortunately the service doesn’t get many complaints. Before coaching I used to respond to complaints by letter with apologies but now I go out to see each patient so they can “tell me about it from your point of view” and “what can we do better?” The feedback from the visits was brilliant. As a result of one conversation I am designing a new leaflet on what to do after a toe trauma. The patient was very happy to be involved in a change being made. The NHS also benefits because if other patients in the same situation know they need to come back to us quickly it will avoid the extra costs incurred: in this case six IV [intravenous antibiotic] appointments as an outpatient, two community matron appointments and a hospital referral back to us.’

The clinician says it is hard to know if she might have done the leaflet anyway without the health coaching, but certainly it is because of the coaching that she now involves team members and patients in complaints handling more, which in this case resulted in the need for the leaflet being identified. So whether direct or indirect she attributes 100 per cent of the benefit to the health coaching approach.

IES explored the costs associated with toe trauma in more detail. According to the Podiatrist we interviewed, it is not a question of preventing the toe trauma per se, rather it is to ensure that a patient who has been discharged from the podiatry service understands that if the toe deteriorates then they should contact the podiatry service immediately. The podiatry team would then resume treatment as part of their normal caseload. It is the delay that can result in an acute outpatients admission and follow-up from other community services.

Using local data supplied by the Trust and with reference to national tariffs, the cost of not returning straight to podiatry service comprises:

Six intravenous antibiotic outpatients appointments is in the region of £119 for the first visit plus £70 for each of five follow-up visits
£119 + (5 x 70) = £469

Two community matron appointments is in the region of 2x £22.18 = £44.36

There is no additional cost to the podiatry service since they would be treating the patient on a regular basis if he had returned sooner.

Total additional cost £469 +44.36 = £513.36

The clinician argues that the object of the leaflet is to raise awareness among patients of the need to reconnect straightaway with the podiatry service. If this patient action prevents any future patients from acute service outpatients admissions then that would result in a cost saving to other parts of the health system of approximately £513 per patient.

### 6.5 Articulating benefits

East of England’s own surveys of health coaching training participants asked clinicians whether they believed that using the health coaching approach had led to positive outcomes which had (or would) result in financial benefits to the NHS. In the June 2014 survey, 65 per cent of clinicians who responded thought there were financial benefits to the NHS. No-one offered any figures and many respondents cautioned that it was difficult to measure the financial impact, it was too early to say and it was difficult to say that it was health coaching alone that resulted in the change. Nevertheless the open text comment boxes pointed to actual or future savings likely to arise from:

- Fewer tests and inappropriate activities needed.
- Fewer follow-up appointments needed by self-managing patients.
- Reduced pharmacy costs and wastage through improved compliance.
- Reduced demand from patients making healthier choices.
- Reduced supplier-led demand.

From IES’ interviews with clinicians we would also add financial benefits identified arising from:

- Reduction in operational costs.
- Increase in personal productivity.
- Improved staff retention from happier more resilient clinicians.

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39 Costs supplied by CCS, 2014.

40 HEEoE surveys, reported on in Health Coaching for Behaviour Change: Interim Progress Report, HEEoE, June 2014.
7 Conclusions and discussion

7.1 Summary of lessons learnt

From the interviews with clinicians, we saw the majority found health coaching a highly valued mind-set for individual clinicians who are able to provide examples of successes with a range of patients in a variety of contexts. Health coaching seems to have been adopted by some clinicians as a ‘mind-set’ which has been fully integrated into their daily practice; for others it is a set of basic skills, ‘tools’ or a mode of working to use selectively in specific practice situations. It seems, either way, that these early-adopters perceive health coaching as an enabler or solution in advancing the overall aim of patient self-management. Health coaching techniques are thought to provide a way of structuring (difficult) conversations, a means of going about things in a more ‘person-centred’ way and enabling effective goal-setting. The minority are not ‘sold’ into the concept and/or do not intend to coach their patients in the immediate future. Within this overall picture:

- There is a wide spectrum of reactions among those who find health coaching useful. For many clinicians using health coaching has been revolutionary involving ‘light bulb’ moments leading to fundamental changes in their own mind-set and practice, and major improvements in the health behaviours of their patients. For others the claims are more modest: it is useful for supplementing what they already do for greater impact.

- Health coaching had been used during the pilot phase on patients involving: chronic depression, weight management, smoking cessation, foot ulcers, chronic pain, diabetes, COPD, poor kidney function, PTSD, anxiety, coronary heart disease, chronic fatigue syndrome and hypertension. It is also likely to be used for patients with eating disorders, IBS and more generally with those who are presenting unwell, tired and overweight or with very embedded behaviour.

- Benefits for clinicians reported included: greater confidence and resilience, a more sustainable way of working in the face of growing workload pressures, an approach for difficult conversations and ‘heart sink’ patients, reductions in caseload, less ‘what do I do next?’ phone calls and patients saying thank you more.

- Benefits for patients reported by clinicians included: more confidence in their own abilities, more realistic idea of what’s possible for them to achieve (given their condition), better support systems (can

Summary of recorded outcomes

- Fifty-one per cent actual increase in new patients onto one clinician’s caseload following adoption of health coaching approach.

- Sixty-three per cent indicative cost saving in using a health coaching approach when compared to using the usual approach in one patient case.

- Potential saving of £12,438 per year full-time equivalent Senior Physiotherapist in reduced clinical time to treat existing patient numbers (assuming reduction in clinical time is replicable over time and across all patients).

- Potential saving of hundreds of thousands of pounds per year per team/service (assuming reduction in clinical time per patient is achieved by all team members following training).
engage the whole family in helping), greater patient satisfaction, saves time and cost of coming back again, more activity and mobility, more motivation, and a greater sense of achievement.

- Benefits for the wider NHS reported by clinicians include: dealing with patients more effectively and efficiently, greater productivity, reduction in the number of episodes of care, and potential for getting through waiting lists quicker.

- Health coaching was thought to have a potentially major role in general practice with health behaviour change and chronic disease review.

- Refresher training, if made available, would be welcomed by many clinicians to help hone confidence and skill.

- Awareness training for those who do not need the full skill set was requested.

From the variety of ways of implementing health coaching taken by the case study sites in their different clinical settings, we can identify a number of key success factors and lessons, as summarised below:

- The organisation's readiness affects the ability of clinicians with limited autonomy to transfer their learning to the workplace. For instance we saw that a health coaching-friendly organisation (one with an open culture where innovation and learning are encouraged) was an enabling factor, whereas a difficult organisational context (one in the midst of reorganisation with job insecurity) can have negative implications for learning.

- The process of implementation also makes a difference - we have seen success from a bottom-up approach with clinicians selling the approach to their peers initially and then getting support from senior leaders and stakeholders to access the local resources needed for roll-out locally.

- The message of health coaching as a new way of relating to old problems has resonance with many clinicians, especially with ‘heart sink’ patients.

- The clinical setting affects the ability of some clinicians to apply their learning to their daily roles and interactions at work. Ideal health coaching users were said to be those with a lot of patient contact who interact with patients in private settings. Coaching, mentoring or team manager support locally after training may help clinicians overcome perceived barriers in other settings.

- Difficulties in accessing the training was an issue in General Practice. Local trainers rolling-out the training may need to consider alternative delivery models (not two full days). We also saw that support and promotion from a CCG linked to a commissioning priority resulted in higher take-up of training across general practices.

- Some clinicians cite the limitations of fixed length appointments in using health coaching tools but, despite the constraints of appointments, other clinicians are finding a health coaching ‘mind-set’ or ‘mode of operating’ easy to use.

- It is too early to establish if the ‘Train the Trainer’ model of embedding health coaching has trained enough clinician-trainers to facilitate scale-up of health coaching within the East of England. A group of internal trainers provided opportunities for mutual support and momentum to inform further roll-out. However, a cadre of internal trainers requires considerable ongoing investment of local resources to release clinicians to deliver training and ongoing support/CPD and this may have been underestimated at the start. Ongoing support for isolated local trainers is required so that the investment made will reap the benefits and prevent those most enthused losing heart. More clinicians are willing to become internal trainers if another programme is made available.

Finally, further data analysis in collaboration with one case study site identified:

- Fifty-one per cent actual increase in new patients onto one clinician’s caseload following adoption of the health coaching approach.

- Sixty-three per cent indicative cost saving in using a health coaching approach when compared to using the usual physiotherapist approach in one patient case. When scaled-up this equates to a potential saving of £12,438 per year for one clinician in reduced clinical time to treat existing patient numbers (assuming reduction in clinical time is replicable over time and across all patients). Potentially therefore a saving of hundreds of thousands of pounds per year per team/service might be possible (assuming reduction in clinical time per patient is achieved by all team members following training).
7.2 Discussion

7.2.1 Education innovation versus organisational change intervention

Health coaching has been described and promoted within the East of England pilot documentation primarily as an innovative educational/training intervention directed at clinicians (see flyer and Newman 2014). But the way the pilot programme has been managed and the effort put into building up clinician-trainers and a co-ordinator infrastructure locally points to the health coaching programme as an Organisation Development or Organisational Change intervention. The two are not mutually exclusive. Indeed training is often the first step leading to new ways of working which can lead to major changes in the way organisations operate. However it can be confusing to those hearing apparently different health coaching messages for the first time. Whilst some organisations and some clinicians did not take-up the training intervention during the timeframe of the pilot, or chose not to put the health coaching mode of working into practice, it does not mean that they will not wish to do so at a later date once they better understand what health coaching is and if they are given another opportunity. As we saw from the evaluation case study sites the degree and nature of the engagement with the health coaching programme was very different: some organisations operated on the basis that this was a purely training intervention (e.g. NNUH) and some perceived it from the outset as an OD/Change intervention (e.g. CCS & NNCCG).

It may be helpful for local promoters to reflect on the potential organisational change aspect, or their current progress, with reference to three well known change models The Change Curve (at individual clinician level), The Change Adoption Curve (at team/service level) and The Gleicher Change Formula (at the whole organisation level).

The Gleicher formula for change (Dannemiller and Jacobs, 1992) for example provides a model to assess the relative strengths affecting the likely success of organisational change programmes. The model suggests that three factors must be present for meaningful organisational change to take place.

These factors are:

\[ D = \text{Dissatisfaction with how things are now} \]
\[ V = \text{Vision of what is possible} \]
\[ F = \text{First, concrete steps that can be taken towards the vision} \]

If the product of these three factors is greater than:

\[ R = \text{Resistance} \]

then change is possible. Because \( D, V, \) and \( F \) are multiplied, if anyone is absent (zero) or low, then the product will be zero or low and therefore not capable of overcoming the resistance.

According to the model, to ensure a successful change it is necessary to use influence and strategic thinking in order to create a vision and identify those crucial, early steps towards it. In addition, the organisation must recognise and accept the dissatisfaction that exists by listening to the employee voice while sharing sector trends, leadership ideas, best practice and analysis to identify the necessity for change. If the training in health coaching were to be more overtly positioned as the first concrete steps towards an overall vision of health services with patients as more active self-carers, then this may help to reconcile potential confusion in the future.

At a macro level within the NHS there may be great dissatisfaction and concern with the present state and the prospect of ever increasing demands on the service coupled with financial pressures and government priorities. There is also a clear articulation of the need to do things differently. If health coaching is to take hold, this model might lead us to speculate that it might be better positioned as either the vision for the future OR as a first step towards a vision. Either way this would require a more top-down approach to rolling out health coaching instead of the current bottom-up approach.
7.3 More evidence required versus different evidence?

If there is a top-down approach through a national system-wide implementation scale-up, there is a case for an accompanying research strand of activity collecting evidence on clinical outcomes and healthcare costs through a series of controlled research projects. The ‘proof of concept’ undertaken in Suffolk has already measured self-efficacy and the present qualitative evaluation of the large scale pilot across the East of England has mainly collected self-reports of impact.

It would be useful for future local research projects or evaluations to compare actual number of patients, throughput and costs at the whole team level, ideally covering multiple teams and over a significant period. According to the literature review of health coaching commissioned by HEEoE41, healthcare costs in particular is an area where the evidence base is currently ‘insufficient’ and more research is needed before a conclusion can be reached on whether health coaching assists health providers in handling increasing demand for services or in reducing healthcare costs. A recent management consultancy report (KPMG, 2014) estimated that activated patients could save providers 8-21 per cent of costs. Whilst a number of research studies have found reductions in hospital admissions42, other studies have found increases in average cost per patient.43

Organisations within the East of England are ideal locations for researchers able to conduct research in service usage and costs. IES understands that a randomised controlled trial is being planned in one organisation in Norfolk and another study with a control group is at the early research design stage by a service team in Cambridgeshire. We hope that these and other local research projects will consider three types of measure: self- efficacy, health outcomes and healthcare costs. Such research projects will be an invaluable contribution to the evidence base about health coaching.

8 Recommendations

8.1 Rolling out health coaching training

- Future roll out should prioritise clinicians in primary care and community care settings where future investment in health coaching training may see the quickest returns.
- Local NHS organisations should think more strategically about where and how best to target health coaching (so that it aligns and supports their wider strategies). This will help determine which clinical services and which patients to select.
- Explore future funding options and business models. There is demand for more training from clinicians and organisations within the East of England. It would be helpful if training was provided at no cost to individual clinicians.
- Consider additional training delivery models. An alternative to the tried and tested two full days of training is particularly important for GPs and practice nurses.

8.2 Improving transfer of learning to workplaces

- More local support is needed to help individual clinicians to overcome perceived barriers to using health coaching in some daily roles. Local mentors, champions, lead health coaches or line managers are potentially all suitable support options.
- Organisational support systems need to be in place to enable health coaching skills to be widely adopted and embedded, e.g. an organisation culture that values innovation and learning and support for health coaching from leaders.
- NHS organisations should be clearer about what they hope to gain, what their success criteria is and how it will be measured and whether any adjustments to the clinical environment might be needed.

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41 The Evidence Centre (2014).
42 E.g. Parry et al. (2009) and Coleman et al. (2006)
43 E.g. Steventon et al. (2013), Cate et al. (2014) and Turkstra et al. (2013)
8.3 **Role of internal NHS clinician-trainers**

- NHS clinician-trainers should primarily focus on providing training in health coaching within their own organisations where their credibility, knowledge of the clinical settings and experience in applying health coaching is greatest.

- Refresher training and support for newly trained clinicians could be provided locally by clinician-trainers.

- Local clinician-trainers need ongoing support and an operational infrastructure to be effective. Continuing professional development and training (as a trainer) and access to materials and external supervision will still be required by all clinician-trainers on an ongoing basis.

8.4 **Further research**

- Quantitative research is now needed on clinical outcomes and costs from health coaching in UK settings to add to the improvements in patient self-efficacy seen in the ‘proof of concept’ Ucs evaluation and the positive clinician views explored in the present qualitative IES evaluation of the ‘large scale pilot’.

- It would be useful for future local research projects or evaluations to compare actual number of patients, throughput and costs at the whole team level, ideally covering multiple teams and over a significant period.
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