

Health Coaching – Area Delivery Template



This document outlines how commissioners and providers might set about developing health coaching capabilities amongst health professionals. It focuses on the role that can be played by a central supporting body or network in sustaining and building a culture of coaching across a particular organisation, set of organisations or locality.

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This document should be read in conjunction with the Quality Framework for Health Coaching – a framework to inform all those seeking to commission health coaching training programmes aimed at the development of coaching skills for health professionals within their organisation or locality. Based on the available research evidence and best practice examples, the framework provides a set of quality standards, an overview of the policy context and examples of strategies and best practice, as well as listing useful references and further resources. To obtain the framework, please [click here](#) [1].

Why Health Coaching?

There can be multiple purposes for health care professionals to pursue a health coaching approach: patient activation, self-management and satisfaction; better health outcomes; reductions in unnecessary admissions and health professional well-being. The Five Year Forward View emphasises the importance of self-management, and Health Coaching has been identified as one of the five key interventions by NHS England in their 2016 substantial self-care programme. The evidence base indicates potential in improving motivation to self-manage, improving the adoption of healthy behaviours, and improving health outcomes for patients, with evidence to suggest reduction in health service use and health care costs [2]. Studies also indicate the potential to reduce unnecessary hospital admissions [3].

There is increasing interest in training health professionals in the conversational and behaviour change skills they require to pursue a health coaching approach, and numerous programmes and initiatives are developing at a local level. This paper outlines activities that could be delivered centrally to add value to the diversity of local programmes, and vice

versa, acting to maximise the value of associated programmes, and to sustain and embed the approach across an area over time.

Rationale

The activities set out below are based on fifty or so conversations with commissioners, providers, champions and experts of health coaching training and related workforce development programmes around the country. From this research, it was found that one of the most effective ways of encouraging the spread of health coaching training at a regional level has been supporting and encouraging leaders and champions of this approach. This suggests that the provision of central support of this kind will be a powerful way of enabling these leaders and champions to add value at a local level.

Health Coaching has been defined as a patient-centred process that is based upon behaviour change theory and is delivered by health professionals with diverse backgrounds [4]

[1] <https://hee.nhs.uk/hee-your-area/north-central-east-london/our-work/attracting-developing-our-workforce/multi-professional-workforce/health-coaching>

[2] The Evidence Centre (2014) 'Does Health Coaching Work? Summary of Key Themes from a Rapid Review of Empirical Evidence' www.cpa.org.uk/.../reviews/CPA-Rapid-Review-Health-Coaching.pdf

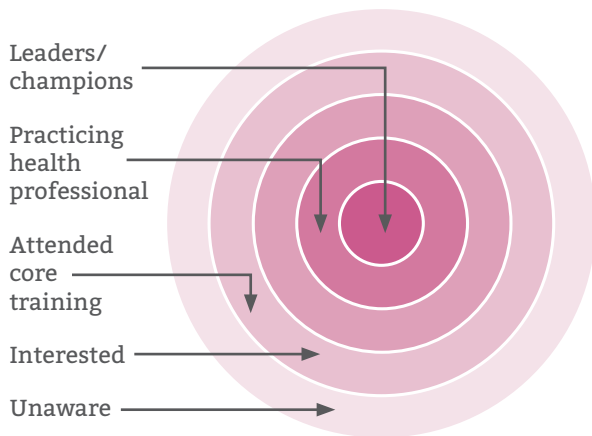
[3] Kibble, S. et al (2014) 'Recovery coaching in an acute older people rehabilitation ward', *BMJ Qual Improv Reports* 3, <http://qir.bmj.com/content/3/1/u205646.w2316.full.pdf+html>

[4] Wolever, R. Q. et al (2013) 'A Systematic Review of the Literature on Health and Wellness Coaching: Defining a Key Behavioral intervention in Healthcare' <http://www.ncbi.nlm.nih.gov/pubmed/24416684> *Glob Adv Health Med.* 2 (4): 38-57

Targeting Support

In order to effectively target this support, we suggest that it will be useful to map the different audiences for health coaching training and development. For this purpose we provide a model, adapted from the Innovation Unit's model of nested communities [5], based on research showing that segmentation of audiences of this kind helps with the process of embedding innovation.

We can identify five different audiences:



- **Leaders / champions** – these are the health professionals who are most active with health coaching (and core coaching) activities. This is not limited to their practice in conversations with patients, but is also applied in management, in meetings, and more broadly as leaders/champions work to co-design systems. This community is likely to include the trainer role and existing coaches as identified in the specification

- **Practicing health professionals** – these are health professionals who are already practicing coaching skills with patients on a regular basis. It's likely that, in addition to attending the core training, they have engaged with embedding activities to keep their skills updated and get regular feedback

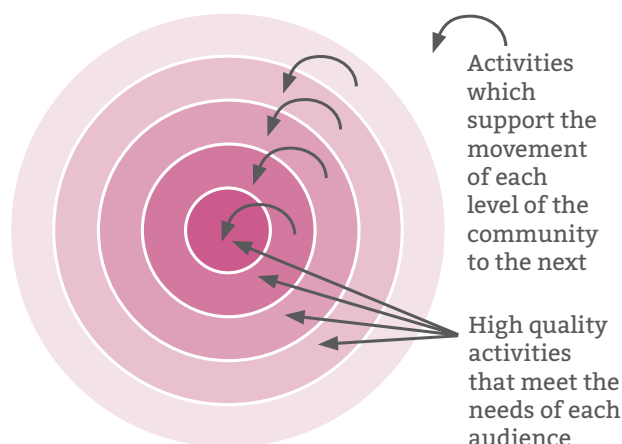
- **Attended core training** – these are health professionals who have attended an immersive health coaching training course which remains the most common method of developing skills in this approach

- **Interested** – these are health professionals who have not yet attended the core training, but have perhaps heard about it and / or have experienced a leader / champion in their advocacy

- **Unaware** – health professionals who are as yet unaware of the approach and associated development activities

While this is a simple model, its utility is that it requires any genuinely sustainable programme to have activities which meet two objectives:

- **High quality activities that meet the needs of each audience**
- **Activities which support the movement of each level of the community to the next**



[5] Albury, D. (2015) 'Myths and Mechanisms: a brief note on findings from research on scaling and diffusion', [www.innovationunit.org/sites/default/files/MYTHS%20AND%20MECHANISMS%20\(1\).pdf](http://www.innovationunit.org/sites/default/files/MYTHS%20AND%20MECHANISMS%20(1).pdf)

Audience	Activity to meet needs	Activity to support movement between communities
Leaders/ champions	<ul style="list-style-type: none"> • Opportunities across the area to further raise the profile of this agenda • Leadership events – training and networking • ‘High end’ activities such as masters courses and train the trainers to build local capacity 	n/a
Practicing health professionals	<ul style="list-style-type: none"> • Range of embedding activities • Collation of existing resources and ongoing communication 	<ul style="list-style-type: none"> • Networking events to meet other leaders / champions • Ongoing communications of health coaching related activities in the area in which they can get involved
Attended core training	<ul style="list-style-type: none"> • High quality core health coaching training 	<ul style="list-style-type: none"> • Marketing of embedding activities to past participants of training
Interested	<ul style="list-style-type: none"> • Co-ordination capacity to sign up to Health Coaching core training 	<ul style="list-style-type: none"> • High quality marketing of core health coaching training (events, word of mouth, etc.)
Unaware or uninterested	n/a	<ul style="list-style-type: none"> • Taster sessions perhaps delivered by champions in the area • Champions speaking about the approach with colleagues and presenting at local events • Targeted communications around the health coaching approach • Dissemination of related evidence where available

Leader / champion activities

Central provision and embedding activities

The next sections of this paper unpack the activities in this table.

1. Leader / Champion activities

1.1 Objective

To support the creation and development of leaders for this approach amongst the health professional workforce, and to maximise their impact on their organisations and local areas

1.2 Potential supporting activities

The following activities are aimed at: supporting existing leaders and champions, encouraging practicing health professionals to further increase their influencing activities to become champions, and encouraging leaders and champions to raise the profile of this approach to unaware health professional audiences (via e.g. tasters and events).

- **Networking within the area** – building links between existing workforce health coaching champions and potential champions to gain inspiration, mutual support and ideas (within and beyond the area). Might include face to face and online discussion facilitation.
- **Building links** with health coaching and related leadership activities in other areas (e.g. within other HE regional teams, Nesta 'Realising the Value' programme and East of England workshops) and with other health professional audiences engaging with a health coaching approach
- **Identify resources** – opportunities for funding, online training resources, collating guidance, accreditation opportunities for those interested, etc. Provide a 'directory' or 'signposting' source of key documents, support tools, case studies and contacts (could include resources from elsewhere in the UK, or international examples of good practice)
- **Creation of new resources** – such as a simple guide / handbook to introduce key concepts, simple messages, taxonomy, real examples of a coaching approach to healthcare alongside other conversational approaches – i.e. giving information, explaining a condition
- **Identify and create opportunities** to raise awareness of this agenda and provide tasters – conferences, events within the area
- **Communications** – engage champions of a coaching approach to healthcare practice in leading communications to raise awareness of the agenda and disseminate evidence where possible
- **Engagement with education bodies** – to influence curricula where possible or provide interesting examples (see also funding of pilots section 3 below).
- **Leadership training** – sessions to increase the impact of leaders (mixture of influence, content knowledge and facilitation). This activity could also link with the work of the national and local leadership academies (several of which are taking a lead on health coaching activities) or with networking and support activities provided by NHS Employers Organisational Development team.
- **Train the trainer programme** – to build local capability (assets) able to deliver health coaching training both centrally and locally (also mentioned below)

- **Ongoing study** – developing activities such as postgraduate courses in health coaching skills for healthcare professionals, and referral to other accredited courses
- **Evaluation** – to support local areas to use the Quality Framework effectively

1.3 Funding required

The following aspects would be required as part of this aspect:

- Co-ordination capacity to support the network and identify opportunities
- Capacity for the mapping/development of resources and making these available to potential audience
- Small amounts of event funding for network meetings (if necessary)
- Potential leadership training
- Development funding for e.g. postgraduate courses in health coaching skills for healthcare professionals
- Potential funding for 'train the trainer' activities (linked to embedding activities below)

1.4 Evaluation

What might be useful indicators of this working?

- Number of people engaged and time spent in various activities
- Seniority engaged
- Length of time engaged
- Feedback/evaluation activities of specific activities (networking events, resources or leadership training provided)
- Activities designed to capture policy and practice changes in the organisations of network members (to capture as case study learning and evaluation)

1.5 Process

The key part of growing any community of practice is to involve its members in the development to build momentum. The potential process could involve:

- Invite initial leaders to co-creation process at three levels:
 - Attend workshop to further develop ideas
 - Complete survey / send in feedback in advance (if can't attend)
 - Register interest
- Scope drawn up as case for funding support
- Begin project

2. Central provision* and embedding activities

2.1 Objectives

- To provide an example of good training practice for local efforts
- To provide high quality health coaching training to interested health professionals from across the area (particularly where these activities are not provided by local commissioners)
- To sustain this skills development through provision of embedding activities
- To develop future leaders and champions of a coaching approach to healthcare (and link into leadership activities)

2.2 Activities

The following activities are aimed at those who are interested in attending the core health coaching training programme, and those who have already attended to continue to develop their skills.

- Delivery of core programme – two day programme as the minimum for effective immersion, run periodically over the year
- Central provision of embedding activities such as:
 - Annual programme of refreshers and masterclasses (perhaps 2-3 per year initially)
 - Action learning sets – monthly evening sessions to include discussion and practice
 - Webinars – evening sessions, perhaps quarterly initially to test interest
 - Email / text out – regular communications with new resources, questions to keep the approach 'live'
 - Effective co-ordination of marketing of these activities
- Other possibilities:
 - Supervisor training (linking to leadership academy trainings of supervisors)
 - Train the trainer – to build up local capability able to deliver central and local training (developing assets – see pilot projects)
 - Developing a postgraduate course in health coaching skills for healthcare professionals (also mentioned above)

N.B. All of these Activities should be informed by the Quality Framework

2.3 Central v. Local

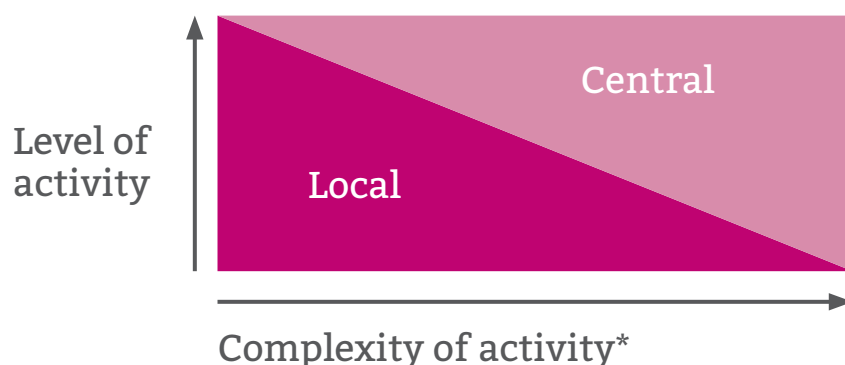
It will be critical that central activities add value to, and don't duplicate, locally funded activities

Complementarity

- Central embedding activities can be marketed to any participant of local activities, enabling them to sustain and develop their abilities
- In turn, these individuals can then be invited into leader and champion activities and networks (moving into the centre of the concentric circles above)
- Those who engage with 'central' activities (like embedding activities) can themselves deliver local interventions, such as tasters, to generate further interest
- The use of the Quality Framework at both local and central levels can continue to improve good practice

Avoiding duplication

- Central provision would involve voluntary and open programmes, open to audiences from any setting and area
- Local provision would potentially prioritise the following needs, avoiding the duplication of central provision:
 - For team based interventions, if it were best to deliver the training, or ongoing development, in situ
 - For shorter programmes
 - For innovative approaches (e.g. asset based work, potentially supported by resources developed in a pilot project – see below)
 - For interventions targeting specific conditions / patient groups, linked to particular evaluation objectives



*Complexity of activities – on the left are more straightforward activities like tasters and shorter programmes: on the right are activities where there is a 'deeper' engagement in health coaching and its ongoing practice (e.g. embedding activities, train the trainer, a postgraduate qualification)

2.4 Evaluation

Evaluation would link to the Quality Framework and provide an opportunity to test/demonstrate best practice from this.

2.5 Process

- Build specification
- Tender out
- Start with comparatively low levels of activity and scale up as required
- Constantly engage audience to improve design (link to leadership activities)

3. Prioritisation

The activities above have been identified as 'ideal' to help sustain and embed this approach in any area. However, it is important to consider the potential situation of limited funds. What might be prioritised?

The following two criteria seem to be important:

- Cost effectiveness
- Activities able to develop and support leaders / champions

Based on this, the following activities stand out for investment in the case of limited funds:

- Embedding and networking activities – to support health professionals adopting a health coaching approach to continue to develop their skills alongside colleagues equally passionate about the approach, sharing ideas of how to support the approach in their area. This could be face to face and/or virtual
- Support for local assets – mapping capability where it already exists (local trained coaches, those trained in health coaching, clinical psychologists, etc.) and providing resources for these audiences to train the health workforce locally at lower cost (see Pilot projects below)
- Co-ordination – some co-ordination function to join up these activities and link them to existing resources from around the country

4. Pilot projects

4.1 Objectives

Given the likely future restrictions in available funds for training and development, the following ideas have been identified as those which could significantly increase impact at comparably smaller eventual cost to the system. The objective would be to learn from related activity elsewhere, design a pilot and deliver and disseminate findings with the aim of scaling across the area and potentially beyond.

4.2 Potential activities

The following are ideas that have come from the research so far:

- Developing and testing new evaluation and monitoring models
- Asset based support

4.2.1 Evaluation and monitoring models

Although our research so far indicated a number of different approaches to 'evaluating' the application of coaching skills to a health professional's practice (mainly gathering feedback from participants in training activities), the opportunity for integrating methods

of monitoring the quality of resulting health coaching conversations has significant potential. This would require the development of simple models that involve patient / health professional feedback, which can also be used to raise expectations (of patient and health professional) and generate comparable data for learning and accountability.

So far, based on conversations with national partners, there seem to be two potential models for this:

- **A Patient Centred Measure**

This would involve asking patients their perception of the 'quality' of the conversation immediately afterwards. Validated tools exist and simple amendments could be made to make it an easier experience, and one that adds value to health professionals too, by acting to manage patient expectations. It would also help evaluate the impact of trainings.

- **Staff satisfaction**

Another tool being used in some areas is staff satisfaction as a proxy for the coaching quality of patient/healthcare professional conversations. The existing Health Foundation tools could be adapted for this context and trialled, as part of a wider intervention, to see the impact.

4.2.2 Asset based support

The current model for for health coaching training involves multi-day immersion. However, there may be less and less money available for such training in future years. In addition, assets exist in local health settings – practitioners (such as clinical psychologists, clinical psychology lecturers and trained health coaches) with high levels of conversational skills. These individuals could be leading and supporting development activities in situ, requiring less funding and less time from stretched professionals. An eventual process might involve:

- Initially mapping potential local assets to understand interest and eventual methods for training and supporting others
- Develop resources to meet these needs
- Pilot and evaluate (impact, interest and cost)

4.2.3 Process

- Identify suitable topic for pilot action
- Develop specification/costing for this
- Obtain funding
- Engage local site
- Develop evaluation strategy (linked to the Quality Framework)