better conversation tools for action

the health coaching coalition
'Never doubt that a small group of thoughtful committed citizens can change the world. Indeed it is the only thing that ever has.'
Margaret Mead

A social movement is a voluntary collective of individuals committed to promoting or resisting change through co-ordinated activity. Social movements produce a lasting and self-generating effect, and create, as they do this, a sense of shared identity.

Join the social movement for better conversation

1. Bibby J, Bevan H, Carter E, Bate P, Glenn R The power of one, the power of many: Bringing social movement thinking to health and healthcare improvement (2009) Institute of Innovation and Improvement

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The health coaching coalition is a collection of organisations and individuals unified in wanting to improve conversations between the health and care system and people seeking care, their families and communities.

Our aim is to enable people to thrive by feeling more motivated, confident and in control of managing their own health and care.

We believe great conversations can transform relationships and health behaviours to benefit patients, staff and the NHS.

To achieve great conversations, we advocate a health coaching approach based on the science of behaviour change.

You are invited to join this social movement.

The following resources are available for all to download, use and share from www.betterconversation.co.uk

•  A short film of clinicians and patients describing health coaching
•  A booklet and call to action
•  A resource guide with detailed information and evidence to help individuals and organisations get started
•  Training materials tried and tested by over 3,000 clinicians and peers

An online community to share resources and experience with other areas
The brand and logo for the social movement

How these materials were created
This call to action booklet and brand was created over the course of four co-design events attended by more than 100 participants from a range of organisations. The work was facilitated by the Innovation Unit, commissioned by Dr Penny Newman and funded by the NHS Innovation Accelerator (NIA) Programme which aims to scale innovations of proven benefit to improve patient care. https://www.england.nhs.uk/ourwork/innovation/nia/
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NOTES ON THE LANGUAGE
This guide refers to coaches mainly as “clinicians”, because its main audience is the NHS. Our first priority and experience was of training clinicians in health coaching. The term “clinician” in this context refers to nurses, doctors, allied health professionals, psychologists and other health care professionals who have been trained in a coaching approach. Evidence is that the skills are equally effective when used by non-clinical coaches such as carers, social workers, health trainers and volunteers (see chapter 5). Similarly, although we wish to avoid language which suggests dependency, for clarity we use the term “patient” to refer to a person or “client” who is seeking care and support.
For patients

Responses from 83,116 people and 159 Trusts indicate only 60% were definitely involved as much as they wanted to be in decisions about their care and treatment and 9% felt that they hadn’t been involved at all.

CQC in-patient survey 2015

“The first time my doctor warned me about my chest and smoking he scared me - I didn’t go back for over a year after that”

“I never thought what I was doing would do any harm - it’s my life, why would I let someone else tell me how to live it”

“I don’t want to be defined by my illness”

Only a third to a half of patients comply with prescribed medications and 10% with lifestyle advice

Bennett H, Coleman E, Parry C, Bodenheimer 2010

20% of patients feel doctors and nurses talk in front of them as if they aren’t there

CQC in-patient survey 2015

“I dread going to clinic appointments for fear of being reprimanded”

Only 3.2% of patients with long-term conditions (LTCs) report involvement in developing their own care and support plan


“People don’t listen to me, they don’t help me change. I can almost put my finger on it - what I want to do - but I never felt I could sit down with my doctor and figure it out”

205,000 written complaints in 2014-2015, up by 30,000 on year before

Health and Social Care Information Centre

“People don’t listen to me, they don’t help me change. I can almost put my finger on it - what I want to do - but I never felt I could sit down with my doctor and figure it out”

Only 39 per cent NHS staff feel they able to deliver the quality of care they wish to patients

31 per cent NHS staff did not agree that they would feel happy with the quality of care in their organisations if a friend or relative needed treatment

Only 42 per cent agreed that their roles actually make a difference to patients

Michael Wast, Kings Fund http://www.kingsfund.org.uk/blog/2016/03/nhs-staff-survey

“The traditional system of doctor-patient advice giving does not appear to be working now that the majority of patients have chronic conditions and require behaviour change to improve their health. The health professional may seek to give advice and the patient may seek to be ‘lay’ in receiving advice but this so often doesn’t result in behaviour change”

Renal Dietician

For clinicians

Workplace Stress

In London, 1,497 nurses across 31 NHS trusts – one in every 29 nurses – took time off (an average of 38 days) because of stress during 2014, up 27% on the 1,179 who did so in 2012


“NHS workplace stress could push 80% of senior doctors to early retirement”

The Guardian 10 Sept 2015

Insufficient Patient Time

43% of GPs report having insufficient time with each patient

BMA National Survey of GPs: The Future of General Practice 2015

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For clinicians

Job Dissatisfaction

The level of overall job satisfaction reported by GPs in 2015 was lower than in all surveys undertaken since 2001. On a seven-point scale (‘extremely dissatisfied’ (=1) to ‘extremely satisfied’ (=7)), average satisfaction had declined from 4.5 points in 2012 to 4.1 points in 2015

J Gibson et al. Eighth National GP Worklife Survey, University of Manchester, 2015

The proportion of GPs expecting to quit direct patient care in the next five years had increased from 8.9% in 2012 to 13.1% in 2015 amongst GPs under 50 years-old and from 54.1% in 2012 to 60.9% in 2015 amongst GPs aged 50 years and over

J Gibson et al. Eighth National GP Worklife Survey, University of Manchester, 2015

“I’m bored of telling people how to take their medicines”
Many long-term diseases affecting our population are closely linked to behavioural risk factors, with 40% of the UK’s disability adjusted life years lost being attributable to tobacco, hypertension, alcohol, being overweight or being physically inactive. Recent figures for England show:

- 2 in 10 adults are smokers
- 7 in 10 men and 6 in 10 women are overweight or obese
- a third of people have drinking patterns that could be harmful
- half of women and a third of men do not get enough exercise
- a quarter of the population engages in 3 or 4 unhealthy behaviours

This is a big problem not just for patients and clinicians but for the NHS as a whole:

- escalating costs (including costs of poor medication compliance)
- increasing rates of hospital admissions
- overwhelmed system
- under-utilisation of patients’ assets

The NHS wasn’t built for today’s or future needs.

The National Institute for Health and Care Excellence (NICE) estimates that the annual cost to the NHS of physical inactivity is £1,067 million, of smoking £2,872 million, of alcohol misuse £3,614 million, and of obesity and being overweight £6,048 million.

Supporting people to make behaviour changes can help reduce premature deaths and disability, helping achieve long-term health, social care and public sector savings.

The gross annual cost of NHS primary and community care prescription medicines wastage in England is currently in the order of £300 million per year... Improving adherence in medicine taking can improve health outcomes

The NHS is unsustainable without a greater partnership with patients

How can things be better?

The relationship, the conversation between clinicians and patients, is key.
Health coaching

Health coaching is helping patients gain the knowledge, skills, tools, and confidence to become active participants in their care so that they can reach their self-identified health goals.


A mindset change

Clinician as Fixer
what’s the matter with the patient

Clinician as Enabler
what matters to the patient

Guiding principles

Health focused:
conversations that aim to improve patients’ health, care and wellness

Goal-oriented:
the conversation involves goal setting and goal clarification, based on what is meaningful to patients

Person-centred:
the conversation is for the benefit of the patient, producing an individualised approach where their preferences and decisions are honoured

Process:
health coaching involves movement forward, a recurring process where action is taken

Enlightening:
insight is part of the process, leading to patients achieving more significant or tangible outcomes through health education, reflective inquiry, identification of barriers and strategies, and self-awareness

Empowering:
empowerment is a consequence of health coaching.

Adapted from Olsen, J.M., (2014)

Help change the conversation
Better for patients
Better for clinicians
Better for the NHS
**Offers patients**

**Healthier lives**
Feel more confident and motivated to manage their own health

**Achieve goals and outcomes that are important to them**

Studies have shown that health coaching leads to improvement in self-efficacy, health outcomes and self-care behaviours, including increasing physical activity, improving diet, improving lifestyle, reducing smoking, and medication adherence.

Does health coaching work? A rapid review of empirical evidence
Health Education East of England, April 2014

**Clinicians reported benefits to their patients including increased confidence and empowerment, increased satisfaction, reduced dependency, more personalised advice and less medication**


“I would say I'm now empowered. I feel better, but really importantly I feel like I have a clear path in front of me, of what to do, who to ask and I know my doctor is there for support, and to keep an eye on my progress and give me a nudge if I need it”

“I feel like a person, not just a patient”

“It's the first time anyone has listened to what I want”

“I have the tools to communicate and take positive action”

“I'm now in the driving seat, not a silenced passenger”

Benefits for clinicians include increased resilience in boundary setting and prioritization, self-compassion and self-care, and self-awareness

Schneider, Kingsolver and Rosdahl, 2014

**More sharing of responsibility as patients and clinicians work together to improve health**

**Improved relationship with patients, greater patient and clinician satisfaction**

Builds on what clinicians know and adds new skills to tool box for use in difficult conversations with patients’ and in leadership roles

In an RCT in primary care, patients receiving health coaching by medical assistants showed significantly improved goal attainment at 12 months (HbA1c, blood pressure and cholesterol) which was sustained at 24 months, with the exception of HbA1c


Benefits for clinicians include increased resilience in boundary setting and prioritization, self-compassion and self-care, and self-awareness

Schneider, Kingsolver and Rosdahl, 2014

“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.”

Acute renal nurse

“A normal caseload for me used to be 40 to 67 patients per month. That all changed after my health coaching training. Within three months my caseload was under 30. I was dealing with the issues quicker and able to discharge them back to their own management. It was partly 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 if they needed to.”

Community physiotherapist

Health coaching works best for people with low levels of self-efficacy, self-management or medication adherence and most severe symptoms, at highest risk or who are vulnerable

Does health coaching work? (2014)
Economic analysis following health coach training of staff on a 28 bed acute rehabilitation ward demonstrated estimated savings of up to £4973 per service user through reductions in length of stay and care placement, equating to net benefit savings of up to £3.6m pa for health and social care and savings to the NHS of £288k pa.


Health coaching can increase patient activation – a measure of a person’s skills, confidence and knowledge to manage their own health related to health behaviours, clinical outcomes and patient experiences. More activated patients experience 8-21% lower health care costs and 4-12% lower readmissions per patient, improved care quality and consistency, quicker discharge off caseload, potential to cut wait times and less waste from unnecessary medication.


Benefits to the NHS from health coaching identified 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 wait times and less waste from unnecessary medication.


Health coaching as fundamental to the patient-clinician relationship
Improves patient experience
Improves patient outcomes
Improves clinician resilience, leadership and engagement
Delivers on national priorities in NHS England’s Five Year Forward View
Reduces costs
Reduces waste (tests and follow up appointments)

Proactive health coaching has been provided to over 12,000 patients across a population of six million, 17 hospitals and 450 primary care centres in Scandinavia. The intervention has delivered 20–40% reductions in unplanned hospital activity within the target patient groups. The impact has also been visible on a “macro level”. Three years after implementation, Stockholm County Council has achieved a reduction in readmissions from 19% to 16%.

Is used in care and support planning
Taps into patient’s assets
Is at the heart of person-centred care
Contributes to shared decision-making

In person-centred care, people who use services work in partnership with their health and social care professionals. They are treated with dignity, compassion and respect. They are supported to develop the knowledge, skills and confidence they need to make informed decisions about and to better manage their own health and care and their care is co-ordinated and tailored to their individual needs.

Health coaching contributes to shared decision-making, which is a process in which clinicians and patients work together to make decisions about care and treatment based on both clinical evidence and the patient’s informed preferences. NICE

Co-production acknowledges that users are experts in their own circumstances and capable of making decisions, while professionals must move from being fixers to facilitators. To be truly transformative, co-production requires a relocation of power towards service users. This necessitates new relationships with front-line professionals who need training to be empowered to take on these new roles.

Care and support planning is a process to enable people with LTCs and their carers to work in partnership with health and social care professionals to design their care shaped by their own assets, goals and priorities. It comprises five steps including preparation, conversation, recording, making it happen and review.

Fund 2014

Some organisations and initiatives with complementary aims

Paths to participation

Paths to participation highlight ways everyone can get involved to enable better conversations with health coaching: Patients (including the general public), clinicians (nurses, doctors, allied health professions, psychologists and other health care professionals) and commissioners (such as CCGs and charities).

Each path follows four stages, from discovery to advocacy. It highlights which channels, activities and experiences could be focused upon to successfully:

- Seed
- Grow
- Strengthen and
- Spread health coaching
How could CLINICIANS engage with the Health Coaching social movement?

1. SEED
   - Be introduced to health coaching via peers, seminars, web-links, email
   - Evolve your role and share successes with your peers, lobby your institutions and challenge ways of working
   - Introduce and educate peers, and seek out patients to coach
   - Demonstrate effectiveness, push to measure outcomes and present to your board

2. GROW
   - Seek new ways to manage poor patient health and inequalities when planning resources
   - Support patients to identify their own meaningful goals about real-life outcomes
   - Create a plan and recommend apps, activities, information and peer groups
   - Train in health coaching and ask more open questions and consider personal and local assets and challenges

3. STRENGTHEN
   - Integrate new Practice and encourage measurement of impact
   - Build a culture of exchanging stories, knowledge and support

4. SPREAD
   - Decide to act after a health crisis or recognition of a need for change
   - A referral via your GP, carer, peers, loved one or a self-referral
   - Decide to act after a health crisis or recognition of a need for change
   - A success story via media, awareness campaigns, events, social media or word of mouth

How could PATIENTS engage with the Health Coaching social movement?

1. SEED
   - A formal introduction e.g. apply for health coach training
   - Volunteer your experience and become a health coach
   - Share your story and advocate Health Coaching
   - Introduce others with a link, information or tools for discussing with a health professional

2. GROW
   - Integrate new Practice and encourage measurement of impact
   - Build resilience by tracking and sharing progress with your support network
   - Arrive prepared with notes and points to offer in the consultation

3. STRENGTHEN
   - See a health coach and start an open, trusting conversation and collaborative relationship
   - Create meaningful goals in a conversation about what’s important in life, not just in treatment
   - Decide to act after a health crisis or recognition of a need for change
   - A referral via your GP, carer, peers, loved one or a self-referral

4. SPREAD
   - Introduce others with a link, information or tools for discussing with a health professional
   - Build a culture of exchanging stories, knowledge and support
   - Build resilience by tracking and sharing progress with your support network
   - Share progress via apps, social media and wearables

Regularly re-assess and adjust support when barriers emerge

Integrate new Practice and encourage measurement of impact

Build a culture of exchanging stories, knowledge and support

Decide to act after a health crisis or recognition of a need for change

A referral via your GP, carer, peers, loved one or a self-referral

A success story via media, awareness campaigns, events, social media or word of mouth
Seek outcomes and evidence from trusted sources, institutions, case studies, patient participation groups and webinars.

Propose exploring health coaching within service developments in board papers. Leverage the case for change.

Establish ROI, financial requirements and resource implications.

Grow evidence base through funding more research in the UK and internationally.

Respond to demand from workforce and patients for Health Coaching e.g. patient satisfaction surveys.

Network with senior health and care leaders and key stakeholders including charities and the third sector.

Promote inclusion of health coaching in CCG awards for best practice, and sponsor Fellowships.

Present case studies to the board highlighting the application and benefits of health coaching across pathways and localities. Present the costs of not adopting Health Coaching.

Embed in strategy: Embed health coaching in workforce strategy and job descriptions.

Champion health coaching in bids, write it into operational and service transformation plans and service specifications.

Measure positive staff impact and see it as an investment in people as well as reaching KPIs.

Align with national directives such as the Vanguard Programme and 5-Year Forward View.

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How could COMMISSIONERS engage with the Health Coaching social movement?

Growth plan

Building the momentum for change

- Revalidate: Make health coaching daily practice
- Publish: NIHR research
- Go viral: Through a TED talk
- Interview: Health and care leaders (and celebrities) to promote
- Connect: To all staff trained in coaching e.g. performance coaching
- Invest: Commission health coaching as part of undergraduate training
- Present: At multiple conferences and workshops
- Share: Powerful stories and case studies from patients/citizens
- Sign up: Build collaborations and offer individuals different ways to engage with health coaching
- Launch: Create series of interactive events, applying the ethos of health coaching and using social media
- Develop: A stakeholder map and clear communications plan

SEED

SPREAD

STRENGTHEN

GROW
Key stakeholders to engage

PRIORITY 3
- Faith groups
- Health insurers and health-related companies
- Scottish Parliament and Welsh Assembly
- Housing Associations
- Leisure facilities
- Schools
- Celebrity champions
- Charities

PRIORITY 2
- Clinical networks
- Health and Wellbeing Boards
- Health Foundation
- Carers’ groups associations
- Public Health England
- Local government

PRIORITY 1
- Health coaches and health coaching trainers
- Clinical and patient champions
- Sympathetic politicians and journalists
- NHS England Vanguards
- Patient groups and associations
- Royal Colleges and professional associations
- Health Education England
- CCGs and Trusts
- NHS Right Care

Enablers, barriers and considerations to health coaching becoming a movement

**ENABLERS**

- **Evidence & Stories**
  - Tracking and measuring clinician satisfaction, patient self-management levels, reduced complaints, increased compliance. Availability of stories of success and best practice
- **Bottom Line**
  - Reduced costs (drugs, operations, admissions) and a reduced burden on professionals, hospitals, clinics and services in the long term
- **Contextualising**
  - Translating the Case for Change into a multiplicity of forms, channels and conversations to encourage adoption by major organisations representing patients, professionals and government
- **Training Supply**
  - The increasing availability and scalability of accessible training for professionals

**CONSIDERATIONS**

- **Develop Understanding**
  - Incorporating evidence into success stories of Health Coaching to be spread amongst health professionals and patients to increase understanding
- **Build Big Picture Evidence**
  - Present current evidence and assess value for money through economic evaluation to win continued support and funding. Focus on areas where the most impact may be made. Provide a simple business case template for services and trusts
- **Leverage Case for Change**
  - Apply the case for change to a broad range of contexts. Use the toolkit and other assets to persuade and increase awareness and adoption. Promote in public settings to raise general awareness
- **Promote Training**
  - Provide clear expectations and communicate value for money to equip managers and justify releasing resources for training and adoption. Build Health Coaching into existing training courses

**BARRIERS**

- **Shifting Roles**
  - Professionals fearing loss of identity, that patients become demanding or litigious rather than empowered. Patients resisting the shift in relationship and remaining in a ‘recipient of care’ mindset
- **Not Perceived as a Priority**
  - As an innovation compared to an established service or requiring same strength of evidence e.g. as a new drug so not given a chance to grow
- **Fear of Change**
  - Inertia, short-termism, bureaucracy and affecting change within the NHS. Seeing Health Coaching as a cost rather than a saving
- **Limited Resources**
  - Lack of funding, time or training as budgets are tied up or cut. Training and support required beyond the initial 2 day training

**Contextualising**

Shifting Roles

- Professionals fearing loss of identity, that patients become demanding or litigious rather than empowered. Patients resisting the shift in relationship and remaining in a ‘recipient of care’ mindset

Not Perceived as a Priority

- As an innovation compared to an established service or requiring same strength of evidence e.g. as a new drug so not given a chance to grow

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Limited Resources

- Lack of funding, time or training as budgets are tied up or cut. Training and support required beyond the initial 2 day training
What next?

For more information and resources for all to use including a short film, resource guide, training materials and an online community
www.betterconversation.co.uk
@betterconvo
#betterconversation

We hope that this has engaged and inspired you to take action and plan your next steps

Please share this resource with peers, teams, colleagues and friends – join, be part of and have an active role in the social movement