Chapter 4

How can we commission health coaching?

This chapter is written for clinical commissioning groups (CCGs), public health departments and local authorities to support the commissioning of health coaching based on best practice. It gives an overview of two main areas of consideration:

- **Ensuring that the health and care workforce has the skills to have enabling conversations with patients, family and carers.**
- **A community based approach where coaching may be delivered by lay people and commissioned from the third sector.**

Both require the same core skills and competencies.

Health coaching is a key mechanism to deliver on chapter 2 in the NHS England's Five Year Forward View[1]. It is one of five NHS England priorities identified as a mechanism to gain more value for the NHS by involving patients and communities in their care[2,3]. It is written into commissioning guidance for community nurses and the wider nursing workforce[4,5].

Figure 9. The health coaching quality framework[6]

A detailed framework for commissioning health coach training has been developed by Health Education England - North Central and East London (HEE NCEL) based on evidence and experience from emerging coaching programmes across the country.

The framework includes consideration of:

1. Programme design - that is evidence based, integrated with other initiatives, targets the right people, is well structured, ongoing and maximises attendances

2. Programme delivery - that is well-planned, practical, delivered by experts, consistent, and of sufficient duration

3. Monitoring and evaluation - attendance is tracked and quality of training and outcome are assessed

4. Sustainability - local champions and train the trainer programmes are considered, leaders developed, patient expectations are managed, longer term funding is explored and data sharing processes are agreed

At a glance

There is growing evidence health coaching can improve health outcomes and reduce cost (Chapter 1)

Targeting patients with low activation or health literacy has the greatest impact

Approaches vary from lay led services offering one to one and group sessions over a number of weeks or months to training clinicians in the use of coaching skills to use in daily consultations and dedicated services

Useful resources
NHS Improving Quality tool for assessing impact of service changes based on collaborative care approaches
http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/ltc-year-of-care-commissioning-model/long-term-conditions-year-of-care-commissioning-simulation-model.aspx

NHS Choices 'What to ask the doctor'
http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/questions-to-ask-the-doctor.aspx

How do we set about the commissioning process?

Here are seven prompts to consider:

1. Develop the business case

Provide a clear rationale based on a national / local evidence base:

a) **Patient need -** Data will be required on the needs of the local population e.g. people with long term conditions, service model and benefit. Consider using Right Care data on variation. Consider working with Public Health colleagues to establish local prevalence and predicted trends, e.g. for diabetes, COPD or multiple long term conditions. Look at linking to segmentation work already under way by vanguards such as in the multi-speciality community provider vanguards[7] (MCP). The greatest change may be realised by targeting people with lowest levels of activation and health literacy and co-morbidities (approximately 30% of long term condition population).

b) **Purpose -** There are differing views on what constitutes health coaching, for example, motivational interviewing, so agree a definition (Chapter 2). Health coaching can be used for primary, secondary or tertiary prevention identified through risk stratification, for people with single or multiple co-morbidities and those at low or higher risk of re-admission.

c) **Evidence -** Linking with Public Health, ensure any impact on potential cost saving to the system is identified, using robust validated data. Evidence on impact is described in Chapter 1.

2. Assess existing capacity

Consider alignment with other person-centered initiatives when health coaching training can augment them, for example, care and support planning (Chapter 9), patient education programmes and ways to help prepare patients for their consultation such as NHS Choices 'What to ask the doctor' [8]. Consider a base line assessment of skills, attitudes in the workforce and a trainer programme for sustainability (case study 5). The following three questions from the GP patient survey[9] are all good indicators of the effectiveness of services and staff in supporting people to manage their own health and wellbeing:

- **Item 21 - How involved in decisions are you?**
- **Item 32 - How supported are you to manage your health conditions?**
- **Item 33 - How confident are you to manage your health and wellbeing?**

3. Service type

What are the main outcomes required from health coaching? Consider for whom, how and when health coaching will be provided, the number and length of sessions and how they will be delivered e.g. as one to one, in groups, online or telephone. Ensure there is a clear description of the service model and pathway, including referral routes and criteria. For example, target people with three or more long term conditions and low levels of patient activation to increase patient activation measure (PAM)[10] in this group year on year basis (case study 6). At a condition specific level, health coaching could be targeted at all newly diagnosed people with diabetes who have poor glycaemic control and specified as part of a care pathway.

4. Local engagement

Commitment to the programme by senior clinicians and staff is vital. Engage local stakeholders, healthcare professionals and patients in service development to ease implementation, and identify local priorities and enablers and barriers to uptake. For lay and community health coaching, build on current self-management programmes. Hold system wide market sounding events to engage with voluntary sector and private sector providers to foster collaborative approaches and deliver a co-produced service.

5. Procure a provider

Commissioners will need to undertake a local procurement process. Identify from potential suppliers who is doing the training, their track record, relevant experience and qualifications. Consider using the HEE NCEL quality framework (Figure 9). Once funding has been agreed, procurement opportunity can be advertised on the national contracts finder website. Commissioners will be required to develop a Pre-Qualification Questionnaire and distribute the formal Invitation to Tender. The Members of Procurement Panel should be agreed in order to carry out Evaluation and Moderation and have good patient involvement. The panel will Award the tender to the successful bidder and commence mobilisation within an agreed procurement timeframe.

6. Payment mechanisms

Be prepared to adapt and change as services and programmes evolve. Year one payment needs to reflect start up and mobilization issues. Some CCGs have used payments based on patients referred and completing coaching linked to base line and completion questioners or numbers of clinicians trained. Commissioning for Quality and Innovation payment framework (CQUIN) enables commissioners to reward excellence, by linking a proportion of the income to the achievement of local quality improvement goals. Consider developing a CQUIN and rewarding quality outcomes and success at targeting key demographics. Consider the different needs of small voluntary and not for profit organizations in NHS payment mechanisms when creating a peer coaching programme. Small organisations are adversely effected by payment mechanisms based on numbers going through a service especially in the first year while capacity building.

7. Measuring quality, effectiveness and activity-contract monitoring (see Chapter 7 for more information on evaluation)

There are a range of outcome measures that are in use for measuring health coaching effectiveness. Patient satisfaction surveys only give limited information. Consider the use of Patient Activation Measure (PAM)[10], Quality of Life Outcome stars (QoLs)[11], health literacy measures[12] and health education impact questionnaire (HEIQ), self-efficacy scales[13] and Patient Reported Outcome Measures (PROMS). Ensure use of patient and clinician stories to provide a qualitative overview. Metrics need to include quality of life as well bio-medical indicators. Attrition rates and reasons for attrition and non-completion are important indicators of the quality of the coaching relationship with patients.

Case study 6

My Health, My Way - Health coaching in a community setting

My Health, My Way was commissioned by Dorset CCG following extensive consultation with patients and national experts. It was designed to address shortcomings in the Expert Patient Programme that the service replaced.

The service aims to provide individualized support to anyone with a long term health condition in Dorset through one to one peer coaching, group sessions and use of online and other communication mediums

The service is led by a local charity, Help and Care, which is a partnership between the local community, Royal Bournemouth Hospital Foundation Trusts and private enterprise. Patients access the service through self-referral and direct referral by health care professionals. All referrals are contacted within two days of the initial referral and start coaching within two weeks.

At a glance

My Health My Way offers an individualised coaching service to anyone living with a long term health condition who needs support to make health related changes

It uses lay health coaches and volunteers face to face and supported by web based tools

The population it serves have an average household income below £15,000 per year and live in rural and urban communities

Significant improvements in outcomes have been achieved across all main indicators for improved self-management behaviors

Useful resources
www.myhealthdorset.org.uk

Who are the coaches?

Coaches are drawn from a variety of backgrounds, some with long term health conditions or experience of making significant life changes. They are helped by volunteers who support group work and online forums.

Resources and tools

Coaches are trained in a range of skills such as pacing, cognitive and relaxations techniques, and understanding health beliefs, to increase individual activation and collective self-efficacy and self-management behaviours. They help patients:

- **Identify long term changes they wish to make**
- **Formulate these into goals**
- **Develop key skills to manage their health**
- **Understand triggers for exacerbations and navigate services**

The service also includes a range of online tools and elearning as well community support mapping tool GENIE[13].

The experience of patients

Independently evaluation of 323 participants showed significant improvements in multiple variables including; emotional distress, health services navigation, social integration and support, skill and technique acquisition, constructive attitudes and approaches, self-monitoring and insight, positive and active engagement in life and positive health behaviours