



better conversation
better health
health coaching



better conversation

a guide to health coaching

the health coaching coalition

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“I believe the 21st century needs a new ambition, to develop not talk but conversation, which does change people. Real conversation catches fire. It involves more than sending and receiving information”

Theodore Zeldin, *How talk can change our lives*

THE NHS NEEDS BETTER CONVERSATION. EVERY DAY THE NHS TREATS MILLIONS OF PEOPLE, AND EVERY ASPECT OF CARE DEPENDS ON THE EFFECTIVE COMMUNICATION BETWEEN STAFF, PATIENTS AND THEIR FAMILIES.

From diagnosis to treatment, great patient care is reliant on us understanding each other. The #HelloMyNameIs campaign has emphasised how important this is, and shown how a small change in how we talk can make a big difference to patients. People want to be in control of their health, and they want to be acknowledged, listened to and heard.

But conversation isn't just about exchanging information – this report provides evidence on how good communication through health coaching can lead to behaviour change.

For the NHS to be sustainable, people need to become more active in managing their own health, wellbeing and care. They need to be supported to make good choices and more equal conversations, based on a strong partnership between clinician and patient, are vital for achieving this.

Smoking, inactivity, alcohol misuse and obesity impact on health outcomes and the growing prevalence of long term conditions, many of which are preventable. We know that people take only between a third and half of their medications, and only about two thirds feel fully involved in decisions about them. As society has changed, medical care has become more specialised and technology has revolutionised how we access information, so how clinicians and patients communicate also needs to adapt to these influences and incorporate the science of behaviour change.

Health coaching supports the NHS values of care, listening and personal responsibility. By providing clinicians with new skills that help patients identify what's most important to them, and tapping into their own internal motivation, evidence shows health coaching can also address health inequalities, improve health behaviours and reduce avoidable admissions.

This resource guide was developed as part of the NHS Innovation Accelerator (NIA) Programme commissioned by NHS England¹ which aims to scale up proven innovations at pace. It provides organisations and individuals with a range of ideas on how health coaching can be adopted by clinicians as well as by lay coaches. It invites readers to join the social movement, to advocate for, and hold better conversations that lead to better health.

Health coaching is also one of five priorities within NHS England's Realising the Value programme. These initiatives deliver on commitments in NHS England's Five Year Forward View and will be helpful for areas in implementing their Sustainable Transformation Plans (STPs).

Given the current challenges of the NHS, we must try changing something different and a change in conversation is something everyone can do.

Professor Sir Bruce Keogh
National Medical Director

1. The NHS Innovation Accelerator Programme (NIA) is delivered through a partnership between NHS England and the Academic Health Science Networks, and is hosted at UCLP. <https://www.england.nhs.uk/ourwork/innovation/nia/>

The Health Coaching Coalition

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About this Work

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 the social movement

This resource guide is one element of a set of resources available to download and use

- **A booklet of infographics and call to action**
- **A short film of clinicians and patients describing health coaching**
- **This resource guide giving detailed information and evidence to help individuals and organisations get started**
- **Training materials tried and tested by over 3,000 clinicians and peers**
- **An on line community to share resources and experience with other areas**
- **The brand to download and adopt**

In return please use the brand, reference the source and join the network to grow the social movement.

This work arose originally in the East of England. Health coaching training was first developed by Drs Newman and McDowell in NHS Suffolk funded by a Regional Innovation Fund, then commissioned by Health Education East of England, and latterly selected onto the NHS Innovation Accelerator (NIA) Programme, a partnership between NHS England and the Academic Health Science Networks (AHSNs), hosted by UCLP. The resources were co-funded by the NIA Fellowship and Health Education England and commissioned and edited by Dr Penny Newman, NIA Fellow. Dr Penny Newman's NIA Fellowship is supported by three AHSNs - the Innovation Agency (North West Coast), Eastern and Yorkshire and Humber.

We are grateful to everyone who has worked with us to co-create all these materials, clinicians and leaders alike.

Note on 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.



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PART ONE

OVERVIEW OF HEALTH COACHING

1. WHY IS HEALTH COACHING VITAL FOR PATIENTS AND THE NHS?

Case study 1. Health coaching in East of England

Case study 2. A carer's story

Case study 3. Recovery coaching in an acute older people's rehabilitation ward

2. WHAT IS HEALTH COACHING?

Case study 4. Preventing readmissions related to medicines

3. WHAT TRAINING IS NEEDED FOR HEALTH COACHING?

Case study 5. Health Coaching train the trainer' - a whole organisation approach

Chapter 1

Why is health coaching vital for patients and the NHS?

The following chapter is written for everyone interested in helping people become more active in managing in their health and care. It describes:

- **Why it is essential for patients to be informed and empowered, why conversational skills are so vital and how this guide can help**
- **An analysis of 162 patient stories that illustrate the impact of patients being involved in their care**
- **The evidence on the impact of health coaching as a different type of conversation to empower patients and communities**
- **A carers story and account of clinicians experience of health coaching in the East of England**

The guide's initial focus is on health coaching and its use by clinicians in NHS settings. Later chapters then describe its use by volunteers and others in the community.

Why is it essential for patients to be informed and empowered?

The sustainability of the NHS depends upon patients and communities playing a greater role in their health and care:

- **Detrimental health behaviours cause 60% of deaths¹**
- **The impact of long-term conditions (LTCs) on patients' quality of life and NHS costs (around 70%) is escalating²**
- **The number of people with three or more long-term conditions is rising especially in older people and more deprived groups, who experience them as more severe³**
- **Patients often ignore professional advice e.g. comply with only a third to half their prescribed medications⁴**
- **Though shared decision-making is associated with improved outcomes, only about 60% of patients feel they are sufficiently involved in decisions about their care⁵**

At a glance

Health coaching is a partnership and different type of conversation between clinicians and patients that guides and prompts patients to be more active participants in their care and behaviour change

This guide provides a range of suggestions, contacts and scenarios to enable anyone interested in commissioning or providing health coaching in the NHS and community to get started

Patients tell us that they have

- Positive experiences of their care when they and their knowledge, experience and resourcefulness are respected
- But negative experiences when they are not respected, their concerns are ignored, and they are excluded from decisions which lead to distress, loss of confidence, lack of compliance, inappropriate use of services and poorer health

By tapping into the resourcefulness of patients, growing evidence indicates health coaching is associated with high practitioner and patient satisfaction, increased patient motivation to self-manage and adopt healthy behaviours, reduction of waste and positive impact on the culture of services and health inequalities

"I felt as though I had been listened to for the first time in over 2 years... I had got to the point of thinking I was making up the pain I still felt"

Woman with long term shoulder pain, Cumbria

Informed, empowered patients have the knowledge, skills and confidence to manage their own health. They make healthier lifestyle choices, personally relevant decisions, adhere to treatment regimes, and experience fewer adverse events⁶. Patients who possess the skills, confidence and knowledge to manage their own health, use services more effectively resulting in savings of between 8% and 21% of costs⁷.

However, while there are many initiatives to support patients to self-manage, and behaviour change interventions at a population level⁸, clinicians may not have had an opportunity to acquire the necessary interpersonal skills to share responsibility with patients and empower them to self-care and change behaviour⁹.

Why are conversational skills so vital?

Conversation has been called the most overlooked skill of the 21st century¹⁰. Every day the NHS treats a million people and holds millions of conversations. This guide aims to ensure the NHS increases the value from those conversations to help more people, particularly those with long term conditions, feel more in control and motivated to improve their health and thrive.

Evidence suggests that the quality of conversations between clinicians and patients are fundamental to wellbeing, enabling clinicians to pose questions and listen, and patients to take control of their condition. The #HelloMyNameIs campaign has demonstrated the need for improvements in basic communication. Complaints to the GMC are rising and over half are about clinical care and communication issues¹⁰. Misunderstandings impact on service use, patient outcomes and satisfaction.

The rapidly changing nature of health care, the emergence of frailty, multi morbidity, dominance of long term conditions, and rising patient expectations, mean professionals now need more complex interpersonal and communication - as well as technical - expertise. Clinicians need to work in partnership with patients to encourage lifestyle change, support self-management, increase medication compliance and aid complex decision making¹². People want to be in control of their health, and they want to be listened to and heard.

Health coaching is used widely in the United States where it is delivered by a range of providers who offer health coaching to individuals and as part of health programmes and systems to increase patient activation, wellness and uptake of interventions, reduce risk and support decision making¹³.

In the UK health coaching is still an innovation. As such it was selected for accelerated diffusion at scale in an NHS England funded programme to contribute to it's Five Year Forward View (FYFV)¹⁴ following extensive piloting and roll out across the East of England (case study 1).

How can this guide help?

This guide is for health and care leaders and clinicians, and others interested in health coaching, and was written by a coalition of 18 pioneer organisations and experts in the field. It covers:

Part 1

Why conversations matter to patients, what health coaching is and the growing international and UK evidence of its impact; training for health coaching

Part 2

Tips and prompts to help organisations get started and commission health coaching, set up a community service, embed it in service provision, and evaluate the outcomes of health coaching

Part 3

How health coaching can be integrated with other approaches including use of new technologies, care and support planning and shared decision making

At a Glance and Case Studies

All chapters have short summaries and case studies are to found throughout the handbook illustrating the health coaching in action in different settings, in the UK and internationally. Here is a list of the case studies;

Chapter 1: Health coaching in the East of England; a carer's story; recovery coaching in an acute older people's rehabilitation ward

Chapter 2: Preventing medicines related readmissions

Chapter 3: Health coaching 'train the trainer' - a whole organisation approach

Chapter 4: My Health, My Way - health coaching in a community setting

Chapter 5: Being Well, Salford - a coach-led health and wellbeing service

Chapter 6: Health and wellness coaching intervention for fibromyalgia

Chapter 8: Proactive health coaching in Scandinavia

Case study 1

Health coaching in East of England

Long term conditions account for 50% of GP appointments¹. To provide primary care clinicians with new skills to support self-care and behaviour change in their patients, in 2010/11 thirteen practice nurses from seven GP practices received a four day pilot accredited health coach training funded by a Regional Innovation Fund. Pre and post coaching questionnaires to nearly 200 patients showed improved self-efficacy and health status^{15,16}.

Following this positive evaluation, in 2013 Health Education East of England (HEEoE) rolled out a two day health coaching training for multidisciplinary teams across the East of England. The aim was to equip a wider range of clinicians with the right skills, knowledge and behaviours to support self-care and encourage behavior change and further evaluate the health coaching approach.

Between April 2013 and February 2015 almost 800 clinicians were trained in health coaching from across the East of England:

- **From 45 organisations including acute and mental health Trusts, community services, County Councils, CCGs and General Practices**
- **Including nurses (44%), allied health professionals (28%) and doctors (9%)**
- **Twenty local trainers underwent a 10 day accredited train the trainer programme and subsequently delivered a 2 day programme to a further 800 clinicians**

Clinicians reported successful use of health coaching skills to help patients self-manage¹⁹:

- **Long term conditions**
- **Lifestyle and behaviours**
- **Mild mental health problems**
- **Medicines - optimisation and adherence**
- **Other health issues including falls and palliative care**

Research indicated very high practitioner satisfaction with the approach, broad applicability of the skills, longevity of the skill set, cost savings, reduction of waste, and positive impact on the culture of services²⁰. Health coaching training based on this approach has since been commissioned in multiple geographies reaching thousands of clinicians²¹.

At a glance

- Accredited health coaching training was first developed as a pilot with practice nurses in the East of England
- 2 day training was then rolled out to nearly 800 clinicians from all professions
- 20 local trainers attended a 10 day train the trainer programme
- Training has now reached over 3,000 clinicians and the train the trainer model adopted in 5 other regions
- Health coaching was chosen as an innovation worth scaling as part of NHS England's NHS Innovator Accelerator (NIA) programme
- For evidence of impact see page 17

"The biggest thing for me was the shift in my mindset from the 'doctor knows best' approach, to where the patient is the 'expert' of their own life, and already has the means within themselves to improve their own health and life experience"

General Practitioner

Useful resources

RCP Future Hospital patient empowerment issue
<http://futurehospital.rcpjournals.org/content/3/2/147>

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Vital for patients - What do patients say?

What difference does it really make whether patients and carers feel “listened to” or “involved in their care”? Perhaps the best way to answer this question is to hear from patients themselves.

One hundred and sixty two stories reported over a two year period between January 2014 and December 2015 on the public website Patient Opinion were analysed and key themes identified to understand what happens when people feel listened to and involved in their care, and when they don't – and how this impacts on their health and wellbeing, and future use of services.

Why does involving people in their care matter?

When people say they feel involved in their care, many patients describe very positive experiences. People feel happy and even empowered when:

- They are given time, and/or listened to
- They are given clear accessible information and explanations
- Communication is two-way, not one-way, and their knowledge is recognised and respected
- They are treated ‘holistically’: as a person rather than a set of problems; as a whole person not just a condition or body part; and as an individual, sometimes with idiosyncratic needs
- They are given options and encouraged to share in decision-making

These features add up to a ‘partnership’, resting on respect for the patient and their knowledge, experience and resourcefulness.

In one story, a patient makes clear what a joint decision looks like:

“Yesterday we both agreed that I would be discharged from her care – please note ‘both agreed’.” [233433]

And a young person describes the impact of being treated with respect:

“At no time has (the school nurse) ever judged me as a person; she has always listened to what I have said and given me strategies and ways to cope... she will challenge me and ask me a little bit more but never ever says I am to blame... This has made me feel so much better in myself as a person. I am now looking forward and not back...” [239440]

Organisational cultures which support and encourage such a “partnership” are noticed and valued by patients:

“This is clearly a very busy but exceptionally well-run hospital with all professionals working together and the patient and family as equal partners”. [247643]

And the result is a direct positive impact on health and wellbeing:

“I now feel I have the tools to improve my quality of life ... The staff have empowered me to deal with different situations through their individual skills and techniques. I feel like a different person leaving here today.” [243398]

Where a “partnership” is present, the impacts on patients and carers include:

- Feeling valued/cared for
- Enhanced confidence (in services and/or in own recovery)
- Enhanced motivation
- More effective self-management
- Greater resilience
- Better health/quality of life

Why can people feel alienated from their care?

Some of the stories described more negative experiences, when people felt:

- They were not given respect
- Their questions and concerns were ignored, dismissed or contradicted
- They were excluded from decisions about their health and care

Experiences like this demonstrate disregard for patients' entitlement to a professional service. But perhaps worse, such experiences show a failure to recognise the necessity for people to be active partners in their own care.

One patient described direct clinical consequences of not being listened to:

"One GP prescribed medication even though I said I would react to it... I then did react to it and had to go to the walk-in centre. The GP did apologise afterwards, but I hadn't been listened to". [233764]

Another recounted their ongoing struggle to have their own priorities (rather than professional priorities) recognised as important:

"I have had type 1 diabetes for 35 years. Same HbA1c since I can recall. Always good control. Same weight since I finished school, always active and lean build ...because of that, I no longer let the NHS weigh me or test my HbA1c because it's always the same. I have no problems with my control, and it's not what I'm interested in measuring. My health care team are consistently openly frustrated and annoyed about this. One time a nurse would not let me see a doctor unless I let her take my blood ... I've become better at ignoring all of their patronising and offensive behaviours and I write down what I need out of each appointment and stay focussed on getting that addressed. I've managed to do that, but each appointment is made so awful because the health care providers show no concern about what's important to me." [208033]

One service user described the impact of being excluded from an important decision about their care:

"A locum psychiatrist I had met only once for a routine appointment for 10 minutes made the decision to discharge me ... Purely based on case notes, no assessment, no discussion with other staff who knew me ... I wasn't given a chance to air my point of view, concerns ... His manner was rude. I was shocked and upset and confused. I have always been involved in decisions about my treatment, care and support." [262603]

In patients' own accounts, the impacts of such experiences of care include:

- Distress
- Loss of trust/confidence in professionals
- Lack of "compliance" with treatment
- "Inappropriate" accessing of services
- Poorer health/quality of life

What can we learn from patient experiences?

It is clear from these many experiences of care being shared on Patient Opinion that a model of health care in which professionals actively engage patients (and their families) in their own care produces a range of important positive outcomes. Such 'partnership' working involves recognising, tapping into and/or enhancing a patients' own skills, abilities and resourcefulness.

Conversely, it is also clear that an approach to care which disrespects patient knowledge and experience, ignores concerns, fails to provide information or excludes patients from decisions about their care, results in a range of negative outcomes for patients and services alike.

These findings are not new – but these stories shared on Patient Opinion in 2015/16 suggests that communication problems remain very real for some patients. Even if only a minority of patients have a negative experience, the overall adverse impact on health and wellbeing, use of services, and health care costs will remain significant - and entirely avoidable.

Case study 2

A carer's story

As a carer for my son (with cystic fibrosis), I used to see my role as a passive one, in which I was the mechanism by which the treatment decided by clinicians was carried out. Health coaching has come as a breath of fresh air, which has enabled me and my son to engage with the management of his condition in a much more positive way.

Cystic fibrosis requires a heavy, relentless treatment burden to stay alive. Traditional methods of ensuring treatment adherence include; nagging, criticism, bullying, threats of hospitalisation, and a default mode of assuming non-adherence. These approaches create dysfunctional working relationships between clinicians and families, resulting in resources being wasted on over-medicalisation and misdiagnosis. The critical patriarchal approach also disengages children and teenagers, often resulting in declining health during adolescence.

I instinctively knew this approach wouldn't work for my son. I also know that I don't want to go to my son's funeral (the median predicted survival is 41 - Cystic Fibrosis Trust). When health coaching came into my life I knew I had found the answer. Health coaching has given me permission to do what I had always wanted to do, but thought that it 'wasn't allowed'.

I now allow myself to listen to my son and enable him to set his own treatment goals. The traditional fear is that the patient (especially a child or a teenager) will opt for low or zero goals; this is a myth. My son wants to carry out treatments in ways which mean something to him. He uses a nebuliser three times a day. The relentless burden of doing this every day means that the average adherence is 40%. Factors affecting adherence are obviously very complicated. My son's average adherence is 80%, because he set himself a goal to avoid having intravenous antibiotics (a regular treatment for CF) as long as possible. He knows that one way of avoiding this treatment is to keep up with the nebuliser which prevents chest infections, thus giving him the internal motivation to stick to his plan.

People with cystic fibrosis struggle to put weight on and are often 'threatened' with tube feeding. They are often given a target weight to achieve by a certain date. This target can then become a disempowering obsession. Instead, my son set his own goal of taking a certain number of digestive enzymes a day, which translates into eating a certain number of grams of fat per day. He has managed to stick to this without developing an unhealthy relationship with the bathroom scales.

Health coaching has enabled myself and my son to find ways of managing his relentless treatment regime, without the negative baggage which comes with 'telling' someone what to do. Health coaching isn't a luxury or an extravagance. It's the only option for positive, humane health and care relationships.

"It's the only option for positive, humane health and care relationships"

Vital for the NHS – what is the evidence on the impact of health coaching?

Health coaching is described more fully in chapter 2. The following description of the evidence of impact is based mostly on:

- **A rapid review commissioned by Health Education East of England (HEEoE) “Does health coaching work?”¹⁷. This led to health coaching being selected as one of five national priorities in NHS England’s “Realising the Value” programme to deliver on Chapter 2 in its Five Year Forward View¹⁸**
- **Evaluation of the case studies described throughout this report**

Assessing the evidence of the impact of health coaching is difficult because of lack of ability to compare studies, poor study design and a lack of definition of health coaching. However, despite these limitations, an evidence base is growing that demonstrates a real benefit of health coaching.

Studies show that health coaching can:

- **Produce positive physiological, behavioural, psychological and social benefits for adults with long term conditions²²**
- **Save costs for inpatient, outpatient and prescription drug expenditures²³**
- **Take the burden off clinicians while building trust and increasing patient accountability²⁴**
- **Increase clinician resilience through boundary setting and prioritization, self-compassion and self-care, and self-awareness²⁵**

Summaries of key studies particularly relating the growing UK evidence base are described in Figure 1. More research is needed on outcomes and cost effectiveness in NHS settings. However, these studies show that health coaching:

- **Increases patients’ activation and motivation to self-manage and adopt healthy behaviours**
- **Works best for people most in need**
- **Can improve outcomes including goals such as HBA1c, cholesterol and pain scores**
- **Can reduce unplanned admissions in high risk groups and from medication related admissions**

Figure 1. Growing evidence on the value of health coaching

STUDY	FINDINGS
INTERNATIONAL LITERATURE	
Patient activation is a measure of a person's skills, confidence and knowledge to manage their own health related to health behaviours, clinical outcomes and patient experiences ⁷	Health coaching can increase patient activation. More activated patients experience 8-21% lower health care costs
Review of qualitative and quantitative peer reviewed studies yielding 15 that met study inclusion criteria ²⁶ (2010).	Six studies identified significant improvements in one or more behaviours of nutrition, weight management, physical activity and medication adherence. Health coaching shows promise and more rigorous study design needed
Systematic review, 5 studies met inclusion criteria, 3 studies of diabetes ²⁷ (2013)	Two studies of HbA1c showed promising results; disadvantaged patients may benefit
Systematic review of 13 studies which met inclusion criteria of coaching by health care professionals for long term conditions, RCT or quasi-experimental design ²² (2014)	Health coaching improves management of chronic disease; positive effects on patients physiological, behavioural and psychological conditions and social life; significantly improved weight management, increased physical activity, improved physical and mental health status
A rapid review of 275 studies mainly in USA commissioned by HEEoE ¹⁷ (2014)	Health coaching works best for people in most need, increases patients' motivation to self-manage and adopt healthy behaviours, is widely applicable, and can be adopted by all professionals. More research needed
Review of 94 RCTs that used health coaching, 16 met the inclusion criteria ²⁸ (2015)	94% of RCTs reported at least one positive outcome
An RCT of 56 patients with type 2 diabetes who received fourteen 30 minute telephonic coaching sessions over 6 months compared to usual care ^{29,30}	Coaching group experienced increased patient activation and perceived social support; improvements exercise frequency, stress and perceived health status; significantly increased medication adherence and reductions in HbA1c, sustained at 6 months
An RCT in USA in primary care of patients receiving health coaching by medical assistants ³¹	Significantly improved goal attainment at 12 months (HbA1c, blood pressure and cholesterol) which was sustained at 24 months, with the exception of HbA1c
Targeted intervention where four Wellcoaches (Boston) worked with 9 fibromyalgia patients for 12- months (case study 8, Chapter 6)	Increase in self-compassion and self-kindness; pain scores decreased 30% and fibromyalgia impact scores improved 35%; 86% decrease in health care utilization during and 6 months post-intervention
Proactive health coaching by Health Navigator (Scandinavia) provided to over 12,000 patients across a population of six million, 17 hospitals and 450 primary care centres ³² (case study 9, Chapter 8)	Health coaching delivered 20–40% reductions in unplanned hospital activity within the target patient groups. Three years after implementation, Stockholm County Council has achieved a reduction in readmissions from 19% to 16%

GROWING UK EVIDENCE

<p>Primary care health coaching pilot evaluation in Suffolk used pre and post coaching patient completed self-efficacy questionnaires in 290 appointments with 17 practice nurses^{15,16} (case study 1, Chapter 1)</p>	<p>Patients reported statistically significant differences in motivation and confidence to self-care and very high or high levels of satisfaction (98%) with health coaching based consultations</p>
<p>An overview of progress of the HEEoE health coaching programme from April 2013 to April 2014 based on 3 feedback surveys with 355 clinicians who attended a 2 day training, including nurses (44%), allied health professionals (28%) and doctors (9%)¹⁹ (case study 1, Chapter 1)</p>	<p>Clinicians reported:</p> <ul style="list-style-type: none"> • A shift from “fixer” to enabler, becoming more patient-centred and adopting a more flexible consultation style • A wide application of skills especially in the management long term conditions, for health improvement and with some mental health problems • Tools for when patients were non-compliant; increased resilience; a renewed enjoyment of consultations; skills used in management roles and for appraisal • Reports of reduced tests and activity resulting from more effective consultations
<p>Qualitative review of five organisational case studies in the East of England including CCGs, mental health and community services, hospitals and GP surgeries^{20,21} (case study 1, Chapter 1)</p>	<ul style="list-style-type: none"> • Nearly all (96%) of clinicians reported good/very good content, learning opportunities and application to their work. More than two thirds of clinicians continued to use their health coaching skills up to one year after their 2-day programme • Two thirds of clinicians were using health coaching with a wide range of patients and conditions and finding it useful including depression, weight, smoking, foot ulcers, pain, anxiety, COPD, coronary heart disease, poor kidney function, hypertension • Reported efficiency benefits to the NHS included improved patient compliance, quality and consistency; reduction in episodes of care, appointments and quicker discharge off caseload; potential to cut waiting list times and for less acute admissions; less waste from unnecessary tests and medication • Reported benefits to patients included increased confidence, empowerment and satisfaction; more personalised care; reduced dependency and medication • A case study demonstrated a 63% indicative cost saving or annual saving of £12,438 per FTE physiotherapist for reduced clinical time
<p>Economic analysis following health coach training of staff on a 28 bed acute rehabilitation ward ^{33,34} (case study 3, Chapter 1)</p>	<p>An estimated net savings of about £4,973 per patient in reductions in length of stay and care home placement, equating to savings of up to £3,620,657 per annum for health and care and £28,000 per annum for the NHS alone</p>
<p>Eighteen pharmacists trained in an integrated medicine management service in acute Trust (case study 4, Chapter 2)</p>	<p>Demonstrates a significant reduction in preventable medicines related readmission within 30 days of discharge; improved identification and communication of medication issues; and improved staff and patient satisfaction</p>
<p>My Health My Way Dorset, a community based peer coaching service (case study 6, Chapter 4)</p>	<p>Independent evaluation of 323 participants showed significant improvements between baseline and follow up in 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 health directed behaviour</p>
<p>In 2014/15, Big Life, Salford received 1,560 referrals, leading to 1,085 assessments and 6,000 coaching sessions (case study 7, Chapter 5)</p>	<p>After using the service 48 per cent fewer people smoked 11 or more cigarettes a day; 44 per cent reported weight loss; 58 per cent felt that they were increasing their physical activity; 66 per cent said that their mood had improved</p>

Case study 3

Recovery coaching in an acute older people's rehabilitation ward

Patients are frequently disempowered by acute care provision, environments and attitudes, which debilitates individuals mentally and physically. For elderly patients this can mean prolonged rehabilitation and care.

To enable staff working on an acute inpatient elderly care rehabilitation ward to work better in partnership with patients and help them identify their own goals for getting home, a programme was designed using health coaching skills and techniques. Supported by the Health Foundation, this project aimed to challenge the fundamental basis of "I do it for you" and shift staff mindsets to "I will do it with you", enabling the person to become an integral partner in their health care.

Data were collected from 46 participants; 22 in the pre-intervention stage and 24 in the post-intervention stage. Improvements were seen in patients' Barthel (activities of daily living score) and self-efficacy mean scores (motivation and confidence to self-care) suggesting that the intervention supported an overall improvement in functional ability and independence on discharge.

Length of stay was reduced as patients were discharged 17 hours earlier. Two thirds of patients went home with the same level of care as on admission and 8% of patients required residential care home placements on discharge compared to 27.3% before the training. All staff felt it gave them the additional skills needed to work in partnership with patients using a caring and dignified approach. Improved job satisfaction was also found within the ward staff.

Health economic analysis indicated a net saving of up to £4,973 per service user in relation to reductions in length of stay and care home placement. For a 28 bed ward over a year this would equate to net benefit savings of up to £3,620,657 per year.

At a glance

Patients are frequently, disempowered by acute care provision, environments and attitudes

Health coaching skills enabled staff on a rehabilitation ward in an acute hospital to support patients to become more active participants in their health

Training led to reduced length of stay, improved functional ability and greater independence leading to a reduce health and care cost equivalent to £3m/year/ward

"We had forgotten how to listen to patients but now we listen to the patient's wishes and decisions too"

"It was really brilliant that it was the whole team and now we work together as a team around our patients"

Contact

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Although the largest financial benefit fell to the local authority from avoided residential care placements, the intervention was still cost effective if only NHS costs are included i.e. the net benefit per service user is £38 per patient, or £27,933 per annum per ward based on 728 patients admitted and an average 14 day stay^{33,34}.

Chapter 2

What is health coaching?

This chapter describes:

- What health coaching is and its applications
- How health coaching relates to wider systems and programmes of care
- How health coaching relates to other similar approaches

How is health coaching defined?

Health coaching has numerous definitions. It 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 goals¹
- A goal-oriented, client-centred partnership that is health-focused and occurs through a process of client enlightenment and empowerment²
- A method of patient education that guides and prompts a patient to be an active participant in their care and behaviour change³
- A behavioural intervention that facilitates participants in establishing and attaining health-promoting goals in order to change lifestyle-related behaviours, with the intent of reducing health risks, improving self-management of chronic conditions, and increasing health-quality of life⁴
- Based on strong provider communication and negotiation skills, informed, patient-defined goals, conscious patient choices, exploration of the consequences of decisions, and patient acceptance of accountability for decisions made⁵

At a glance

Health coaching is a patient-centred process that entails goal setting determined by the patient, encourages self-discovery in addition to content education, and incorporates mechanisms for developing accountability in health behaviours

The evidence is that there are many benefits associated with health coaching. In order for it to be fully effective health coaching may need to be implemented as part of a wider programme supporting education and behaviour change

A health coaching approach is synonymous with person-centered care and the skills are central to many related approaches including care and support planning and shared decision making (Chapters 9 and 10)

Useful resources

Teaching patients to fish
<http://www.aafp.org/fpm/2013/0500/p40.html>

A consensus definition was created in 2013 from 284 research studies which highlights the changing roles of clinician and patient⁶ (Figure 2).

Figure 2: Consensus definition of Health Coaching (Wolever, 2013)

ROLE OF PATIENT	ROLE OF CLINICIAN
A patient-centred approach wherein patients at least partially determine their goals, use self-discovery and active learning processes together with content education to work towards their goals, and self-monitor behaviours to increase accountability all within the context of an interpersonal relationship with a coach.	The coach is a healthcare professional trained in behaviour change theory, motivational strategies, and communication techniques, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and wellbeing.

What are the key principles and skills of health coaching?

The common characteristics of health coaching (taken from two rapid reviews of 275 and 210 articles respectively^{2,7}) are summarised in Figure 3.

Figure 3. The principles and skills of health coaching

KEY HEALTH COACHING PRINCIPLES (ADAPTED FROM OLSEN, 2014)		
Principles or mindset	Purpose Belief Partnership Focus on benefit for the person	<ul style="list-style-type: none"> to improve the health and wellness of patients that people are resourceful and have potential to self-manage the active participation of both patient and clinician thereby providing a tailored or personalised approach
Behaviour change skills	Goal setting Movement Creating insight Empowerment	<ul style="list-style-type: none"> and goal clarification, based on a person's preferences rather than professionals helping people assess where they are and how they would like to move forward, a recurring process where action is taken through health education, reflective inquiry, client identification of barriers and strategies and self-awareness is perceived as a consequence of health coaching
Clinical skills	Integration	<ul style="list-style-type: none"> builds on the skills of the coach, eg. clinical skills or lived experience if a lay person or peer

How is health coaching used and by whom?

Health coaching is applicable to a broad range of conditions, can be used by all professional groups and is delivered through multiple routes⁷.

1. Purpose: Health coaching can be used to improve health-related behaviours, increase medication compliance, in care and support planning (Chapter 9) and shared decision making (Chapter 10), and to support people with single and multiple long term conditions to self-manage⁸.

2. Application: Health coaching has been used effectively in smoking cessation, weight reduction, reduction in cardiovascular risk factors, diabetes control, asthma management, readmission, management of depression and for medication compliance⁷.

3. Clinical and non-clinical coaches: Studies suggest that nurses, doctors and allied health professionals may be equally effective as coaches. People with long-term conditions who have received training in health coaching can be just as effective as health professionals⁷.

4. Access: Health coaching can be a standalone intervention, integrated into clinical practice or part of a system of care; carried out by telephone, on line, face to face or in groups⁷.

5. Skill level: Health coaching skills can be applied by a wide range of professionals, either in routine practice or as part of bespoke health coaching consultations. Professionals require increasing levels of skill from basic to more specialist and ultimately accredited skill sets.

How can health coaching enhance long term condition delivery systems?

Health coaching is best delivered as part of a programme of care, rather than in isolation. Examples are given below.

1. Chronic Care model

Elements of an effective approach to chronic disease management (as described by Wagner) include;

- a proactive health care system focused on keeping a person as healthy as possible
- empowering patients to look after their health and
- enabling clinicians to provide continuous self-management support⁹.

2. The House of Care

The House of Care is the long term condition delivery system recommended for the NHS¹⁰. At its heart is a co-ordinated patient consultation, which is supported by activated professionals and patients, system change and commissioning^{11,12}. Health coaching contributes to the co-ordinated patient consultation (Chapter 9) and activating professionals and patients (Figure 4).

Figure 4. House of care delivery system for long term conditions



3. Co-production

Another model to which health coaching aligns is co-production. Here authors argue that health care is not a “product” manufactured by the health care system and given to patients, rather a “service” on which the outcome is equally dependent on the end user. Therefore the service needs to be co-created by healthcare professionals in relationship with one another and with people seeking help. The co-production continuum starts at the clinician patient relationship - a health coaching conversation - and extends into co-creating services with the wider community and society¹³.

4. Behaviour change programmes

Most people know they need to adopt more healthy behaviours, but can find putting this into practice difficult. Behavioural science offers a number of reasons why this is the case and suggests ways to address barriers to change at an individual and system level^{14,15}.

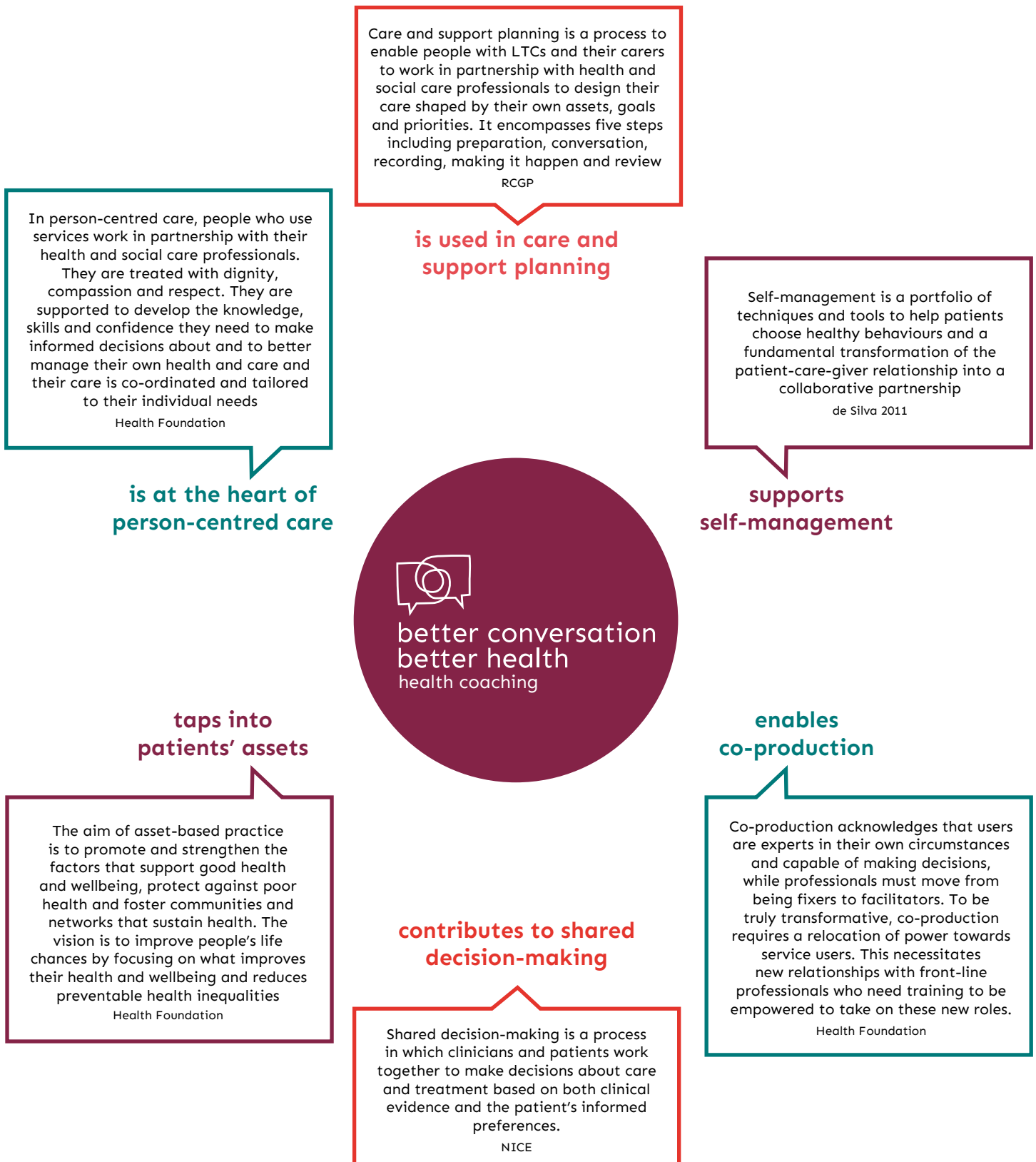
Health coaching includes behaviour change techniques at an individual level, for example, creating a “growth mindset” where change is possible, and goal setting and feedback to tap into internal motivation and reinforce success (Chapter 3).

Other aspects of recommended behaviour change programmes include behaviourally based segmentation (Case Study 9), peer support networks, reducing blocks that cause unnecessary effort e.g. social prescribing and new technologies (Chapter 8)¹⁴.

What is the contribution of health coaching to other self-management approaches?

The development of health coaching skills is one of a number of approaches that aim to share responsibility and/or decision making between clinicians, patients and communities. These are described in Figure 5 and chapters 9 and 10.

Figure 5. Health coaching and aligned approaches



Case study 4

Preventing medicines related readmissions

In 2012-2013 there were 5.3 million emergency admissions to hospital in England, costing about £12.5 billion¹⁶. About 5% of hospital admissions and readmissions are medication-related and preventable¹⁷. Improving evidence based, patient centred prescribing at discharge can increase adherence and thereby improve health outcomes¹⁸.

There is published data on predictive tools to identify and enable the targeting of patients at high risk of readmission, but currently no nationally accepted method. Integrated medicines management services (IMMS) are an alternative method of reducing preventable medicines related readmission.

IMMS was introduced in 2008 to Northwick Park Hospital, a 658 bedded district general hospital. The service is provided by 18 pharmacists who all attended two-day health coaching training and are supervised by a Consultant Pharmacist and health coaching trainer.

IMMS includes:

- **Medicines reconciliation and optimisation**
- **Patient-centred medicines consultations**
- **Medicines related discharge planning with patients, carers, health and social care teams**
- **Pre and post discharge communication to the GP and full documentation of changes**
- **Referral for community pharmacy follow up e.g. New Medicines Service or Medicines Use Review**
- **Post discharge telephone follow-up for patient and/or carers**

The IMMS pharmacists support patients and carers using a coaching approach to promote medicines optimisation. Patients are identified using the PREVENT© tool¹⁹ and supported with medicines adherence, which follows NICE guidance. Consultations are conducted face to face in hospital and by telephone following discharge.

At a glance

Pharmacy staff in the dispensary at London North West Healthcare NHS Trust offer a coaching approach to consultations about medicines:

- Studies show that about 5% of hospital admission and readmissions are medication related and preventable
- Up to 50 % medicines are not taken as intended
- A health coaching approach adopted by 18 pharmacists in an acute trust led to reduced preventable medicines related readmission within 30 days of discharge

“This is the first time anyone has asked me what I want from my medicines since I had my stroke. The pharmacist made me feel that my opinion of my medicines was important – and it is!”

Contact

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Useful resources

The benefits of this approach integrated within IMMS are:

- **Staff now address issues that are important to patients first**
- **Significantly reduced preventable medicines-related readmission within 30 days of discharge**
- **Improved patient safety through improved discharge communication**
- **Improved staff and patient satisfaction**

The full health coaching training course was re-commissioned for 2016 in order to up-skill pharmacy staff working with patients across the trust.

Chapter 3

What training is needed for health coaching?

Health coaching training aims to equip clinicians and others with the knowledge, mindset and skills to have coaching-style conversations that activate and support people to better manage their own health.

This chapter covers:

- **The evidence base of health coaching training**
- **What health coaching training involves**
- **Developing local health coaching trainers**

What is the evidence about health coaching training?

Evidence on the most effective health coaching training interventions is limited due to lack of clarity about what is involved¹; ill-defined roles of coaches²; varying backgrounds and approaches of the practitioners³; confusion between motivational interviewing and health coaching⁴; and a variety of applications. However, clarity is now emerging, including an agreed definition of health coaching⁵ (Chapter 2) and competencies for health and wellness coaching defined as a basis for a national certification in the USA⁶.

Successful training has been described for general practitioners⁷, occupational health nurses⁸, practice nurses⁹, physical medicine and rehabilitation physicians¹⁰, physiotherapists¹¹, dentists¹² and community health workers¹³.

Health coaches use reflective enquiry and facilitative strategies to explore the clients' experience. These include creating rapport, encouragement and affirmation, taking a non-judgmental approach, focusing on progress, reflection to check understanding and overlapping speech. Active interventions on the part of the coach include reframing, tentative suggestions/advice, offering information and rationale and guiding to specifics¹⁴. Evidence is that at least two days' training is required to achieve a mindset shift amongst clinicians¹⁵, plus ongoing support and reinforcement.

At a glance

Training in health coaching includes adoption of principles and practice from psychology, behaviour change science and performance coaching integrated with clinical skills

Good health coaching training is an experiential process with opportunities to test application of learning in the workplace

Evidence shows a minimum of 2 days training is required for effective mindset and skill acquisition

Train the trainer models can effectively develop an internal training resource for organisations

"I feel that ideally all health care professionals should have access to this type of training."

General Practitioner

"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

Contact

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What does health coaching training include?

Health coaching is an umbrella term used to describe many different interventions that 'coach' or actively support people to self-care. The aim is to move away from a dependency creating approach to one that is empowering and shared, based around a person's own aspirations and goals.

Effective health coach training integrates a range of skills and principles taken from three core disciplines of psychology and behaviour change science, performance and development coaching and clinical skills (or lived experience if a peer) (Figure 6).

A two day training programme is conducted over two weeks to enable practice and skills assimilation.

Core training includes:¹⁶

- Structuring conversations using a coaching approach to increase personal accountability for plans
- Active listening and how to build trust and rapport
- The use of effective questions to raise awareness and provide supportive challenge
- Applying a range of directive and non-directive communication approaches
- Setting goals important to the person to encourage intrinsic motivation
- The use of approaches that focus on strength and positive emotions
- Applying the principles of patient activation and readiness for change
- Understanding health behaviour and barriers to change (cognitive, emotional, behavioural, etc.)
- Applying specific coaching and behaviour change techniques in a variety of circumstances (including but not limited to motivational interviewing)
- Reflection and planning for the application of learning to practice

Figure 6. Health coach training content

Integration of principles and skills



What does the health coaching training process need to involve?

Effective health coaching training models a coaching style that is experiential and highly interactive. It includes:

- **Opportunities to share experiences, develop relationships, network and plan how to apply new learning**
- **Practicing on each other which challenges existing perceptions and limiting beliefs (i.e. “we are already doing this”) as clinicians personally experience moving away from a directive approach**

Key ingredients in health coaching training reported by participants include:

- **Practical focus** – emphasis on addressing the challenges of using health coaching in clinical practice and achieving behaviour change
- **Active learning** – incorporating a range of inputs and activities, e.g. theory, discussions, reflection, group learning and skills practice
- **Experiential process** – through a process of having an experience, observation and reflection, the formation of new ideas and testing in new situations
- **Personally meaningful** – skills practice about personal experiences drives an appreciation of the usefulness of the techniques and approach

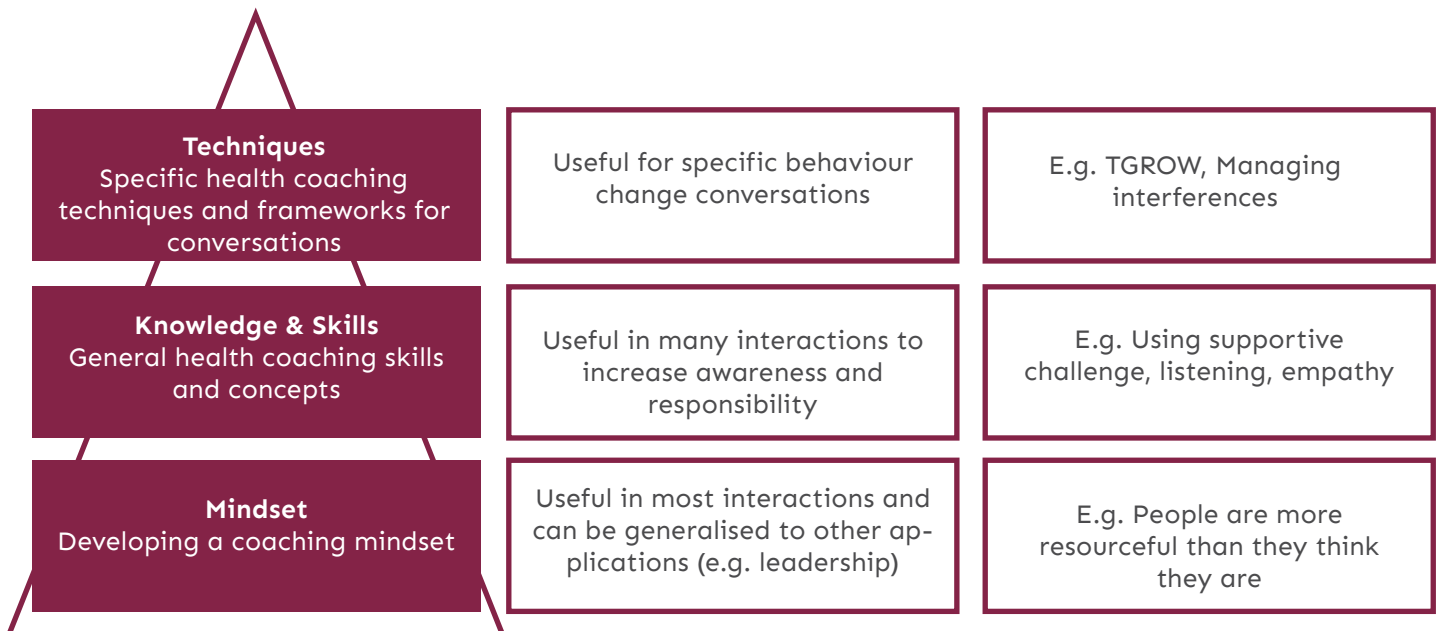
- **Holistic approach** – engaging the head (cognitive knowledge), heart (emotional), and hands (practical skills)
- **Application to workplace** - opportunities to think about and plan how to close the knowing, doing and being gaps in applying learning to clinical roles and adopt a mindset to embed the approach

Does training in health coaching work?

Health coaching training that works supports the development of knowledge, skills and mindset and an understanding of when and how to use them (see Figure 3). Clinicians have reported using the health coaching mindset with all patients, the knowledge and skills to build on consultation skills such as listening and developing rapport, and the behaviour change skills with specific patients¹⁷ (Figure 7).

Since 2010 the training described in this chapter has been delivered to over 3,000 practitioners from over 100 different organisations. Clinicians have used health coaching in a variety of ways including daily practice (case study 1); on a rehabilitation ward (case study 3); in medicines optimization (case study 4); across a health and social care system incorporating hospitals, community health and local authorities¹⁸; as a telephonic intervention tailored to levels of patient activation; and with non-clinical health coaches. The effectiveness of these skills in practice are listed in Figure 1 in Chapter 1.

Figure 7: Using a coaching mindset, skills and techniques¹⁷



How do we develop an internal training resource in health coaching?

To create a sustainable and cost effective training resource within the NHS, there is a need to train clinicians and others as trainers. A number of studies demonstrate the effectiveness of train the trainer interventions for clinical skills development¹⁹; developing skills in shared decision making²⁰; for teaching motivational interviewing skills²¹, and encouraging person-centred care in non-clinical staff²². However, there are no studies of train the trainer programmes in health coaching. Reports on Making Every Contact Count²³ and Co-creating Health²⁴, emphasise the use and importance of train the trainer strategies but do not provide details of the structure or content of those initiatives.

In 2014/15 HEEoE commissioned a train the trainer health coaching programme, and trained 20 local health coaches who have subsequently independently trained over 800 clinicians. Other regions have since adopted a similar approach, which now requires evaluation.

The East of England approach involved a 10 day programme including:

- **An introduction to core health coaching skills programme (2 days)**
- **Foundation level health coaching (2 days)**
- **Facilitation skills development (2 days)**
- **Two opportunities to co-deliver the core health coaching programme with an experienced lead trainer, with assessment and accreditation (4 days practice in total)**

Critical elements in the train the trainer programme include the selection of participants, ongoing continuous professional development and organisational support (case study 5). Local health coaching trainers report the following factors enabled them successfully to deliver their roles:

- **Ongoing commitment from organisations and senior organisational sponsorship**
- **Organisational and logistic support for coordinating training programmes**
- **Time to practice skills and develop confidence**
- **Access to a community of practice for supervision and development of learning**
- **Access to continuing professional development workshops and skills refreshers**
- **Access to mentoring and coaching to manage new situations and overcome skills deficits**

Figure 8. Questions to consider when planning health coaching training

Questions to reflect on when considering commissioning health coaching training	Questions to reflect on when considering developing an internal training resource
<p>Thinking about the service you want to develop ...</p> <ul style="list-style-type: none"> • How are clinicians currently having conversations? • What shift do your local clinicians hope to make in how they communicate? • What behaviours, skills and mindset would they like to use? • What are the likely benefits of introducing a health coaching approach and where could it be used most effectively? 	<p>To what extent is there...</p> <ul style="list-style-type: none"> • Support and commitment for health coaching among workforce development, clinical leaders and senior decision makers? • An already tested approach by 2-3 early adopter teams with positive results? • Staff who could be identified and supported to become health coaching trainers? • A plan to disseminate training (teams, specialties, obvious challenges to address)?

Case study 5

Health coaching train the trainer - a whole organisation approach

In 2014 East Coast Community Healthcare C.I.C. (ECCH) set out an ambitious programme to embed health coaching as the key operational approach for all adult services teams. The aim was to change the nature of clinical relationships, particularly for patients with LTCs, promoting independence, self-management and improving the outcomes of care.

Three senior clinical staff were selected to undergo the 10 day HEEoE accredited train the trainer course. Within 18 months of completing the course they had trained 248 staff (66%) and 32 staff from partner organisations in primary care.

The lead trainer was the Director of Quality and Primary Care and the two further senior therapists were selected on the basis of clinical experience and commitment to take the programme forward. They all received regular Continuing Professional development (CPD) provided by HEEoE.

Key enablers for roll out across the organisation included:

- Health coaching was championed from the outset by the CEO to enhance its credibility and sustainability
- The initiative began with a full presentation to the Board in October 2014 followed by regular updates and evaluations
- Participants were booked through normal learning and development processes leaving the trainers responsible for training only
- The commitment from the Board was that training would be made available to all clinical staff above Agenda For Change (AFC) Band 4
- The organisation provided the training resources and made the commitment to release staff and trainers as a priority
- The value of the programme was spread through internal social media, promotional circulars, word of mouth and training evaluation. The reputation grew and clinicians became keen to attend creating a waiting list for programmes

Evaluations included participant surveys and action learning sets. The impact has included benefits at patient, team and organisational level:

- **For patients: More effective consultations; aiding healthier choices; motivating patients, building their confidence and enabling self-management; setting realistic patient owned goals; improved medication**

At a glance

- ECCH health coaching programme was aimed at all clinical staff above band 4
- 248 of 372 staff were trained in under 2 years (66%)
- Trainers are 3 senior experienced clinicians chosen for credibility and sustainability
- Full support and sign up from the Board and CEO champion
- Board understood benefits both for patients and resource management
- Positive and motivational feedback from staff
- Plan to go forward using health coaching to build strong partnerships across agencies

Staff Quotes

"I feel more confident that I'm doing the right thing"

"I have a gut feeling that I'm wasting less time with patients and getting less resistance"

Patient Quotes

"I was surprised, didn't know how to react, I am the expert!"

"I get the idea, I'm really pleased"

Contact

Noreen Cushen

Director of Quality and Primary Care

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concordance and improved health outcomes

- **Organisational and financial: Reduce inappropriate activity e.g. repeat attendances and follow up rates; reduction in wasted pharmacy costs**
- **Teams and individual staff: Training reduced pressure and "feelings of failure" when patients did not adopt healthy behaviours; made it easier to identify patients who were open to change and goals that were owned by patients; increased clinicians confidence that patients were happy with care; led to more constructive conversations, and greater ability to challenge patients supportively.**

The training will now be rolled out to more clinicians, include partners from primary care, social care and the voluntary sector partners and be evaluated to identify outcomes for patients.

PART TWO

TIPS AND PROMPTS ON HOW TO COMMISSION, EMBED AND EVALUATE HEALTH COACHING

4. HOW CAN WE COMMISSION HEALTH COACHING?

Case study 6. My Health, My Way - Health coaching in a community setting

5. HOW DO WE SET UP HEALTH COACHING IN THE COMMUNITY?

Case study 7. Being Well, Salford - a coach-led health and wellbeing service

6. HOW CAN WE EMBED HEALTH COACHING IN SERVICE PROVISION?

Case study 8. Health & Wellness Coaching Intervention for Fibromyalgia

7. HOW DO WE EVALUATE THE OUTCOMES OF HEALTH COACHING?

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 View¹. 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 framework⁶

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.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'

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 vanguards⁷ (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 survey⁹ 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 measures¹² and health education impact questionnaire (HEIQ), self-efficacy scales¹³ 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.

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**

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

- **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 GENIE¹³.

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

Chapter 5

How do we set up a health coaching service delivered by lay people and peers?

This chapter is written for organisations and individuals who want to commission or run health coaching as a standalone service, predominantly staffed by lay people and peers. It describes:

- **What is meant by a peer and volunteer service**
- **The evidence of its effectiveness**
- **How to set up a service**

What is peer or lay coaching?

Peer or lay coaching is a standalone community-based service delivered by lay people, offering dedicated one to one and small group support. These may be provided, for example, over 6-9 weeks with weekly meetings of 45 minutes tailing off as the person gains the confidence, knowledge and skills to achieve their goals. These approaches are different from other types of self-management programmes that offer fixed curriculum courses.

Lay coaches are people with lived experience trained in coaching skills who are drawn from the communities they work in. They can have a variety of backgrounds, and may be volunteers, employed or long term unemployed, retired or have a range of conditions such as multiple sclerosis and diabetes.

Lay coaches help patients:

- **Tell and understand their story**
- **Identify what is important to them and what their long term goals are**
- **Identify and achieve the first steps towards a goal**

Goals may be as varied as losing weight to moving to more appropriate housing. Lay coaches help and support the patient to overcome blocks and barriers through a process that utilises the client's own strengths and assets and previous experiences of success. The coach does not give advice or comment on treatments, medication or the person's health condition.

Whereas health coaching in the clinical setting draws on the health care professional's expert knowledge, lay coaches focus on what is important to the individual in managing their day to day lives with a health condition. The coaches' skills include understanding core self-management processes such as pacing, planning, relaxation and other self-management tools.

At a glance

Lay coaches support patients to tell and understand their story, identify what is important to them and their goals, and achieve their first steps towards these through:

1. One to one sessions
2. Small groups
3. Online support
4. Telephone
5. Webinars and videos

Outcomes include:

- Ability to self-manage
- Improved well being
- Improved service navigation
- Achievement of lifestyle related goals
- Improved weight management
- Increased exercise

"It got me to do something outside being ill... I couldn't understand my strengths and what I can do after being ill for so long"

"It makes you think about what you can do to help yourself instead of just sitting there"

Useful resources

for quality standards

An established service in Dorset

For a EU perspective

Health coaching and other forms of self-management support

Does peer coaching work?

Evaluation of lay coaching is in its infancy in the UK with a limited number of studies so far. However, emerging evidence from programmes is promising. An external evaluation of the My Health My Way service in Dorset (case study 6) showed significant improvement in multiple areas as measured by the Health Education Impact Questionnaire (HEIQ)¹.

In Salford the "Being Well" wellbeing coaching service has found that in 70% of people studied, self-efficacy (confidence and motivation to self-care) improved after an average of 6 sessions of peer coaching with 74% of people reporting improvements in wellbeing. Around 1200 people use the service each year² (case study 7).

How to establish a successful service?

There are five prompts to consider:

1. Design and Planning

Early consideration should be given to the aims and ethos of the service as well as the design. For example, the service should support people living with long term conditions, and those who care for them, to gain the confidence, motivation and skills to deal with:

- **Medical management of the condition - such as diet and exercise, medication compliance and moving towards being more in control and a partner in care**
- **Day to day activities - maintaining what is important, being socially active**
- **Managing emotions - such as anger, fear, grief and loss associated with the condition, and supporting the process of acceptance and change.**

In rural areas it is important to consider access to appointments and need for home visits, and using local libraries, community rooms, or coffee shops where coaches can meet patients.

Ensure IT systems are in place and fit for purpose, identify necessary data sets, ensure effective data capture and clarify information governance issues.

2. Engagement

Most community-based programmes take time to build up awareness of the service, often 18 months or more. A communications plan with multiple messages for a range of audiences is required. Generate early support amongst clinicians and stakeholders to ensure appropriate pathways, referrals and signposting. Look at how to link to advocacy services, community prescribing and care co-coordinators as health coaching can enhance these approaches. Feedback to referrers such as GPs is important, as it helps clinicians understand how the service benefits patients and increases trust.

3. Recruitment and training of lay coaches

Key to recruiting volunteer coaches is ensuring people have the right aptitude. To support people who may be returning to work or who may have been service users consider flexible recruitment processes, using role play and workshops to assess aptitude to the role. Put in place ongoing assessment through observation of practice and supervision. Encourage peer feedback and shadowing. People training in level 2 and 3 counselling skills are often keen to take on coaching roles. Contact local adult education colleges.

Key considerations in training include:

- **Need for flexibility - for some people with health conditions long days may be difficult**
- **Experiential training - use of role play and practice over theory**
- **Basic requirements - cover issues such as safeguarding, confidentiality and data protection**

At least 5 days of training should be allowed based around core competencies. This may be shorter if the people selected for training have some previous experience in reflective listening skills or other transferable skills. A basic training programme would cover:

- **Setting and maintaining appropriate boundaries**
- **Managing and making effective use of time**
- **Appropriate use of goal setting including scaling**

- **Appropriate use of problem solving and goal follow up**
- **Managing resistance to change and ambivalence**
- **Understanding of the bio-psycho-social models of health**
- **Use of a solution and asset based approach**
- **Creating and maintaining a safe and positive relationship**
- **Understanding of social learning and self-determination theory**
- **Being responsive and sensitive to the needs and beliefs of the client.**

4. Evaluation and quality improvement

Continual review based on data and evaluation will ensure that service quality is maintained, reassure commissioners and increase learning to continually improve the intervention's effectiveness.

Key considerations include reporting requirements and use of outcome measures such as Patient Activation Measure (PAM), goal attainment, Health Education Impact Questionnaire, Health Literacy scales. Consider how patient stories are captured and used and patient experience including Friends and Family Test. Ensure consent from patients to allow use of stories and to be contacted for evaluation.

“In rural areas it is important to consider access to appointments and need for home visits, and using local libraries, community rooms, or coffee shops where coaches can meet patients.”

5. Maintaining change

Consider setting up monthly drop in groups so that patients who have finished coaching can still access support if needed. Utilise people who have been through the service as volunteers to run monthly groups and support small coaching groups. Where appropriate offer training in coaching skills and core self-management skills so that volunteers can move into paid roles if appropriate.

Case study 7

Being Well Salford – a coach-led health and wellbeing service

Being Well Salford, commissioned by Salford City Council, aims to empower participants to make positive changes. It reaches communities and people who are most disadvantaged and unlikely to respond to public health messages.

It works with people who want to change two or more lifestyle issues, for example, low mood, activity levels, weight, smoking, or alcohol.

They are likely to be people who are low in confidence, find it hard to believe they can effect change, and aren't sure what to tackle first; typically, they have already accessed specialist services and not met their goals.

Being Well Salford's team of coaches and participants meet in community settings ranging from health centres to fire stations and Job Centres, with the option of telephone sessions too.

Coaches use motivational interviewing techniques; this involves regular one-to-one meetings with a participant, encouraging them to set their own goals, and giving them the tools and techniques to achieve them.

Collaborative approach

To deliver the service, 11 Salford organisations – predominantly from the third sector – work in partnership. Operating within a shared set of values and aims, and steered by a central board, this model of delivery allows for wider co-production across the city, and enables participants greater access to alternative and additional support.

The experience of participants

In 2014/15, the service received 1,560 referrals, leading to 1,085 assessments. Working with these participants, coaches delivered almost 6,000 sessions.

At a glance

Being Well Salford is a one-to-one coaching service for people who want to change two or more lifestyle issues

Coaches use motivational interviewing and other behaviour change techniques

The service works with disadvantaged communities and people, is based in community settings and is a collaboration of 11 different organisations

Following coaching, 44-60% of people reported positive changes in smoking rates, weight loss, physical activity and mood

www.beingwellsalford.com

More information

After using the service:

- **48 per cent fewer people smoked 11 or more cigarettes a day**
- **44 per cent reported weight loss**
- **58 per cent felt that they were increasing their physical activity**
- **66 per cent said that their mood had improved**

Participants reported that they felt more in control of their journey, were motivated by setting their own goals, and valued having a personalised service that listened to them.

Chapter 6

Embedding health coaching in service provision

This chapter is written for health and care leaders and clinicians who want to champion health coaching in their organisation, team, service or across a care pathway. It is based on the literature and experience of East of England health coach trainers. The chapter presents:

- **A model of embedding change with a step by step commentary on applying the model**
- **Practical advice and tips from early adopters of health coaching on what helps and hinders, how to gain support from key stakeholders**

How can we start to embed health coaching?

Health coaching is still an innovation in the NHS, and as a relatively new concept it is important to create a plan to gain support, accelerate and sustain further roll out locally across whole or parts of organisations. The aim is to enable health coaching to become an established part of every professional's work and/or to establish a health coaching service targeting specific groups of patients.

The seashell model at Figure 11 below shows how health coaching journeys might unfold, to help advocates of health coaching facilitate change. It is adapted from an evidence-based model already used in the NHS¹. The term 'organisation' is used as a catch all to include a new approach, service or pathway across a range of agencies.

Early adopters of health coaching perceived barriers and enablers in spreading and embedding health coaching² (Figure 10).

- **Barriers included:** organisational and professional culture; time pressure of fixed appointment slots; difficulty releasing staff in small teams for training; lack of privacy for coaching conversations in busy ward environments; and training single clinicians who then struggled to share the approach with their colleagues.
- **Enablers:** which increased the impact of health coaching included: commitment of the most influential staff within the practice/organisation; connecting with and building on existing service improvement initiatives or organisation goals; targeting whole teams or services; data on numbers of patients coached; recording of activity and outcome data; and a supportive infrastructure and organisational culture.

At a glance

- Less than 30% (estimated) of sustained change in organisations is successful³. Leadership at all levels is key to success⁶
- Large changes in organisations need a vision that's better than the status quo⁴
- Board level support is vital to the spread and effectiveness of health coaching⁵

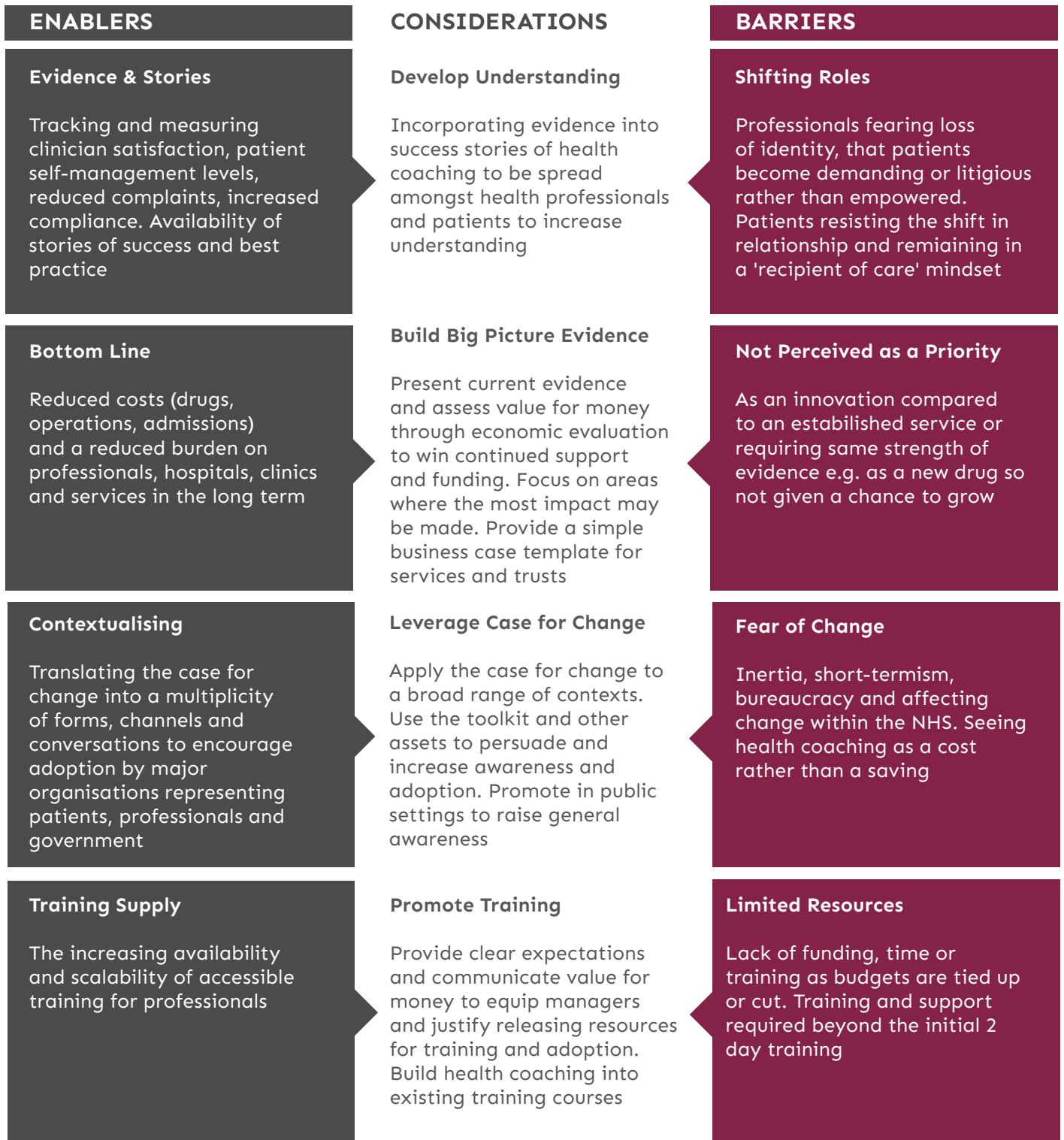
"You need management buy-in to spread health coaching. We highlighted our work on health coaching to our Chief Executive in the context of his vision for self-management and patient empowerment. This led to a big push within the organisation to build on health coaching. The key was to align with national and local agendas and keep linking back to these."

Advanced Physio Practitioner

Useful resources

A communications toolkit

Figure 10. Enablers, considerations and barriers to health coaching



How can we use the “seashell model” to embed health coaching?

There are eight prompts to consider when embedding health coaching in services:

1. Create a vision of success

Large scale change begins by identifying a need for change. Have a clear and understandable vision for stakeholders interested in adopting a health coaching approach, and be flexible on specifics. Link to values and national strategies of LTCs, self-management, patient participation, recovery etc.

2. Describe health coaching

Use a patient or clinician “story” to connect emotionally with people. Talk to the CEO, executive team and clinical leads about health coaching. Be clear about organisational gains, what success looks like and how it is judged. Build evaluation in from the start. Create urgency. Recognise that people are different and tailor the message to the audience. State clearly the support, resources, access or actions needed for health coaching.

3. Target and train clinicians

Find a way to convince professionals to take part, if appropriate, or to provide support. Involve the most influential clinicians locally. Decide where to start: target one service/ward/team and one patient group or have a clear rationale for casting the net more widely. Get the training/education team involved to organize and provide venues. Train targeted personnel as quickly as possible. If possible train whole teams as they will support each other in using their new skills with patients.

Figure 11. ‘Seashell’ model of embedding health coaching in organisations
Source: Carter, 2016 (adapted from Bevan et al, 2011)



4. Deliver health coaching to patients

Greatest impact will accrue with a critical mass of trained clinicians and targeted service/ward/team to create a common language and culture and so any team member can then follow through with patients. Help clinicians overcome perceived barriers to health coaching in their daily roles if skills are not being used as part of a specific targeted service. Local champions, line managers or mentors can all be tasked to offer support.

5. Review – Identify results, celebrate success and make progress visible

The appearance of success matters so use collected evidence. Spread the word about health coaching achievements. See the evaluation chapter for ideas. Connect to national/local strategies. Share new clinician and patient stories to keep health coaching in everyone's mind. But be reflective and look for problems. Where is the health coaching not working? What's getting in the way? What could be done differently? What help is needed?

6. Re-describe the "story" for different audiences

If more support is needed, perhaps from commissioners or funders, cast the net wider. Build on what has already been accomplished. Present at their meetings and use clinical examples of achievements and give a demonstration. If one particular story isn't engaging, find another description for what health coaching can do.

7. Target and train more clinicians

Keep momentum. Use resources to support those already trained or to train more clinicians. Target other areas which may benefit.

8. Attract more supporters and resources

Continually attracting new supporters is key in spreading health coaching, shifting mind-sets and changing practice. Without them health coaching may well fizzle out or only the few champions who have "got it" will keep using it. Convince previously neutral people to help.

9. Build capacity

If you are pursuing a whole organisation model of health coaching, build capacity and capability to make health coaching sustainable (chapter 2). Get health coaching integrated into management systems. Ask team leaders to put training into performance reviews. Ask HR to timetable introductory slots on induction days. Ask the training/education team to get health coaching integrated into relevant professional requirements.

10. Spread delivery wider

Keep going until health coaching becomes embedded in teams, services and across local health systems.

For health coaching to become an established and valued tool keep repeating this pattern of re-describing, attracting new supporters and integrating health coaching into corporate systems.

Case study 8

Health and Wellness Coaching Intervention for Fibromyalgia

Wellcoaches Corporation, in strategic partnership with the American College of Sports Medicine, has trained 10,000 health professionals in 45 countries in health and wellness coaching. The Wellcoaches protocol is now published in 12 peer-review papers. This study was submitted for peer review in August 2016.

What is Fibromyalgia?

Fibromyalgia (FM) is a member of a class of disorders called "medically unexplained symptoms" which present significant diagnostic and therapeutic challenges in healthcare⁷. The economic impact of FM is enormous; current estimates suggest that as many as 25% of FM patients in the US receive some form of disability or injury compensation^{8,9}. Various reports suggest that overall healthcare costs of FM are more than double that for people without FM^{10,11}. Two factors that determine FM patients' health and quality of life are a positive diagnosis and effective treatment¹².

What is Health and Wellness Coaching (HWC)?

The purpose of this study was to test the hypothesis that a Health and Wellness Coaching-based (HWC) intervention for FM would result in sustained improvements in health, quality of life, and reductions in healthcare-related costs as documented by subjective global improvement and health care utilisation. The HWC approach employs health professionals who have completed the Wellcoaches professional health and wellness coach training and certification (125 live hours training over 18 months). The training curriculum integrates evidence-based theories in behaviour change, self-determination, self-efficacy, self-regulation, motivational interviewing, positive psychology, and communication techniques into a standardised patient-centred protocol. HWC helps patients identify a personal vision of thriving, mentally and physically. Coaches assist patients in developing autonomous motivation, new resources, improved self-efficacy, and sustainable changes in mindset and behaviour that deliver more thriving through improved health and well-being.

At a glance

With medical support four Wellcoaches-certified coaches worked with 9 FM patients for 12-months leading to:

- Increase in self-compassion and self-kindness
- Pain scores decreased 30% and fibromyalgia impact scores improved 35%
- 86% decrease in health care utilization during and 6 months post-intervention

"I am more comfortable with having fibromyalgia and being able to get through it; I know I am going to be okay; I started going to the gym twice/week; I still have a lot of fatigue but the pain has subsided"

"I've always been a goal setter and do things no matter how much I hurt; my coach and I have worked on taking time for myself and sleeping more; getting more restful sleep; I am seeing a difference in pain levels – decreased soreness to the touch and less trouble with my legs"

"I would have had a different life if I'd had this 10 years ago"

Contact Gary Sforzo sforzo@ithaca.edu

The 12 Month HWC Protocol

The HWC protocol combined 60-minute, phone-based group coaching sessions (twice per month for 6 months) with 45-minute, private phone-based coaching sessions (up to 20 sessions over 12 months). Web-based educational webinars were provided, prior to each group coaching session, drawing upon the latest neuroscience discoveries to encourage patients to work on "rewiring their brains" – thinking and feeling patterns, and personal wellness habits.

- **Group coaching sessions addressed webinar self-coaching topics including taming emotional frenzy, deep focus and flow, mindfulness, self-compassion, positive emotions, leveraging one's strengths**
- **Individual coaching sessions were customized while encouraging patients to discuss their learning and application of the content in the webinars and the group coaching sessions**

Following the HWC intervention, patients expressed an appreciation for feeling increased calm, more in control of health issues, greater self-compassion, and decreased stress leading to healthier choices.

Chapter 7

How do we evaluate the outcomes of health coaching?

This chapter aims to help health and care leaders, clinicians and others identify outcomes from health coaching activities.

Most organisations supporting health coaching monitor progress by tracking numbers of health professionals or teams trained and numbers of health coaching conversations taking place. These are the inputs. Evaluation is about outcomes and analysing the impacts of health coaching on patients and/or services.

The three prompts given below on early adopter organisations' experiences and coaching evaluation literature.

1. Why evaluate?

Executives and funders expect hard evidence of costs and outcomes to back up anecdotal claims of benefit. When a concept is not long established the call for a 'business case' is to be expected. It pays to be ready by building in evaluation from the start.

Evaluation can also help everyone involved in making health coaching sustainable learn from experience, record and share learning, keep focused on the ultimate goal, identify strengths and weakness in project management and inform future planning decisions.

2. What to evaluate?

Start by articulating the definition and expected outcomes from health coaching and how these are to be achieved. Try to be as precise as possible. Typical expected changes might be how clinicians react, behave or change practice, through to how patients might react, behave or change leading to the clinical and/or organisational improvements expected.

Clarity about who wants what from the evaluation is important. Pose an evaluation goal as a question to help narrow the scope. Consider what signs or 'indicators' will identify whether health coaching is on the right track. Health coaching outcomes for patients could be explored by identifying any changes in hard clinical outcomes (e.g. HbA1c) and/or patients' perceptions of how they are feeling or behaving e.g. from surveys or interviews.

At a glance

Not many organisations systematically evaluate training¹. Spend on health coaching as an innovation is more likely to be scrutinised compared to a well established practice

Multiple approaches can be used to evaluate health coaching locally. More rigorous evaluation is required to demonstrate cost –effectiveness in teams and individuals

It is important to measure the use of new skills or evaluation efforts will be undermined²

"Our own personal experience of health coaching, the experiences of our patients and the feedback from the clinicians we have trained has been the most useful evidence of success over our first year of rolling out health coaching. We are now working with our organisation to provide more concrete outcome data."

Clinical Specialist Physiotherapist

Useful resources

Free to use Stanford self-efficacy instruments:

Measures to consider include self-efficacy (as in example 1), patient experience, quality of life, satisfaction, confidence, personalised advice, patient activation measure (PAM), goal attainment scores and medication compliance. These measures can provide evidence on whether health coaching has 'worked'.

Example 1 (case study 1): Increased patient self-efficacy³

One evaluation of 199 patients used the Stanford self-efficacy outcome measure, administered before and after the patients had received health coaching appointments from 13 general practice nurses across seven practices. It showed significant improvements in self-efficacy; very high or high patient satisfaction (98%); greater patient understanding of their conditions (74%); and greater understanding of tests and treatments (61%).

Health coaching outcomes include any changes in activity or costs. Key performance indicators (KPIs) are already collected for other purposes. There are many options, including post-discharge follow ups; clinical time; appointments per patient; length of stay; caseload; waiting times; prevention of acute (re)admissions; discharges, tests and medication; episodes of care; quality and consistency; and staff retention.

By assigning a monetary value to quantifiable activities, most hard measures can provide the "business case" on whether health coaching is cost-effective in local health economies. Focus on one important indicator to yield straightforward and compelling results (e.g. average number of GP appointments per patient per year).

Example 2 (case study 3): cost effectiveness⁴

One evaluation in an older persons rehabilitation ward found that, by using the techniques of health coaching, patients became more engaged in their recovery. The local service provider's data showed the resulting average length of hospital stay was reduced by 17 hours per patient whilst 8% of patients in the intervention group were discharged to residential care homes (compared to 27.3% in the control group⁵). Using these findings an economic evaluation found the intervention to have been very cost effective with a net benefit value per patient

of £4,973. Not all of the benefits identified will be cash releasing. Some of the outcomes identified will produce a financial benefit, such as an avoided need for residential care; others, such as the reduction in the length of hospital stay, may serve to improve the flow of patients through the hospital and reduce delays in admissions and transfers.

3. How to evaluate?

Evaluation should capture credible evidence of impact within time and budget constraints. If the skills and budget for a Randomised Controlled Trial (RCT) are available this will be seen as a 'gold standard' of evidence. Other approaches include the use of a control group, comparing outcomes relevant to specific patient groups, or comparison of healthcare costs at a team level, ideally covering multiple comparable teams over a significant time.

Whilst waiting for the results of formal or independent evaluation research, measuring where it is easiest can still be persuasive e.g. a comparison between pairs of clinicians using and not using health coaching (as in Example 3 below), or comparing a single clinician's activity before and after commencing with health coaching is possible (as in Example 4 below).

Example 3 (case study 1): Cost saving from reduced clinical time⁵

One clinician found that use of health coaching enabled her to reduce total patient contact time because patients needed less follow up. Local management data were used to compare the cost of clinician time in a health coaching approach versus a non-coaching approach. By calculating the actual hours spent on both approaches, and calculating the monetary value of the time based on salary plus employment costs, a 63% indicative cost saving by health coaching was shown. This was equivalent to a potential annual saving of £12,438 per FTE (from assuming reduced clinical time was repeatable and sustainable over time).

"The potential cost saving in our modest team alone could be significant".

Physiotherapist

Example 4 (case study 1): Increase in personal productivity⁶

A part-time community physiotherapist attributed reductions in her caseload to health coaching because empowered patients were discharged quicker. Taking on more new referrals instead was helpful in reducing waiting times. As the first in her team to use health coaching, it was not possible to compare patient throughput, costs or other KPIs at a whole service level.

Instead, audited departmental activity records were used to compare her own appointments over 12 months, revealing 28 extra patient referrals between comparison periods: 55 new patients in the six months before using health coaching, and 83 afterwards (51% increase).

Make use of what has been found. Think about why progress may have been slower than expected and what can be learnt from that. Share your experience with other organisations.

“The biggest enabler has been getting the Chief Executive on side...The story about my reduced caseload ticked his boxes.”

Physiotherapist

4. How to collect data?

Gathering evidence for evaluation is a key part of the process. Be as clear as possible about the starting point. This will make it easier to assess the distance travelled later on. Set up a system to gather data on a regular basis. Think about records that will be collected anyway. If possible integrate any additional data required specifically for the evaluation into existing data gathering mechanisms to minimize clinician time. Don't collect any more information than needed.

Working out what the data is saying is the next stage. Does it show goals have been achieved? Does it highlight achievements or problems to be tackled? Be alert to unexpected outcomes both desirable and undesirable. Allow plenty of time to pull the information together. Feed initial findings back to a wider group of stakeholders to add their insights.

PART THREE

PROCESSES COMPLEMENTARY TO HEALTH COACHING

8. HEALTH COACHING AND DIGITAL TECHNOLOGIES

Case study 9. Proactive Health Coaching in the Vale of York

9. CARE AND SUPPORT PLANNING

10. SHARED DECISION-MAKING

Chapter 8

How can health coaching link with digital technologies?

The purpose of this chapter is to provide a brief overview of how emerging digital technologies might augment health coaching, both now and in the future. While several examples are provided, the products mentioned are neither endorsed nor recommended.

The chapter is written for health and care leaders, clinicians and others and covers:

- **The rationale for combining health coaching with technology**
- **A number of key areas where technology can support behaviour change**
- **Quality assurance**

What are the opportunities?

Over recent years there has been a significant expansion in the use, types and scale of digital health technologies. For example, take-up of smartphones has continued to increase, with two-thirds of adults (66%) now owning one. Over half of households (54%) had a tablet computer in early 2015¹.

There are tremendous opportunities to tap into this technology revolution, to support the challenges of improving health and well-being.

These technologies can enhance the impact of health coaching by:

- **Identifying those at risk and who may benefit from health coaching**
- **Activating, engaging and empowering patients**
- **Setting goals and tracking progress**
- **Providing opportunities for peer support**
- **Giving access to patient information**
- **Delivering more sophisticated health behaviour models**

Digital interventions alone may be insufficient challenge to change individual mindsets and behaviours, while professional or peer coaching can be costly and/or inaccessible. Together the interpersonal support of a health coach combined with easily accessible technology could be a highly effective combination.

At a glance

The rapid growth of digital technologies offers considerable opportunity to augment one to one health coaching and better motivate patients to self-manage and adopt more healthy behaviours

Technologies that augment health coaching include those that enable tailoring of interventions through segmentation, including cognitive profiling, as well as shared records, apps to track progress, and peer support and disease specific self-care platforms

Digital interventions alone may be insufficient to change individual mind-sets and behaviours, while professional or peer coaching can be costly and/or inaccessible. Together the interpersonal support of a health coach combined with easily accessible technology could be highly effective combination

"Information technology plays an essential and rapidly expanding role in empowering people to take charge of their own health, by providing information, support and control"

Useful resources

Examples of the digital health technologies mentioned in this chapter are listed in Figure 13

What are the potential uses of digital technology with health coaching?

1. Digital technologies for risk stratification

Risk stratification software now uses a wide range of data, criteria and sophisticated algorithms to identify those at most risk of disease deterioration and admission and hence those who would most benefit from health coaching. The sophisticated use of artificial intelligence and self-learning diagnostics, for example in retinal screening for diabetes, means that through early identification patients can be engaged to change behaviours to prevent disease progression.

Health Navigator (case study 8):

- Uses an evidence-based algorithm
- Assesses a patient's risk of unplanned inpatient care over six to twelve months
- Clinicians assess whether patients will respond well to health coaching
- Patients are invited to receive the support of a health coach who also helps them navigate their health and care, without providing direct clinical advice

2. Technologies to enhance patient-centred care

Electronic patient records shared with the patient can provide useful insights for the health coach. Agreed goals and actions can be recorded securely, including those that are important to the patient. Approaches such as care and support planning can be greatly enhanced through shared patient records (Chapter 9).

With **Patient Knows Best** the patient:

- Owns the copy of their medical information
- Chooses who to share this record with
- Maintains a record of all aspects of their health and wellbeing
- The record can include progress towards agreed goals and records of discussions, reinforcing and supporting behaviour change

2.1. Peer support

Many people, particularly with long term conditions, can feel isolated and vulnerable. Linking people together through on-line peer support networks provides the opportunity to share information that can create and reinforce ideas for change i.e. before and after health coaching sessions.

HealthUnlocked and Patients Like Me provide opportunities for patients to link to others with similar conditions and share their anxieties and strategies for living with their conditions.

2.2. Reinforcing and supporting behaviour change digital health technologies and apps

There are over 160,000 health apps³ many of which provide simple and effective ways to set goals and track progress in a timely way by the patient or health care professional to reinforce behaviour change.

However, sufficient attention to psychological theory needs to inform the design and use of these apps⁴. Gaming theory, cognitive profiling (see below) and personalised decision aids may play an increasing role in improving the effectiveness of behaviour change supported by technology.

Puffell is a social media platform that enables people to self-manage their own health and wellbeing. It has also developed a bespoke asthma platform that:

- Supports people with asthma to understand and better manage their condition
- Offers tools and trackers to enable users to track their symptoms and to understand what might be impacting their condition
- Provides a history that can be shared with their health professional
- Offer features for peer to peer support
- Supports wider life - beyond just asthma
- Helps to support the diagnosis of asthma as opposed to viral wheeze

2.3. Psycho-social and personalised "precision digital"

Perhaps one of the most exciting potential developments in digital health technology is the assessment of psycho-social characteristics, to create bespoke solutions.

Behavioural understanding will become increasingly important if we are to treat and manage disease.

“...we need to look at someone’s psychometric and behavioural profile before prescribing digital health solutions. For example, if you are more competitive person who is constantly driven by targets and goals then you might respond better to a more gamified app than someone who is less competitive.”⁵

In particular, cognitive profiling can help identify the barriers to behaviour change, which are often unconscious and could be addressed through health coaching.

Mind Field Solutions has developed an evidence-based and validated tool that identifies unhelpful health beliefs based on neuroscience that compromise the patient's ability to effectively self-

manage. Specifically, a conscious and subconscious cognitive profile of the underlying decision-making processes is provided. Health coaches can then provide a more tailored and relevant support system for the patient⁶

3. How do we assess the quality of technology?

With thousands of apps available to download, it can be difficult for the public and professionals to determine which apps and technologies are the most useful and effective, particularly if prescriptions of apps and technology become as common as drug prescribing. A process for app accreditation is currently being developed by the National Information Board to enable them to make the right health and care choices⁷.

The Organisation for the Review of Care and Health Applications (ORCHA) in the absence of any formal national process, provides health professionals with a live updated resource of “approved” apps, based on a robust rating system, and which offers support and guidance to app developers.

Figure 12 gives an over view of the potential use of digital technology in combination with health coaching.

Figure 12. Summary of potential uses of technology with health coaching



Figure 13. Link and resources complimentary to health coaching

Complimentary IT Solutions	Links
<p>Ofcom</p> <p>National Information Board (2014)</p> <p>Health Navigator</p> <p>Patient Knows Best</p> <p>Health Unlocked</p> <p>Patients Like Me</p> <p>Puffell Mind Field Solutions</p> <p>Morrison (2015)</p> <p>Organisation for Review of Care and Health Apps (ORCHA)</p>	

Case study 9

Proactive Health Coaching in Scandinavia

A small share of the population accounts for the majority of healthcare costs. About 1% of the population account for approximately 35% of non-elective admissions. This is a transient group which typically follows a pattern of rapidly deteriorating health leading to increased use of A&E and acute services. Often these highly resource-intensive patients are identified too late to prevent the expected deterioration.

Targeting high risk patients

Patients are identified by a proprietary predictive model based on data from hospital Trusts and GPs which predicts who will have increased avoidable health care use over the next six months. These patients are offered a predominantly telephone-based health-management service, delivered by trained health coaches over a period of typically 6-8 months. The service helps patients identify personal drivers for health service contact, and systematically addresses underlying triggers for urgent access which may include e.g. better understanding of their long-term condition(s), addressing social isolation, how to self-manage or navigating the local healthcare system with a designated point of contact.

Proactive health coaching

Proactive health coaching (PHC) 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%⁸.

Evaluation

Data using the SF-36 shows over 54% of patients experience an increase in quality of life⁸. Patient's value the holistic listening, continuity and dependability of the

At a glance

Health Navigator, an organisation focused on innovative behavioural interventions, offers a Proactive Health Coaching (PHC) service for patients with frequent non-elective admissions:

- 1% of patients account for approximately 35% of non-elective admissions
- PHC identifies such patients and offers a structured, individualised, intense program of health coaching
- PHC uncovers drivers and triggers for acute health service use and addresses them through a nurse-driven, telephone-based service
- PHC reduces non-elective admissions by up to 40%¹

"Someone who cares, follows up, has the time to listen, calls when promised and whom you can contact when you need to"

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Useful resources

health coach. The calls between health coaches and GPs provide the GP with a better basis for decisions to prevent patients deteriorating, without increasing the number of GP visits. PHC does not require any changes in the system but supports and reinforces appropriate use of current structures and pathways.

Introduction into UK settings

PHC has been introduced to Vale of York CCG, with additional CCGs joining in 2016. The aim of the CCG with York Teaching Hospitals NHS Foundation Trust and other stakeholders is to reduce the need for non-elective admissions and emergency care. Between August 2015 and July 2016, 200 UK patients have received PHC, and outcomes are being evaluated by the Nuffield Trust through a randomised controlled trial.

Chapter 9

Health coaching and care and support planning

This chapter is written for commissioners, organisations and individuals who want to understand care and support planning and how it relates to health coaching. It describes:

- **What is meant by care and support planning**
- **Evidence of its effectiveness and policy context**
- **The five steps to care and support planning**
- **Its relationship with health coaching**

What is care and support planning?

Care and support planning is a structured and formal process which enables people to identify what is important to them, what they can do to live well and manage their own health and what support they need from both formal and informal services.

The process results in a plan detailing the person's goals and how they will be supported to achieve them. If appropriate, the plan will also detail how the person's personal budget will be spent. The plan is reviewed on an annual basis to reflect on what is working and not working, and make changes.

Care and support planning brings together contributions from family, friends, community, statutory health and social care services, and the voluntary sector around the person and their outcomes and goals. It is proactive rather than reactive and determines how services will be designed and organised around the person.

Is it central to government policy?

Person-centred care and support planning has been a central component of government policy for social care for many years, firstly for people with learning disabilities¹, and more recently as a core aspect of the personalisation policy².

At a glance

Care and support planning is a five-step process that enables people with care and support needs to identify what is important to them, what they can do to live well and manage their own health and what support they need from both formal and informal services. The process results in a plan detailing the person's outcomes and how a person will be supported by others.

Key facts

- There is a legal duty to provide plans as set out in the Care Act⁴
- The process improves physical and psychological health⁷
- Including people in the process leads to best outcomes⁹

"If care and support planning like this had been in place earlier, I would have more control from the beginning... and everything would have been a lot easier"

Alex, cancer survivor

Useful resources

Support Planning Tool¹⁰
Think Local Act Personal Care

In 2014, The Care Act³ made it a legal duty for local authorities to provide a care and support plan that reflects what is important to the person and their aspirations. The act also stressed that plans should be integrated across health and social care. More recently NHS England's Five Year Forward View⁴ recognises care and support planning as the key to achieving a new partnership between health services and people and communities and it is a fundamental ingredient of its New Care Model Vanguard and Integrated Personal Commissioning (IPC) 'demonstrator' programmes.

“By April 2015 everyone with long-term conditions, including people with mental health problems, will be offered a personalised care plan that reflects their preferences and agreed decisions.”

The NHS mandate⁵

What is the evidence for care and support planning?

The Cochrane systematic review⁶ brings together the evidence base for care and support planning. It states that:

“Personalised care planning leads to improvements in certain indicators of physical and psychological health status, and people's capability to self-manage their condition when compared to usual care. The effects are not large, but they appear greater when the intervention is more comprehensive, more intensive, and better integrated into routine care.”

The Year of Care programme⁸ demonstrated that person-centred approaches not only benefit the

individual, but can also lead to improvements for care professionals and commissioners.

More than 80% of over 4,000 people surveyed reported that a personal budget had made things better or a lot better when it came to dignity in support and quality of life. The study also showed that when people were included in the process of planning their support e.g. through care and support planning, they were twice as likely to report good outcomes⁹.

What is the process for care and support planning?

A proactive five-step approach has been developed that provides a bridge between the two traditions of planning in health and social care¹⁰ (Figure 14).

1. Preparation

Both practitioner (sometimes called ‘partner’ or ‘supporter’) and the person (‘patient’) need to be prepared by sharing information beforehand and allowing time for reflection. This means:

- a) **Preparation for the process** – making sure that the person knows what care and support planning is, why it is important and what will happen when. This step involves ensuring that the person is at the centre of decision-making, and that all information is accessible to them.
- b) **Preparation by the person** – the person is supported to think about what matters to them, what is working and not working, and their aspirations for the future. The support may be ‘prompt sheets’, through a telephone call, videos and guides, or someone supporting them to reflect and answer these questions. Here the person sets their priorities for the conversation.
- c) **Preparation by the practitioner** – the practitioner ensures that any relevant tests or assessments are completed (including indicative allocations for a budget if necessary) and that this information is shared with the person before the conversation.

2. The Conversation

The conversation starts with what matters to the person, what is working and not working for them, and where they want to be in the future – therefore setting their agenda, and moving towards the outcomes that the person wants to achieve. Together the person and practitioner:

- **Agree what is important to the person and what outcomes they want to achieve**
- **Look at the information**
- **Consider what support is available locally**
- **Explore the available resources, including personal budgets where applicable**
- **Work out what support the person needs and what they need to do themselves – this includes support from traditional/formal services, and community-based/informal supports and support for self-management**
- **Discuss any risks e.g. of not having or not having a certain treatment**
- **Work out the actions needed to put those supports in place**
- **Agree how to review progress**

3. Record

The Care Act requires that there is one plan. The record - the written element of care and support planning - needs to provide the information that the person wants, the information that practitioner needs, and inform commissioning through aggregated data¹¹.

4. Making it happen

The actions that are agreed to meet the outcomes may be ones that the person simply does themselves, or with help from family, friends or a circle of support. People may use their personal budget to employ personal assistants, use traditional and/or specialist health or social care services, universal services or community resources that are available

like Timebanking. Timebanks are community groups where members earn time credits for helping each other out or giving practical help, which can then be spent on getting help when the person needs it¹². Universal services are the places (libraries, parks, community centres), services (swimming lessons, health services), groups (sports clubs, church groups) and businesses (shops, cafes, hairdressers) that are available to everyone in the community.

5. Person-centred review

The conversation that happens at review is as important as the initial conversation. Here the person will review what has worked and not worked, or what they have tried and learned. This may result in new aspirations, outcomes and actions. The process is not finished here, but is ongoing - with action, planning and review on a continuous loop.

Health coaching and shared decision making

Health coaching and care and support planning are entirely complementary and both key to delivering person-centred care. The care and support planning 'conversation' will be very similar to a health coaching conversation. Both conversations:

- **Aim to empower people to take control of their lives and conditions**
- **Require a mindset in which people and practitioners are both seen as experts**
- **Enable shared goals or priorities to be set**
- **Can be powerful catalysts for self-management**
- **Require good communication skills and an empathetic relationship between the professional and the person they are supporting**

Health coaching mindset, skills and techniques (chapter 2) can be used in the conversation at key stages of care and support planning stages two and five (Figure 14).

The main difference is that health coaching is particularly focused on the interpersonal dynamic between the practitioners and the person they are

supporting, and uses communication techniques, principally to achieve behaviour change. Care and support planning on the other hand also involves a conversation where a clinician's and person's expertise are equally valued, although ultimately its purpose is the co-creation of an annual plan.

Figure 14. The five stages of care and support planning



Chapter 10

Coaching and shared decision making

Shared decision making is fundamentally the conversation that happens between a patient and their clinician to reach a healthcare choice together. This chapter is written for anyone interested in shared decision making and covers the following:

- **What shared decision making is and why it is important**
- **The evidence**
- **Essential and ideal elements**
- **The relationship with health coaching**

What is shared decision making and why it is important?

Enabling patients and citizens to be active participants in their health and healthcare is a critical goal for the NHS in England.

Shared decision making (SDM) is **‘a process in which clinicians and patients work together to select tests, treatments, management or support packages, based upon clinical evidence and the patients informed preferences. It involved the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients’ informed preferences’¹**

Shared decision making occupies the middle ground between traditional clinician-centred practice, where patients rely on their doctor or clinician to make decisions about their care, and consumerism where patients have access to information and make their own choices.

In shared decision making there are two sources of equal expertise that come together to enable better decisions – clinician and patient. In shared decision making the patient’s knowledge and preferences are taken into account, alongside the clinician’s expertise and the decisions they reach in agreement with each other are informed by research evidence on effective treatment, care or support¹. This leads to better

At a glance

Shared decision making (SDM) is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

The conversation brings together the clinician’s expertise, such as treatment options, evidence, risks and benefits, with the areas the patient knows best - their preferences, personal circumstances, goals, values and beliefs.

Health coaching sits within the clinical practice model to enhance the SDM conversation

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decisions and outcomes for both the patient and clinician.

In addition to the clinical reasons to undertake shared decision making, from an ethical perspective it is important to ensure that patients have unbiased and clear information on options, benefits and harms. It is the right thing to do.

A recent landmark case, *Montgomery v Lanarkshire Health Board (Scotland) [2015]* has focused the legal requirements to undertake shared decision making. The importance of a patient’s right to make their own decision has been advocated in legal cases before, but the *Montgomery* case confirms that the need for ‘informed consent’ is firmly part of English law. This ruling recognises a growing appreciation for patient’s self-determination and ability to understand the consequences of a particular treatment. Clinicians now have a clear duty to take reasonable care to ensure that patients are aware of material risks. Shared Decision Making is a key way of ensuring this.

What is the evidence for effective shared decision making?

Evidence shows that what makes shared decision making flourish is the collaborative conversation. The Health Foundation² reviewed the evidence from eleven large scale change projects which covered a wide range of areas. The review found key learning including:

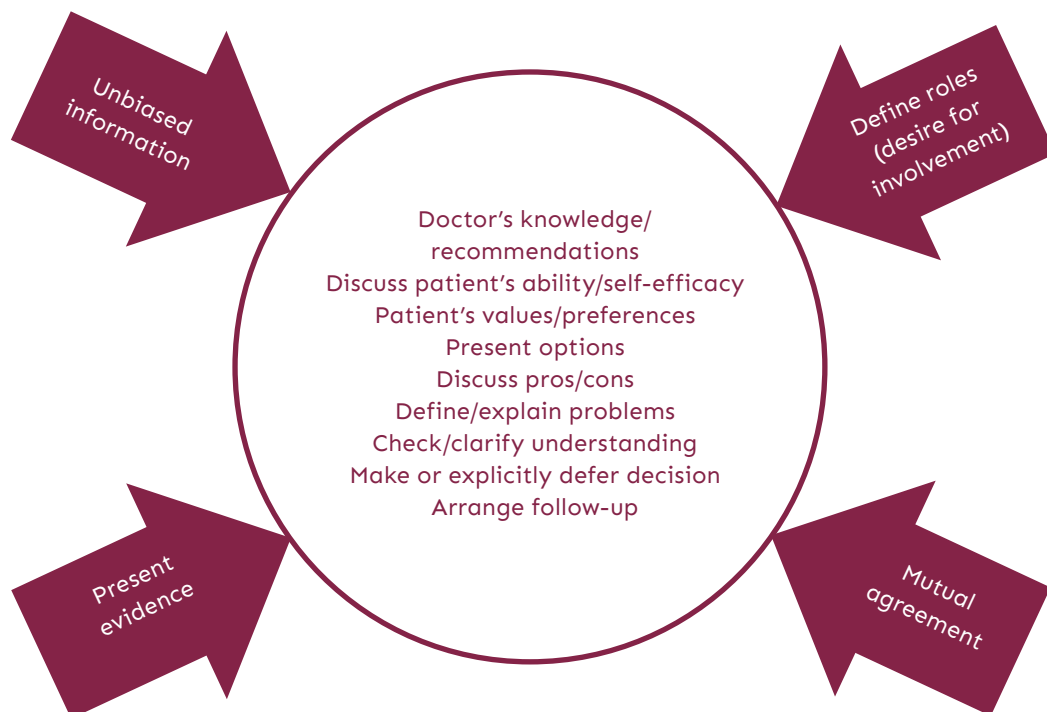
- **Decision support tools alone will not achieve shared decision making**
- **Offer people a range of support options to choose from, so that they can select to suit personal preferences and needs**
- **Recognise that people are different and tailor interventions appropriately**
- **Changing professional roles, behaviours and mind sets is vital, challenging, but not impossible**
- **Train the whole team, not just individuals**

Shared decision making has sometimes been seen as synonymous with decision support tools and approaches. The Health Foundation and other studies³ conclude that for tools to effectively work they should be embedded within the consultation, so that they function as part of a collaborative relationship.

What are the key elements of shared decision making?

There are a number of different models of shared decision making, but it is possible to define the core concepts³. The key concepts include 'patient values/preferences' and 'options'. Figure 15 outlines a model

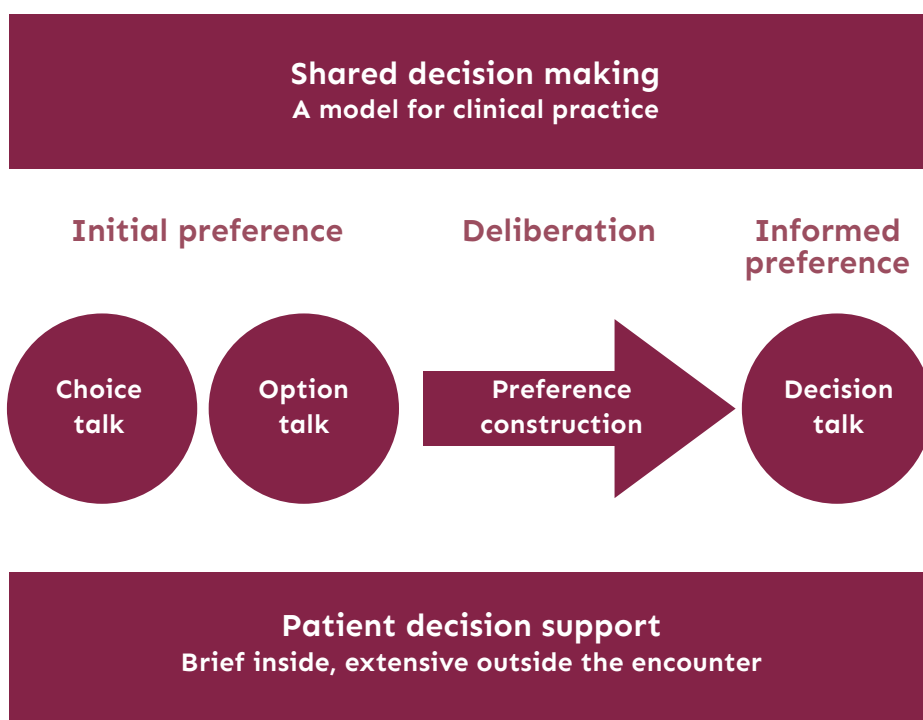
Figure 15. Essential and ideal elements of shared decision making



built up from a consensus of concepts and describes essential and ideal elements of shared decision making.

To accomplish shared decision making a three-step model for clinical practice is suggested⁴. The model illustrates the process of moving from initial to informed preferences (Figure 16).

Figure 16. Shared decision making - a three-step model for clinical practice



The relationship between health coaching and shared decision making

Health coaching is a key skill, approach and mind-set that can be used effectively to enable shared decision making as part of a collaborative conversation.

For example, one definition of health coaching is very similar to SDM where it is

“based on strong provider communication and negotiation skills, informed, patient-defined goals, conscious patient choices, exploration of the consequences of decisions, and patient acceptance of accountability for decisions made”.

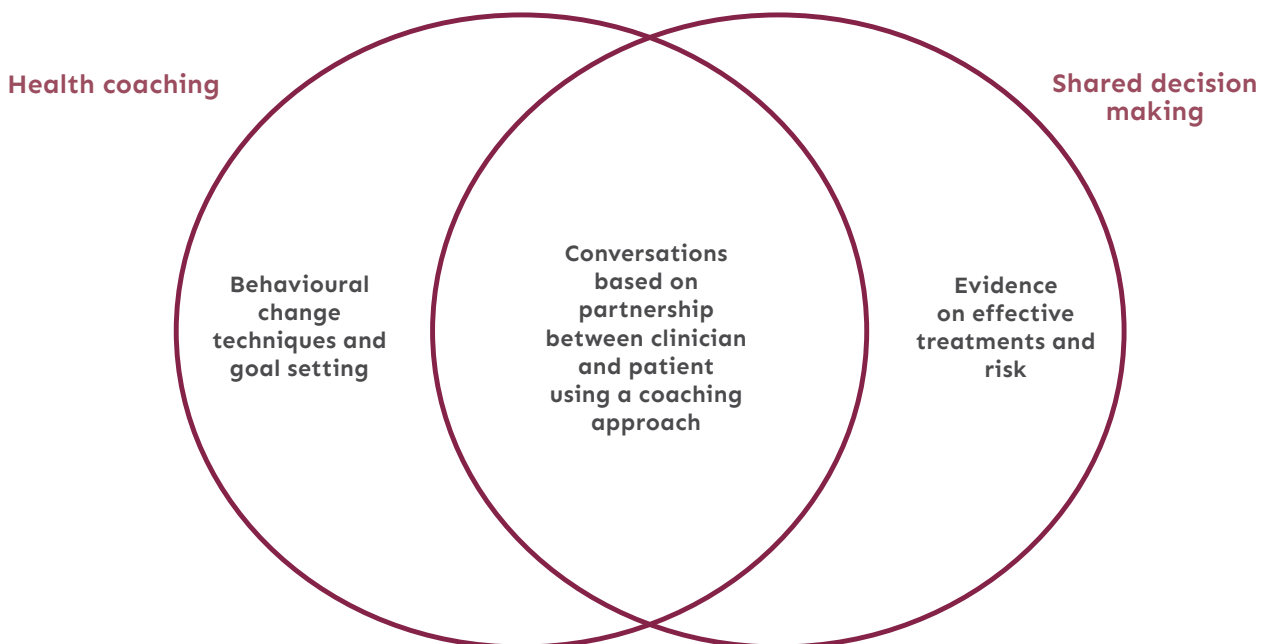
Both health coaching and shared decision making have significant similarities. Each is based on:

- **A partnership relationship between clinician and patient and the expertise of both**
- **An assumption that people have assets, are resourceful and can use these to help themselves e.g. to make decisions or change behaviour**

- **A therapeutic model which aims to support people to get to where they want to be**
- **A personalised approach**
- **The creation of an action plan and agreement of next steps**

However, although health coaching and shared decision making are complementary they differ in emphasis and intent – namely, to support change in health behaviour and make informed decisions respectively. Figure 17 outlines the key differences and how they inter-relate.

Figure 17. The Inter-relationship between shared decision making and health coaching



Glossary

FM	Fibromyalgia
HWC	Health and Wellness Coaches
MPC	Multi-Specialty Community Provider
HR	Human Resources
CEO	Chief Executive Officer or overall leader of an organisation
GMC	General Medical Council
HR	Human Resources
IPR	Individual Performance Reviews
LTCs	Long term conditions
FTE	Full Time Equivalent
PAM	Patient Activation Measure
KPI	Key Performance Indicators
RCT	Randomised Controlled Trial
FYFV	Five Year Forward View
NIA	NHS Innovator Accelerator programme (commissioned by NHS England)
CF	Cystic Fibrosis
NICE	National Institute of Clinical Excellence
IMMS	Integrated medicines management service
ECCH	East Coast Community Interest Company
HEEoE	Health Education East of England
HENCEL	Health Education North East and Central London
QoLs	Quality of Life Start
HWC	Health and Wellness Coaches
ORCHA	Organisation for the Review of Care and Health Applications
PHC	Proactive Health Coaching
RCT	Randomised controlled trial
CCG	Clinical Commissioning group
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
AfC	Agenda for Change
IT	Information Technology
SDM	Shared Decision Making

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