ies Report

Institute for Employment Studies

Reflections and insights from a place-based approach to implementing coaching

Better Conversations Test and Learn Pilot at Berkeley Vale

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One Gloucestershire
Transforming Care, Transforming Communities

better conversation
better health
health coaching

Institute for Employment Studies

IES is an independent, apolitical, international centre of research and consultancy in public employment policy and HR management. It works closely with employers in all sectors, government departments, agencies, professional bodies and associations. IES is a focus of knowledge and practical experience in employment and training policy, the operation of labour markets, and HR planning and development. IES is a not-for-profit organisation.

Acknowledgements

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Executive Summary

Context

The Gloucestershire Local Workforce Action Board, together with its associated OD Group and Better Conversations Sub-Group, supports the Integrated Care System (ICS) Delivery Board. During 2018-19 four training pilots were funded via the local HEE discretionary budget to build a coaching approach into existing healthcare roles. The focus of the 'test and learn' training pilot exercise at Berkeley Vale was to generate learning about 'how' health coaching is introduced in support of an ICS to integrate working practices and create an ICS culture. This was termed a 'place-based' approach to health coaching.

Of note is that the cluster management team at Berkley Vale decided to continue with implementing and then embedding a coaching approach, beyond the CCG supported pilot period.

Implementing the 'place-based' approach to coaching

Berkeley Vale comprises six GP practices plus associated delivery partners (acute, community, mental health, social care and voluntary provider organisations).

The implementation model was co-designed by the Sub-Group and Berkeley Vale Berkeley Vale Cluster Management Team, using an emergent action learning process that responded to on-going feedback from staff and training participants in what was useful and practical. Seventy local staff participated in 2-day training courses delivered by ICE Creates Ltd during the period and a champions group was established and supported by the CCG. Post-training activities included skill-share lunchtime sessions to support individual staff and a separate session for team leads to consider their role in embedding the approach and supporting their staff.

The Institute for Employment Studies (IES) was commissioned in September 2018 to assist the champions group to reflect and document their learning and so inform wider roll out decisions within and potentially beyond Gloucestershire.

The report presents views of staff adopting a coaching approach and other local stakeholders' views collected by IES researchers. The experiences and top tips captured formally and informally by the CCG and Berkeley Vale team leads and managers, as the test and learn exercise unfolded, have also been included.

Key insights

Some learning is common with other implementation approaches reported elsewhere in the academic and practitioner literature. At Berkeley Vale learning included the need for:

- Post-training support for individuals to change mind-sets and practice from 'fixer' to 'enabler' is needed. Opportunities for reflection and practise helps confidence grow, skills develop further and the approach becomes embedded into personal practice.

- Communications support is needed to raise local interest among service providers in engaging with training and maintain visibility and momentum after initial training

- Engagement with service users locally to explain the new approach so that it doesn't come as a shock (e.g. leaflets and posters in GP surgeries).

Other findings from the Berkeley Vale pilot shine new light on implementing health coaching and may be, in full or in part, due to the place-based approach:

- The mix of different professions, roles and organisations in training supported the creation of local relationships, as well as seeding a place-based (not organisation-based) culture. This may support developing Primary Care Networks (PCNs)

- Involving team leads in post-training support for front-line staff enabled systemic barriers to adoption to be identified quickly and, where possible, tackled. This may accelerate the embedding of coaching as 'the new way working around here'.

- Providing initial training for individuals is absolutely crucial but is the wrong place to start: a significant pre-training phase is required to prepare both the system and the people. System leaders need to own and champion coaching as a way of working that is here to stay, shared goals need to be articulated and commitment secured from local partners; and patient record keeping/sharing and supervision infrastructure reviewed. Preparing the people includes briefing training participants about what to expect (and why health coaching is important) and their managers and colleagues about the support required before and after training.

- Whilst funding constraints can understandably drive the rush to commission and deliver training (as that's where spend comes into play), to make the most of the organisational development and culture change opportunity, pre-work is not a 'nice to have'. Preparing the individuals, the organisations and the local system is considered necessary to maximise the systemic benefits a coaching approach can provide stakeholders and staff at Berkeley Vale.

Implementation model for health coaching

The embedding activities undertaken at Berkeley Vale to date were developed and provided as a result of the commitment of the individuals locally to respond to on-going feedback about what was needed to 'make this work'. The specific activities may be transferable to other settings. However the main learning is the necessity of preparation work with the system leads to gain their commitment to releasing staff for embedding activities and to identify people to take on the roles of staff supporters and champions. As local influential supporters of health coaching, champions should be

able to persuade staff of health coaching's benefits and tailor stories to their audience. Individual champions are operating in very different contexts in terms of influence and their role varies tremendously: for example, in the community setting it is very structured; in primary care it is more diverse and freeform.

Taking into account insights from the 'test and learn' exercise, IES proposes an implementation for place-based approach to health coaching which takes into account the need for significant pre-training and post-training support. The proposed model is presented in Figure E.1 below.

Figure E.1: Proposed implementation model for place-based approach to coaching

Preparing the people and the system → Initial training → Ongoing support and reflective practice → Embedding and spreading
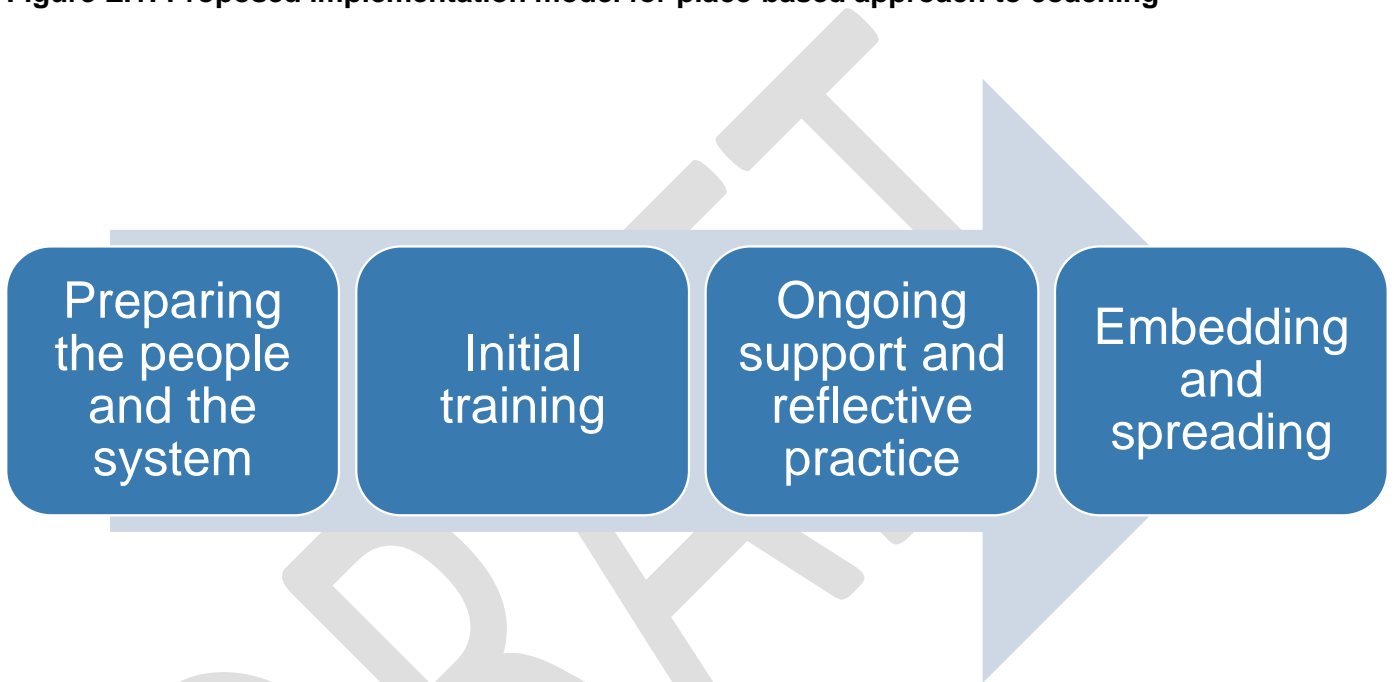
Source: IES, 2019

1   Introduction and background

1.1 Background

Healthcare providers across the globe are facing an increasing demand on services, which is often combined with reduced financial resources. The rise of long-term conditions is significantly contributing to the pressure that the services are facing. In England and Wales people with long-term conditions account for over 50 per cent of GP appointments and over 70 per cent of in-patient bed days, and the cost to care for those with long-term conditions is around 70 per cent of the NHS's total spend[1]. In 2019, health coaching as part of supported self-management (SSM) was incorporated into to the NHS Long-Term Plan, emphasising the need for greater engagement between patients and healthcare professionals leading to more personalised care[2].

There is already a growing evidence base which demonstrates that health coaching services have a positive impact on patient health and wellbeing (see, for example, Sforzo et al, 2018) and has also been found to reduce the demand on healthcare services (see, for example, Edgren et al. 2016). In the UK evaluations have found improvements in patient self-efficacy (Thomas, 2011), perceptions of clinician's own well-being (Newman, 2014) and indicative cost savings in service provision (Kibble et al, 2014).

How to exploit or spread new ideas and innovative practices is a challenge in any sector. With support from the NHS Innovation Accelerator Programme (NIA) from 2015 onwards and support events for local health coaching trainers and leads from the NHS Leadership Academy during 2018, it is known that many sites have been introducing health coaching. During the financial year 2018-19 four training pilots were funded via the local HEE discretionary budget to build a coaching approach into existing healthcare roles. Although no comparison was intended at the outset, the training pilots each adopted a different implementation delivery model encompassing a team, service, profession and place-based approach.

1.2 Understanding a coaching approach

Health coaching is an approach which empowers patients to self-manage their health and wellbeing. Health coaching aims to help patients to self-care, through enabling clinical professionals to have the right kind of conversations with their patients. Health coaching is therefore congruent and supports self-management by enabling people to manage their

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[1] Department of Health and Social Care, 2012: https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition

[2] More information about the Comprehensive Model for Personalised Care can be found on NHS England website https://www.england.nhs.uk/personalised-health-and-care

lives, including their symptoms. Compassion, listening and a positive relationship are geared towards the behaviour change required for better health outcomes.

There is an increasing interest in adopting a health coaching approach in the UK, although according to NHS England[3], health coaching is not embedded everywhere in the NHS yet. Health coaching can take many different forms, although the innovative approach nurtured and being spread within the UK is one built into existing roles. In this form, existing staff are trained to use the techniques and tools within their routine NHS consultations or service user interactions.

The first health coaching skills training was trialled and evaluated in the East of England in 2010 and the approach of integrating health coaching skills as routine practice, has been gaining momentum ever since. Since its inception, it is estimated that over 6,000 healthcare professionals have been trained in health coaching with 80 of these clinicians additionally trained as clinician-trainers: this includes within four Vanguard sites.

The 'coach' is sometimes a trained healthcare professional, who uses behaviour change theory, motivational strategies and communication techniques, in combination with their existing professional knowledge, to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and wellbeing. However, a coaching approach is sometimes also used by non-clinicians who are part of the wider health and care delivery system e.g. social workers, support workers and GP practice managers.

1.3 Purpose of the test and learn exercise

The test and learn exercise at Berkeley Vale did not seek to 'prove' whether health coaching works. Rather the focus of the exercise was to generate learning about 'how' coaching is introduced in support of an Integrated Care System (ICS) direction of travel to integrate working practices and create an ICS culture where organisational boundaries are blurred and teams are orientated around serving their local populations. This was termed a 'place-based approach' to health coaching. There was an expectation for the Better Conversations Sub-Group that a place-based approach will be effective by:

■ Enabling the underpinning cultural shift needed;

■ Creating the critical mass of change across professions and organisations; and

■ Becoming a "golden thread" that runs through delivery of care.

In addition, the test and learn approach was expected to better support the adoption of coaching approaches because it:

■ Does not place undue pressure on the system;

■ Supports longer term learning and change;

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[3] NHS England (2019 forthcoming) Supported Self-Management: Summary Guide

- Nurtures the mindset change that underpins practice change;

- Delivers added value in terms of improved team working; and

- Staff can engage with it.

Berkeley Vale was selected as the test and learn site in part because it had already started on its place-based journey with a management cluster board already established and chaired by one of the GPs. In addition, there are comparatively low levels of staff turnover, a good track record of coping with the additional demands of trialling initiatives on behalf of Gloucestershire and giving constructive feedback.

Stroud and Berkeley Vale is managed by an Integrated Locality Board and has a registered population of 120,601 people. One of its four clusters is Berkeley Vale, which comprises 6 GP practices plus associated delivery partners (acute, community, mental health, social care and voluntary provider organisations).

1.4 How the place-based approach was introduced

The overall implementation model was co-designed by the Sub-Group and Berkeley Vale, using an emergent action learning process that responded to on-going feedback from staff and training participants in what was being useful and practical. The model was overseen by the cluster management team and comprised three main elements:

- Initial training delivered to 70 local staff in groups over two one-day sessions during the period September 2018 – January 2019. The initial training was delivered by the external training provider ICE Creates Limited.

- Establishment and support from the CCG for a Champions Group of staff and team leads from multiple professions and local organisations. The Champions group met on four occasions during September 2018, November 2018, February 2019 and March 2019.

- Design and delivery of post-training activities:

  o   Skill-share lunchtime sessions were provided for those trained to support individual staff in adopting the approach and increase confidence. Three sessions were designed and delivered by local team leaders with external provider in attendance with more planned.

  o   A support session for team leaders and supervisors was provided for them to consider their role in supporting staff to apply and embed their skills.

1.4.1   Initial Training Sessions

Berkeley Vale has six types of delivery partners in the local primary care network (then known as the cluster) including: GP Practices; mental health trust, community trust, acute care, social care and voluntary sector. As can be seen in Figure 1 (overleaf), four of these partner types put forward individuals for initial training. In total 70 staff and managers participated.

Figure 1: Take-up of initial training at Berkeley Vale, by organisation and profession

Organisation/Role	Numbers Trained
Community Trust (GCS)	
Manager/professional lead	6
Nurse	19
Reablement Worker	11
Physio	3
OT	3
Referral Centre Manager	1
Mental Health Trust (2gether)	
Managers/Professional Lead	2
Nurse	4
OT	4
Psychologist	1
VCSE	
Manager	2
Community worker	4
Primary care	
GPs	6
Practice Nurse	2
HCA	2
Total	70
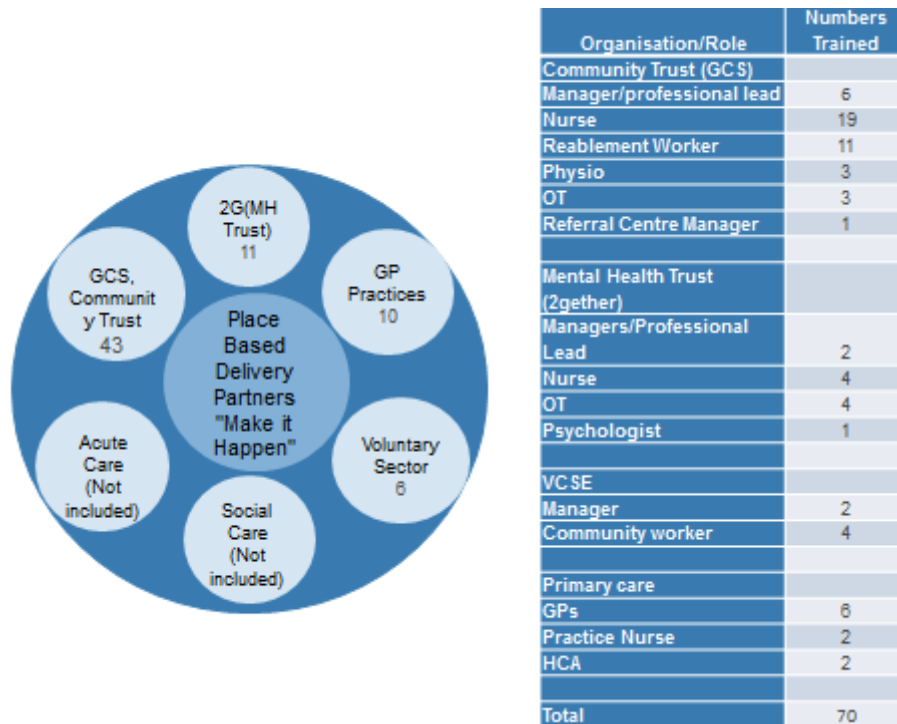
Source: Gloucestershire CCG, 2018

1.4.2   Champions group

A key part of the approach to making health coaching work in practice on the ground was the use of a formal Champions Group. 10 out of 13 'champions' were able to attend one or more champions group meetings before the end of the pilot period (ie. before end March 2019). The idea was that champions would, as individuals, role model coaching skills and offer practical support to other staff. In addition there was an expectation that collectively they would promote health coaching across the cluster and create a positive environment for coaching. Figure 2 (overleaf) explains the role of the Champions Group as co-created at their first meeting and presents the commitment signed up to by the champions.

During the funded pilot period, the champions group at Berkeley Vale was provided with three sources of external support: programme management and logistics from the CCG/Better Conversations Sub-group; health coaching inputs from the Training provider ICE Creates ; and learning capture expertise from Institute for Employment Studies (IES).

Figure 2: Berkeley Vale Champions Group Role and Commitment

Our Role	Our Commitment	
Create a Health Coaching Environment	• Believe in a coaching approach • Embed coaching in what we do • Promote Health Coaching across the MDT • Give permission to have a go	• Be resilient – pushing on and not falling back into old ways • Be a promoter (but not necessarily an expert)
Offer practical support	• Be available to talk – people need access to support	• Offer support and challenge • Be positive
Role Model: Developing your coaching skills	• Be committed to developing your own coaching expertise • Be willing to develop your own coaching style	• Learn not to "fix" others, but enable • Welcome feedback
Making it work in practice	• Be flexible with the approach • Be confident to challenge • Be systematic- PDP, Supervision and induction	• Continue to develop our toolkits • Support each other as champions
Connecting across the system	• Think creatively – how we can overcome issues across the system and also for individuals	• Share Learning • Support each other
Seeing the bigger picture	• Help people see that Berkeley Vale has a special role	• Help people understand they are part of a bigger national movement

Source: Gloucestershire CCG, 2018

1.4.3 Post-training sessions

An initial lunchtime skill-share session was run by team managers for community care trust personnel who had participated in training during November 2018. The feedback was very positive so the decision was made to invite all staff trained across the Berkeley Vale cluster to future sessions. At the time of writing (April 2019), six sessions had been run or were planned. 11 members of staff (initial training participants) attended one or more of the skill-share sessions with the majority coming from community and voluntary sector organisations with limited attendees from mental health and primary care organisations .

1.5 Structure of this report

This report focusses exclusively on the place-based approach to implementing coaching in Berkeley Vale. The work of the other training pilots is written up in separate reports.

The report seeks to bring together learning in one document the work conducted by IES researchers but also includes the views and experiences and top tips captured formally and informally by local team leads and managers themselves.

In Section 2 the method underpinning the various types of data captured is presented. The findings are presented Section 3 from two main perspectives: the views of staff adopting a coaching approach and the views of other local stakeholders. Finally, in Section 4 we discuss conclusions about the place-based approach and its implementation in Berkley Vale and the implications for future implementation elsewhere in Gloucestershire and more widely across the NHS.

2   Method

In summary, 118 reflections were collected as part of the data gathering process (see Figure 3). However, please note that this is not 118 different people contributing, as some individuals were involved in more than one data collection activity due to their reflections being considered useful from more than one perspective. For example, many of the champions group members were active in supporting others in adopting a coaching approach (through formal/informal or one-to-one/group activities) whilst simultaneously attending the training and adopting the approach in their own clinical practice.

Figure 3: Data sources and types

Data sources and types	Number of contributors

Staff
- Interviews (IES)
- Feedback forms (Provider/ CCG)
    - Support groups meeting notes (BV)
    - Usage tracking (CCG)
	17
	63
	14
	7

Stakeholders
    - Champions focus group (IES)
    - Cluster managers focus group (IES)
    - Training provider interview (IES)
	9
	6
	2

TOTAL	118

Source: IES, 2019

2.1 In-depth telephone interviews with staff trained

17 in-depth telephone interviews were conducted by IES research staff during January and February 2019 with a range of personnel who had participated in the initial health coaching skills training ('training participants'). Self-identified roles of the interviewees are shown in Figure 4 (overleaf). Interviewees included a mix of professional backgrounds from community and primary care contexts as well as voluntary sector. The purpose of the interviews was to gather feedback on the successes and challenges to using their health coaching skills in practice.

Initial invitations to participate in an interview were sent by CCG and Berkeley Vale managers and, where individuals agreed to participate, arrangements were made with IES.

Figure 4: Training participants interviewed

6 Nurses (3 Practice Nurses & 3 Community)	**4 Occupational Therapists**
2 Voluntary sector (GEM Navigators)	**2 Community Wellbeing Agents**

1 Team Manager	**1 Community Manager**	**1 General Practitioner**

Source: IES, 2019

Four of the interviews were paired which gave a valuable opportunity to elicit shared insights from people who work closely with each other. Two of the staff who volunteered for interview were unable to participate due to their leave and unavailability during the research period.

All interviews were conducted in line with the principles of voluntary informed consent. All interviews were recorded where consent was provided and detailed notes typed up from recordings including quotes. Each interview lasted 30 minutes. A topic guide was designed by IES to be used flexibly with interviewees and to allow for detailed follow-up questioning. The aim of the interviews was to seek views and experiences from across the local system. Interviewees were asked for their views on:

- The training provided;
- Their personal experience of applying health coaching skills;
- Any changes which had arisen in their practice following the training;
- The value of health coaching to practice;
- Any issues that they felt were enabling or inhibiting the local adoption of a coaching approach; and
- Any other issues they wanted to raise.

After the interviews were completed, an initial thematic qualitative analysis was undertaken during March 2019 across all participant interviews. Results were reported at a Better Conversations 'Sharing the Learning' event for stakeholders across Gloucestershire held on 20 March 2019.

2.2 Training feedback forms

The CCG analysed training session evaluation forms from 63 training participants (out of 70 trained). Survey respondents were asked by the CCG for their views on:

■ How participants would rate various practical aspects of the training and their programme overall; and

■ How the coaching models, skills practice and 'mindset' change had been introduced and how they had landed.

The results were presented to the Better Conversations Sub-Group in early 2019 and there is a separate in-house report of collated participant training feedback.

2.3 Staff support group meeting notes

Session notes were drafted by local team leads following the staff support skill-share sessions. These notes did not attribute experiences or views of individual staff or patients, rather they included:

■ Real stories/vignettes of experience in using the coaching approach and the result;

■ Personal reflections about what is working well/not so well in practice; and

■ Requests for help or support on specific matters.

These notes were shared and discussed at champions group meetings to inform action planning and design of future training, and to identify any infrastructure changes that may be required.

2.4 Usage tracking data

A survey instrument for capturing coaching usage data was co-designed by IES, Champions and CCG in order to track if/how usage increases or decreases over time. Survey data was captured and analysed by CCG. At this initial stage, data from only seven practitioners was forthcoming, which is insufficient to be confident in the results. However, the instrument is likely to be more useful in a year's time to provide a quantitative indicator of how many staff are actually using the approach and whether they are still finding it useful.

2.5 Focus group discussions and interviews with stakeholders

IES designed and conducted two focus group discussion sessions: one with nine champions and one with six cluster management team members. Both sessions were held on 5 February 2019 and took place as an agenda item within longer meetings. In addition, a paired in-depth telephone interview was conducted by an IES researcher with two members of the training provider team on 8 February 2019. Stakeholder focus group attendees and telephone interviewees were asked for their views on:

- Readiness of the cluster to introduce a coaching approach and how the training landed;

- Issues enabling or inhibiting the local adoption and impact of a coaching approach;

- The choice of a cluster as a vehicle for introducing a coaching approach and what advice they would give to the CCG about any further rollout;

- What they have learnt about implementing a coaching approach as a whole cluster and what practical tips they would give to other cluster management teams who might follow in their footsteps;

- Implications of how the provider role was specified by the commissioner and whether it could be done differently next time; and

- Any other issues or points they wanted to raise.

After the stakeholder interviews and focus groups were completed, an initial thematic qualitative analysis was undertaken during March 2019. Interim results were reported at a Better Conversations learning event for stakeholders across Gloucestershire held on 20 March 2019.

3   Findings

3.1 Views of staff adopting the coaching approach

3.1.1   The health coaching training
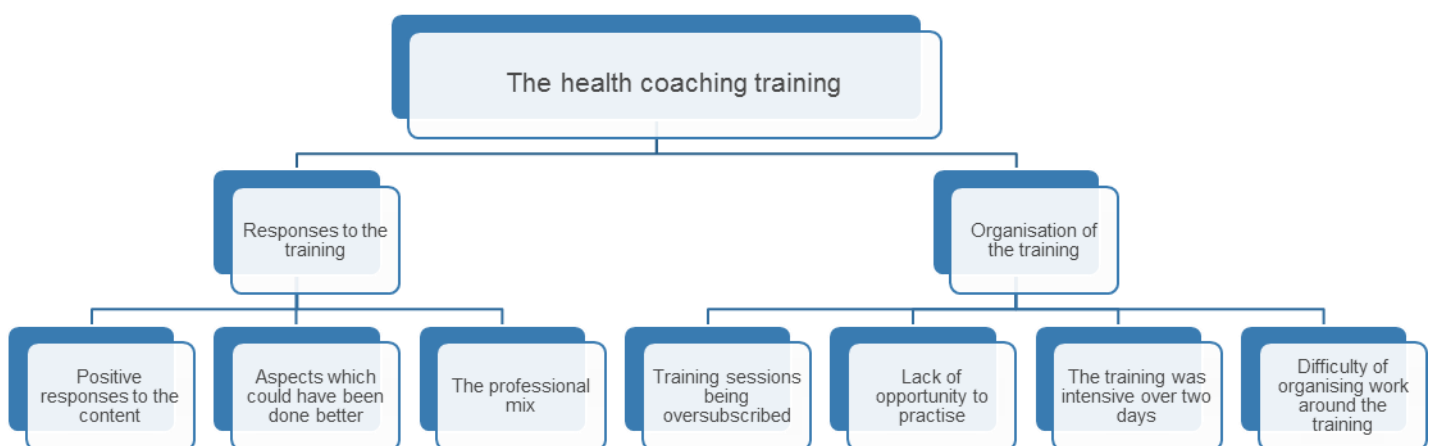
Responses to the training

Positive responses to the content

There were positive responses: for some, a lot of it was familiar, a good refresher, and felt like time well spent. It was felt that as health coaching is going to be adopted as an overall approach for the cluster, it is important that staff are involved. A couple of participants thought it was useful to look at the case studies that had an applied focus, such as mental health cases.

> *'Working in learning disabilities, communications, it's what we do, liaising with clients and carers and a lot of the approaches weren't necessarily new to me, but in a slightly different context perhaps, perhaps repackaged almost but essentially the approach, working with the client to get the best you can from them, but working with what they've got, it's exactly what we've always done in learning disabilities anyway. Just trying to get the best you can with what you've got. And that solutions-focussed approach.'*
>
> Nurse

Aspects that could have been done better

One issue related to the timing of the course. There was a lot of content and some felt it was rather rushed. Others felt it was model-heavy, with lots of acronyms. Two people

reported they had struggled to see relevance, and others felt it was what they do in their work anyway. Some thought that preparatory work before the course would have been helpful in understanding some of the concepts covered. One person thought unqualified staff might have struggled with these concepts.

The professional mix

Most of the staff thought this was good for networking, and for understanding the roles and functions of people that they work alongside in the cluster. A few participants suggested that it might have worked better if the training groups had been divided by levels of prior experience of coaching; the advantage of doing so would have been the effect of learning on a deeper level. However most participants felt that the mix of professions was the best approach and a reflection that colleagues work in multi-disciplinary teams.

One interviewee said that in their training sessions there were quite a few other community wellbeing agents so the group was not as varied as it could have been.

Organisation of the training

Training sessions being oversubscribed

One interviewee had not done the second day of training, as it was oversubscribed. Some interviewees said that earlier training sessions had been overcrowded, and others had attended a spill over session.

Lack of opportunity to practise

Some participants felt the time and opportunity to practise what was covered was unavailable during training. Others felt that exercises in the training would have been beneficial to reflect actual practice. There was a widely held view that more time to practise coaching conversations and guidance on how to structure conversations would be helpful.

The training was intensive over two days

As is commonly found when participants are asked to reflect on classroom based skills training there were diametrically opposed views about the optimal training delivery format with equal numbers commenting that the elapsed time taken was either too long or too short. Many saw the two-day model as quite intensive and felt the training might be better over more, shorter, sessions. However, they acknowledged this would require a greater time commitment. Some thought two half-days would have been sufficient, but this depended on the individuals' experience and knowledge of coaching. Two mental health practitioners suggested that they have more opportunity to use coaching-type techniques within their existing usual practice and as a result suggested that a differentiated training model could have been better. However, one of these also commented that more differentiation by prior experience of coaching-type techniques might compromise the benefits of the professional mix.
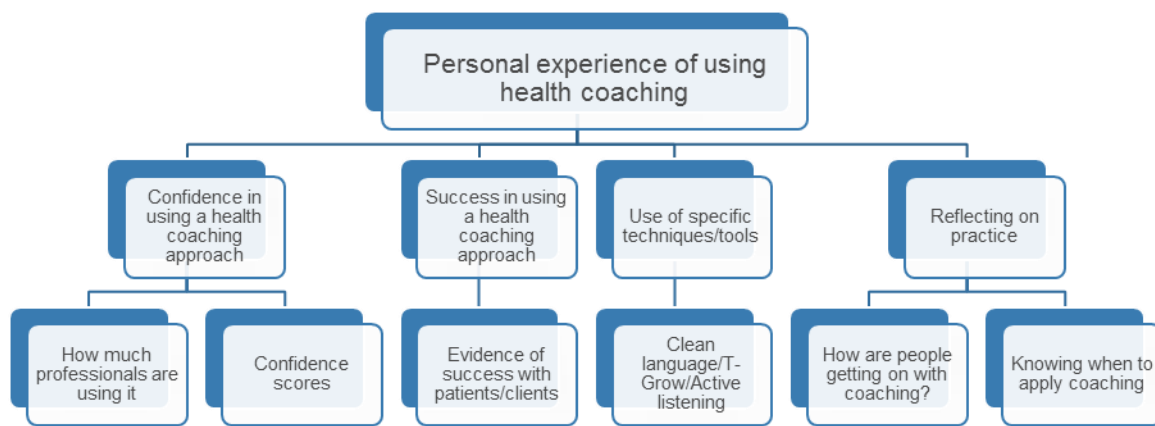
Difficulty of organising work around the training

It took some juggling to ensure that a service could keep going while the staff attended training and this was expressed most strongly by the participants from primary care settings.

> *'Two days out of their practice was considerable.'*
>
> General Practitioner

3.1.2   Personal experience of using coaching

Confidence in using a health coaching approach

How much professionals are using it

Following the training, many practitioners report that they are using coaching in a thoughtful and considered way. Coaching gives everyone an understanding of the way that people are engaging with patients. One person talked of how coaching is encouraged in her team with all staff and co-workers helping to embed it.

Confidence scores

Interviewees gave a 1-10 score on how confident they felt about using a health coaching approach. 17 people gave an average of 6.5. For those with a higher score, coaching is not an approach as such, and they do not use a 'coaching' label for what they do. It is more a style that they are confident in using with patients. For those with a lower score, they needed to practise a coaching approach.

Success in using a health coaching approach

Evidence of success with patients/clients

The overwhelming response was that coaching adds real value. One person said that they were able to negotiate a plan with the patient, something that had seemed difficult to

achieve at the beginning. Others say that they are focussing on the application of a coaching approach: practitioners model the approach, go to a patient with a goal in mind, and suggest coaching practices to them. Coaching encourages patients to look at things differently.

Coaching is beneficial in raising staff members' awareness of responsibilities, and the need to encourage and enable clients to take responsibility for their health. Moreover, it is something that builds confidence for staff as well as clients.

> 'Health coaching has helped me to put the onus on [the patients] to work out what do they want and how I can help you and how can we move forward together.'
>
> Occupational Therapist
>
> 'It was like a light switched on and she could see the value in doing it.'
>
> Occupational Therapist
>
> 'Through subtle questioning there was a little light bulb moment…it's got to come from me!'
>
> Occupational Therapist
>
> '…there is more benefit in the long-run in people being more responsible and activated in their care because even if it doesn't necessarily make a difference this time it might make a difference next time they are feeling unwell or how they approach things when next time things are getting more difficult. Which is why doing things across the system feels like a good way to work. If we're all taking a similar approach then one day people will start to have that attitude themselves and have more chance of people trying to find their own solutions or working with us in a different way.'
>
> Team Manager

Use of specific techniques/tools

Clean language/TGROW/Active listening

One practitioner reported that a combination of clean language with motivational interviewing and NLP with a patient produced a very quick turnaround in behaviour. An Occupational Therapist reported she had used TGROW to break down a patient's issues linking their behaviours to wider health issues, which resulted in a successful outcome. Another practitioner reported how active listening applied in all her patient interactions. Clean language was highlighted throughout as a particularly useful tool.

Reflecting on practice

How people are getting on with coaching

Health coaching is being widely used across different healthcare roles. Some practitioners felt it was hard sometimes to identify a particular coaching tool when working with clients. However, the way practitioners are approaching patients can be different when following a

coaching model. More listening is involved, and different questioning changes the conversation.

Some still find coaching somewhat awkward (others find it a powerful tool), but confidence appears to be growing amongst practitioners. One way to increase confidence is for practitioners to ask for patient feedback on their health coaching experience.

> *'Patients should feel the difference'*
>
> Staff support group

Many interviewees reported that setting expectations with the patient is useful to prioritise what to work on together. Beginning with a coaching style is a good way of setting the tone and context for working with a patient. Patients should be encouraged to identify and articulate their own goals so they are an active partner. The health coach then supports them in owning these goals. Unpacking a patient's potential goal by asking questions allows small steps without losing sight of the bigger long-term goal.

> *'This training has made me think most of the time there is a way forward…sometimes having those conversations with the patient is exactly the way around it.'*
>
> Community Nurse
>
> *'The central tenet of the health coaching approach helping people resolve the issues and taking responsibility for what they're doing can give people confidence and self-belief.'*
>
> Community Wellbeing Agent
>
> *'It is a negotiation between your own goals and the goals of the client or carer so it's a case of how to empower the individual. Through a lack of capacity or choice for some clients it is necessary to make decisions for them through the Mental Health Act for example. I wouldn't necessarily call it coaching but it is a model of working I employ often. If I am working with another member of staff I get them to reflect on what their own needs are and if they have an issue as a service user how they can explore that together trying to encourage them to look at ways to do that. They know what they want they have the answers but you're acting as a sounding board.'*
>
> Nurse

Knowing when to apply it

In spite of a very positive response to health coaching, practitioners reported that they are not certain about appropriate patients and circumstances. It is easy to *not* coach in particular situations, and so preparation before seeing a patient is important. It is also valuable in spotting opportunities to use coaching when talking to a patient or client. Coaching can work well with new patients, as they do not have pre-conceived ideas about working with a practitioner.

There are challenges that can stop a coaching approach. Referrals may be more solutions-based and applying coaching may be impossible. A patient may be the focus of multi-disciplinary teams and therefore be particularly challenging. Some patients' self-limiting beliefs present challenges to the health coach. Older people can be less receptive

to coaching, with the feeling that professionals should take control; younger people can be naturally less deferential and more receptive. Nonetheless, shared decision-making is important for older people and in keeping with an empowered coaching approach.

Other challenges are present when dealing with a carer or family member, if they do not accept or know of their relative's health situation. Family contexts can be complicated to manage, and do have an impact on coaching. Some patients may be receptive to coaching but their families are not, believing that their relative does not have the capability or know their health goals.

Many interviewees highlighted the need to *adapt* health coaching to different clients and the benefits of it as a flexible approach.
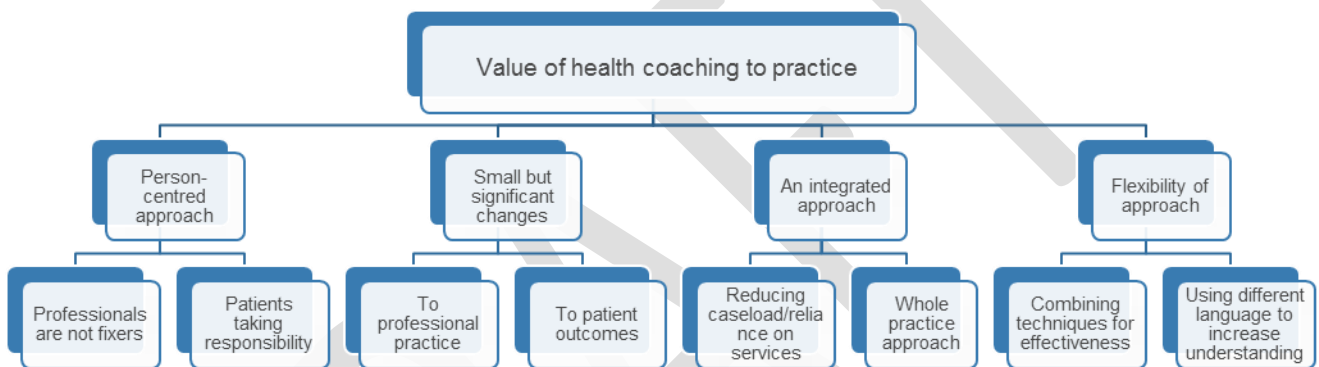
3.1.3 Value of health coaching to practice

Person-centred approach

Professionals are not fixers

Patient-facing healthcare professionals acknowledge that they are not 'fixers', and should not see themselves in this way. Coaching requires a change of mind-set, and some are aware they revert to fixer mode. A barrier to using coaching is patient expectation: they also expect to be 'fixed'. Some patients' attitudes may never change but others, even if they have been under care for a long time, may do so.

> *'I'm aware of when I'm still going into fixer mode and I'm trying to do something about that.'*
>
> Community Wellbeing Agent

Allocating and sharing responsibility

Participants talked a lot about giving the patients more responsibility in making changes and the increased self-confidence and sense of achievement they observed in their patients which resulted from those changes. It seems that health coaching conversations were considered as a means for finding the right balance of responsibility between each health care practitioner and each patient. A few participants said that giving patients

ownership of their own actions relating to health gives them the necessary responsibility to make positive changes. One practitioner referred to waiting for a moment when the patient will say something in passing to indicate that they are setting a goal with them. Another said that helping people to resolve issues also gives people self-belief.

Small but significant changes

To professional practice

By making small but significant changes, practitioners have facilitative interactions with patients and these can bring immediate successes. Rather than asking patients to take on additional tasks or burdens, they ask them to tweak or enhance the way they do things.

To patient outcomes

Health coaching recognises that clients and professionals take small steps in the process, and what these mean in terms of achievement. Practitioners know that sometimes patients have to go at their own pace and, if they are receptive, it is possible to set small goals.

> *'Anyone can do it…you just have to read up a bit and change how you work with people.'*
>
> Community Wellbeing Agent
>
> *'Setting and achieving smaller goals with the client can be effective.'*
>
> Community Wellbeing Agent

An integrated approach

Reducing caseload/reliance on services

A major benefit of health coaching is that patients are eventually less reliant on other services and this has longer-term benefits. This was recognised by different levels of healthcare staff.

> *'Working in an integrated way will reduce caseload of nurses.'*
>
> Team Manager
>
> *'A benefit is you see patients less.'*
>
> Practice Nurse

Whole practice approach

Several staff highlighted a need for consistency and a whole practice approach in using health coaching. Two practitioners got to the same point with a patient independently but using the same coaching approach. Others adopted a co-ordinating role with other

professionals in the team to recognise that they had reached a solution that produced better health for the patient.

> *'I think it's about everybody having the same approach with the same people and getting there quickly...working collegially.'*
>
> Occupational Therapist

> *'… through co-ordinating efforts with the GP and district nurse, and "asking the right questions" a patient was encouraged and eventually took charge of her treatment....It took a bit of time but we actually managed to let her take control.'*
>
> Community Nurse

Flexibility of the approach

Combining techniques for effectiveness

Those who have now had health coaching training have recognised techniques and strategies from the coaching model, and are now able to co-opt from the approach. By combining techniques, practitioners are finding that coaching has a powerful effect. One interviewee held the view that coaching is not a directed or structured approach (unlike a clinical model). Therefore, different conversations take place between professionals and patients, and professionals anticipate that this will result in different outcomes.

Using different language to increase understanding

By using health coaching tools such as clean language, and exploring metaphors in conversations, practice is showing these might be helpful to lead to solutions-focussed behaviours. By using different language, it is possible to check patients' understanding.

> *'It comes back to me about that there are things around specific techniques that people can use, ways of asking questions, but actually it's finding your own language and finding something which is natural and which works for you as an individual and which fits in with the work that you do rather than putting on a coaching hat.'*
>
> Team Manager

3.1.4 Barriers to health coaching
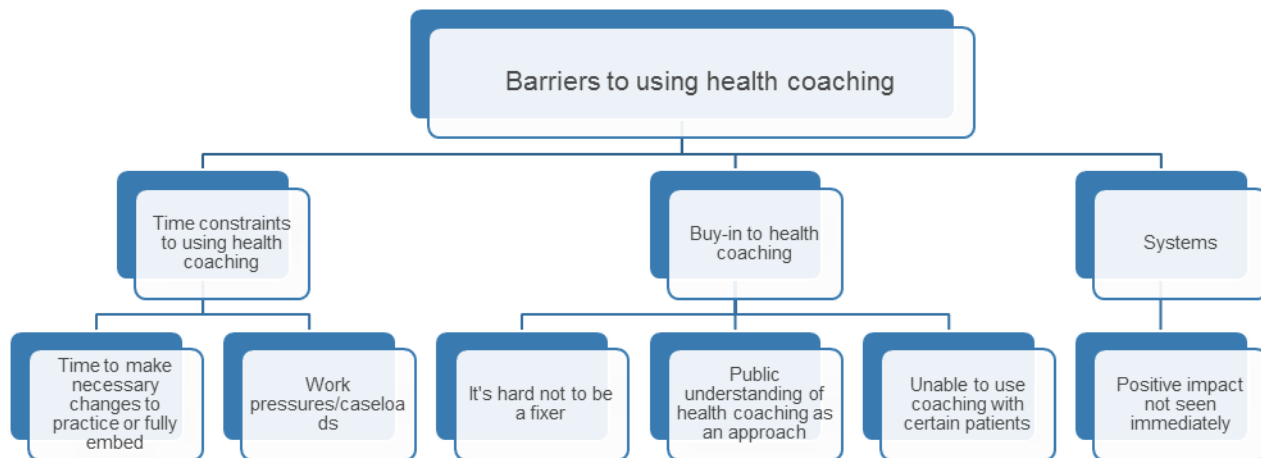
Time constraints to using health coaching

Time to make reasonable changes to fully embed practice

It was clear from staff across healthcare that time constraints are a barrier to using health coaching. Taking the additional time for a health coaching approach is difficult. However, practitioners also acknowledged that an effective health coaching approach saves time in the long term.

Finding time to learn coaching techniques, and to have group meetings to embed and keep using them, is helpful. It can be time-consuming to get to a useful point with a patient or relative, and one interviewee (a Senior Community Nurse) said '*I took as long as I needed*'. The additional time required, however, is not always readily available.

> *'There is a long way to go.'*
>
> Team Manager
>
> *'The conversation took an hour but that potentially saved many more hours down the line.'*
>
> Community Nurse

Work pressures/caseloads

Health coaching was thought to increase a practitioner's workload in the short term, a significant barrier to its use. If visits take longer than the usual 90 minute assessment because of trying something new and unfamiliar with clients, that reduces the number of cases dealt with on a day-to-day basis. '*Opening a box of worms*' was mentioned in one staff support group (1 November 2018), a reference to practitioners feeling out of their depth after getting into conversations with clients, or feeling unable to deal with someone's concerns in the time available.

> *'Everyone is working flat out at the moment and there is no capacity in the system it seems…'*
>
> Nurse

Buy-in to health coaching

It's hard not to be a fixer

There is a spectrum between prescribing and facilitating: several of the practitioners reported that some fixing and some coaching are more usual in dealing with a patient. There are all sorts of coaching skills between the ends of the spectrum, and practitioners need a range of tools and techniques at their disposal to achieve the right balance.

> *'My sense a bit that from the multi-disciplinary responses was that some people weren't feeling that confident about how they could, obviously in training you get the gold standard, and then in reality you have the time constraints, and maybe in the more clinical setting it can't be quite as holistic and getting to know the person, as we can in mental health. So I feel it's the right sort of thing we should all be learning about, regardless of setting but I don't know how joined up that is likely to be.'*
>
> Nurse

Public understanding of health coaching as an approach

Clients also see professionals as 'fixers' so it is important to change this mind-set. Several practitioners highlighted the importance of changing people's perceptions about healthcare provision.

> *'It would help to have advertisements in practices and in the media which promote health coaching; leaflets to give to patients.'*
>
> Practice Nurse

Unable to use coaching with certain patients

Pragmatism is needed when deciding who receives health coaching. Patients need the right headspace to take responsibility, so those with mental health conditions, dementia or memory loss, and end-of-life patients, are not suitable candidates for coaching. However, one community nurse recounted how a coaching approach had been effective with a patient's spouse when it seemed they were unable to agree to administer medication at home.

> *'Some patients are just too unwell.'*
>
> Community Occupational Therapist

Systems

Lack of impact

The challenge of health coaching is getting everyone on board. In the NHS there are many different starting points. In multi-disciplinary teams some people do not feel very

confident about how to achieve success with coaching. Two interviewees reported that it could undermine the confidence of both professional and patient if an initial approach does not work and they have to try something else. One clinician's view was that there are some 'easy wins' such as smoking cessation, but it will not always be possible to know if coaching has had a positive effect longer-term.

There are also issues related to the recording and sharing of steps taken or goals achieved with a patient. Many interviewees and staff support group members reported that these systems need to be in place. In addition to shared record-keeping, suggestions for staff to pair up on visits and observe each other's practice was an idea presented to help and challenge others. An effective feedback template would be needed for observers to enable a useful two-way learning process.

3.1.5   Additional support for health coaching

Formal and informal support

More training in specific techniques

There were requests from staff for more training on clean language as some were not yet confident in using it. Several practitioners mentioned the videos of people using health coaching as being particularly helpful for showing coaching in action, and for help with 'setting the coaching tone' with a new patient.

Regular helpful reminders of health coaching tools included in the initial training to facilitate development, and refresher sessions on how to use them would reinforce the principles behind certain topics. The staff support groups also requested training on boundaries (mental health); how to extricate safely from a situation; how to look after themselves if they are having particularly difficult conversations with clients; and how to deal with disclosure in practice.

Follow-up sessions (Champions Group, networking or group sessions)

The vast majority of people who provided feedback had suggestions for the further support they needed to take health coaching forward. These suggestions included

forums, support networks, group supervision, drop-in sessions, and regular linking in with others in Berkeley Vale.

More informal staff sharing was suggested by the staff support groups so that they can learn from each other. Sharing 'real-life' coaching successes, they said, would be useful. Sharing experiences and practising (roleplaying) techniques would also be helpful, with one practitioner taking the coaching role and the other taking the patient role, and then swapping over. With these 'coaching buddy' practices, a system would also need to capture these to share learning and encourage others. Staff support sessions are valued and more are wanted, perhaps with smaller group sizes.

Opportunities to reflect on own practice

A key factor for one practitioner was a professional's own awareness about when they are trying to do too much for a client. Therefore, helping to reflect on one's own practice will build up confidence and enthusiasm for it.

> *'It's about keeping it uppermost in your mind.'*
>
> Community Wellbeing Agent

Changes in working practices across the system

Management encouragement to use health coaching

A key factor in the success of health coaching in practice is the role of a senior manager in sharing of best practice and helping to embed coaching.

> *'Health coaching does have the support and the focus of management in Berkeley Vale.'*
>
> Community Nurse

Commitments from practitioners across teams

Six interviewees commented on a need to share the positives of coaching as an approach. Being able to discuss the difficulties they experience, and share best practice, is good inter-linking with the community services team. Discussing specific cases across the team in both practice and MDT meetings is also helpful, where GPs, practice managers, nurses, and receptionists are represented. New staff entering the practice/service/team should be encouraged to use health coaching.

> *'Opportunities for my team to talk to each other are invaluable. We are all still getting used to the idea and the training. And because none of us are experts yet I think that having external support would be helpful to embed the learning. I don't feel confident enough yet to initiate that support.'*
>
> Community Nurse

Barriers to further support for coaching

Professionals reverting to old ways of doing things

Going back to being task-focussed when a person is overwhelmed with their workload is a risk that several interviewees identified. Practitioners need additional time to use the coaching approach, and it is important to keep it in the front of their minds.

> *'There is a need to unlearn a whole way of being which requires time and attention.'*
>
> Team Manager

Time constraints of workload preventing further training/embedding

A few practitioners reported that they are now unsure of which follow-up health coaching sessions or meetings to attend, and which to prioritise, around their workload. For others, there may be a lack of time capacity for follow-up workshops. Staff members from one practice suggested that protected time would enable training because they were so busy.

3.1.6 Sustainability of health coaching in Berkeley Vale
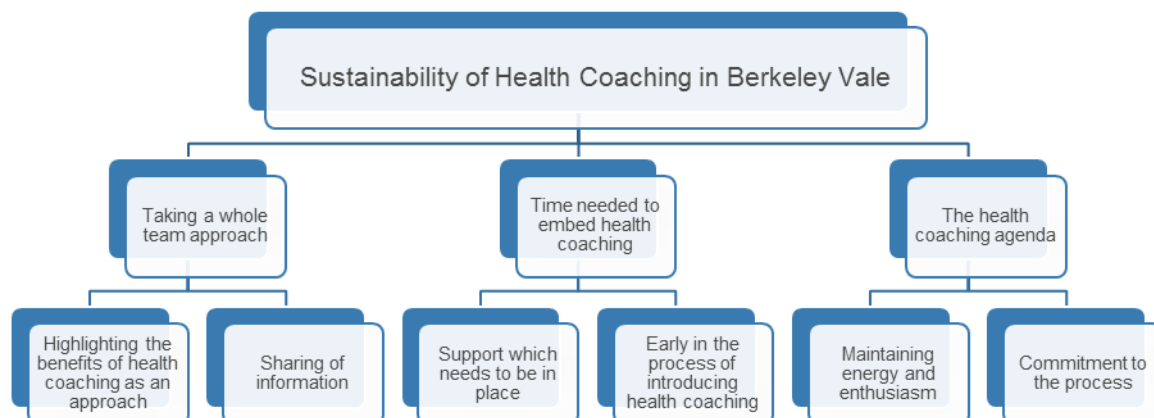
Taking a whole team approach

Highlighting the benefits of health coaching as an approach

Long-term health issues such as mental health, obesity, and poor fitness are not going away and the overriding feeling among the trial practitioners is that people have to take responsibility for these conditions. This requires a fundamental behaviour change, not only from patients but also in professionals. Many staff perceive that conversations need to happen more often between them in order to help promote health coaching as an approach.

> *'It's got to be the way forward.'*

GEM Navigator

'It reminds me of the work we do.'

Nurse

'With people living longer it's about patients needing to be educated on how to cope with and manage their conditions and that 'we can't always mend-mend-mend things.'

General Practitioner

'I think, still, some nurses and doctors will find it hard to understand that, in the long-run, it should save time and the anxiety that it will mean a longer consultation, that's the key…to try and get people to understand that this could save time.'

Occupational Therapist

Sharing of information

A major point arising from both the interviews and the staff support groups is that patient records need to be kept and shared with relevant practitioners to embed health coaching. Evidence is needed to show the approaches adopted, for example, and the goals that have been set. There is a need to share patient goals amongst the different health and care providers across the system. In addition there is a need to track usage of a health coaching approach within the system.

'I think that it would be beneficial for the whole team to be aware and familiar with the approach but I don't think it would be the solution to everything that we encounter in our work…it would depend on where someone's at with their journey of recovery, it might also be more potent to use with carers or families of people who can't engage themselves.'

Community Occupational Therapist

Time needed to embed health coaching

Support which needs to be in place

One practitioner said health coaching is more likely to be sustainable if there is a wider forum available, going back over ideas using real-life examples. Another suggested that the staff support groups should keep running. One occupational therapist suggested that Patient Activation Measure (PAM) interviews would give health coaching an easier starting point.

'It will take 6-12 months with refresher training to embed.'

Occupational Therapist

'A lot more buy-in and regular support is needed for health coaching to give it clarity.'

Team Manager

Early in the process

Some staff think it's too early to say if health coaching will be successful in the longer-term. It needs to be measured over time in order to demonstrate its effectiveness.

> *'I think it is sustainable but I feel that even though we're a few months in it hasn't taken off yet.'*
>
> Team Manager

Keeping health coaching on the agenda

Maintaining energy and enthusiasm

There is a need for people who are confident with the health coaching approach to talk to others. Several staff commented about the need to keep up the energy around health coaching.

> *'Keeping up the momentum at this point is critical.'*
>
> Team Manager

Commitment to the process

The passion and commitment of people to health coaching is evident, and at this time is working well to keep the focus on health coaching. The commitment and involvement of senior management will also be critical to the process.

3.2 Views of local stakeholders

3.2.1   Consolidating learning and encouraging practice
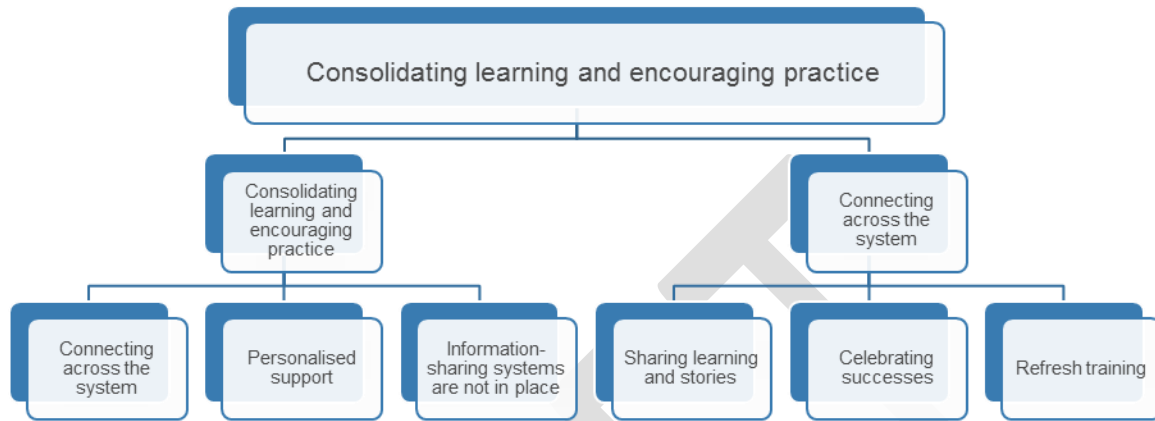
Consistency of the health coaching approach

Consistent practice across the cluster

Stakeholders regard health coaching training as most effective when a whole team is involved. There is a need to promote it across the multi-disciplinary teams in Berkeley Vale. This view was echoed by interviews and support groups. In order to do this, line managers of different organisations in the system need to collaborate and involve L&D and OD wherever possible.

The stakeholders do not yet have a clear grasp on how many practitioners are using a coaching approach. At time of writing, only six of 70 people trained have returned the usage tracking forms, so it is difficult to tell at this stage. There was some concern that a patient may meet staff across the system that have not been to the training and may use different patient approaches, causing confusion.

'Integrated working meant we should not operate in organisational silos.'

Stakeholder at Champions Group meeting, 15 November 2018

'Is this the right way to introduce coaching? Yes. Without doubt it makes sense to ensure consistency across the Integrated Care System. But it is not a quicker way.'

Stakeholder at Champions Focus Group

Personalised support

A view held by one stakeholder group is that it is important to flag the health coaching Champions to all staff who attend training. To do this, a register of the Health Coaching Community – all those who have been on the training course – should be created and shared.

Support at a higher level

Support is now needed at a higher level. Senior staff have to intervene to offer support and encouragement where engagement is lacking. The Learning Event held in March 2019 was a good opportunity to share the learning from the various work streams.

Support at a wider level

Support is also needed *across* the system. The new NHS Long Term Plan (and its effect on practices, funding and recruitment), was noted as significant for the development of health coaching practice. Stakeholders also acknowledged that some parts of the system are not engaging with health coaching. This could be because contact between some health professionals across the cluster is very fragmented, or there are staff shortages in some services.

Training and resources

The staff interviews showed the importance of awareness training at future skill share lunches, and that health coaching staff support groups will help staff to understand how to deal with/handle issues that may come up during health coaching such as disclosure. Another suggestion was made for improving mental health services for veterans, including a website offering resources, training, and health support information.

Information-sharing systems are not in place

The staff response also highlighted a major issue of how to record learning and development as a group of champions for test and learn. A particular challenge was noted that coaching is not part of some supervision, recording or information-sharing systems. Capturing activity with a form to track use, and a discussion guide around adopting coaching for use with staff groups, was suggested as a way of supporting staff.

> *'The system makes it hard for people to do health coaching. It is not part of our existing system which makes it harder to sustain initial enthusiasm for individuals.'*
>
> Stakeholder at Champions Group meeting, 24 September 2018
>
> *'There has been a lack of systems to support it for example there is currently no obvious way to record keeping about coaching conversations. We are identifying what needs to change.'*
>
> Stakeholder at Champions Focus Group

Connecting across the system

Sharing learning and stories

The importance of healthcare professionals sharing learning was a major thread running through the stakeholder and staff groups. One group noted that during the staff support sessions, small differences in the approach can make a phenomenal difference to patients. Sharing case studies and good practice across the cluster will, therefore, support health coaching trainees. The stakeholders took these ideas further and suggested various ideas as important for embedding health coaching as an approach:

Peer support

Working with a partner for mutual support will sustain motivation in championing this way of working. Using a critical friend in a similar vein will support development and learning. The sharing of best practice examples which show coaching in practice was felt to be good for training.

During training, staff discussed the need to move from 'unconscious incompetence' to 'conscious incompetence', with support from Champions and peers seen as critical in enabling this to happen.

'We have had success in encouraging people who have been on initial training including looking across organisations and across professions.'

Stakeholder at Champions focus group

'There have been some real nuggets shared about what has worked well for me.'

Stakeholder at Champions Focus Group

Consolidating learning

One stakeholder group raised the question of how health coaching can be built into the supervision of staff to strengthen the approach. There was a suggestion for a regular forum with an opportunity for outside speakers to join it to develop further competence. The idea of employing creative thinking to overcome issues across the system and for individuals was discussed. Further suggestions included an intranet site where resources can be shared, and a Better Conversations sub-group to look for online resources which can be used to refresh learning.

Celebrating successes

There was a suggestion to open the support group beyond Berkeley Vale, but there was also an acknowledgement of being careful not to dilute the current focus on the introduction of health coaching. Sharing records of coaching discussions with staff will be a proactive way of celebrating successes and sharing case studies.

'At the support groups people have been able to talk about what they have tried what worked/didn't work for them and are so encouraged to develop their own and each other's practice as a coach.'

Stakeholder at Champions Focus Group

Refresh training

Further development and training for health coaching were noted as vital so that the approach is maintained by all staff, and this was reflected in the staff response. To date, there have not been specific 'teaching' opportunities for new content, or chances to revisit previous content. There have been requests from trainees for time to be spent refreshing content and theory. Regular practice sessions are also needed for health coaching techniques. The stakeholders suggested further resources such as bite size knowledge

chunks, practice exercises, more development of the health coaching toolkit, and signposting and links to articles and materials.

> *'Taking an 'action learning' approach as a group has been useful as each meeting they do some 'checking in' which is a chance to reflect on what they have done since the last meeting and what they can learn about what actions to do next.'*
>
> Stakeholder at Champions Focus Group

3.2.2   Barriers and enablers to using health coaching
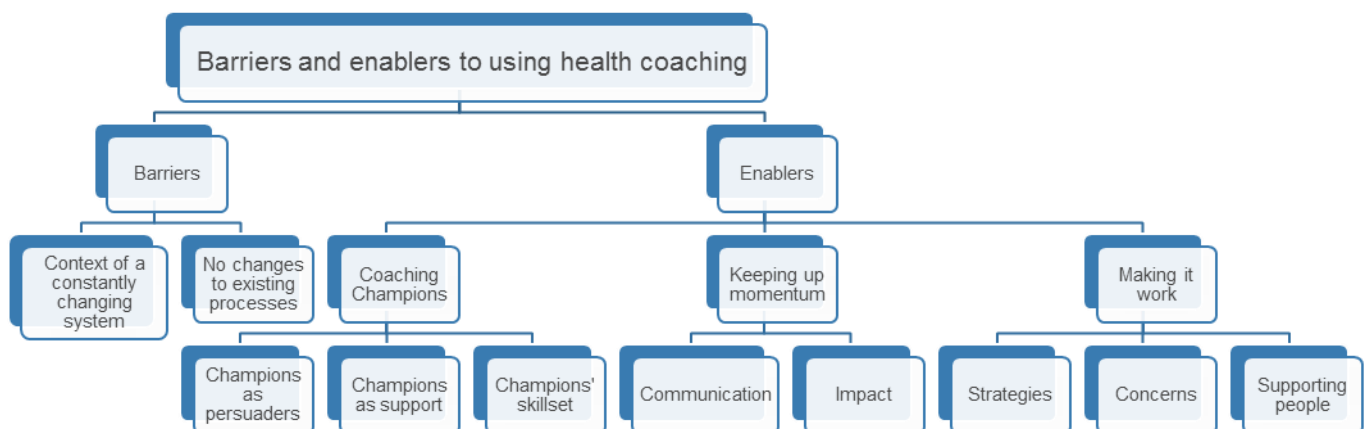
Barriers

Context of a constantly changing system

Different organisational and professional aspects of the healthcare system were discussed by stakeholders as barriers to health coaching. This took a wider perspective than the obstacles which had been described by staff in their individual practice. If line managers are not informed about the training, there is a risk of a difference between what they, and their employees, understand to be effective practice. This could also lead to professionals working on their own with a health coaching approach or culture rather than it being 'joined-up'.

There have been lots of distractions in some services with, for example, structural change. One example is restricted 10 minute appointments in primary care. In another locality with lots of pressures, health coaching might present a huge additional challenge. The Quality Outcome Framework was mentioned in one stakeholder group as a potential barrier to successfully implementing and embedding the coaching approach as a standard approach.

One way to unlock obstacles is to have conversations with stakeholders, and to make health coaching 'business as usual', by introducing systemic changes in documentation, plans, PDR, supervision and induction processes.

No changes to existing processes

Champions agreed that giving permission for health staff *not to use coaching* was to be avoided, or it could become the default position. This might be a daunting and difficult change, with professionals still reverting to the role of 'fixer'. However, by actively giving permission for people to have a go and by not falling back into 'old ways', champions can help professionals be resilient and to keep trying the approach.

Enablers

Coaching Champions

The role of champions was frequently discussed at focus groups, and this was something that had not been mentioned by staff members at this stage. As local influential supporters of health coaching, champions should be able to persuade staff of health coaching's benefits and tailor stories to their audience. Individual champions are operating in very different contexts in terms of influence and their role varies tremendously: for example, in the GCS it is very structured; in primary care it is more diverse and freeform.

> *'The best champions are those who have a passion for a topic for whatever reason and a personal story to tell.'*
>
> *'We are the kick off group of people for this. We are the right people to start.'*
>
> Stakeholders at Champions Focus Group

Champions' support

Champions can provide a key support role to help staff with emotional awareness. They know how to adopt different approaches with different individuals, encouraging or withdrawing as appropriate, which means that they can provide tailored support. Champions can help people to see their progress and make coaching the default approach. They are also able to address people's fears, provide an escalation route where professionals can access help beyond their peers. Although the 'Champions Commitment' document produced at the outset explicitly stated that champions needed to be 'enthusiasts' not 'experts' nevertheless some of the champions described the ideal person as someone who could fulfil a dual-role of expert and coach, and one stakeholder group suggested that the next generation of champions need to be front line users of the approach, not managers as they are at present.

> *'We need to consider how we will cascade via those who are keen.'*
>
> Stakeholders at Champions Focus Group

Champions' skillset

Champions need to be accessible to people for support and talk. They should be committed to developing their own coaching expertise and other individuals' own coaching styles. They also need to be resilient and positive in advocating the health coaching approach.

Keeping up momentum

Communication

Across the stakeholders, more meetings and champions' groups were recommended. A framework for 'What Good Looks Like' would help make it 'The Way We Do Things'. The view was that they are putting energy into health coaching as a few months had elapsed since the initial training.

> *'We need to ensure people know coaching is here to stay because we see its value and we chose to carry on with it beyond the pilot.'*
>
> Stakeholders at Champions Focus Group

Capturing impact

Capturing impact through good evaluation is important for knowing the difference health coaching is making in practice.

> *'We can only give a snapshot of our learning so far.'*
>
> Stakeholders at Champions Focus Group

Making it work in practice

Strategies

Time management strategies are needed for professionals' meetings with patients or clients if health coaching is to be successful. Staff comments show this to be a major barrier in using health coaching. Knowing who to use a coaching approach with – people they have been working with for a long time or those new to the service – is key to moving it forward. The stakeholders acknowledge that support is needed from the integrated clinical environment.

Dealing with concerns

Some practitioners are anxious about being overwhelmed by lots of issues, and that staff do not feel competent enough to deal with some of them. Therefore, stakeholders accept that it will be important to ensure that there is plenty of support available.

> *'Making it real and putting our learning into practice has only just started.'*
>
> Stakeholders at Champions Focus Group

Supporting people

At the support groups, people have been able to report on early experiences and progress made, so these meetings have been considered very useful and successful for everyone using a health coaching approach for the first time.

3.2.3 Using effective communication
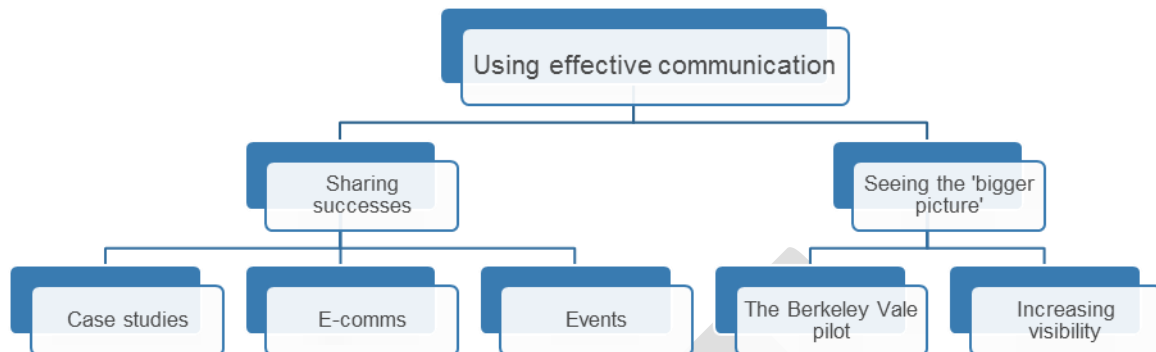
Sharing success

Case studies

Using case studies in regular emails or newsletters will keep demonstrating the new ways of working to healthcare professionals across the cluster. Sharing stories with a wider audience is likely to inspire others. One stakeholder group suggested that a case study template is provided as a way to easily share material.

E-comms

Various options were suggested as ways to connect with people. One suggestion was that the comms team at CCG is should help with posters, and the general 'visibility' of health coaching. Signposting the health coaching coalition and the Better Conversations website will also be beneficial. Sharing 'nuggets' via blogs and adding the 'coaching champion' designations to health coaches' email designations will help to increase visibility.

Events

The Better Conversations 'Sharing the Learning' Event for the test and learn pilots across Gloucestershire on 20th March 2019 was an opportunity for the management cluster to get key messages across to an audience outside Berkeley Vale. The groups, which have been running across the cluster, are widely considered to be a useful way of sharing learning and views. There has been an overall desire for them to continue.

> *'Getting people together has been very positive.'*
>
> Stakeholder at Champions Focus Group

Seeing the Bigger Picture

The Berkeley Vale pilot

Helping people to understand that Berkeley Vale has been specially chosen as a test and learn site is important in the stakeholders' view for promoting health coaching in the county. It will also help staff to understand that they are part of a bigger, national movement. The champions were keen that people should know health coaching is here to stay; they understood its value and chose to carry on beyond the pilot.

Increasing visibility

There is an identified need to raise the visibility of health coaching, be clearer about the long-term strategic goal, and why coaching will help to achieve that goal. The stakeholders feel that this will give them confidence in asking for senior support. The stakeholders raised the issue of health coaching being joined up to the other current health initiatives.

3.2.4   Reflections on the test and learn exercise
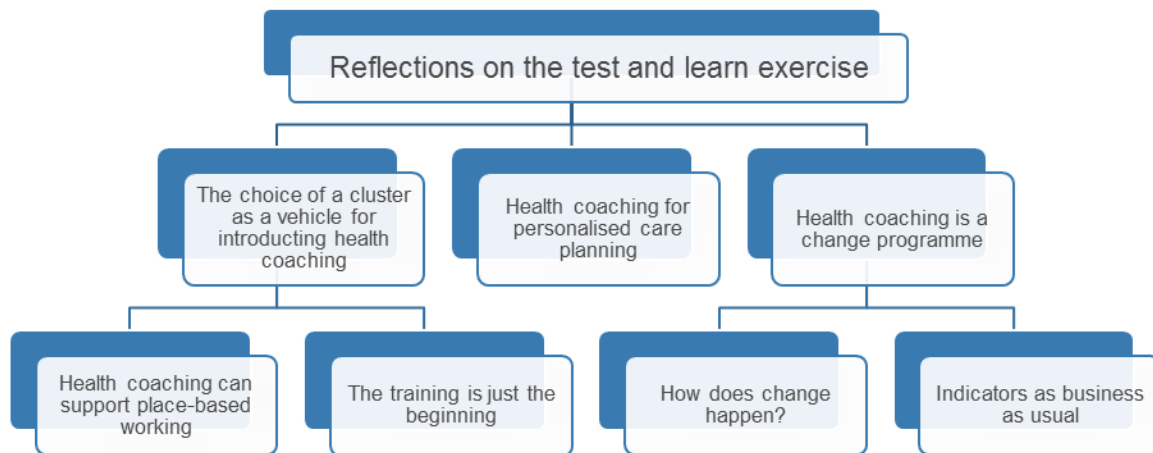
The choice of a cluster as a vehicle for introducing health coaching

HC can support place-based working

One stakeholder group reflected on whether the place-based working route (i.e. as part of an ICS) was necessary for a place-based approach to health coaching to work. They felt that an established management cluster team helped, but the joint training was actually the key enabler in supporting place-based working. At Berkeley Vale the health coaching training was the first time their front line staff had learned together.

The training is just beginning

Some stakeholders held the view that getting practice engagement was very difficult: two whole days for health coaching training was a long time for practice staff to be released.

Two half-days might have been more manageable for primary care staff, and they were generally less well represented on the training. One person said that there may be back-fill issues, and two days is too long for them to take out. The issue was also raised that back-fill monies had not yet been claimed by practices where staff had done the training, and that staff were expected to make up work on their return.

The training providers reflected on how future clusters or localities might usefully increase readiness of individuals to coach, of workplaces for individuals to coach and of the sponsors on behalf of the local system. It may have been better if the scene could have been set in advance and if more people could have arrived to the training ready and open to doing something differently. Seeing, appreciating and welcoming the need for change before they arrived would have been a big help.

> *'Some attendees didn't seem to understand why they were at the training. Perhaps team leads could have brought their respective teams together to explain what's not working now and to explain the need for a coaching approach and why they were going to be trained to do it.'*
>
> Training provider

Other stakeholders agreed that pre-work from the management team is needed before rolling out training. Management teams could assess individual and collective readiness for a coaching approach, and then brief trainers accordingly. A one-size-fits-all approach to training can be difficult as all attendees are starting from different places. Whether a professional was more familiar with a 'fixing' approach or 'enabling' approach affected their experience of the training and their subsequent practice.

The training providers also identified that some managers can be blockers within the system. For staff, if their manager did not "get it" for whatever reason, that was a big influence on whether someone was likely to change their practice. Hence, the providers suggested that local systems can increase readiness by briefing and engaging managers beforehand, making them more receptive to staff coming back with ideas and skills and seeking permission to 'make it real'. An additional suggestion was that all team managers attend health coaching skills training themselves, ideally early on in the roll out of the programme.

All stakeholders felt that establishing the champions group was a worthwhile and effective idea but might have been even more effective in its sponsorship on behalf of the system. This was explained by one interviewee thus:

> *'If the champions group had been up and running before the first training programme took place, they could have empowered and supported people in integrating coaching into their practice from Day 1. Also, would have been helpful for them and the cluster management team to have their training early on if not before the formal programmes began. No one completely knew what coaching meant for them until after their training so there was a delay in planning for joining up. Although that is happened now, it would have been better for individuals and the system if that has started before the training rather than some months later.'*
>
> Training Provider

However, a place-based approach offers gains from putting people with mixed skills together and has a positive impact. It helps progress the journey to place-based working. Courses might be made more attractive by highlighting the clarity of shared purpose. Actively selling the benefits to primary care practitioners is important for getting buy-in.

'Preparatory work for lower grade staff would have been helpful as they might have been intimidated by the process.'

Stakeholder at Champions meeting

'It's not just about the grade or type of staff as it is equally tricky for practice nurses and GPs to take the time out.'

Stakeholder at Management focus group

Health coaching for personalisation of care

Although there is a huge emphasis in mental health training on working in a person-focussed way, health coaching opens up new conversations for different ways of approaching patients. People need to feel that this is the direction of travel, and that they do not want to be left behind. Giving the right positive message to healthcare professionals will be vital to health coaching adoption.

'There is evidence that health coaching increases job satisfaction. And caseloads get smaller. Why wouldn't you give it a go?'

Stakeholder at Management focus group

Health coaching as a change programme

How does change happen?

Reflective practice can be a good indicator of engagement with health coaching by professionals. However, this might only show that adoption is happening at an individual level, not an organisational one. Caseload turnover could indicate the approach is being more deeply embedded. High Intensity User (HIU) data may also change, and this could be an indicator of patients taking ownership of their own health.

Berkeley Vale, working in close alignment with partner providers, has good staff engagement. The ICT is coterminous but other providers cover a wider area. At the management cluster focus group one stakeholder noted that other clusters may need to build confidence in networking, so uptake of health coaching might be slower elsewhere.

Indicators as business as usual

How the Berkeley Vale and other management teams will know when a coaching approach becomes usual practice across a cluster depends on everyone adopting a coaching approach as their usual way of working. This includes new joiners who may never have heard of health coaching, urging the team to consider how new people will be introduced to it.

4   Conclusions and Insights

As with any innovation, especially in a context as complex as the NHS, the spread and rate of change can be slow[4]. At Berkeley Vale better conversations through health coaching was regarded as still in its infancy in the NHS; themselves considered as early adopters with much to learn.

4.1 Adoption and innovation

4.1.1   Positioning the coaching approach

Identifying the context and understanding Berkeley Vale's need was an important first step for the site. This was to ensure the way coaching was implemented was fit for purpose for their specific context. A key consideration and decision in other sites (see, for example, Edwards et al, 2019) is whether to introduce a health coaching approach as a vehicle/means to support the delivery of a broader strategic priority versus the provision of workforce training as an end in itself. Berkeley Vale cluster managers and champions were thinking big picture from the start. Their stated belief was that Better Conversations was a vehicle for culture change across the local system through the provision of a common language and a "better" way of working.

The presence of a clear vision and direction of travel seemed to act as an enabler for getting on with embedding the coaching. Management buy-in and support for health coaching was considered instrumental in creating the momentum for change, both from a resource perspective but also by endorsing the approach as a way of working which was "here to stay". Furthermore, having a group of individuals, responsible for driving forward the adoption, seemed to help get the initial implementation off the ground.

4.1.2   The place-based implementation model

One of the core reasons innovations in health care tend to fail is because of their inability to be reproduced in difference contexts[5] . Health coaching can be implemented and adapted to a wide range of contexts. At the outset, the site perhaps did not appreciate that the place-based approach they had been selected by the CCG to pilot (a "done deal") was a less usual approach. However, the champions group members were quick to describe it as the 'best' possible approach for them and what they would have chosen for themselves.

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[4] Collins, (2018) https://www.kingsfund.org.uk/publications/innovation-nhs
[5] Horton, Illingworth & Warburton (2018) http://reader.health.org.uk/the-spread-challenge/executive-summary

At Berkeley Vale, the skills training offer was open to everyone (both clinical and non-clinical staff). In other contexts, key considerations and decisions tended to include:

- Training clinical staff only, non-clinical staff only or a combination;

- Outsourcing the initial training of staff and on-going support or develop a cadre of internal trainers; and

- Start small and expand the reach in a targeted and gradual manner or think big and introduce widely so the message is clear that this new way of working is here to stay.

Although the initial training provided by ICE Creates was dominated in terms of numbers by clinicians, non-clinicians within health and social care had also been invited to participate. Once the approach has taken hold, there is a hope that in future they will find a way to spread the coaching approach to social care and acute care.

4.2 Implementing and embedding health coaching

The embedding activities undertaken at Berkeley Vale were developed and provided as a result of the commitment of the individuals locally to respond to on-going feedback about what was needed to 'make this work'. The specific activities may be transferable to other settings. However the main learning is the necessity of preparation work with the system leads to gain their commitment to releasing staff for embedding activities and to identify people to take on the roles of staff supporters and champions.

4.2.1   Describing, communicating, advocating and role modelling

A few months after the initial two-day training sessions, it became clear to the champions group members that they needed to start telling the coaching story. Whilst the initial training had created an initial 'energy for change' among individuals, there was a danger that energy was/might start to ebb away without an effective communications plan. Spreading the word about the range of beneficial outcomes locally already accruing from coaching and sharing of patient stories, from within the local system, was also considered effective in sustaining momentum across the system so that barriers to adoption could be tackled.

4.2.2   Post-training support for practitioners for skills and confidence

The provision of on-going support to individuals to embed and use new skills in their own practice was considered an enabler for behaviour change. At Berkeley Vale this was provided primarily through opportunities to share learning, both formal (such as team meetings and individual coaching/mentoring by team leads) and informal (such as skills-share support sessions) as well as paired practice with colleagues.

Most of those engaging in support activities were from the community services trust: this might suggest that their structured environment or their proximity to where the sessions were held may have helped them to participate. The voluntary sector also appeared keen to have an opportunity to engage with statutory colleagues. Others considering a place-

based approach may wish to consider how they might get greater engagement in follow-up activities from primary care colleagues.

4.2.3   Identifying impact

At the time of writing, the focus at Berkeley Vale was primarily on process measures of training uptake and adoption/usage of coaching rather than outcome measures. Others introducing a health coaching approach may wish to simultaneously consider the anticipated outcomes, and how they were going to measure them The site identified a broad range of hoped-for impact under three broad categories: patient outcomes, staff outcomes and organisational/system outcomes.

4.2.4   Conceptualising the 'introducing' coaching process

According to the briefing given to IES by CCG Programme Manager during September 2018 (and later confirmed by Berkeley Vale stakeholders), the main implementation phases of the 'test' planned, described in order, were: provide training, then set up a champions group to support individuals and the local system. At their first meeting, the champions then set up support sessions for staff. IES conceptualises that approach as seen in Figure 5 below.

Figure 5: Implementation model used at Berkeley Vale
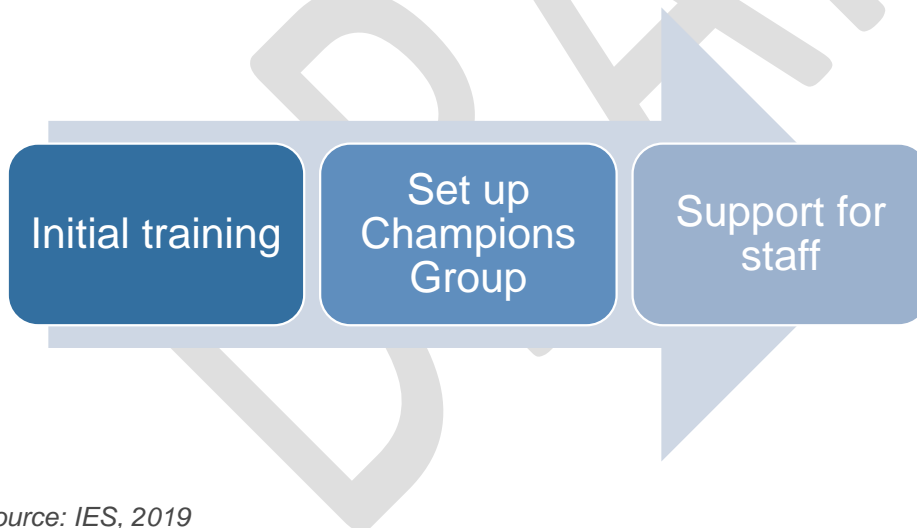
Source: IES, 2019

To bring in learning from elsewhere to Berkeley Vale, the experience of accredited health coaching clinician-trainers within East of England was shared with Berkeley Vale champions during September 2018. The 'seashell' model (Carter & Newman, 2017) was developed by early adopter practitioners to lend support to other organisations seeking to introduce and embed health coaching. The model was not specifically developed with 'place-based' implementation in mind but was nevertheless considered highly relevant as it is based on an existing evidence-based model of large scale change already used in the

NHS[6], which has been a useful tool for organisations. The seashell model was discussed with the champions at their first group meeting to assist with their reflection and action planning processes. In part it may have influenced their decisions in communicating their coaching story widely and the provision of on-going support for individual clinicians which were considered most effective with the early adopters' sites in East of England.

4.3 Top tips from practitioners at Berkeley Vale

At a champions meeting on 12 March 2019, considerable thought was given to what advice should be given to primary care network managers who might follow in Berkeley Vale's footsteps in implementing a place-based approach to coaching. Following the period of reflection which participating in focus group discussions allowed, and in preparation for the Better Conversations 'Sharing the Learning' Event on 20 March 2019, some of the Berkeley Vale managers spent time preparing and presenting, in their own words, the advice they would give (see Figure 6 below).

Figure 6: Top Tips for other practitioners from Berkeley Vale managers and champions

Starting out

- Preparation : multi-profession training was helpful, but - preparation is needed because everyone is starting from a different place

- We would recommend multi-professional training, but it is challenging for some staff and trainers

- Prepare champions, at all levels; early instigators with passion!

- Recognise that this is not just learning some new skills, cultural change required

- "Coaching" or a "coaching approach"? We are not creating coaches, we are creating Nurses/OT's/etc who use a coaching approach

- Develop a plan beforehand for how conversations and goals are recorded and shared- a plan is still needed!

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[6] Bevan, Winstanley & Plesk, 2011

Making it work

- Implementation that coincided with establishment of Place Based Working was helpful

- Works both ways – Place-based working gave the opportunity to do this and training together helped to build links

- Strategic vision and approach have to link with OD framework - joined up planning, sustainability

- Variety of methods of support are necessary to help establish this as "our way of working"
  - One-to-one conversations, supervision, case discussions, handovers, staff support groups, additional/refresher training

- Real stories are powerful - even small wins and little changes make a difference and build confidence

Source: Berkeley Vale, 2019

4.4 Conclusions about a place–based approach

Much has been learned from the Berkeley Vale test and learn site. Some learning is common with other implementation approaches; for instance the need for post-training support for individuals to practise so that confidence grows, skills continue to develop and the approach becomes embedded into personal practice.

Arguably the biggest and most consistent message from the place-based approach is a practical scheduling one: providing the training for individuals is absolutely crucial but is the wrong place to start. Local reflections and 'learning' all point to the need for a significant preparation phase.

Whilst it could be argued that preparing individuals for any skills training is usually a good idea (so they make the most of the individual opportunity afforded), with a collective place-based approach to implementing coaching, it is much more than this. If coaching is a vehicle for system-wide culture change, then line managers, team leads and champions at every level need to understand what coaching is before their staff are trained, making a briefing beforehand (and ideally a taster experience or the full training themselves) essential. It is not just so they can better support and encourage the individuals when they return to workplaces, although clearly that would help knowledge and skills transfer. There is also a need for them to anticipate and remove organisational and professional barriers to making it happen. At Berkeley Vale, the champions were quick to recognise this once enough of them had had their own training but some champions were trained months after their staff and were consequently 'on the back foot' until then and playing 'catch-up'. It became hard to sustain staff energy when barriers to adoption are not addressed.

Whilst funding constraints can understandably drive the rush to commission and deliver training (as that's where spend comes into play), to make the most of the organisational

development and culture change opportunity, pre-work is not a 'nice to have'. Preparing the individuals, the organisations and the local system is considered necessary to maximise the systemic benefits a coaching approach can provide stakeholders and staff at Berkeley Vale.
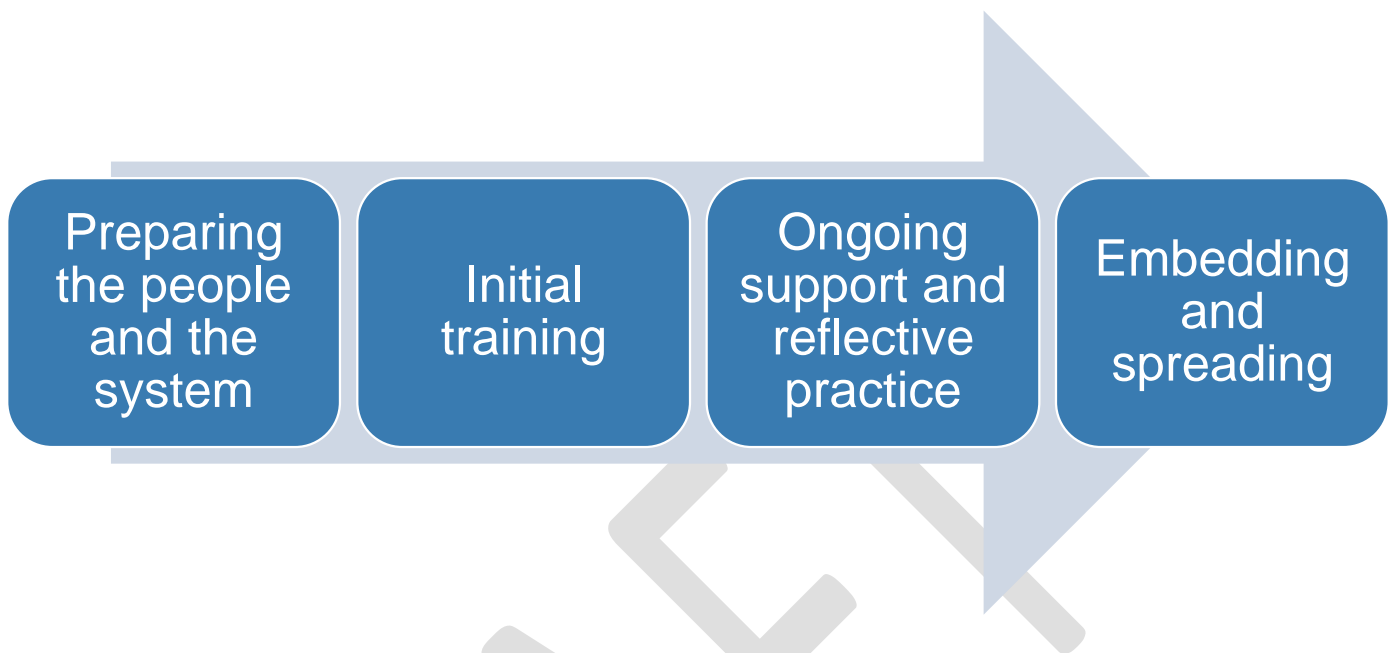
It is important to note that the management cluster at Berkley Vale have decided to continue with implementing and then embedding a coaching approach, beyond the CCG supported pilot period. However, they recognise that they still have much to do to embed coaching as a way of working across their local system. Plans include a process of continual action learning; support for a different type of champion - staff who can champion coaching with their peers; and in-house quality assurance and periodic evaluation for a clearer sense of how many people are using the approach and how well are they doing it.

If the Better Conversations Sub-Group decided to roll out a place-based approach to introducing coaching across Gloucestershire, a different implementation plan is suggested. Two main changes are proposed to the original implementation plan used at Berkeley Vale. Firstly is the addition of a significant 'preparation' phase as previously discussed. Preparation for a place-based approach to implementation comprises two aspects:

- Preparing the system e.g. articulating the shared goals (what health coaching is intended to deliver); securing commitment from local partners; reviewing and if necessary adjusting the leadership, patient record keeping/sharing, professional development and supervision infrastructure so that it will support the adoption of health coaching

- Preparing the people e.g. briefing training participants about what to expect (and why health coaching is important) and their managers and colleagues about what will be required before and after training to support

Secondly, the addition of an embedding and spreading phase is indicated. New joiners will have missed initial training so there needs to be a way to bring them up to speed with the way things are done: this may for instance involve reviewing existing induction and on-boarding processes. Delivery partners locally who for whatever reason may not have been committed or not able to release staff for training at the outset may be ready to join in later on: how to do this will need to be considered. New approaches to collecting, analysing and sharing patient records and other systems will emerge over time and someone will need to ensure the digital leads know of any requirements locally to support the health coaching approach.

Figure 7 (overleaf) presents the revised model of implementation.

Figure 7: Implementation model proposed for future place-based approaches to coaching

Preparing the people and the system → Initial training → Ongoing support and reflective practice → Embedding and spreading

Source: IES, 2019

4.5 Recommendations for those embarking on a place-based approach elsewhere

Based upon the place-based test and learn experience at Berkeley Vale and supplemented by learning from an organisational case study from a city-wide approach to coaching in Leeds (as reported in Edwards et al, 2019), a number of recommendations are suggested.

4.5.1 Prepare the people and the system

■ Assume that embedding this change in ways of working will span multiple financial years; it is not just a matter of funding some skills training. Replicating the success of a health coaching approach elsewhere is just as hard as introducing other large scale change.

■ Think of health coaching as a culture change rather than an end in itself. Describe clearly which problem(s) a health coaching approach will help to solve and ideally embed your initiative within a strategic priority. Define your goals, what success looks like and how you are going to measure it before you start.

■ Ensure line managers, team leads and champions at every level understand what coaching is before their staff are trained so briefing beforehand (and ideally a taster experience or the full training themselves) is essential.

■ Identify how coaching conversations and goals will be recorded and shared.

4.5.2   Roll out initial training

■ Brief training participants in advance on the need for a different and consistent way of working across the system, from a 'fixer' to an 'enabler' mind-set so they understand what the point of the training will be. Help people to understand how health coaching will benefit them, service users and the wider system.

■ Bring people together for training from different professions and from different organisations. A shared training experience can help break down barriers and build links across the system.

■ Developing a shared language matters so, as a place-based approach, you may need a 'citizen' focus rather than a 'patient' focus.

4.5.3   Provide staff with on-going support and reflective practice opportunities

■ Health care professionals need time and space to practice newly acquired skills and the opportunity to reflect on and share their learning with colleagues. Support staff to digest and embed their new knowledge and skills following the period of training.

■ Create an environment and space which facilitates the sharing of learning and practice and supports further skill enhancement and behaviour change.

■ A follow-up support package is needed. Consider access to resources (e.g. videos of good practice) and mainstream health coaching refresher sessions as part of your professional development offer

■ Ensure senior staff role model coaching as the new way of working in the system.

■ Adopt an attitude of 'practising what we preach' by extending the coaching approach internally to reinforce the culture change. The skills learnt on the training can also be used as a way to communicate within an organisation and cross-service with colleagues and peers.

4.5.4   Embed and spread until a coaching approach becomes business as usual

■ Consider establishing a co-ordination team whose role is to kick start the approach and drive it forward. It's important if you don't have pilot funding or external resources to support you. Consider releasing some time from their day jobs so that they have capacity to lead and steer the initiative.

■ Engage with service users and explain the different approach that they will be experiencing so that a coaching approach won't come as a shock to patients who may be expecting to 'be fixed'.

■ Remind leaders that health coaching as a culture change, not just a one-off training programme, and relationships are key to getting more people involved. Ensure senior managers buy in to both 'better conversations' as an end goal, and also the steps that

will be necessary to achieve it. A few key strategic advocates will make a big difference in securing the support and resources needed over time.

■ Find the common ground and build on it. Not all parts of the system will have been ready to participate at the outset so ensure you have a plan for bringing them along with you when they are ready to maximise consistency of approach across the system.

■ Evaluate the impact of health coaching using both qualitative and quantitative methods. Qualitative data can be very powerful, especially narratives/stories of the impact on individual service users. However, quantitative data to demonstrate the progress and impact of a large-scale cultural change takes time to produce. It is important to have a measurement plan in place as soon as possible to give commissioners confidence that success is being measured.

■ Advertise and communicate the successes, large and small, to create momentum for the approach.

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