

# The Case for Health Coaching

Lessons learned from implementing a training and development intervention for clinicians across the East of England

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## Executive Summary



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## Introduction

This paper summarises the findings and lessons learned from an IES evaluation of an education initiative/development intervention for clinicians across East of England. The intervention consisted of a 2-day health coaching programme for 777 clinicians and a further 4-day programme for 25 of the clinicians to become in-house NHS clinician trainers in health coaching for skills transfer and sustainability. The intervention was commissioned by Health Education East of England during 2013/2014.

### Aims of the evaluation were:

- To explore views on whether health coaching has been a useful approach for clinicians and their patients; and whether it has resulted in any changes to their thinking and practice.
- To describe the health coaching intervention within each pilot organisation; contextualise it within local strategies on long term conditions (LTC), engagement and patient experience, and the process of implementation.
- To liaise and support local representatives in identifying outcome data relevant to their unique context and examine evidence of impact.

### How the evaluation was conducted

The IES evaluation was in addition to three post-training participant surveys<sup>1</sup> conducted by Health Education East of England which indicated high levels of clinician satisfaction with the programme content and a positive early picture of health coaching challenging clinician mind-sets as well as changing patient mind-sets.

The purpose of the IES evaluation was to elicit subjective clinician views about the outcomes from using health coaching and identify lessons learned from implementing health coaching in a range of clinical and organisational settings. The evaluation used a qualitative 'deep dive' case study approach in five NHS organisations.

Data collection methods included desk research; expert interviews; focus groups with clinicians; interviews with clinicians, team leaders, local stakeholders and site co-ordinators; and (in one organisation) analysis of local departmental records and cost data. For the design, conduct and compositional phases of the case study reporting IES drew heavily on guidance from Yin (2009)<sup>2</sup>. Following an initial scoping phase, we conducted five focus groups (comprising 42 clinicians) and 33 follow-up interviews.

In total 56 different NHS staff members from five organisations were involved in the evaluation.

## What the evaluation found out

### Clinician views on usefulness of health coaching

More than two thirds of the clinicians IES encountered (up to one year after their 2-day training) were continuing to use their health coaching skills. This is high percentage when compared to other soft skills training interventions.

Health coaching was being used with a wide range of patients and conditions and being found useful. Conditions included depression, weight management, smoking cessation, foot ulcers, pain management, anxiety, coronary heart disease, poor kidney function and hypertension. Clinicians reported benefits to their patients including increased confidence and empowerment, increased satisfaction, reduced dependency, more personalised advice and less medication.

In addition to presenting a positive picture of health coaching as an effective solution to the patient-centred care and self-management agendas, a picture of health coaching as an efficient way of working also emerged. Benefits to the NHS from health coaching identified by clinicians included higher patient compliance, reductions in episodes of care, reductions in appointments per patient, improved care quality and consistency, quicker discharge off caseload, potential to cut waiting times and less waste from unnecessary medication.

<sup>1</sup> Newman P (2014), *Health Coaching for Behaviour Change: Interim Progress Report*, HEEoE, June

<sup>2</sup> Yin R (2009), *Case Study Research Methods*, Fourth Edition, SAGE

Specific comments included:

*'Currently there are on average over four appointments per patient per year. Within that overall figure LTC or elderly patient groups have on average nine to ten appointments per patient per year. This is a cause for concern. Since self-managed patients don't need to see their GPs so often, more self-management is what primary care needs. Health coaching is ideal to support this.'*

Health coaching site co-ordinator (General Practice setting)

*'It [health coaching] is indeed excellent... in particular as it focusses on a ten-minute conversation rather than a lengthy session.'*

National Recovery Lead (Mental health setting)

*'A normal caseload for me since 2005 has been 60 to 67 patients with 12 to 13 new patients per month. That all changed after I did my two-day health coaching training. Within one month my caseload was down to 35. Two months later it was under 30. I was dealing with the issues quicker and was able to discharge them back to their own management. It was partly that I didn't feel so responsible for them and was able to let go but mainly it was that the patients felt confident to carry on without me, knowing they could come back to me if they needed to. It is now eight months since my training and I have 27 on my caseload... If everyone in the team was using this approach think of the impact this could make on our waiting list.'*

Physiotherapist (community setting)

*'Very useful in teaching people how to self-manage chronic conditions, especially those who were having multiple hospital appointments trying to seek a cure. [Health coaching] taught me how to help people feel like they were part of their cure and take ownership of it. It was helpful to have the techniques to engage passive patients and help them make positive changes.'*

Renal nurse (acute setting)

*'I have always listened to patients but it is in a different way now. The reaction from patients has been good. A lot more patients are coming back saying "Thank you. I've sorted it [e.g. weight loss]. I'm back to me".'*

General Practitioner

### Organisation experiences of implementing health coaching

IES found that impact from health coaching at the organisation level was dependent on many factors including: the degree of commitment of the most influential staff within the practice/organisation; the time devoted to health coaching; the number of patients coached in self-care; recording of relevant activity and outcome data; having processes for assessing the readiness of individual patients to change; and the context in which the clinicians are operating. It is not just about the quality of the training provided.

IES noted that health coaching became a catalyst for organisation change. Whilst it was promoted as an innovative educational intervention, it was managed by HEEoE as an OD and change intervention. The two are not mutually exclusive. Training can often be seen as a first step leading to new ways of working which in turn can lead to major changes in the way organisations operate.

Health coaching effectiveness and widespread adoption within a clinical setting seemed primarily dependent on high organisational support. IES found that a wider coaching culture and having management support systems in place led to more success in targeting and embedding the health coaching (e.g. at the community case study organisation). Although some GPs and acute clinicians found health coaching useful for their own practice, there were more barriers to implementation and adoption within their teams, e.g. organisational and professional culture, time pressure, difficulty releasing staff for training in small teams/organisations, and lack of privacy for coaching conversations in busy ward environments.

A summary of approach taken by the organisations and lessons learnt from the five case studies is presented in the table below.

Sector	Approach taken	Lessons learned
<p><b>Community Services</b></p>	<p><b>95 clinicians trained + 6 clinician- trainers</b></p> <ol style="list-style-type: none"> <li>1. Casting the net widely at the outset</li> <li>2. Clinicians selling the approach to peers</li> <li>3. Getting support from senior stakeholders</li> <li>4. Rolling out training internally at scale and pace</li> <li>5. Documenting the evidence</li> </ol>	<p><b>Managed as an organisation-wide long-term 'culture change' initiative</b></p> <ul style="list-style-type: none"> <li>• A health coaching-friendly organisation culture was an enabling factor for success.</li> <li>• Concept sold successfully as a new way of relating to old problems.</li> <li>• A group of internal clinician-trainers provided opportunities for mutual support and momentum to inform further roll-out.</li> <li>• A cadre of internal trainers requires ongoing investment of local resources to release clinicians to deliver training and ongoing support/CPD.</li> <li>• Engaging the Chief Executive and other leaders early proved extremely helpful in making the necessary resources available for roll-out.</li> </ul>
<p><b>CCG Commissioner</b></p>	<p><b>27 clinicians trained + 1 clinician-trainer</b></p> <ol style="list-style-type: none"> <li>1. Targeting the 'right' individuals to support Integrated Care Agenda</li> <li>2. Tapping into local resources and persuading people to participate</li> <li>3. Focussing on outcome measures</li> </ol>	<p><b>Managed as a project supporting a commissioning priority</b></p> <ul style="list-style-type: none"> <li>• Promotion from a CCG linked to a commissioning priority resulted in take-up of training across all 20 practices.</li> <li>• Impact data is needed to support the spread.</li> <li>• Despite the constraints of ten-minute appointment slots, some are using health coaching successfully.</li> <li>• Refresher training will help hone confidence and skill.</li> <li>• Awareness training for senior clinicians who do not need the full skillset would be helpful.</li> <li>• Support for isolated local trainers required so that the investment made will reap the benefits.</li> </ul>
<p><b>Mental Health Services</b></p>	<p><b>33 clinicians trained + 1 clinician-trainer</b></p> <ol style="list-style-type: none"> <li>1. Clear link to new ways of working and National Recovery Model</li> <li>2. Targeting nurses and Improving Access to Psychological Therapies (IAPT) practitioners</li> <li>3. Rolling out through HR Strategy</li> </ol>	<p><b>Managed as 'skills acquisition' training to support new ways of working</b></p> <ul style="list-style-type: none"> <li>• Quality of training praised.</li> <li>• Training attendance should be voluntary.</li> <li>• Some difficulties with transferring learning into clinicians' everyday routines; support locally after training may help.</li> <li>• Refresher training would be welcomed if made available.</li> <li>• Demand exists for more 'Train the Trainer' places if made available.</li> <li>• Difficult organisational context (e.g. reorganisation, job insecurity) can have negative implications for learning.</li> </ul>

<p><b>Primary care (General practice)</b></p>	<p><b>0 clinicians trained<sup>3</sup> + 0 clinician-trainers</b></p> <ol style="list-style-type: none"> <li>1. Designing a test pilot</li> <li>2. Clinicians to receive training</li> <li>3. Support requested from CCG</li> <li>4. Reviewing results</li> </ol>	<p><b>Planned (but not implemented) as a 'research' project</b></p> <ul style="list-style-type: none"> <li>• Selling the concept and value of HC to GPs needs resource.</li> <li>• Accessing two full days of training can be difficult especially for clinicians in small practices. Roll-out may need alternative training delivery model(s).</li> <li>• Highly valued by some individual clinicians as an easy to use 'mind-set' within ten-minute appointment slots.<sup>4</sup></li> <li>• Many examples given of successes with patients.<sup>5</sup></li> <li>• Little evidence as yet of practices thinking strategically about where and how best to target health coaching.<sup>6</sup></li> </ul>
<p><b>Acute services</b></p>	<p><b>32 clinicians trained + 1 clinician-trainer</b></p> <ol style="list-style-type: none"> <li>1. Testing health coaching (HC) as tools to support patient self-management</li> <li>2. Targeting specialties with longer interactions with patients</li> <li>3. Booking onto training courses</li> <li>4. Team leaders reviewing whether to adopt</li> <li>5. No plans for roll-out</li> </ol>	<p><b>Introduced as a 'new training intervention' to be tested</b></p> <ul style="list-style-type: none"> <li>• Major difficulties in transferring learning from the training to daily roles.</li> <li>• Some clinicians using HC successfully especially those with high job autonomy and/or specialist roles.</li> <li>• Local mentoring, championing or line management support needed for individual clinicians.</li> <li>• Concern over lack of privacy for coaching conversations in busy acute wards.</li> <li>• A view of health coaching as a set of tools that has to be explicitly 'done' to patients.</li> </ul>

<sup>3</sup> No-one from this pilot site was trained within our evaluation timescale although many clinicians from within other primary care settings were trained. IES therefore selected three GPs and two practice nurses (from five different general practices) for interview to hear their experiences of using health coaching and their views on how useful it was.

<sup>4</sup> Not from case study - lessons learned from interviews with GPs and nurses in range of other practices

<sup>5</sup> As above

<sup>6</sup> As above

## Cost effectiveness

IES explored with two clinicians in one case study organisation the claims they made about measurable financial benefits to the wider healthcare system. Using audited departmental records on activity and local management data on costs provided by team leaders and the finance department we found:

1. Fifty-one per cent actual increase in new patients onto one clinician's caseload following adoption of the health coaching approach.
2. Sixty-three per cent indicative cost saving (through reduced clinician time) in using a health coaching approach when compared to using the usual approach in one patient case.
3. Potential saving of £12,438 per year full-time equivalent for one Grade 6 physiotherapist in reduced clinical time to treat existing patient numbers (assuming reduction in clinical time is replicable over time and across all patients).
4. Potential saving of hundreds of thousands of pounds per year per team/service (assuming reduction in clinical time per patient is achieved by all team members following health coaching training).

The view at the community services case study site is summed up thus:

*'The maths stacks up. Training one clinician alone costs about £400. Training one clinician-trainer costs about £2,000. Each clinician trained in health coaching sees armies of patients.'*

(Chief Executive, community setting)

## Summary of recommendations

- Future roll out should prioritise clinicians in primary care and community care settings where future investment in health coaching training may see the quickest returns.
- Local NHS organisations should think more strategically about where and how best to target health coaching (so that it aligns and supports their wider strategies). This will help determine which clinical services and which patients to select.
- Explore future funding options and business models. There is demand for more training from clinicians and organisations within the East of England. It would be helpful if training was provided at no cost to individual clinicians.
- Consider additional training delivery models. An alternative to the tried and tested two full days of training is particularly important for GPs and practice nurses.
- More local support is needed to help individual clinicians to overcome perceived barriers to using health coaching in some daily roles. Local mentors, champions, lead health coaches or line managers are potentially all suitable support options.
- Organisational support systems need to be in place to enable health coaching skills to be widely adopted and embedded, e.g. an organisation culture that values innovation and learning and support for health coaching from leaders.
- NHS organisations should be clearer about what they hope to gain, what their success criteria is and how it will be measured and whether any adjustments to the clinical environment might be needed.
- NHS clinician-trainers should primarily focus on providing training in health coaching within their own organisations where their credibility, knowledge of the clinical settings and experience in applying health coaching is greatest.
- Refresher training and support for newly trained clinicians could be provided locally by clinician-trainers.
- Local clinician-trainers need ongoing support and an operational infrastructure to be effective. Continuing professional development and training (as a trainer) and access to materials and external supervision will still be required by all clinician-trainers on an ongoing basis.
- Quantitative research is now needed on clinical outcomes and costs from health coaching in UK settings to add to the improvements in patient self-efficacy seen in the 'proof of concept' Ucs evaluation and the positive clinician views explored in the present qualitative IES evaluation of the 'large scale pilot'.
- It would be useful for future local research projects or evaluations to compare actual number of patients, throughput and costs at the whole team level, ideally covering multiple teams and over a significant period.

## About IES and the research team

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

**Dr Alison Carter** was Lead Researcher for the evaluation. She is an IES Principal Associate, Fellow of Chartered Institute of Personnel and Development (CIPD) and a global leader in coaching programme evaluation. She is a former Director of the European Mentoring and Coaching Council (EMCC) and was Co-Chair of the Harvard 2nd International Coaching Research Forum, which addressed issues in measuring coaching processes and outcomes.

**Dr Penny Tamkin** is an IES Associate Director. She is experienced in organisation based research providing insight into whole systems issues.

**Dr Linda Miller** has recently retired. She was an IES Senior Research Fellow and an experienced researcher within the NHS including in collecting anonymised data about patients from GP practices.

**Dr Sally Wilson** is an IES Research Fellow. She has a background in clinical research and designs bespoke survey research tools to capture behaviour change.

To discuss the implications of this research or coaching evaluation in work settings more generally, please contact the Lead Researcher, Dr Alison Carter: [alison.carter@employment-studies.co.uk](mailto:alison.carter@employment-studies.co.uk)

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The health coaching training was originally co-designed and piloted by Dr Penny Newman, GP and Clinical Lead for Health Coaching and Dr Andrew McDowell, Director and Lead Trainer, The Performance Coach.

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