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Title

Multi-disciplinary perspectives: application of the Consolidated Framework for Implementation Research to evaluate a health coaching initiative

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Multi-disciplinary perspectives: application of the Consolidated Framework for Implementation Research to evaluate a health coaching initiative

Abstract

Long term conditions are a leading cause of mortality and morbidity. Their management is founded on a combination of approaches involving government policy, better integration between health and care systems, and individual responsibility for self-care. Health coaching has emerged as an approach to encouraging individual responsibility and enhancing the self-management of long term conditions. This paper focuses on the evaluation of a workforce initiative in a diverse and socially deprived community. The initiative sought both to improve integration between health and care services for people with long term conditions, and equip practitioners with health coaching skills. The aim of the study was to contribute an empirical understanding of what practitioners perceive to be the contextual factors that impact on the adoption of health coaching in community settings. These factors were conceptualised using the Consolidated Framework for Implementation Research (CFIR). A stratified purposive sample of 22 health and care practitioners took part in semi-structured telephone interviews. Data were analysed using the CFIR as an analytical framework. The perceptions of trainees mapped onto the major domains of the CFIR: characteristics of the intervention, outer setting, inner setting, characteristics of individuals involved, and process of implementation. Individual patient expectations, co-morbidities and social context were central to the extent to which practitioners and patients engaged with health coaching. Structural constraints within provider services and the wider NHS were also reported as discouraging initiatives that focused on long term rewards rather than short term wins. The authors recommend further

research is undertaken both to understand the role of health coaching in disadvantaged communities and ensure the service user voice is heard.

Key Words

- Chronic disease management
- Evaluation
- Multi-disciplinary working
- Self-care
- Health coaching

What is known about this topic?

- Long term conditions are leading causes of morbidity and mortality globally
- Government policy emphasises individual responsibility in the management of long term conditions
- Evidence suggests health coaching may increase patients' feelings of trust in their healthcare providers, support behaviour change and improve health outcomes

What this paper adds

- Practitioners are less confident of the potential of health coaching to succeed when patients are either socially deprived or present with comorbidities
- Practitioners take an individualised approach to health coaching, drawing on a selection of core skills to meet the needs of individual patients and the context in which the consultation takes place
- Whilst taking a multi-disciplinary approach to health coaching training has the potential to encourage networking and relationship building, different philosophies of care can act as a barrier to integration between health and care services

- Using the CFIR as a framework for analysis served to demonstrate the inter-relationships and complexity of workforce innovation in an evolving health and care economy

Introduction

Long term conditions are the leading cause of mortality and morbidity globally. Of the 57 million deaths that occurred in 2008, almost two thirds were due to one or more long term condition such as cardiovascular disease, chronic respiratory disease, diabetes and cancer (World Health Organization, 2010). The implications are considerable as people with these conditions are more likely to utilise health and care services; for example, they account for 50% of general practitioner (GP) appointments and 70% of hospital days in England (Department of Health, 2012). Long term conditions also place a substantial financial burden on society; for example, they account for 86% of all healthcare spending in the United States (US) (Gerteis et al, 2014).

The management of long term conditions is founded on a combination of approaches involving government policy, better integration between health and care systems, and individual responsibility for self-care (Nolte and McKee, 2008). In the United Kingdom (UK), health is the responsibility of the National Health Service (NHS) with health interventions being delivered by a range of community providers including GP surgeries, nursing services, and pharmacy contractors. Care includes both social work and assistance with personal care activities (such as washing and dressing, and the management of medication). In the absence of supportive family or friends, personal care activities are the responsibility of local authorities, which commission personal care services from non-government organisations (NGOs) (such as charities and voluntary and community groups) and private

providers. Evidence suggests that integration can enable better coordinated and more continuous care, improve health outcomes, and deliver greater efficiencies (Kings Fund, 2013).

In relation to individual responsibility, it is argued that it is often the things that people do in relation to modifiable risk factors (such as increasing physical activity and optimising medicines use) that make the most difference to their quality of life and health outcomes (World Health Organization, 2009). Moreover, there has been a fundamental shift in the relationship between the state and its citizens, with governments requiring citizens to be self-responsible, self-governing subjects (Howard and Ceci, 2012). In the UK, Government policy emphasises individual responsibility in the management of long term conditions. The NHS Five Year Forward View (NHS England, 2014) placed significant emphasis on upgrading preventative and public health services, and on encouraging individual responsibility and greater control by patients of their own health.

In recent years, health coaching has emerged as an approach to encouraging individual responsibility and enhancing the self-management of long term conditions. It has been defined as health education and promotion within the context of a thought provoking and creative conversation, to enhance the wellbeing of individuals and to facilitate the achievement of their health-related goals (Palmer et al, 2003). The common characteristics of health coaching are listed in Table 1. The role of the coach is to help people explore options, identify challenges to making healthy choices, plan enduring changes, and provide support to enact change.

Evidence from the US suggests that health coaching may increase patients' feelings of trust in their healthcare providers (Thom et al, 2014). There is also encouraging evidence from a

systematic review of the literature that found health coaching had a positive effect on physiological, behavioural, psychological and social outcomes in people with long term conditions (Kivelä et al, 2014). However, evidence to suggest health coaching can lead to fewer GP appointments and hospital admissions remains equivocal, with an evaluation of Birmingham OneHealth, England's largest example of telephone health coaching, finding an increase in hospital admissions amongst people with diabetes or heart disease (Steventon et al, 2013).

The focus of this paper is a workforce initiative in a London borough. The initiative sought to improve integration between local health and care services for people with long term conditions and equip practitioners with health coaching skills. The paper contributes an empirical understanding of what practitioners perceive to be the contextual factors that impact on the adoption of health coaching in community settings. By investigating how health coaching is experienced by these practitioners, the barriers and opportunities that may need to be addressed for effective implementation are explored.

Background and setting

The initiative took place in an ethnically diverse area of London, which contained some of the most deprived neighbourhoods in England. Life expectancy was lower than the England average and the main causes of death were cardiovascular disease, cancer and respiratory disease (Public Health England, 2017). To tackle these complex and interlinked issues, providers and commissioners of health and care services agreed on a number of principles that should underpin local health and wellbeing initiatives. These principles included a clear focus on prevention, helping people take responsibility for their own health, and promoting resilience by developing social and community networks.

The health coaching initiative was developed by the local Community Education Provider Network (CEPN) and received funding from Health Education England. Community Education Provider Networks were established to deliver improvements in population health through the development of the health and social care workforce. The networks are comprised of community-based providers including GPs, nurses, pharmacists, and optometrists. They also include representatives from local authorities and NGOs, as well as patient involvement and service user representatives. These networks are committed to breaking down barriers between disciplines and use training to encourage collaboration and improved continuity of care.

The health coaching programme consisted of a bespoke multi-disciplinary training programme delivered over two days (see Table 2). Between December 2014 and December 2015, a total of 176 health and care practitioners from 82 different organisations completed the programme.

Health Education England requires funded programmes to be evaluated. Two independent researchers (JB and CM) were commissioned to undertake the evaluation. To conceptualise the factors that impact on the adoption of health coaching, we drew on implementation science and a model for considering the spread of innovation in healthcare.

Consolidated Framework for Implementation Research

Implementation science explores the factors that influence the effective use of innovations in practice in order to determine what may be further required (National Implementation Research Network, 2015). A number of evidence based models for considering the spread of innovations in healthcare have been developed. One model is the Consolidated Framework for Implementation Research (CFIR), which is composed of five major domains and 37

underlying constructs, drawn from multiple fields (including psychology, sociology and organisational change) that are likely to influence implementation of complex programmes (Damschroeder et al, 2009). The five domains indicate a whole systems approach covering: characteristics of the intervention, outer setting, inner setting, characteristics of individuals, and process of implementation (see Table 3).

The CFIR has previously been used as an organising framework in research synthesis. For example, it has been used in an evaluation of a large-scale weight management programme in the US (Damschroeder and Lowery, 2013). Similarly, it is used in this study to provide a pragmatic structure to meeting our research objectives: identify and explore the barriers and facilitators to the adoption of health coaching by health and care practitioners; compare and contrast the different perspectives of health and care practitioners in relation to health coaching adoption; and consider tensions when national policies pertaining to integration between health and care services and individual responsibility are implemented in practice.

Methods

Design

The study was framed by a qualitative exploratory design involving one to one semi-structured interviews. The aim was to recruit a sample of health and care practitioners who had undertaken health coaching training up to December 2015. Ethical approval was obtained from the participating university's research ethics committee. Data were collected in March 2016.

Recruitment and sampling

Health and care practitioners who had completed the health coaching training programme were eligible to take part in the study (see tables 4 and 5). The largest disciplinary group to have attended training were pharmacists. Fewer nurses, GPs, patient and service user representatives, and local authority and NGO employees had attended. Purposive stratified sampling was employed to obtain variation in perspectives and capture the opinions and experiences of trainees from each disciplinary background. A decision was made that half the sampling frame should be pharmacists and half non-pharmacists, and amongst non-pharmacists should be at least two participants from each disciplinary background.

Initially all trainees were contacted by email. This approach yielded twelve volunteers who were stratified according to their disciplinary background. In order to gain insights from multiple voices, specific trainees were identified and subsequently contacted by telephone. This approach yielded an additional ten participants. The final sample included eleven pharmacists and eleven non-pharmacists (see tables 4 and 5).

Interview process

Interviews were conducted by telephone using a topic guide. Telephone interviews were selected to accommodate participants' work schedules and to maximise participation. Three overarching questions framed the topic guide:

- Prior to attending this course, what experience had you had of health coaching and what were your motivations for attending?
- What impact did interaction with people from different disciplines have on your learning during the training programme?

- What has been your experience of integrating health coaching into your day to day practice since completing the training?

Twenty-two interviews were conducted, each lasting up to 30 minutes. Participants were asked to consent to the interviews being digitally recorded. Permission was granted in all but four cases. When consent was withheld, written notes were taken during the interview and a word processed copy was made immediately afterwards. Data collection only stopped when similar themes were reiterated by participants both within and between different disciplines and no new insights were produced.

Data analysis

The data were sifted and interpreted using the Framework Approach to qualitative data analysis (Ritchie and Spencer, 1994). This approach is considered to be appropriate where there are a priori assumptions since it allows the analytical process to be informed by issues designated in advance as well as emergent concepts (Gale et al, 2013). In this approach, the transcription process is followed by six stages: familiarisation with the interview; coding; developing a working analytical framework; applying the analytical framework; charting data into the framework matrix; and interpreting the data. Given that a key objective was to use the CFIR to identify and explore the barriers and facilitators to the implementation of health coaching, the analytical framework was already established and, after the familiarisation stage, it was possible to move onto indexing transcripts using the domains and constructs within the CFIR. The charting and interpretation stages were undertaken independently by both researchers who met regularly to explore ideas, connections and interpretations.

Member checking and stakeholder review

Member checking is a technique for exploring the credibility of results (Birt et al., 2016). Although participants were asked whether they wanted to comment on the accuracy of their interview transcripts, few provided feedback. Therefore, opportunities to establish member checking groups were explored.

One such opportunity was as part of a previously scheduled event for pharmacists within the borough where data had been collected. Five pharmacists volunteered to take part and, whilst all had completed health coaching training, none had participated in data collection. The group was therefore used as a stakeholder review of the concepts emerging from the data.

Attendees were asked whether the emergent concepts reflected their own views, feelings and experiences. Their responses were recorded in the form of field notes. At the end of the session, we reviewed the notes and concluded that no variation existed between our understanding of the data and the understanding of the stakeholders. Had variation been identified, additional interviews would have been deemed necessary.

Findings and Discussion

The findings reflected the five major domains within the CFIR and ten of the underlying constructs. In Domain 1 (intervention characteristics), trainees perceived the adaptability and relative advantage of health coaching impacted on the readiness to adopt it. In Domain 2 (outer setting), trainees perceived that patient needs and resources, as well as external policies and incentives impacted on the implementation and sustainability of health coaching. In Domain 3 (inner setting), trainees described how networks, communications and the implementation climate impacted on the assimilation of health coaching. In Domain 4 (characteristics of the individuals involved), trainees described how beliefs about

the intervention and individual stage of change influenced the implementation and sustainability of health coaching. Finally, in Domain 5 (process of implementation), trainees described how the execution of masterclasses impacted on the sustainability of health coaching. The findings did not map against every construct in the CFIR. This was expected as the findings represent the trainees' subjective prioritisation of events and as such may not have linked to all stages of the implementation process.

Domain 1: Intervention characteristics

Construct: Adaptability

This refers to the extent to which health coaching could be tailored or reinvented to meet the needs of trainees in practice. Most trainees identified opportunities to draw on the core components of health coaching in their work. These components included prioritising and encouraging patients to find their own solutions:

> *Certainly there are parts of it that you can use… you may be talking about something where a behaviour change is required … smoking, alcohol, weight loss. So I think there are opportunities within a consultation where you can use part of the core skills…* (General Practitioner (GP): 02)

This trainee emphasised the use of a selection of core skills. This is important because interventions can be conceptualised as having core, essential and indispensable elements together with peripheral components. The peripheral components are considered adaptable elements that can be modified without undermining the integrity of that intervention (Damschroeder et al, 2009). Boehmer et al (2016) suggest there is a paucity of evidence pertaining to the components of health coaching that are necessary for its effectiveness. In this study, trainees expressed some uncertainty as to whether or not they

were coaching patients in the way that had been intended by their trainers and few reported rigidly following each of the taught steps:

> *I've used some bits... We were told about formalised methods and exercises to enthuse people. To be frank it needs tweaking for the person you are dealing with. Most don't fit the regimented method, so I've used it in a modified way but not as a whole* (Pharmacist (P): 07)

The reasons given for using only a selection of the core skills were threefold. Some trainees felt that only a selection of skills were required and/or tolerated by patients, whilst others worked in roles that involved only one-off contacts with patients, which meant they were unable to monitor patient progress. The remaining trainees cited time constraints, with many believing the ideal situation was one where they delivered dedicated coaching sessions. In the absence of such sessions, trainees modified the taught material to fit a particular consultation or interaction. For example, several pharmacists applied the core principles within the Medication Use Review (an advanced pharmacy service, which provides patients with an opportunity to discuss the use of their medicine).

Coventry et al. (2014) emphasised the key influence of individual characteristics and circumstance on the effectiveness of self-management, which would condone the individualised approach taken by some trainees. Likewise, Olsen (2013) exposed variation in articulated definitions of health coaching both within and between different disciplines, proposing a concept definition of health coaching that encompassed the attributes of the concept rather than the mechanisms of the process. Emphasis on the goal orientated nature of the partnership between the patient and the practitioner, the health focus and client enlightenment allows for individual adaptation to the individual context.

Construct: Relative advantage

This relates to trainees' perceptions of the benefits of implementing health coaching versus maintaining the status quo. For many trainees, the status quo was a biomedical or paternalistic approach. The status quo was seen to consume excessive resources and often ignore the root causes of health problems:

> *I don't think we are doing ourselves any favours by [going] down a [solely] mechanised biochemical path and there seems to be this culture that for every symptom there is a pill… I think a lot of people have an external locus of control and expect to see a solution from outside... For example, with a headache it is very difficult for people to understand it is often a consequence of how they live their life, tension headache, and it isn't actually a disease* (GP: 01)

In contrast, health coaching was presented as an approach that promoted autonomy by emphasising active listening, asking questions to raise awareness, and giving feedback:

> *Through the training I have been able to guide and support [service users] without telling them what to do. The outcome is their outcome, if I tell them what to do, it doesn't work – normally when you go back to review you will find that they aren't happy and things haven't changed because it was your decision not theirs* (Local authority or NGO employee (LA/NGO): 03)

As such, health coaching was considered a more effective and constructive approach to encouraging behaviour change and improving quality of life.

<u>Domain 2: Outer setting</u>

Construct: Patient needs and resources

A number of pharmacists and GPs expressed concern that health coaching exerted limited traction amongst some sections of the population:

> *A lot are from [different cultural] backgrounds… These patients often have expectations that they will be told what to do rather than encouraged to come up with their own solutions and this makes it more difficult to use the skills* (P: 06).

Furthermore, trainees differed in the extent to which they believed coaching was a useful tool for their patient population. This was linked to the complexity of their patients' lives

and the disadvantages they experienced. General practitioners, nurses, local authority and NGO trainees were aware that patients often experienced a wide range of concurrent health and social problems, which impacted on their ability to make behavioural change. Not only were patients in some cases too unwell to respond to health coaching, but comorbidities also limited their ability to focus on one particular issue. Conversely, one pharmacist recalled a patient who had multiple problems but by being allowed to focus on and successfully tackle just one was enabled to move forward and tackle others. These findings reiterate work by Coventry et al. (2014) who argue that patient engagement in self-care involves three dimensions: capacity, responsibility and motivation. Structural capacity in terms of access to social, economic and material resources, together with physical, emotional and interpretive capacity all work to influence the ability of an individual to adopt self-management behaviours.

These findings also highlight a tension between government policies encouraging individual responsibility and trainees' perceptions that many patients had limited self-care potential. Diminished capacity to self-care was attributed to the degree to which patients thought they had control over the outcomes of events in their lives, the social distance between practitioners and patients who spoke little or no English, and competing patient priorities in the context of concurrent health and social care problems.

The study was undertaken in an area characterised by the diversity of its population and high levels of deprivation. Whilst studies have identified patients' readiness to change as a barrier to health coaching approaches, with major life events making it difficult to prioritise the management of their condition (Liddy et al, 2014), limited research has been conducted on the effectiveness of health coaching approaches within diverse and socially

disadvantaged communities. One notable exception is the evaluation of a health coaching initiative that sought to develop the health and wellbeing of twelve homeless and formerly homeless individuals in San Francisco (Jordan, 2013). The evaluation found that whilst participants responded favourably to setting goals and developing concrete plans, health coaching led to no positive changes in lifestyle or health improvement for homeless participants and only modest improvements for formerly homeless individuals. Our findings reiterate the work of Jordan (2013) in that health coaching may help some people transition from passive recipients of public health services to more empowered consumers capable of initiating preventative health action but, for many more, attention needs to be paid to the upstream needs of safe housing, education, and job opportunities.

Construct: External policies and resources

Several trainees from a range of disciplines perceived external policies and incentives to have influenced the adoption of health coaching approaches. Financial incentives and targets could either enhance or unintentionally inhibit implementation. The former was demonstrated by trainees who worked in pharmacies that had committed to take part in a newly commissioned self-care initiative, which attracted financial reward and required pharmacists to develop personalised patient care plans. Participation in health coaching training was an essential requirement for any pharmacy bidding to deliver the self-care service. However, financial incentives and targets also had the potential to unintentionally inhibit health coaching. For example, the complex system of targets and monetary reward in the NHS impacted on the extent to which GPs were able to change working practices:

> *Talking to colleagues, there is a definite appetite out there for things to change and to have more partnership with patients but the way that we get paid for hitting various targets just keeps the hamster wheel turning in the way that the system already is* (GP: 01)

The NHS payments by results system (Department of Health, 2012) was clearly a disincentive to the implementation of health coaching and this trainee believed that unless services were commissioned in a way that did not focus on short term wins, it would be hard to invest in long term goals.

Domain 3: Inner setting

Construct: Networks and communication systems

Few trainees described existing networks and communication systems and opinions were mixed as to whether the multi-disciplinary nature of the training encouraged relationships to develop that might help embed health coaching in practice. For example, pharmacists were ambivalent about the multi-disciplinary nature of the training, whilst there were trainees from other health disciplines who felt the multi-disciplinary nature of the training had limited value. This assessment was based on these particular trainees supposing that pharmacists had few opportunities to engage in health coaching in practice. In contrast, trainees from local authority and NGO backgrounds alluded to the development of insight through multi-disciplinary collaboration:

> *In one of the sessions, I was with a [GP] practice manager… she applied coaching with staff members. It was interesting to see how it can be applied to different situations and environments. It was [also] interesting to hear GPs because they come from a very different perspective – it was enriching* (LA/NGO: 08)

At the same time, these trainees together with trainees from patient involvement and service user groups expressed a desire to develop collaborations beyond the initial training intervention in order to maintain momentum and troubleshoot possible coaching related problems in the future.

As Pathman (1996) suggests, there are many steps to complying with new practice. Trainees not only needed to be aware of health coaching skills but philosophically agree with them, including an awareness of the role of others round them, acknowledgement of the value of these roles and drawing on the roles of other practitioners in their own practice. The self-care model that pharmacists were incentivised to adopt draws on the assets of the community to support individual patients. Potentially, an outcome of integrated training is heightened awareness of each other's roles and the community assets on which trainees could draw to support patients.

Construct: Implementation climate

This construct refers to the extent to which trainees perceived the organisational environment as being conducive to the adoption of health coaching. Some trainees argued that workplaces needed to be altered to effectively accommodate health coaching. Amongst GPs, lack of dedicated time for health coaching, together with the need to meet other organisational and patient led expectations, were significant barriers to offering coaching with any fidelity:

> *It's a good idea but it ends up being a tick box exercise because you are trying to do it in the 2-3 minutes at the end of a consultation. The time to elicit what the patient actually wants and a goal that they would really engage with just isn't there* (GP: 01)

In the context of general practice, a number of logistical constraints were identified to establishing dedicated coaching sessions including limited staffing and physical space.

<u>Domain 4: Characteristics of the individuals involved</u>

Construct: Knowledge and beliefs about the intervention

This construct relates to trainees' attitudes towards, and the value they placed on health coaching, as well as familiarity with related facts, truths, and principles. Some trainees valued the acquisition of coaching skills to such an extent that they undertook the training outside normal working hours and purchased resources to further their learning. Such an investment was rewarded by subsequent positive experiences of using the approach in practice:

> *I have changed my technique and style. I can really see that patients are more engaged. They are more interested. They want to know more… I had a patient who wasn't compliant with medication. He didn't understand the real cause of diabetes, what is going on. So with mixing patient education and using the health coaching approach, it has helped him to become more stable…. He is more involved…* (P: 04)

Conversely, some trainees expressed ambivalence as to the effectiveness of health coaching, particularly in the long-term, which may be related to how they perceived patient capacity and autonomy:

> *It's effective in quite a few patients in the short term for sure. It is difficult to tell in the long term, it's difficult to evaluate* (P: 11)

Yzer (2012) reiterates the importance of capacity and autonomy as dual aspects of behaviour prediction. Interventions that focus on skill building and autonomous decision making may, over time, enhance the way the trainees perceive patient control and in turn alleviate the ambivalence impacting on the day to day application of health coaching skills in practice.

Construct: Individual stage of change

This construct relates to the phase an individual is in as they progress towards skilled, enthusiastic, and sustained use of a new approach or way of working. For some mental health nurses, local authority and NGO trainees, health coaching did not represent a

substantive departure from their usual interactions with patients. Amongst the remaining trainees, categories of adopter types can be identified based on the way they responded to the implementation of the new approach (Rogers, 2003). There were clearly some innovators, risk takers who had been the first to adopt health coaching:

> *I'm actually doing a [related qualification]… obviously this is one of my specialities and my interests… I thought [the training] was a great opportunity to find out what was happening [locally], so yes, when I heard I was very excited that other people were interested and passionate about this …* (GP: 02)

Others were early adopters, people who were willing to try out new ideas because they could see the benefit of change. Some were the early majority, thoughtful people who accept change more quickly than average. A minority were sceptics who were cautious to commit. The latter included those who felt pressured to attend the training by managers or as a requirement of the self-care service. There was a sense that the sceptical trainees needed to adjust their perspective before they could use coaching effectively and some were clearly successful in achieving this change in thought processes:

> *I can now support patients to be self-caring. We do too much for them and they then can't do things for themselves because we do it for them. This [training] has helped me see that they can do things for themselves* (Nurse (N): 01)

This also relates to the trainees' perception of the extent to which health coaching was a simple or complicated intervention, or as the data suggests, found the process of becoming an adept and skilled coach challenging. The first stage in this process was a change away from a paternalistic approach to more a participatory approach. This reflects research by Newman, Varham and McDowell (2013) who identified the need for a 'mind-set shift', which encourages practitioners to view the patient differently and see that they are capable of change.

This mind set change was greater for some trainees than it was for others. Some mental health nurses and local authority and NGO trainees suggested that the principles of person centred care, effective communication and the promotion of informed choice were already congruent with their professional role and the biopsychosocial model in which they worked:

> *The questions [in our assessment documentation] are framed in a coaching way because we are not supposed to decide for them or give them answers, the answers should come from them because we believe that they are the experts and if there is any change they want, they are the experts so we get the answers from them. The health coaching model really fits the work I'm doing* (LA/NGO: 03)

However, this was not necessarily the case for all pharmacists:

> *It is difficult because [you] have to unlearn things… you have to break old habits… We shouldn't be persuading we should be encouraging people to change and that's not as easy as when you see it written down* (P: 07)
>
> *It is really interesting but challenging. It is a different way of working so it was hard at first.* (P: 06)
>
> *A different type of approach now, we normally, in the past, when we tried to motivate patients – for example, if you wanted to give up smoking or take up a healthier lifestyle – you do talk to them, but telling them what to do. I noticed that we didn't get results.* (P: 10)

Farrell et al (2013) argue that re-orientating models of care requires practitioners to realign their skills and this may present a challenge to those embedded in a particular philosophy of care. This is especially pertinent for pharmacists, given the shift that has occurred over the last 20 years in the profession, with a move to taking responsibility for patient outcomes rather than a focus on providing drug education and information for doctors (Hepler and Strand, 1990). Depending on the time of their socialisation into the profession, pharmacists may be at various stages of this perspective shift and may respond differently to the transition to a self-care model. For all trainees, navigating these changes may prove difficult and old practices may re-emerge (McGuire, 2006), especially if health coaching is not reinforced by ongoing professional development and practise.

Domain 5: Process of implementation

Construct: Executing

Whilst a number of pharmacist trainees reportedly attended follow up masterclasses, they were not accessed by trainees from other disciplines. This was in part due to uncertainty as to whether they were open to all disciplines and invitations not being received:

> *I thought that was going to happen when we gave out email addresses at the [end of the] training but I don't remember ever receiving anything* (LA/NGO: 06)

Although masterclasses were perceived as having potential value by a number of trainees, in some cases opportunities for ongoing support and development were established organically between trainees and peers.

The value of sharing knowledge and standardising practice by establishing links and networks has been highlighted as a means of supporting integration between health and care services (le May, 2009). Mentoring can be used to enhance links and networks (Farrell et al, 2010). However, in this initiative, there was a missed opportunity to develop structured networking, buddying or mentoring arrangements, which would potentially have supported trainees embed health coaching in practice, particularly isolated trainees from newly established NGOs.

Limitations

Inevitably the context in which the evaluation took place influenced the study methodology and some limitations are acknowledged; for example, participants were self-selecting, therefore their views may not be representative of all trainees. Of particular note was the fact that there was only one patient and service user representative, which limits the transferability of any findings for this particular group. Four interviews were recorded using

field notes, which meant that verbatim quotes could not be provided for these participants. Finally, few opportunities for member checking were identified.

Conclusion

In conclusion, this study contributes to knowledge about the implementation of health coaching in a multidisciplinary context, specifically about implementation in a diverse and socially disadvantaged community.

The health coaching trainees identified enablers and constraints to the use of health coaching on both an individual and organisational level. Individual patient expectation and social context were seen to be central to their ability to engage with self-care behaviours. Social deprivation and co-morbidities, both prevalent in the study setting, were identified as key influences on patient motivation and capacity to take responsibility for self-management. Trainees argued that structural constraints, in both provider organisations and the wider NHS, also impacted the development of the proactive implementation of health coaching. The payment by results system for GPs discouraged initiatives that were less likely to reap immediate reward, whereas financial incentives for pharmacists essentially mandated the requirement to implement self-care programmes.

Fundamental to these tensions is the need to address detrimental societal structures in parallel with the proactive behavioural work with the individual. Whilst it is important to empower patients to manage their long-term conditions, this will neither impact on the incidence of new cases, nor resolve the deprivation that impacts on patients' capacity and motivation to change. The findings also suggest that implementation of health coaching will only be successful if practitioners are philosophically aligned to the self-care model. Therefore, integration between health and care services at the point of patient contact

should be married with concurrent strategy developments in the outer setting; practitioners and policy must work towards the same self-care management goals.

The authors recommend further research to understand the role of health coaching in disadvantaged communities, ensuring the service user voice is central to these studies.

Conflicts of Interest

The authors have no conflict of interest to declare

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Table 1: Common Characteristics of Health Coaching (Evidence Centre, 2014)
• Empowering people to take ownership of their own health • Focusing on people's goals rather than what professionals want to achieve • Developing a collaborative relationship between the participant and coach • Assuming that people are resourceful and have potential • Helping people assess where they are and what they would like to achieve • Helping people plan how to achieve their goals in easy steps and do things they may have struggled to do in the past • Challenging habits and beliefs that inhibit people or are barriers to positive change

Table 2: Programme Content	
Day 1	**Day 2**
Introduction and welcome	Two week reflection
Context	Recap
Models and principles	T-GROW demonstration
T-GROW Framework	Coaching practice
Demonstration and practice	Non-directive questioning
T-GROW deconstruction and practice	Challenging and practice
Transactional analysis	Patient motivation
Arnstein's Ladder and clinical scenarios	Motivational and coaching practice
Action planning for two weeks	Action planning and next steps

Table 3: Consolidated Framework for Implementation Research (Damschroeder et al, 2009)	
Domain	**Underlying Construct**
Characteristics of the intervention	• Intervention source • Evidence strength and quality • Relative advantage • Adaptability • Trialability • Complexity • Design quality and packaging • Cost
Outer setting	• Patient needs and resources • Cosmopolitanism • Peer pressure • External policies and incentives
Inner setting	• Structural characteristics • Networks and communications • Culture • Implementation climate
Characteristics of the individuals involved	• Knowledge and beliefs about the intervention • Self-efficacy • Individual stage of change • Individual identification with the organisation • Other personal attributes
Process of implementation	• Planning • Engaging • Executing • Reflecting and evaluating

Table 4: Training attendees and study participants		
Discipline	**Number of practitioners attending training**	**Number of trainees participating in study**
Pharmacists	142	11
Adult nurses and mental health nurses	14	2
General practitioners	5	2
Patient and service user representatives	3	1
Local authority or non-government organisation employees	12	6
Total	**176**	**22**

Table 5 : Organisations represented in the training and study		
Type of organisation	**Number of organisations represented in training**	**Number of organisations represented in study**
Pharmacy contractor	40*	11
Adult and mental health nursing provider	1	1
General practitioner surgery	5	2
Patient and service user representative group	1	1
Local authority	1	1
Non-government organisation	5	3
Total	**53**	**19**
* Contractor details only available for 72 of the 142 pharmacists attending health coaching training		