Health Coaching

Background

Three practices all located in an inner-city environment have come together to develop a team of health and wellbeing coaches for long term condition management and health checks to empower patients to have a greater quality of life. The Practices are Thistlemoor Medical Centre (looking after circa 30,000 patients), Central Medical Centre (looking after circa 14,000 patients) and Thorpe Road Surgery (looking after circa 10,000 patients). The Practices look after some of the most deprived and challenged populations in Peterborough, many who face problems relating to their health, mental wellbeing and have high incidences of smoking and alcohol consumption. Many of the population work in zero hour contracts and with low levels of financial support and therefore prioritise their work to enable themselves to survive. Peterborough has a high proportion of patients from a BAME and Eastern European population and these practices workforce reflect this.

The concept is to develop health and wellbeing coaches from the local community which should in turn enable the health and wellbeing messages to have most impact and therefore this workforce will come from the Polish, Lithuanian, Russian and Asian backgrounds of the majority of the staff. Funding for the training of the team has come from support from the STP, the local federation Greater Peterborough Network and the Practices.

A Health Coaching approach involves having conversations that help people change the way they are seeing things, and supporting them to use their own resources in navigating towards their self-identified health and wellbeing goals.

As health coaches became part of the workforce supported by NHS England in April 2020 the experience from these three practices will help generate the understanding and evidence for other areas regionally and nationally.

Details of the service

Eleven health care assistances have undergone health and wellbeing coach training (7 from Thistlemoor Medical Centre, 4 from Central Medical Centre and 1 from Thorpe Road). The training consisted of a 5 day distance learning course.

Focussing on Thistlemoor: Initially we will have four health coaches running 5 sessions per week with the possibility for a greater number of sessions down the line. This also allows for annual leave and continuity with practitioners.

The service will be gradually developed by building an in-house team that will be able to provide health coaching . One of the GPs undertaking specific training in lifestyle medicine will support the knowledge base.

Eligible patients will be those who 1) belong to a QOF chronic disease register[1] (asthma, COPD, cardiovascular disease, hypertension, ischaemic heart disease, heart failure, AF, TIA and stroke, peripheral vascular disease, diabetes, chronic kidney disease and osteoporosis), 2) eligible for an NHS Health Check, 3) request help to improve lifestyle factors or 4) referred by a health professional.

[1] asthma, COPD, cardiovascular disease, hypertension, ischemic heart disease, heart failure, AF, TIA and stroke, peripheral vascular disease, diabetes, chronic kidney disease and osteoporosis

The appendix shows triaging questions which could be used by health professionals to use with patients. Patients be groups in Group 1 (proactive invite based on QOF register or eligible for Health Check) and Group 2 (response based on patient or health professional request).

Group 1 patients will be invited during their chronic disease review or health check based on a set of screening questions (as shown in the appendix). If patients answer yes to the final question they will be asked to complete a lifestyle and readiness to change questionnaire, document BMI and BP, and placed on the health coach waiting list. Group 2, 3 and 4 will also be asked the screening questions as this will help guide the coaches and build the relationship with the patient.

Patients on the waiting list will be groups into cohorts of 50 patients every 6 weeks. The aim of the waiting list will be to help patients within 1-2 weeks of identifying patients. This will be monitored and if the waiting list builds up more than this then recruitment may be paused or additional capacity brought in. The first 50 patients will be cohort 1, the second 50 patients will start after 6 weeks and be cohort 2, etc. Via this staggered entry process, we believe we can probably admit 8 cohorts within a 12-month period, and therefore potentially up to 400 participants in the first year.

Health coaching will target the following key areas, smoking, alcohol, drugs, stress/mental wellbeing, diet, inactivity and weight management. Health coaching will be complimented by active signposting to relevant services that can support individual's aims e.g. smoking cessation services, Aspire alcohol services, Drug clinics, psychological wellbeing service, physiotherapy and dietetics. It will also be complimented by partnering with local individuals who are trained, such as personal trainers, physiotherapists and experts in diet and nutrition. There will be up to six sessions at weeks 1, 3, 5, 9, 17, 29 (thus 3 sessions at two weekly intervals, one after 4 weeks and then a further 8 and 12 weeks), although the exact number will depend on the patient. Each session will last 30 minutes initially. Later follow-ups may be shorter.

Over time information sheets and online videos may be developed that will provide more information and support to reinforce information provided during the consultations.

Evaluation plan

We will undertake a mixed methods waiting list controlled evaluation. Data will be collected from the electronic patient record and from patients directly. Data collected from patients will take place at three time points

- At the point of screening
- At the start of health coaching
- At mid point and at 29 weeks

Data collected from patients will include a lifestyle questionnaire and, at 29 weeks, an assessment about whether the goals agreed had been met. The lifestyle questionnaire will include questions on smoking, alcohol, drugs, stress/mental wellbeing, diet, inactivity and weight management. We will utilize the WHO Well- Being Index which is available in different languages.

Data collected from the electronic patient record will include age, ethnicity, number of medication and health care use.

After 12 months we will seek to speak to upto six patients who have undergone health coaching and hold a group discussion with the health care staff who were the health coaches. These discussion will be used to

The analysis will compare those on the waiting list with those who received health coaching.

Team

Neil Modha, Thistlemoor Medical Centre
Emma Hamilton, Thistlemoor Medical Centre
John Ford, University of Cambridge and Cambridgeshire and Peterborough CCG
Christina Melam, National Lead for Social Prescribing link workers
Luisa Docherty, GP Registrar
Susan Waller, Integrated neighbourhood manager (STP)

Timelines

Activity	**Deadline**
Agree outline	End of June
Agree data collection tools and process	1st two weeks of July
Start health coaching screening and waiting list	3rd week of July
Start health coaching sessions (cohort 1)	Last week of July
Health coaching cohort 2 starts	Mid August
Early review of service and modification if necessary	Mid September
Health coaching cohort 3 starts, etc	September
Patient discussions and group discussion	(11-12 months after service begins)
Analysis	(12 months after beginning)
Evaluation report	(13 months after beginning)
Write up for publication	(13 months after beginning)

Outputs

We will produce an evaluation report at the end of 12 months which will be aimed at patients, other primary care organisations and commissioners (e.g. CCG and NHSE/I). We will aim to present this at a conference and write up for publication. There may be other opportunities (e.g. podcasts).

Appendix 1: Screening questions

What two things in your life could you change that would make you healthier and happier?

If the mention other issues such as housing, financial struggles they may be referred on to other appropriate services such as the social prescribing team

Are you ready and able to make that change right now?

(this might reveal that they would like to make a change but have circumstances that mean they are not in the right position to target it right now)

If the answer is no at this stage we would ask

Would you like us to provide you with some written information?

Are you happy for us to contact you again in 3 months to revisit this?

Would you like our support in making these changes?

If the answer is yes we will add them to the health coaching waiting list.

Appendix 2:

Input from other Team Members

General Practitioner lead

Oversight

Clinical governance

Debriefing

Review of plans

Review of service alongside other leads

Consideration of development of resources to support patients

Personal Trainer

Information - Where to start with exercise

Goal Setting

Planning / Plan to follow for patient

Discussion about benefit of Exercise

Discussion re effective nutrition to support exercise goals

General lifestyle advice - re smoking, stress, alcohol and impact on these goals.

Goals: Weight loss, Improve CVD fitness, Improve Strength, Energy and Mental Wellbeing

Physiotherapists -

Importance of keeping active

Keeping mobile and strong

How to keep fit and strong if you have a pre-existing condition / MSK issue

Prevention of injury (stretching / balance etc)

Virtual physio

Mental Wellbeing -

Why is it important and how do do it

How to manage stress, low level anxiety and mood

What are the different therapies how do they work and what might be right for you

Self-help - what can people do to help

Effect of alcohol, caffeine, diet etc

Nutrition (could be part of PT or dietician / physio)

How to have a healthy balanced diet

Food groups

Food and different conditions

Differing options to help i.e. intermittent fasting. dietdoctor.co.uk