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Feasibility and acceptability of multidisciplinary team training in health coaching: Case study in adolescent rheumatology

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ABSTRACT

The central importance of the biopsychosocial model of chronic disease is increasingly recognised in the management of long-term conditions (LTC), which are often associated with chronic pain, fatigue and disability. Despite the physical and mental health impact, 'struggle' to maintain self-efficacy, gap in effective transition to adult pathways and long term consequences of poor disease control and lifestyle choices in young people with LTCs, innovation in this age range is rarely reported in generic journals. This paper explores the feasibility and acceptability of health coaching with young service users to increase engagement and self-management, achieved through multidisciplinary team (MDT) training in Adolescent Rheumatology.

Background

The period of early adulthood is generally characterised by instability, as young-people go through critical physiological, emotional, educational and social transitions notably leaving the home to become independent. At the same time, the day-to-day management of their LTC largely relies on the commitment and organisation of the individual as young people move away from the protection of the paediatric model of healthcare with its support, safety netting and parental involvement.[1] The need to cope with multiple demands and take responsibility for their health when peers are rebelling, can be very stressful. Consequently, young people may have poor adherence to medications and lifestyle measures, self-confidence and agency[1,2] which health coaching can address.[3]

Although patients and clinicians' agendas may differ, they are complementary and collaboration through co-production is increasingly recognised as best practice.[4] Health coaching is such an approach that gives people the knowledge, skills and confidence to become more active in their care to maximise personal well-being and health.[5] It is a way of exploring, in tandem with clinical enquiry, the unique psychological, biological and social impacts of chronic disease on an individual and then create tailored interventions to improve health outcomes co-produced with the young person based on individual needs and motivation. As such, supporting young-people using health coaching conversations can potentially help them take more control of their health and change behaviour. Anecdotal reports from clinicians suggest that the impact of health coaching is diminished if the approach is used inconsistently, where patients experience some care from staff who habitually use the normal directive biomedical approach, while others trained in health coaching use a more non-directive, enquiring style in partnership.

Following its introduction into the NHS in 2010,[4] health coaching was scaled nationally through the NHS Innovation Accelerator Programme[6] and is now embedded in new roles within primary care networks as part of the NHS England Personalisation model.[7] Very few reports have evaluated the impact of the training at team level.[8] This case study describes MDT training in health coaching to offer patients a uniform approach no matter who they visit within the team, to encourage and reinforce motivation to sustain healthy life styles and increase medication adherence.

Study setting

The Adolescent and Young Adult Rheumatology Department at University College London hospital consists of an MDT of 12 members who manage over 2,500 young people with diverse childhood onset rheumatic diseases. Services provided include a well-developed chronic pain service and dedicated nurse-led helpline for direct access to medical, social care and wellbeing support. Since its inception, the MDT has

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Table 1
Project timeline of improvement journey.

Phase 1–identification of need and set up	January 2021	Assessment of need Project planning Engagement with young people Funding applications
	August 2021	Funding approval Engagement with young people Planning for course
Phase 2–training	January 2022	Core skills in HC training Participants encouraged to select people to work with after day 1 and practice peer coaching Post course survey Engagement with young people
	March–April 2022	Four members of the team completed core skills in HC
Phase 3–co-production with service users	June 2022	Team workshop Engagement with young people
Phase 4–embedding and evaluation	July 2022	Face to face workshop with young people Key priorities in service improvement Three young people taking part in internship programme Clinician encouraged to use HC tools in clinic consultation 6-monthly post course survey
	November 2022	Workshop to capture opportunities and barriers in embedding HC in routine care

strived to involve patients and public in research and service development. The adoption of health coaching within the team, and working with service user representatives, was a continuation of its coproduction ethos.

Aims and objectives

The departmental health coaching initiative between January 2022 and January 2023 aimed to assess the feasibility and acceptability of innovative, multidisciplinary health coach training to standardise personalised behaviour change consultations in routine care, and make recommendations for further application. The intention was to apply a health coaching approach to all consultations which clinicians deemed appropriate for young people aged 18–25 year old.

Methodology

The project timeline is outlined in Table 1 in four phases;

Phase 1 - identification of need and set up

The need for additional consultation skills for the whole MDT arose from surveys and interviews of young people and staff as part of a wider quality improvement project.

This involved:

1. A four month audit of the helpline between October 2021 and Jan 2022 identified 1,651 helpline queries (Median 103 queries/week, IQR:93–112) and highlighted the difficulty that young-people face in self-managing aspects of their disease.
2. A small pilot survey of all 12 MDT members (83% response rate) which revealed for most staff their consultations focused solely on clinical care (70%) and were not long enough to discuss how best to support long-term management (60%). Relatively few members effectively supported self-management (30%) or were aware of what health coaching entailed (30%).
3. The team invited young people at the end of clinic consultations to learn about the department improvement strategy, and of the 30 who replied positively, 15 participated in one to one and focus group discussions and workshops around what mattered to them. The initial training events were planned for clinicians alone to allow them to individually engage with health coaching. A service user was invited to the follow up training to explore the application to the service as a whole. As a result of these engagements, two projects were prioritised by the department for young people; improving clinic consultations and establishing a peer support scheme.

Phase 2 – health coaching training

Health coaching training was delivered to all members of the MDT over two separate days, 1 week apart. It provided collective skills training linked to service development facilitated by educational material, presentations, and group discussion, all delivered in a coaching style by an external training provider accredited with the Personalised Care Institute (PCI). Training and workshops included theoretical and practical activities, Practical activities included use of structured conversations, active listening, reflective individual and group questions, behaviour change models and content presentations from young service user, team member and facilitators all to raise awareness, to enable participants to apply their skills in a supported learning environment. Four members of staff including the senior registrar, physiotherapist and two nurse specialists received an additional two days training to European Coaching and Mentoring Council (EMCC) accredited level supported by monthly webinars.

Phase 3: embedding and sustaining

At a follow-up team huddle 4 months later, team members agreed to commission a further 1 day workshop to reinforce the skills and develop the service which was held 9 months after the original training.

Evaluation of the impact of the training included surveys before (described above, 83% response rate), immediately after (91% response rate) and 6 months after (83% response rate) training to all 12 MDT members.

Results

The post training survey indicated all MDT members who answered the survey (91%) were satisfied with the course content, delivery, facilitation and opportunities to work and learn with colleagues, believed there were benefits for patients and the service and a wide application for the team (Fig. 1). The training was considered feasible by all participants.

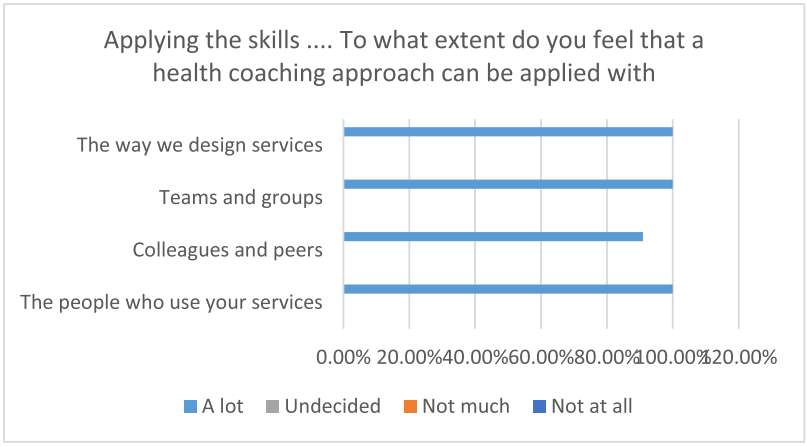

Fig 1. Post health coaching training staff perception in relation to patient and service benefits from the use of health coaching.

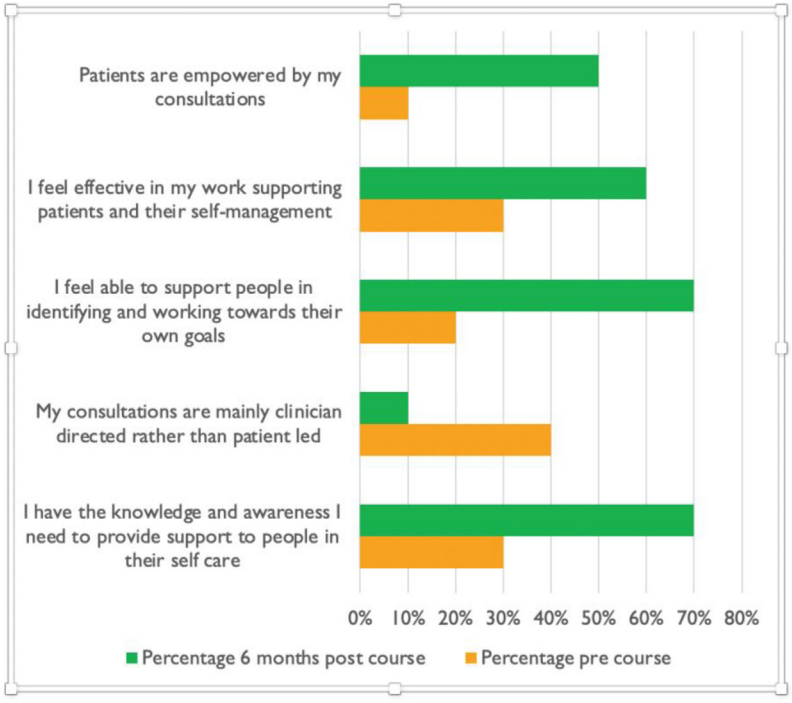

Fig 2. Health coaching: pre course and post course staff survey This figure details staff perceptions before and after training and indicates a shift in their sense of ability to support young people to self-care, while becoming more patient-led.

Notably, respondents reported that the mindset and techniques were applicable to their work and could be used to improve self-management, empower young people to develop self-efficacy and potentially reduce demand on services.

By 6 months, all MDT members had started to implement some aspect of health coaching in their routine care and over two thirds (70%) reported they had retained the knowledge to support self-management. However, all cited limited consultation time and increased workload as the main barriers to fully adopting the techniques (Figs. 2 and 3). This may explain the variable numbers of patients who routinely received health coaching during their consultations.

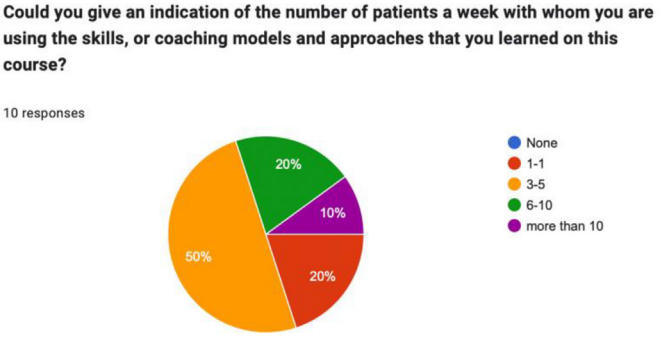

Fig 3. Average number of patients receiving Health Coaching per week (10/12 respondents), at 6 months post training.

Discussion

Symptoms of a chronic disease result from the interaction between diseases related, environmental, behavioural and social factors. It is imperative that the 'social determinants of health'[8] and health-behaviour related modifiable risk factors (smoking, physical activities, unhealthy diet) are considered in the treatment of long term conditions.[9–13]

Given the significant hurdles faced by young people in self-management over their life time, an enabling multidisciplinary team early on to embed positive health behaviours is the cornerstone of holistic treatment. While the need to engage people in their own behaviour change is fully accepted by other disciplines, namely health psychology and behavioural science, the usual approach to care in this age group continues to be based on the biomedical model.[14,15]

This case study, indicates 100% acceptability and feasibility for working in a new way as an MDT that involves young people in their own care and creates agency for change, although limited by time and

workload pressures. The mindset and skills were maintained at nine months and sustainable impact of the training seen elsewhere in years.[16]

One of the main strengths in this project is the engagement of the whole team and young people together in the service development. Engaging young people made the case for change and improved consultations, and having a service user present at the training day catalysed team development and capability building around a more holistic service and what was important to them. The team placed high value on time spent working and learning together to reconnect and improve relationships as an MDT, especially in the post COVID period.

One of the main limitations of study is the lack of outcome measures in relation to young people's health and added value to consultations. It would be unrealistic to expect a change in outcomes within the first year of the project, and while there is some evidence health coaching is cost effective when applied to clinician training,[5] a larger study and economic evaluation is needed.

In the early days of health coaching in the NHS, training was offered to improve consultation skills across all professions to improve routine care. Since adoption of the new role of health and wellbeing coaches in general practice, these skills are mostly assigned to one team member, rather than all. The benefits for the whole team and a consistent approach should not be over looked as well as offering dedicated clinics.[7] As health coaching embeds in the NHS, rigorous evaluation is needed of new roles and services.[17] The way training is delivered also requires evaluation to ensure consistent standards by PCI to enable their replication. To the best of our knowledge, there is a gap in relation to the most effective training model to enable team skills to be built, system and organisational change and incentives to embed and reinforce new ways of working.

Conclusion

The basis of treatment for young people with LTC should be active self-management. This paper describes the feasibility and acceptability of health coaching training for the whole MDT to improve engagement, self-efficacy and behavioural change in young people with rheumatic diseases. Whilst the small numbers are insufficient to prove benefit, before and after surveys show health coaching is a highly valued consultation tool. Similar innovative training to encourage active self-management consistently across the team, rather than solely by individuals, should be adopted widely in this age group especially.

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Ethics approval statements

Not applicable.

Declaration of competing interest

The authors declare there is no conflict of interests.

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