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REVIEW ARTICLE

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Implementing coaching programmes for healthcare professionals—A review of the barriers and facilitators

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Abstract

Background: The European Union faces severe and worsening personnel shortages in healthcare. Coaching has emerged as a human-centred strategy to enhance sustainable employment and retention. While the number of efficacy studies on coaching continues to grow, knowledge about the barriers and facilitators to implementing coaching interventions among healthcare professionals (HCPs) remains scarce.

Objectives: This systematic review aimed to describe common barriers and facilitators to the implementation of coaching interventions for HCPs.

Methods: In April 2023, five databases were searched for eligible articles. Barriers and facilitators were systematically identified and mapped onto the constructs of the Consolidated Framework for Implementation Research (CFIR). Directed content analysis yielded thematic areas and a reporting frequency.

Results: A total of thirty (n = 30) studies were included in this review, representing twenty-five (n = 25) distinct coaching programmes. Implementation determinants were clustered under two CFIR domains: the *Inner Setting* (8 facilitators, 5 barriers) and *Implementation Process* (6

facilitators, 1 barrier). Barriers included (i) limited organisational capacity, (ii) lack of psychological safety, (iii) competing work demands, and (iv) insufficient leadership buy-in, while facilitators were the (i) allocation of protected time for participants and coaches, (ii) promotion through opinion leaders, (iii) embeddedness in existing Continuous Professional Development programmes, and (iv) programme co-creation.

Conclusion: The findings of this study provide practical insights to guide the future implementation of coaching interventions at an organisational level. In particular, the identified barriers and facilitators suggest, for optimal efficacy and sustainment, coaching interventions must be implemented within a safe, supportive organisational climate.

KEYWORDS
coaching, Consolidated Framework for Implementation Research, healthcare professionals, job demands-resources theory, systematic review

Highlights

- Barriers and facilitators covered all Consolidated Framework for Implementation Research domains, particularly the *Inner Setting*.
- The *Implementation Process* created trade-offs in psychological safety and cost.
- A safe, supportive *Inner Setting* and leadership buy-in were necessary conditions.
- Future implementation can be guided by the implementation strategies provided.

1 | INTRODUCTION

The newly termed 'Mass Exodus' refers to a post-COVID-pandemic social and economic trend of employee resignation, notably, from healthcare.[1] In the European Union (EU) the current shortage of nurses and medical specialists is severe.[2] and likely to increase. In a recent survey, 47% of European respondents stated they plan to leave their position in 2–3 years.[3] Healthcare professionals (HCPs) are paramount to equitable healthcare delivery, hence, the paradox of reduced supply met with increasing demand for healthcare has significant implications for public health.[4]

Healthcare attrition and turnover rates are influenced by factors both external (e.g., migration patterns and technological advancement) and internal (e.g., ageing and burn-out) to healthcare organisations.[4] Recently, the COVID-19 pandemic placed an additional strain on health systems, significantly exacerbating and drawing attention to pre-existing challenges.[5] Yet, Poon et al.[6] found 'intention-to-leave' remained consistent pre- and post-pandemic and was predominantly associated with working conditions.

The working conditions that affect HCPs can be grouped under the physical, logistical (e.g., work hours, staffing levels), and psychosocial work environment.[7,8] When these working conditions require sustained physical or psychological effort, they are categorised as a 'job demand' under the Job Demands-Resources (JD-R) model.[7,9,10] The JD-R model suggests 'job resources' can counteract health impairment due to 'job demands' by reducing the costs of 'job demands' and fostering personal growth, learning, and engagement.[7] Recently, professional development coaching has emerged as a 'job resource' and gained considerable attention[11] to enhance sustainable employment and improve retention in healthcare.

Through efficacy research, coaching has demonstrated benefits on both an individual- and organisational-level. For instance, randomised-control trials[12] show the role of coaching to prevent exhaustion and emotional distress[13] as well as to promote self-efficacy and work-life balance.[14] In the Cleveland Clinic, peer-based coaching was associated with improved physician retention, yielding a potential cost saving of 133 million dollars.[15] Given its dual-benefits, coaching is increasingly being viewed as an important tool to, 'shift organisational culture with a new narrative around meaning and purpose',[16] broadly aligning with O'Connor & Cavangh's[17] 'ripple effect'.

Much like other well-being and professional development programmes for HCPs, despite their benefits, system-wide uptake, and implementation of coaching interventions remains limited.[18] Hence, additional research is needed to identify barriers and facilitators that impact the likelihood of successful programme implementation. Previously, reviews have described the implementation determinants for workplace well-being initiatives[19] and surgical (skills) coaching,[20] but, to date, none have been published for the implementation of professional coaching among HCPs.

Therefore, this study seeks to identify and describe common barriers and facilitators to the implementation and delivery of coaching interventions for HCPs. The Consolidated Framework for Implementation Research (CFIR) was selected as a guiding framework to outline these barriers and facilitators (or determinants).

The CFIR offers a comprehensive taxonomy of influencing factors across several socio-ecological levels (community, organisation and individual level), making it less likely to overlook important themes and clear construct definitions.[21] Additionally, unlike other frameworks from Implementation Science Research (ISR),[22] the CFIR includes *Implementation Climate*, one of the six organisational-contextual features identified as important determinant to the implementation of evidence-based practices in healthcare.[23,24]

2 | METHODOLOGY

A systematic review was conducted (from April to June 2023) including qualitative, quantitative, and mixed-methods studies. In combining the strengths of quantitative and qualitative study findings, this type of review can provide a more comprehensive and practical understanding of complex public health interventions and programmes.[25,26] The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA),[27] Cochrane methodology,[28] and Pluye & Nha Hong's[25] 'seven standard systematic review steps' were followed.

2.1 | Search strategy

The search strategy was developed in four steps: (i) reviewing search strategies from previous published systematic reviews within Implementation Science; (ii) (preliminarily) screening the literature to identify common/key terms related to coaching; (iii) organising key terms into the PICO framework[29]; and (iv) piloting, refining, and adapting the search strategy in PubMED for use in other databases.

Key terms used in the searches were 'healthcare personnel', 'coaching', and 'well-being'. To reach 'barriers and facilitators', the search string included terms such as 'implementation' and 'programme evaluation'. Search terms were then combined with Boolean Operators to form a search string (Supporting Information S1). Lastly, MeSH

Terms, truncation, and proximity searching were used to optimise the search string for each individual database (e.g., Medline, Embase, Web of Science, CINAHL, and PsycINFO). The final search strategy was validated for accuracy and completeness by a Biomedical Information Specialist at Medical Library, Erasmus University Rotterdam, The Netherlands.

2.2 | Eligibility criteria

A full set of inclusion and exclusion criteria as listed in Table 1.

Articles using qualitative, quantitative, and mixed methods were included. Non-empirical (white) literature was also screened to capture relevant information from sources outside the peer-reviewed literature and reduce publication bias (e.g., organisational reports, research reports, perspective pieces, and manuscripts).

The search was limited to articles published from 2020 onwards in English or Dutch language. This was to prevent a significant overlap with recent systematic reviews on similar topics.[30] Additional criteria for exclusion were informed by definitions of the intervention[31] (i.e., coaching) and outcome[32] (i.e., career wellness). This was important to distinguish coaching from other interventions with which it is often confused (e.g., feedback, teaching, mentoring, peer support).

2.3 | Screening and selection

In accordance with the PRISMA guidelines,[27] articles went through two screening rounds (title/abstract screening and full-text screening), each round lowering the number of remaining eligible articles.

2.4 | Data extraction

Relevant characteristics of coaching interventions including publication details, study characteristics, occupational group, intervention, and outcome was extracted. Coaching is an evidence-based intervention,[14] therefore, while outcome measures (e.g., effectiveness, feasibility, etc.) were extracted, they were not reported on, rather the focus lies with 'type 3 evidence: implementation and context'.[33] Based on reporting guidelines from Garousi et al.,[34] separate data extraction table was developed for white literature.

TABLE 1 Exclusion criteria.

Category	Exclusion criteria
Population	Non-hospital working healthcare professionals (e.g., dentists, medical school professors) or medical students (following ISCO-08 classification)
Coaching	Coaching that does not meet the ICF (2023) standard definition (e.g., involving observation of technical skills or reliance on psychological interventions)
Outcome	Coaching was used to improve technical skills, performance, or patient satisfaction
Language	A language other than English or Dutch
Publication year	Studies before 2020
Study design	Study protocols, commentaries, systematic reviews, meta-analyses, and letters to the editor
Study type	Empirical studies without any form of programme evaluation and non-empirical studies without a clear reliance on empirical research literature

Two in-depth readings of the included studies were performed: a first, to become familiar with and highlight all relevant text quotations and, a second, to code those highlighted quotations using the CFIR. Generally, barriers and facilitators were extracted from the results and discussion sections of the included studies.[21,35] Extractions included: (i) verbatim quotations from research participants; (ii) excerpts, quotations or entire passages from studies using documentary analysis; and (iii) narrative descriptive summaries of results.

2.5 | Risk of bias assessment

According to Bach-Mortensen & Verboom,[36] reviews on barriers and facilitators should assess the robustness of identified factors and/or themes and provide appraisals of the level of certainty in their findings. Therefore, quality assessment was performed by one reviewer using the Mixed-Methods Appraisal Tool (MMAT).[37]

2.6 | Data synthesis

There is no best practice method to analyse barriers and facilitators.[36] In this systematic review, both deductive and inductive coding practices were applied. First, all data was coded deductively for best fit[38] with a CFIR construct (following CFIR Codebook definitions), through directed content analysis.[35] Subsequently, data coded under each CFIR category was re-coded into barriers and facilitators. While extractions from qualitative studies were coded directly against the CFIR constructs, quantitative data was first narratively synthesised and then analysed together with the extractions from qualitative studies. The number of included studies describing a particular CFIR construct was reported, yielding a reporting frequency (RF).[39] Barriers and facilitators described in three or more included studies were considered 'commonly reported'. Lastly, given the context dependency of barriers and facilitators, especially within complex health and social systems,[36] inductive analysis focused on identifying emerging themes among these commonly reported barriers and facilitators.

3 | RESULTS

The systematic search of five databases yielded a total of 2399 results, as shown in the PRISMA flow chart (Figure 1). A total of 30 records were included, representing 25 distinct coaching interventions/programmes. Software-assisted removal[40] (n = 1996 duplicates), followed by title and abstract screening by the principal investigator (n = 2345 excluded) resulted in 54 records for full-text assessment. Overall, the quality of evidence was low, with only 4 of the 25 appraised studies (16%) adequately addressing every question on the MMAT (Supporting Information S2).

3.1 | Study characteristics

A complete and detailed overview of study characteristics (including study design, coaching intervention, occupational group, and outcome) can be found in Supporting Information S3. Across these programmes, coaching approaches included executive, professional developmental, and resilience coaching. Most coaching programmes were delivered one-on-one (n = 17), while others involved a group component. Participants were trainees, specialists, nurses, or a combination of occupational groups, who were recruited from multiple sites, predominantly female, and/or below the age of 35 years. Coaches were either (novice) faculty members, physicians with experience in coaching, or professional (external) coaches. Almost half of the coaching interventions (n = 11) were

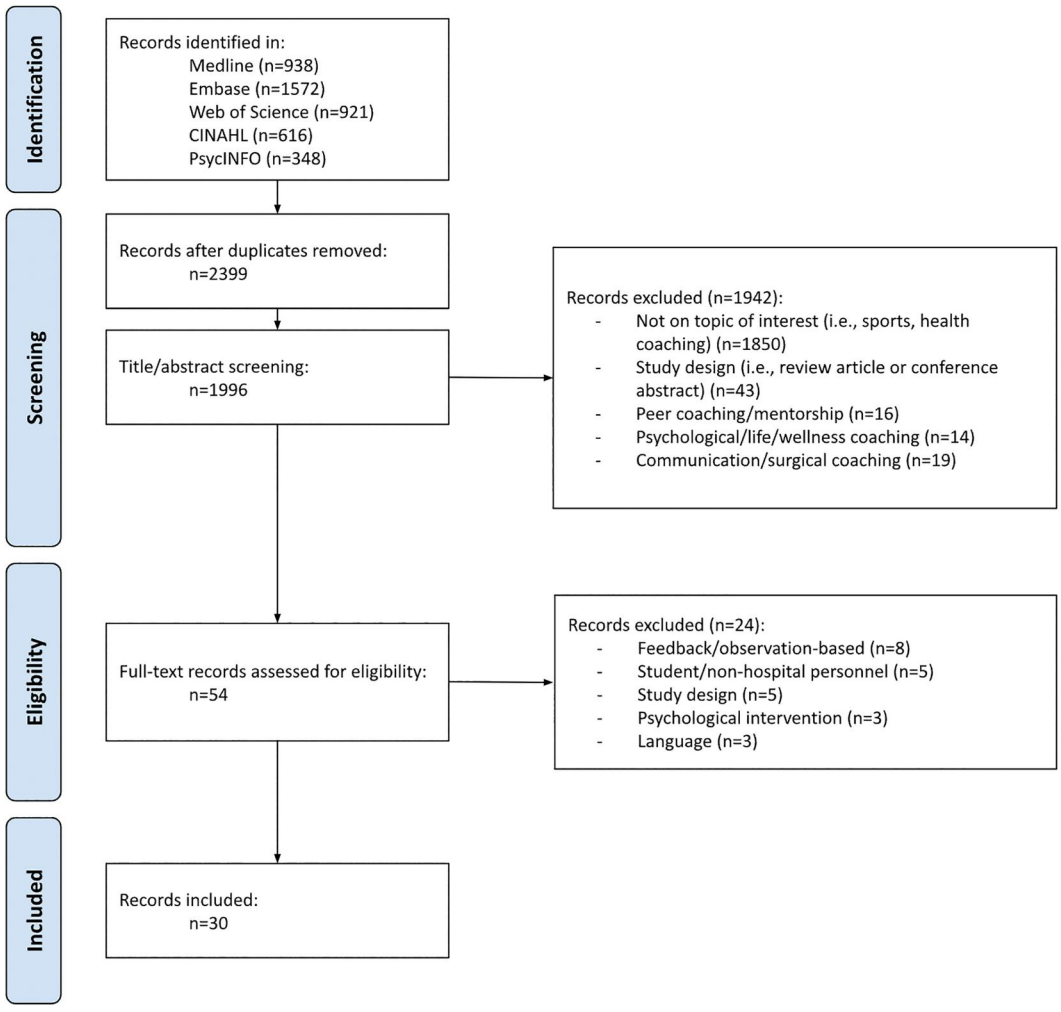

FIGURE 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram.

embedded within broader leadership, educational, or resilience programmes. Lastly, the duration of coaching sessions varied, with a maximum of 60 min, and typically offered four times within the study period.

3.2 | CFIR domains

Barriers and facilitators were found across all domains of the CFIR and within 20 of 39 constructs (Figure 2). Table 2 provides the RF, expressed as a percentage of the number of included articles (n = 30, 100%). Barriers and facilitators were concentrated in the CFIR constructs of *Inner Setting* (RF: 87%), *Implementation Process* (RF: 80%), and *Intervention Characteristics* domain (RF: 77%). The Inner Setting domain had the highest RF (RF: 87%) and included eight facilitators and four barriers. In contrast, the *Individual Characteristics* domain and the *Outer Settings* domain had the lowest reporting frequencies of 60% and 50%, respectively.

The following results are presented in order of highest to lowest RF per CFIR domain.

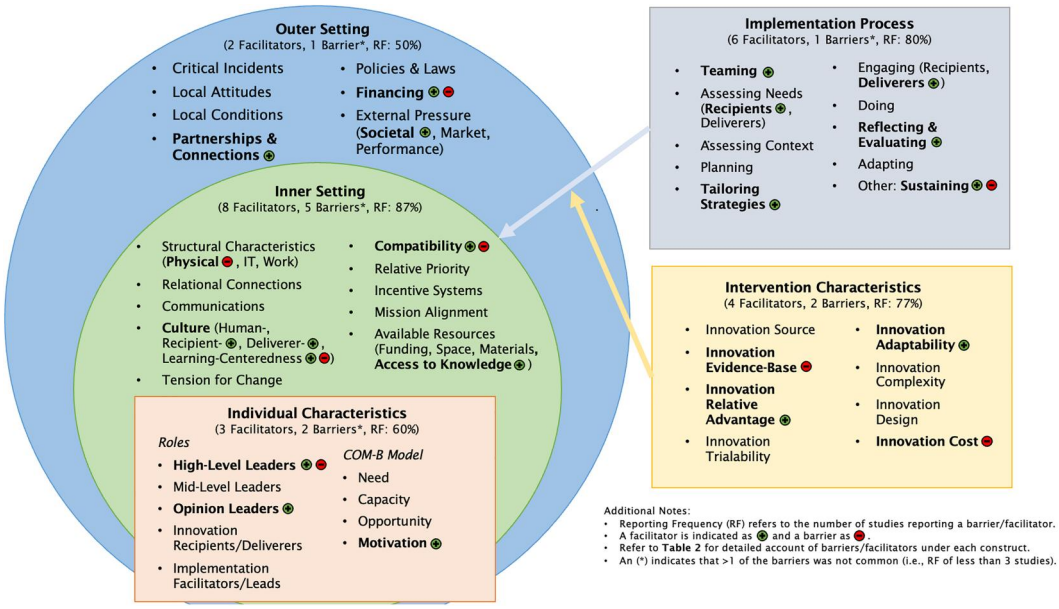

FIGURE 2 Barriers and facilitators across the Consolidated Framework for Implementation Research domains.

3.2.1 | Inner Setting

The *Inner Setting* domain revealed barriers and facilitators across five constructs: *Work Infrastructure*, *Communication*, *Recipient-Centeredness*, *Deliverer-Centeredness*, and *Learning-Centeredness*. Under *Work Infrastructure*, competing work demands were a barrier to both participant (health professional) engagement and deliverer (coach) availability.[41–49] This emphasised the need for allocating protected time to coaching interventions. In addition to this, delineating programme time-commitment and responsibilities was viewed as a key facilitator to programme success.[50] To create clarity around roles and time-commitment informational videos,[47] in-person discussions with HCPs,[42] word-of-mouth,[51] and e-mail or social media[52–54] were used.

Culture had a relatively high RF (RF: 67%), with three sub-constructs specified. First, with regards to *Recipient-Centeredness*, appropriate coach pairing was considered a key component to the delivery of coaching.[41,48,52,54–56] Therefore, in some programmes, participants could make coach preferences (e.g., based on videos or by ranking) or be paired with a coach based on their 'personal and professional interests'.[41] In some studies, the use of a faculty coach or coach with a medical background was seen as a facilitator to improve the delivery of coaching. Winkel et al.[57] stated, 'introducing coaching by way of established faculty may have the potential to infiltrate the culture'. Concerning the deliverers (i.e., *Deliverer-Centeredness*), sufficient support for coaches was a facilitator. For (novice) faculty coaches, coaching was 'a distinctly new experience',[57] therefore, coaches were often provided a formal training, step-by-step guidelines, and refresher trainings.[42,47,52,54,57–61]

Within *Learning-Centeredness* facilitators included a positive learning climate, psychological safety, and trust. Several studies show the lack of a 'learning climate' (i.e., opportunities for reflection, seeking feedback behaviors, etc.) has a hindrance to implementation and delivery of coaching interventions.[47,49,50,57] For instance, participants feared the coaching intervention would have, 'implications for their permanent record'.[50] Participants were often paired with a coach outside of their specialty to protect separate coaching from formal evaluation and, thereby, protect psychological safety.[52–54,59,61] For group coaching, where psychological safety could not be protected through the same strategy, ensuring 'confidentiality'[51] and 'anonymity'[46] were critical to implementation and delivery of group-coaching.

TABLE 2 List of barriers and facilitators under Consolidated Framework for Implementation Research with reporting frequency (RF).

Domain (RF)	Constructs (RF)	Sub-Construct (if applicable)	Barrier (RF)	Studies no.[a]	Facilitator (RF)	Studies no.[b]
Intervention Characteristics (n = 23, 77%)	Evidence Quality (n = 8, 27%)		(–) Limited transferability and generalisability of study findings to different settings, contexts, and participant groups (n = 8, 27%)	[5, 6, 12, 17, 18, 26, 27, 30]		
	Relative Advantage + Adaptability (n = 19, 63%)				(+) Adapting to individual needs, values, and/or contexts (n = 10, 33%)	[4, 5, 10, 15, 16, 18, 23, 24, 27, 29]
					(+) Discussing organisational structure and teamwork (n = 9, 30%)	[4–6, 12, 16, 22, 24, 25, 28]
					(+) Virtual offering (COVID-19 or national access) (n = 6, 20%)	[1, 5, 14, 18, 26, 30]
	Cost + Adaptability (n = 5, 17%)		(–) Limited organisational capacity (human resource or financial) across settings (n = 9, 30%)	[4, 7, 15, 17, 18, 23, 27, 28, 30]	(+) Adapting to faculty-led or group-coaching (n = 5, 17%)	[3, 5, 7, 13, 26]
Outer Setting (n = 15, 50%)	Partnerships & Connections + Financing (n = 11, 37%)		(–) Temporary funding from COVID-19 response or (pilot) research grants (n = 2, 10%)	[23, 30]	(+) Funding through partnerships with medical associations or universities (n = 10, 33%)	[5, 6, 13, 14, 18, 19, 26–29]
	External pressure	Societal pressure (n = 4, 13%)			(+) National or regional calls for health personnel well-being and/or professional development (n = 4, 13%)	[1, 17, 21, 29]
Individual Characteristics (n = 18, 60%)	High-Level Leaders (n = 10, 33%)		(–) Insufficient organisational support and/or leadership buy-in (n = 3, 10%)	[10, 15, 17]	(+) Sufficient leadership buy-in (funding, time allocation, embeddedness, and sustainability) (n = 7, 23%)	[4, 8, 19, 22, 24, 26, 30]
	Opinion Leaders (n = 5, 17%)		(–) Lack of diversity among programme leaders (n = 2, 7%)[c]	[5, 30]	(+) Internal programme champion (health personnel) (n = 5, 17%)	[5, 8, 15, 17, 30]
	Motivation (n = 9, 30%)				(+) Participant interest and engagement with coaching (n = 9, 30%)	[1, 2, 9, 13, 23–25, 29, 30]
Inner Setting (n = 26, 87%)	Structural Characteristics	Work Infrastructure (n = 14, 47%)	(–) Insufficient protected time for participants (healthcare professionals) (n = 12, 40%)	[1, 2, 5, 8, 9, 13, 22, 29, 30]	(+) Allocating dedicated time for coaches (n = 5, 17%)	[8, 15, 16, 19, 28]
		Communications (n = 7, 23%)	(–) Lack of awareness about coaching (n = 2, 7%)[d]	[7, 15]	(+) Delineating programme time-commitment and responsibilities (n = 7, 23%)	[7, 9, 15, 19, 22]
	Culture (n = 20, 66%)	Recipient-Centeredness (n = 9, 30%)			(+) Pairing (coach and coachee) based on personality, professional interests, and specialty (n = 6, 20%)	[1, 7, 18, 23, 26, 29]
					(+) Selecting professional (external) coaches with a medical background (n = 4, 13%)	[1, 4, 5, 28]
		Deliverer-Centeredness (n = 11, 37%)	(–) Insufficient means to evaluate the efficacy of coaching skills (n = 3, 10%)	[17, 20, 26]	(+) Offering training, guidelines, and debrief sessions to standardise coaching (n = 11, 37%)	[2, 3, 6, 7, 10, 17, 18, 20, 22, 26, 28]

TABLE 2 (Continued)

Domain (RF)	Constructs (RF)	Sub-Construct (if applicable)	Barrier (RF)	Studies no.[a]	Facilitator (RF)	Studies no.[b]
		Learning-Centeredness (n = 14, 47%)	(–) Lack of a learning climate (n = 4, 13%)	[19, 22, 28, 30]	(+) Using external or out-of-specialty coaches to protect psychological safety (n = 6, 20%)	[3, 14, 17, 18, 24, 26]
					(+) Ensuring confidentiality (n = 4, 13%)	[2, 12, 13, 22]
	Compatibility (n = 11, 37%)		(–) Tension from competing roles (i.e., supervisory and coaching) (n = 2, 7%)[e]	[27, 28]	(+) Embeddedness in a larger educational or professional development programme (n = 10, 33%)	[4, 6, 7, 15–17, 19, 22, 24, 28]
Implementation Process (n = 24, 80%)	Teaming (n = 6, 20%)				(+) Developing the programme and/or guidelines together with facilitators, health personnel, and/or experts (i.e., co-creation) (n = 6, 20%)	[9, 14, 15, 20, 23, 27]
	Assessing Needs + Tailoring Strategies	Innovation Recipients (n = 14, 47%)			(+) Offering coaching at multiple times and through multiple modalities (virtual) (n = 6, 20%)	[5, 10, 13, 21, 25, 30]
					(+) Inform the adaptation of coaching programmes through pre-assessment (n = 7, 23%)	[6, 8, 17, 22, 27, 29, 30]
					(+) Contracting with participants (n = 4, 13%)	[2, 6, 19, 29]
	Engaging				(+) Developing a 'coaching culture' and community of practice among coaches (n = 7, 23%)	[1, 9, 19, 22, 26–28]
	Reflecting & Evaluating + Sustaining	Innovation (n = 6, 20%)	(–) Persistence of systemic factors (n = 2, 7%)[f]	[10, 30]	(+) Continuous feedback, improvement, and stakeholder dedication (n = 4, 13%)	[6, 7, 15, 19]

Note: [a–b]Study no. refers to the study no. in the study characteristics table, Supporting Information S3. [c–f]The reporting frequency was less than 3 studies, therefore not a common barrier.

Lastly, where coaching interventions were integrated into existing educational or leadership programmes, facilitators emerged under *Compatibility*. When this alignment was lacking, participants' perception of being valued by their organisation was diminished. On the other hand, the degree of intervention embeddedness created a 'tension from competing roles' for faculty coaching (e.g., balancing their supervisory with educational roles).[57]

3.2.2 | Implementation Process

Barriers and facilitators under the *Implementation Process* domain involved four constructs: *Teaming*, *Tailoring Strategies*, *Engagement*, and *Reflecting & Evaluating*.

Firstly, *Tailoring Strategies* emerged frequently and described the use of customisation of coaching sessions to accommodate unpredictable schedules. Strategies included offering various session times, allowing participants to choose modalities, and employing a process known as 'contracting' to specify session details.[46,50] Moreover, to guide customisation a pre-assessment was performed, a focus groups or pre-participation survey, which provided additional insights to what participants valued in the time-limited space.

Facilitators under *Engagement* involved deliverers, whereby a 'community of practice' among coaching was seen as beneficial to intervention delivery. This included regular discussion and debriefs between coaches to standardise

coaching practices.[41,45,47,50,52,57] Parsons et al.[50] stated, 'successful implementation and maintenance of our coaching programme requires deliberate, ongoing cultivation of a professional culture and sense of community among coaches'. Furthermore, *Teaming* during the programme development, with programme leaders, the International Federation of Coaching, or HCPs, supported later implementation.[45,51,53,56,57,62]

Lastly, under *Reflecting & Evaluating* the need for continuous programme monitoring and improvement was described. This was considered a facilitator as it could reinforce leadership buy-in. For instance, in Gascon et al.,[59] two evaluations were conducted of the programme processes and outcomes to justify the costs.

3.2.3 | Individuals

Under the *Individual Characteristics* a lack of leadership buy-in was seen as a barrier to success, durability, and consistency of coaching interventions.[51,54,60] Conversely, leadership and organisational support was, '[key] to success for sustained implementation',[52] specifically, the allocation of funding and protected time to deliver and/or participate in coaching.

Furthermore, the use of 'internal programme champions' or *Opinion Leaders* supported implementation through promotion and participant engagement.[43,44,49,51,54] Lack of diversity among programme leaders, however, negatively influenced participant recruitment,[43,49] with only one explicitly mentioning efforts to reach underrepresented groups.[49]

Regarding *Motivation*, only one of the 25 coaching programmes included was mandatory.[62] Therefore, motivation from participants was seen as necessary to achieve implementation success. Johnson et al.,[45] described this phenomenon in extensive detail under a theme titled 'Tension between Mandatory and Voluntary Delivery', wherein they debated the benefits and drawbacks of making the programme compulsory.

3.2.4 | Intervention Characteristics

The *Intervention Characteristics* domain revealed barriers and facilitators under three constructs: *Adaptability*, *Relative Advantage*, and *Cost*. *Adaptability* involved adjustments in participant numbers, delivery mode, and deliverer type. For instance, one-on-one coaching[43,48,51,54,56,57,60,62–64] increased participant engagement by focussing on personal needs, while virtual[52] coaching interventions proved beneficial in enabling expanded access.

On the other hand, one-on-one coaching was considered logistically challenging and costly.[46] Insufficient organisational capacity to resource coaching was mentioned as a barrier for implementation,[57] particularly when coaching interventions were implemented across multiple sites. As such, group-coaching was favoured for cost reduction and increased feasibility by maximising the number of participants per session. Likewise, training internal faculty as coaches was seen as a cost-effective alternative to hiring certified coaches.[43,46,52,55,58]

3.2.5 | Outer Setting

Barriers and facilitators within the *Outer Setting* domain were identified for three constructs: *Partnerships & Connections*, *Financing* and *Societal Pressure*. Notably, *Values & Beliefs* and *Policies & Laws* did not yield commonly-reported implementation determinants.

In Parsons et al.,[50] *Financing* was considered, 'vital for the implementation and subsequent success of the coaching programme'. Funding for coaching interventions came either from internal funds[43,46,49–51] or external[48,52–54,57,59] funds. In addition, *Societal Pressure* emerged as a driving force for investments in coaching interventions; driven by national calls to address gender gaps and promote provider well-being on a systemic

level.[41,65] However, this construct also presented a barrier: temporary funding sources like COVID-19 grants hindered sustainable development and limited the scalability of coaching programmes. For instance, Yi-Frazier et al.[49] noted that being a pilot study constrained the course's broader implementation.

3.2.6 | Construct relationships

Commonly reported barriers and facilitators in coaching interventions were found to vary based on three characteristics: occupational group, type of coaching, and method of implementation.

First, for all occupational groups, nurses,[42] specialists,[47] multiple professions[44,45,49] and trainees,[42,43,46,48] the implementation and delivery of coaching interventions was hindered by, 'insufficient protected time for participants (healthcare professionals)'.

Second, in studies describing a coaching intervention delivered by internal faculty coaches, implementation determinants were often centred around the coach (*Deliverer-Centeredness*) and the learner (*Learner-Centeredness*). For instance, psychological safety was a frequent barrier under faculty-led coaching interventions.[47,49,50,57]

Third, where multi-site implementation and organisational support were mentioned, variations were also observed across articles for *Innovation Cost*, *High-Level Leaders*, *Work Infrastructure*, *Compatibility*, and *Tailoring Strategies*. For instance, 'limited organisational capacity (human resource or financial)' was more prominent among coaching programmes implemented across multiple sites or included participants from multiple sites.[49,51,54–57,63] In addition, where 'sufficient leadership buy-in' was a critical facilitator, 'embeddedness in a larger educational or professional development programme' also supported implementation/delivery.[47,50,61,63]

4 | DISCUSSION

This systematic review examined the barriers and facilitators to implementing and delivering coaching programmes for HCPs using the CFIR. These findings contribute to a growing body of evidence that seeks to understand the process (type 3 evidence), rather than merely the outcome (type 2 evidence) of coaching interventions. In doing so, the identified barriers and facilitators can inform future implementation of coaching interventions across diverse healthcare contexts.

4.1 | Comparison with existing literature

An interrelated set of determinants was mapped across 20 of the 39 CFIR constructs, yielding a total of 23 facilitators and 11 barriers. The highest reporting frequencies occurred in the *Inner Setting* (RF: 87%) (for *Culture*, RF: 66%), *Implementation Process* (RF: 80%), and *Intervention Characteristics* domain (for *Relative Advantage* and *Adaptability*, RF: 63%). The identified barriers and facilitators were both unique to coaching interventions and generic for healthcare organisations.

Within the *Intervention Characteristics* domain were those implementation characteristics unique to coaching. Namely, the flexibility of coaching interventions was considered advantageous for implementation; accommodating individual needs and organisational capabilities. However, this characteristic also brought about specific challenges and trade-offs: (i) while individualisation was viewed as a Relative Advantage, it created obstacles in terms of cost; (ii) when financial or human resource constraints were overcome by adopting a faculty-led or group coaching approach, it gave rise to barriers associated with psychological safety.

Outside of the *Intervention Characteristics* domain, implementation determinants seemed generic to healthcare organisations. Previously, implementation determinants have been identified for workplace well-being

programmes[66,67] and Continuous Professional Development programmes[68] in healthcare settings. Across these studies, barriers to implementation included work pressures, financial constraints, and insufficient organisational investment, while facilitators were effective communication and advertisement, conducting a needs analysis and evaluation before, during, and after implementation, and supportive organisational culture.

Throughout the broader literature, as well as this study, barriers to implementation within healthcare settings typically refer to a 'lack': lack of resources, time, organisational support, and learning climate. This reinforces the importance of assessing and creating the necessary conditions,[69] in pre-implementation phases, to establish and sustain coaching interventions among HCPs. Moreover, the breadth of barriers and facilitators indicates some complexity of these necessary conditions. Karamitri, Talias & Bellali[70] characterise healthcare organisations as highly heterogeneous, lending to a wide array of implementation determinants.[71] Predominantly, however, barriers and facilitators rest in the *Inner Setting* (5 barriers, 8 facilitators) and, specifically *Culture*. This reinforces the broader narrative in ISR that organisational culture significantly impacts the implementation of evidence-based practices through the behaviours, attitudes, and motivations of HCPs.[10,24]

4.2 | Implications for practice and policy in the EU

Although validating current evidence holds significance, the recurrence of these discoveries underscores a more widespread problem: organisations have persistently failed to address widely recognised challenges. By applying the CFIR framework, this study has identified actionable barriers, levers of change, and relevant components of the implementation process; some of which will be discussed here.

First, this study drew relationships between various constructs and found where 'insufficient leadership buy-in' was reported, there was also a lack of programme embeddedness, protected time, effective communication, and internal funding. In contrast, Parsons et al.[50] described institutional support and effective communication as essential to secure funding, dedicated time, and programme embeddedness. This suggests organisational and high-level leadership support for coaching are critical antecedents to implementation.

Second, in the multi-level CFIR framework, the absence of implementation determinants also provided valuable insights. Specifically, facilitators that could enhance organisational support for interventions like coaching were not identified within the *Policies & Law* construct of the *Outer Setting* domain. Likewise, a 2019 review[72] of occupational health and safety policies in the EU found only 35.4% of EU establishments take measures to prevent psychosocial risks at work. Brady & Kuiper[73] advocate for the incorporation of initiatives to improve the well-being of the healthcare workforce within the EU in the upcoming European Mental Health Strategy and the European Health Union's new comprehensive, prevention-oriented and multi-stakeholder approach to mental health.[73,74]

Third, *Culture* and *Motivation* held a considerable number of barriers and facilitators. This implies creating access to coaching through a top-down approach alone is unlikely to ensure sustained implementation, especially where a learning climate or psychological safety are lacking. Inevitably, promoting work-based well-being and/or professional development requires individuals to be able to recognise and report when they can no longer meet current work demands.[75] In healthcare organisations, the prevailing organisational culture often fosters fear of stigmatisation and reluctance to show vulnerability, which hinders the uptake of mental health services.[76] In addition, HCPs express concerns that accessing such services may negatively affect their medical licensure or evaluations.[77]

Coaching programmes must be sufficiently tailored to align with the legal (i.e., privacy laws) and cultural contexts (i.e., norms, attitudes, and perception of mental health) of individual EU Member States and healthcare organisations. In this study, implementation strategies were found to mitigate barriers within the organisational culture and included: targeted coach pairings, ensuring confidentiality, and a preliminary needs assessment. As well, communication through opinion leaders can help normalise a coaching culture and promote its benefits. Similar Hunt et al.[75] suggests to improve psychological safety its current must be assessed and practices encouraged by leadership.

Collectively, these findings indicate the need for a 'whole-system approach', wherein the initial implementation of coaching interventions should be led by committed, high-level leaders. Leadership buy-in is crucial for establishing access, creating the necessary structural conditions (i.e., protected time), and avoiding unintended effects (i.e., heightened job-demands). However, the sustainability of coaching interventions largely relies on aligning with the preferences and priorities of those who shape, deliver, and participate in them and the overarching organisational culture. Therefore, fostering a process of so-called 'co-creation' (i.e., bottom-up approach), through which programme recipients, deliverers, and implementers share power and provide valuable insights on both individual and organisational level,[5] may be highly supportive of implementation.

4.3 | Future research

Three areas for future research have emerged from this review:

(i) First, contrary to Damschroder et al.[78] the results of this study suggest constructs within the *Inner Setting*, particularly *Culture*, may be influenced by the implementation of a given innovation (here, coaching). Namely, several studies included in this review argue that the implementation of coaching interventions can foster discussions about organisational structure and teamwork and, thereby, affect organisational culture.[43,47,57,59,61,63,64,79,80] This may be particularly relevant in healthcare organisations, for which the deep-seated drivers of burnout and attrition rates reside within the workplace culture and environment.[81,82] Additional individual- and systems-level research is needed to explore the link between organisational culture and coaching interventions;

(ii) Second, in this study, regular examination and dissemination of programme processes and outcomes was found to facilitate sustained leadership and participant buy-in. However, the overall quality of included studies was rated as moderate, and coaching interventions were highly heterogeneous in nature. In the future, a standardised definition and set of outcome measures (i.e., Physician Well-Being 2.0) will be necessary to reduce programme variation and establish a data infrastructure that supports evaluation and quality improvement (see call in NICE guideline [NG212][19]);

(iii) Third, although CFIR has obvious utility for identifying barriers and facilitators to implementation, it is not designed to address the question of why some healthcare organisations may initiate coaching interventions in an unsystematic and reactive way. Therefore, it is important in future research to focus on the level of operationalisation (e.g., identification of concrete, executable actions fully informed by knowledge of complex, system-level issues) of the coaching intervention itself.[83]

5 | CONCLUSION

The healthcare workforce crisis is a 'wicked problem,' with complex social, political, and economic aspects, as well as conflicting priorities. As such, it calls for several, multi-level efforts. Coaching presents a low-threshold opportunity to invest in the professional and the personal development of HCPs. To deliver its intended effect, however, thoughtful and targeted implementation that addresses barriers and leverages facilitators is necessary.

Guided by the CFIR, this review presents the barriers and facilitators to implementing and delivering coaching programmes for HCPs. Overall, the findings of this research show barriers and facilitators exist within the organisation (e.g., culture, investment), team (e.g., workload, climate, psychological safety), and individual (e.g., stigma, taboo). Furthermore, while several implementation determinants were specific to coaching interventions, many were generic for implementation in healthcare settings. This reiteration emphasises the need to address long standing barriers, particularly those rooted in the organisational culture of healthcare settings.

Lastly, the findings of this study may guide implementation strategies that increase adoption, use, and maintenance of coaching interventions. Among other suggestions, co-creation was considered a proactive strategy to unify organisational and individual needs in the pre-implementation stages. Further research, is needed to improve the quality of evidence on coaching implementation and address the identified implementation challenges, including initial validation and consensus with focus groups.

6 | STRENGTHS AND LIMITATIONS

The strengths of this systematic review included the (i) integration of evidence derived from diverse methodological traditions and disciplines, (ii) codification of data under a standardised structure, and (iii) transdisciplinary approach (i.e., the research team was made up of public health, human resources, and the healthcare profession perspectives).

There were several limitations to this research. Firstly, the included articles were predominantly published in the United States and describe the implementation of coaching interventions for medical trainees/specialists, rather than nurses. Similar factors identified in different contexts may relate to different issues, thereby limiting the ability to generalise findings. Secondly, the reported barriers and facilitators are unlikely to remain static over time, especially the rapidly evolving nature of healthcare. Therefore, the examination of implementation determinants must be an iterative process. Lastly, some factors may have been more easily identified than others, due to the specific interests and biases of primary researchers. As such, this study may more readily report the salient, uncontroversial, and easily communicated factors, than those that are complex or unanticipated.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Not applicable.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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