An evaluation of the suitability, feasibility and acceptability of diabetes group consultations in Brigstock Medical Practice

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Abstract

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Summary
In early 2018, the Brigstock and South Norwood Medical Partnership (Brigstock) introduced an innovative service improvement. They introduced group consultations as their first contact for General Medical Services Quality and Outcomes Framework (QOF) diabetes reviews.

A year down the line, evaluation has found the group care model to be a suitable, feasible and acceptable alternative to one-to-one reviews. The practice's prescribing pharmacist and nurse prescriber team have reviewed 48% of the practice's 1,054 patients with Type 2 Diabetes in a group, with people seen only once or followed up more frequently in line with clinical need.

As a result of introducing group clinics, there has been an 18% increase in the number of patients receiving all eight care processes set out in National Institute for Health and Care Excellence (NICE) guidance.

Whilst maintaining the total number of patients reviewed, the practice has reduced its diabetes clinics from eight three-hour one-to-one clinics a week (a total of 24 hours of clinic time) to two one and a half hour group clinics and one three hour one-to-one clinic, reserved for patients not suitable for a group review (a total of six hours of clinic time). This equates to a saving of 18 hours of clinician time and five half day sessions a week; equivalent to a 0.5 full time clinician post.

Group clinics have also improved access. They have freed up practice nurse and pharmacist appointments in one-to-one clinics and reduced waiting times for diabetes reviews from six weeks to two weeks. There are early indications of positive impact on 'Do Not Attend' (DNA) rates, with the DNA rate for group clinics running at 5.94% and all Brigstock clinics' DNA rate running at 11.70% - a 49% reduction. There are also early indications of medicines optimisation, with patients sharing decisions and de-prescribing happening.

Whilst it remains early to measure the impact on clinical biometrics, clinical audit of a sample of 65 patients with at least two separate follow-ups over six months found that 70% had improved HBA1c, 61% had improved blood pressure control and 10% had lost weight.

Patients self-report increased knowledge of their condition after group clinics. They also report high levels of satisfaction with the experience. Clinician job satisfaction has also increased.

Keywords: shared medical appointments, group consultations, suitability, acceptability, feasibility.

Background

The National Diabetes Audit[1] indicates that as many as 50% of Type 2 Diabetes patients are poorly controlled and do not get the bundled eight indicators prescribed in Quality and Outcomes Framework guidance,[2] namely:

- BMI measurement
- BP measurement
- HbA1c measurement
- cholesterol measurement
- record of smoking status
- foot examination
- albumin:creatinine ratio
- serum creatinine measurement.

One of the 'Ten High Impact Actions' in the General Practice Forward View,[3] group consultations are planned clinical care with a clinician consulting with up to 15 patients in a supportive group setting in which patients benefit from meeting others in a similar situation and have up to one hour with their doctor, pharmacist or nurse, including a group and a personalised one-to-one discussion.

Group consultations - also called Shared Medical Appointments (SMAs) in the literature - have an established evidence base in diabetes, with randomised controlled trials demonstrating improvements in HBA1c compared to usual care.[4]

Brigstock is in an area of acute deprivation in Croydon, with a diverse Black and Minority Ethnic (BME) and Eastern European community. The nursing team and a prescribing pharmacist undertake most chronic disease management reviews.

Despite eight diabetes clinics a week, Brigstock was failing to reach QOF targets. Reducing Hba1c was a particular concern, with patients finding it challenging to sustain change and take control of their condition. With 1,024 people with Type 2 Diabetes registered, and six weeks waiting for reviews, the team was spending a lot of time reviewing patients and repeating the same information and advice about diabetes but outcomes were not improving.

Responding to the evidence base, they saw introducing group consultations as an opportunity to improve outcomes and access whilst providing a more holistic consultation with more time to address psycho-social concerns and complete clinical work prescribed in QOF.

Introduction

Group consultations are still an emerging practice in England. With a higher profile created by their inclusion as one of the Ten High Impact Actions in the GP Forward View, interest is growing.

To date, around 400 clinical teams have been trained across England and there is established best practice about the optimum way to set up and deliver group clinics in primary care.

Group clinics should be co-delivered by a non-clinician facilitator and the consulting clinician. The facilitator is responsible for delivering a well-planned, positive, safe group experience. The clinician is responsible for ensuring the clinic agenda is covered and all patients get personalised care and support.

The process works as follows. The facilitator welcomes the group and works with patients to think of questions for their clinician. These questions become the 'patients' agenda' in the clinical session. To help patients decide what to ask, they are introduced to the 'Results Board'. This lists patients' first names and their key biometrics. Its design ensures that the group consultation ticks all QOF boxes and National Institute for Health and Care Excellence (NICE) guidelines. For example, a Type 2 Diabetes Results Board summarises each patient's HbA1c, blood pressure, cholesterol and Body Mass Index (BMI). It also indicates whether individuals have had eye checks, foot checks and a medication review.

The clinician who is consulting at the group clinic joins after about 15 minutes to lead the clinical session. After a short break where the facilitator briefs the clinician, they review patients' questions, decide how to make best use of time and the clinical session then begins. The clinician addresses the group's common questions upfront and then consults one-to-one with each individual, answering specific questions or concerns. The facilitator supports the clinician by managing the time and group dynamics. The whole group listens and learns from each other's consultations. To build the confidence of patients, the clinician encourages the group to answer each other's questions, share advice and share experiences wherever possible. Medication is changed if needed, and the clinician proactively raises their issues of concern and reminds people about overdue tests or immunisations e.g. flu immunisation. These may be done during or just after the group consultation.

After the 45-60 minute clinical session, the clinician leaves and the facilitator supports the group to reflect and set personal goals around keeping well and managing their condition. In this way, the group consultation closely mirrors 'Collaborative Care and Support Planning', which the Royal College of General Practitioner has specified as the optimal way to support people with long-term conditions.[5]

Whilst care and support planning is recognised as requiring more clinician time compared to usual care, group clinics have the potential to offer significant efficiency gains. Introducing a group care model offers a way of introducing a more person-centred approach and easing mounting pressure on primary care teams. This is dependent, however, on group consultations being confirmed by appropriate evaluation as suitable, acceptable and feasible. The findings in this respect for Brigstock are summarised in this article.

Method

This was a service improvement programme. For that reason, ethical approval was not sought.

Following a practice based learning support programme, Brigstock switched from eight one-to-one diabetes clinics to two daytime group consultations for adults living with Type 2 Diabetes, delivered with the support of non-clinician facilitators. Brigstock also retained a single one-to-one clinic for those for whom group consultations were unsuitable e.g. people with severe and enduring mental health issues and learning disabilities.

The Type 2 Diabetes Results Board covered all eight care processes included in QOF reviews. Patients were followed up after their initial group clinic as clinically appropriate. Where people did not require follow-up, they attended as a 'one-off' and were recalled 12 months later. Poorly controlled patients were invited to return within six to eight weeks. The patient was encouraged to book in when they were ready to return, mirroring patient initiated follow-up, which is a care model that is gaining popularity in outpatient and post-surgical care.[6]

All patients requiring a diabetes QOF review were invited to attend a group consultation. The team used the practice's usual follow-up systems to contact patients i.e. repeat prescription recalls, letters or text reminders and opportunistically booking

people into clinic during their blood test appointments. GPs encouraged patients to attend group clinics as the first contact point. Receptionists were trained to explain how group consultations work and why they were being introduced.

The invitation letter to patients informed them that their biometrics would be shared on the Results Board. They also signed the confidentiality agreement at the start of their first group clinic and were reminded of the importance of maintaining confidentiality when the facilitator set up each session (Figure 1).

Results

Brigstock has seen 509 patients in group clinics; 48% of its 1,024 diabetic list. Group clinics are fully booked. Patient and clinician acceptability is high. The group clinic model is responsive and has been modified to incorporate the Care and Support Planning Locally Commissioned Service (LCS), which has reinforced its value.

Furthermore, through clinical audit and evaluation of patient feedback, Brigstock has measured important changes as follows.

Improved outcomes

At baseline in one-to-one clinics, Brigstock achieved all eight care processes in 53% of patients; just above the national average.[1] Following the introduction of group consultations, this has increased to 63%, an 18% increase. This represents a corresponding 18% improvement in quality of care and QOF compliance.

Although longer follow-up in a larger cohort of patients is needed, clinical audit suggests positive impact on biometrics. In a sample of 65 patients followed up at least twice over a six-month period, 70% showed a reduction in HbA1c and 61% recorded an improvement in blood pressure. Weight loss was recorded in 10% of patients.

In an online survey, 80% of patients reported they had a better understanding of their condition and that they learnt more in the group clinic compared to one-to-one sessions.

Group clinics have also had more qualitative impacts on patients' attitudes, expectations and behaviours. For example, clinicians have observed changing attitudes with patients more readily recognising and accepting the need for lifestyle change.

Patients' expectations of being involved in their care and provider responsiveness have changed. Whilst initially referrals increased, patients who attended the Croydon 'Improving Access to Psychological Therapies' (IAPT) service did not respond well to its highly structured, didactic style. Used to setting the agenda at their diabetes group consultations, patients wanted IAPT sessions to be more responsive and flexible. This is being followed up with IAPT to encourage the service to respond with a more person-centred, collaborative model of IAPT care that shifts power in similar way to group consultations.

There is anecdotal evidence that group consultations are supporting social inclusion. Patients report feeling more connected and less isolated. Some patients are forming friendships and gaining ongoing support from peers outside the group consultation, which builds confidence to engage. For example, patients report attending community activities that social prescribing link workers have recommended together, whereas they would not have gone on their own.

Clinicians have found that patients challenge each other directly in ways clinicians would like to but do not. For example, patients regularly ask each other questions such as "Why are you eating that?" or "Why aren't you checking your blood sugar?" or make statements such as "Stop making excuses for not doing exercise".

Clinicians also find that patients are more likely to tell the truth, which provides greater clarity about non-adherence to medication and lifestyle recommendations. This increases the ability of clinicians to offer personalised support and build on and reinforce the positive experiences and successes of others.

Perhaps the most powerful change is that clinicians no longer feel solely responsible for patient outcomes. Clinicians and patients jointly own outcomes and share responsibility. This is a huge shift in culture and is empowering for both parties.

This sense of shared responsibility is reinforced by Brigstock's approach to follow-up, with clinicians encouraging patients to initiate follow-up when they have made changes and want a review rather than clinicians dictating when patients must return.

Improved medicines optimisation

There have been several improvements in medicines optimisation:

- Clinicians have found that group discussion encourages and supports patients to ask more meaningful questions about their medications.
- Peer interaction makes patients more engaged with discussions about their medication.
- The group dynamic supports broader discussion of the risks, benefits and consequences of starting new medication, taking certain medication or a combination of medications, and stopping medication.

This richer discussion supports and enhances shared decision-making. Of the patients consulted within the groups, over 124 patients have made a shared therapeutic decision.

Furthermore, clinicians have experienced more honesty, with patients more readily disclosing non-adherence. Quite often, after disclosure, the clinician is able to de-prescribe for an agreed period of time. This engenders trust in the therapeutic relationship such that, when specific medications need to be taken, patients are more likely to comply.

A database search has shown an increase in the prescribing of SGLT2 medications and a reduction in the use of sulphonylureas for routine glycaemic control.

Adherence interventions have not been READ coded. The recording of such data in future work will provide more insight into this and other impacts group consultations have had on the medicines optimisation process.

Brigstock and South Norwood Partnership Group Consultations Confidentiality Form

Name (Please print clearly):
Home Address:
Date of Birth:
Daytime phone number:

Introduction to this Confidentiality Agreement

As a participant in group consultations, both you and the other patients who are sharing the appointment will discuss medical information in the presence of other patients, and also staff. Your clinician (doctor or nurse) and the group consultations healthcare team will be doing likewise and are bound by their employment contracts and professional codes of ethics to respect patients' confidentiality. Please read the statement below, and if you agree with it, please sign the form where indicated.

Statement of confidentiality

By signing this agreement, I undertake to respect the confidentiality of the other members of the group consultation by not revealing any medical, personal, or other identifying information about others in attendance, after the session is over. My own information however, belongs to me, and I understand that I am encouraged to discuss my own details with my carer or other family member, as appropriate.

I understand that if I have health concerns that are of a very sensitive nature, I may of course, ask to discuss them with the relevant staff member in a private treatment room or to schedule an individual practice appointment.

I understand that I am under no obligation to share personal information with other patients, or healthcare staff, unless I choose to do so.

Signed (patient):

Date:

Signed (carer/support person if applicable): Date:

I CONSENT AS ABOVE IN **ALL** OF MY GROUP CONSULTATION SESSIONS AT THE PRACTICE FOR DIABETIC REVIEWS

Figure 1: Confidentiality agreement

Improved experience of care

In an online feedback survey, 90% of patients reported feeling more 'listened to'. 85% would recommend group consultations to friends and family. Patients report peer learning and support being powerful and empowering:

> *" We come together. We can relate to each other. We encourage one another to look after our health. This is important to us as diabetic people…I love it because I am learning a lot about how to manage my diabetes. so I would not give this up for nothing... I feel like crying because it changed my life.."* Brigstock patient.

The clinician experience is also positive, with greater job satisfaction, closer team working and less repetition, making group consultation more energising.

To watch a video of clinicians in Croydon talking about their experiences, go to: https://youtu.be/8EoN05SS164

To watch a video of patients from Brigstock and south Norwood Medical Practice, talking about their experiences, go to: https://youtu.be/ZhXgOdT2FZQ

Efficiency gains

Compared to one-to-one care, Brigstock has calculated efficiencies made in the use of clinician time. These were realised as early as eight weeks after the change was made. The nurse practitioner and prescribing pharmacist time that has been released is being spent on improving the quality of care of those with complex needs and on developing additional services e.g. an intrauterine device (IUD) and contraceptive clinic.

Whilst maintaining the total number of patients reviewed, Brigstock has reduced the number of diabetes clinics from eight three-hour one-to-one clinics a week (i.e. a total of 24 hours of clinic time) to two one and a half hour group clinics and one three hour one-to-one clinic a week, reserved for patients not suitable for a group review (i.e. a total of six hours of clinic time a week). In total, the diabetes group clinic model has freed up a total of 18 hours of clinician time and five half-day sessions a week. This represents a 75% efficiency gain and is equivalent to at least a 0.5 full time equivalent clinician post.

Introducing group clinics has reduced waiting times for diabetes reviews from six to two weeks.

Audit indicates a positive impact on 'Do Not Attend' (DNA) rates, with the DNA rate for group clinics running at 5.94% in comparison with that for all Brigstock practice clinics at 11.70%, which is a reduction of 49.2%.

There are also further efficiency gains linked to DNA inherent in the group clinic model. Clinician time is not lost waiting halfway through clinics when patients DNA because everyone arrives at the same time and the group clinic runs its course with a smaller group. Group clinics are also more likely to finish on time.

Furthermore, Brigstock has observed that group consultations nudge a more systematic approach to diabetes management. Perhaps because gaps in the eight care processes are highly visible on the Results Board, full compliance has improved from 53% to 63% of patients; an 18% increase. This translates into greater QOF compliance, which impacts positively on practice income.

Group consultations are also impacting on workforce and skill mix. To create further capacity and realise greater efficiencies, the team is considering expanding group clinics for other long-term conditions and employing a group consultations programme and session facilitator to help manage the change.

Improved access

There has been a measureable improvement in access and patient perceptions of access have improved in line with this. Alongside reduced waiting times for diabetes reviews from six weeks to two weeks, there are more appointments available in one-to-one clinics. This means that all patients benefit from group clinics whether or not their care is delivered that way.

In an online survey, 85% of patients reported improved access and that they perceived spending more time with clinicians. Patients spending up to 60 minutes with their clinician rather than 20 minutes in a one-to-one session is the most likely explanation for this change in perception amongst patients with diabetes.

Service improvements

Brigstock has responded to feedback from patients and improved the service.

Once they became familiar with their 'numbers', patients recognised that underlying mental health issues were impairing their ability to take control of their diabetes. In response, the team invited the local IAPT service to attend and describe their support offer.

The team has made links with local social prescribing link workers so that it was easy for those who felt socially isolated or wanted to make lifestyle changes to tap into local community initiatives and support.

The team has responded to a LCS aimed at embedding care and support planning by more explicitly incorporating the process into its group consultation design so that patients co-create a 'Care and Support Plan' and this is documented in line with the LCS.

Finally, to improve access for working people, the team has introduced evening sessions alongside daytime ones.

Discussion

This trial indicates that group consultations offer a suitable, acceptable, and feasible alternative way to deliver QOF diabetes reviews in primary care at scale.

Brigstock has successfully reviewed almost half of its patients living with Type 2 Diabetes. The new model has saved time and improved access and quality of care. Continuous improvement is supporting the integration of care and support planning, which is the recognised gold standard of personalised care. Having a highly visible Results Board nudges the team to more

closely audit compliance with the eight care processes, which is improving quality of care and QF compliance.

The new consultation model is also changing culture by raising patient expectations about involvement in their care and supporting shared responsibility for improving outcomes. Patients report learning from peers and that their support helps them sustain lifestyle change.

There are early indications that the new care model may also be improving shared therapeutic decision making, medicines optimisation and key biometrics, which bodes well for future health and wellbeing.

Conclusion

Primary care group consultations are a suitable, acceptable and feasible alternative to one to one care for patients living with Type 2 Diabetes.

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Declaration of interests

- Dipti Gandhi reports personal fees from Experience Led Care (ELC) and from Group Consultations Ltd during the conduct of the study and personal fees from Croydon CCG Diabetes Clinical Lead and Brigstock and South Norwood Partnership outside the submitted work.
- Georgina Craig reports payment from Croydon CCG in 2016/17 to deliver group consultation training to 6 practices in Croydon, including the Brigstock Practice. She is currently commissioned by NHS England to support the spread of group consultations in primary care. She leads The ELC Programme and provides practice development support to NHS providers.

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