Group clinics to support the delivery plan for recovering access quality and outcomes in General Practice and Primary Care

System Briefing

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Executive Summary

Group clinics are a strategic initiative that aim to revolutionise Primary Care services. A decision to implement group consultations in GP practices across England with a list size of 10,000 patients, switching 50% of patients' appointments to delivery as a group clinic across 20 QOF indicator pathways would release at least **1,400 hours of clinician time and over 8,500 scheduled one to one appointment per annum**.

In its 2018 health survey, NHS England found that 43% of people aged over 16 live with at least one long-term condition (NHS England, 2018). 14.2 million live with two or more (Stafford et al 2018). Enhancing their outcomes is a top priority for all Integrated Care Systems (ICS).

Whilst they account for 50% of all appointments in Primary Care (Kings Fund 2012), most people manage their long-term health conditions alone or supported by their loved ones. This means that supporting people to self-manage and maintain lifestyle change over decades is now critical to health system sustainability. And yet, medical appointments and the way that we connect and work with our patients is largely the same as it was 75 years ago.

Since 2020, despite the growing evidence of impact, there has been no orchestrated spread programme to realise the benefits of group clinics across England in Primary Care. Given the access challenges facing Primary Care currently, group clinics provide a solution that maximises patient outcomes and experience. During the COVID-19 response period video group clinics were established, tested, and evaluated, showing that the method was effective at maintaining access even in difficult delivery situations. Additionally, it reduces the workforce demand, releasing clinician time.

There is mounting evidence that switching to group clinics has a positive impact on the retention and wellbeing of the workforce. Staff describe the relief of having the autonomy to improve simple clinical interventions and find this autonomy highly motivating.

Focusing on group clinics as an alternative way to deliver chronic disease management reviews initially is likely to maximise efficiency and quality gains and be acceptable to clinical teams and patients.

Introduction

Group consultations (also called group clinics) have been recognised as a valuable practice improvement since the GP Forward View when they were cited as one of ten high impact actions. More recently, they have been promoted as a vehicle to deliver the General Practice Long Term Condition management and to improve access and support recovery post-COVID-19.

Group clinics can be delivered via video or face to face. 6-10 patients attend. They last around 90 minutes. The clinician is present half the time (45 minutes), depending on the number of patients in the group. They offer an alternative way of delivering planned reviews and follow up appointments for patients with chronic conditions in primary, community, and specialist care settings – including outpatients. They can also be used to undertake health checks and reviews e.g., for carers or for those with a learning disability. They also work well as part of triage early in pathways e.g., Long COVID, menopause.

Group clinics have a robust evidence base (Hayhoe et al 2017). This includes many randomised controlled trials (with a control group who attend one to one appointments). These confirm a positive impact on patient outcomes and experiences compared to one-to-one appointments. Furthermore, there are over forty case studies of their application across a wide range of pathways in English and Welsh primary and community care settings.

Group consultations are especially well suited to delivery of “simple” clinical care (Christensen, 2000). This is clinical work that is often protocol or guideline driven and where clinical risk is lower, and intervention is usually planned. It accounts for a large volume of planned care in all parts of the NHS, and these elements of care pathways are often undertaken by nurses and allied health professionals.

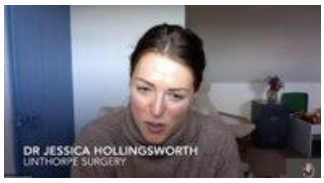
Over recent years, our collaborative development of group clinics has endeavoured to remove or reduce any clinical or information governance barriers that were present and restricting widespread adoption. This includes our work with NHS Resolution to indemnify the delivery method within the Clinical Negligence Scheme for General Practice (CNSGP).

Having scoped the risks associated with delivering care in group consultations, in 2020 NHS England co-created standardised risk management procedures for clinical teams to adopt, including: how to gain verbal consent to participate and maintain confidentiality and how to establish patients’ location and identity without compromising privacy (video group consultations only). In 2020, NHS Resolutions indemnified clinical work undertaken in group consultations (face to face & video).

Despite the strength of the evidence base and historical NHSE endorsement through the GP Forward View, group clinics are not integrated into current national guidance, aimed at supporting access and recovery that would encourage their adoption and spread as an integral part of access recovery plans across English Integrated Care Systems (ICS). With the recent publication of the Delivery plan for recovering access to Primary Care, there is a need to reconsider the historical approach and look toward group consultation integration into future General Practice access and recovery plans.

Dr Jessica Hollingsworth, GP – Used VGC with Long COVID-19 patients.

"This is a great example of peer support where patients answer their own questions and share experiences, which you would never happen in a 1:1 consultation."



Dr Frances Blackmore, GP – Used VGC with Diabetes patients.

"Attracted not necessarily the type of patient we expected to attend, there is something about VGCs that attracts patients who then stay engaged. and think about their illness more."

Maggie Bradley, Practice Nurse – Used VGC with Cancer patients.

"Best use of an hour for our patients! Providing information, interaction, and the ability to easily involve outside agencies resulted in great feedback."

Rationale and Benefits

Group clinics offer numerous advantages over traditional one-on-one consultations. By bringing together patients with similar conditions or needs, group consultations foster a sense of community, enable peer support, and promote shared learning. Patients benefit from increased access to care, as group clinics allow for more frequent appointments and therefore reduce waiting times. The collaborative nature of group consultations enhances patient engagement, leading to improved treatment adherence and ultimately better health outcomes.

Including group clinics in the Primary Care delivery model can support Primary Care recovery. With an aging population and an increase in chronic diseases, the need for efficient and effective Primary Care services has never been greater. By introducing group consultation, we can address these needs while differentiating ourselves as pioneers in modernising Primary Care across England, realising the benefits seen in other parts of the world. With this model, we anticipate attracting new patients and retaining existing ones seeking improved access to timely, quality care, experience, and outcomes.

The idea of providing planned care, follow up reviews and support for patients in a group rather than a one-to-one appointment has been around since the turn of the century. Inspired by his personal experiences of group therapy and recognising that many of its benefits would hold true in a medical appointment, Noffsinger developed the concept of shared medical appointments or SMAs (Noffsinger, 2013).

Following the report Making Time in General Practice (Clay and Stern, 2015), NHS England signalled to Primary Care in its GP Forward View (NHS England 2016) that “group consultations” were one of the new appointment types it wanted to see adopted, alongside e-consultations. Despite this no national programme of support was funded to enable the change and spread this innovative new way of working.

There is a robust evidence base for group consultations. This evidence base has expanded rapidly since 2019, with four innovative studies of the spread of VGCs in England and Wales (Gandhi and Craig 2019, Papoutsi et al 2022, Scott et al 2023, Lynch 2022) and two systematic reviews of the international evidence (Wadsworth et al 2019, Graham et al 2021).

Impact on access & waiting lists, operating model, patient outcomes, and staff training.

Impact on access

Recent systematic reviews identify that group consultations improve access (Wadsworth et al 2019, Graham et al 2022). In UK general practice, Gandhi, and Craig (2019) found that introducing group consultations to the delivery mix offered an acceptable alternative for 50% of their patients and:

- **Freed up 0.5 FTE advanced nurse practitioner to undertake other clinical operations.**
- **Reduced waiting times for annual diabetes reviews from 6 weeks to 2 weeks**
- **Reduced did not attend (DNA) rates, which were 5.94% for group reviews compared to 11.7% DNA rate for one-to-one reviews.**

Using data drawn from published research and case studies (Gandhi & Craig, 2019), the Primary Care Nursing Team calculates that in a GP practice with a list size of 10,000 patients, switching 50% of patients; appointments to delivery as a group clinic across 20 QOF indicator pathways would release at least 1,400 hours of clinician time and over 8,500 scheduled one to one appointment per annum.

Impact on waiting lists.

The introduction of group clinics will substantially reduce the length of waitlists for Primary Care services. As the demand for appointments is distributed across multiple group clinic sessions, patients will experience shorter waiting times, leading to increased patient satisfaction and a more efficient use of healthcare resources.

Two Long COVID group clinic pioneer sites that the Primary Care Nursing Team is working with who have introduced video group consultations (VGCs) for initial assessment of patients referred to their service have significantly reduced waiting times as a direct result of VGC.

Bradford District and Craven reduced the average wait from 100 days to 7 days and reduced their waiting list from 400 to 100 patients. In Suffolk and Northeast Essex, prior to VGC they saw 30% of patients within 6 weeks. Now they see 75% of patients within 6 weeks.

Operational model and approach to implementation

Our proposed operational model entails establishing pioneer group clinic sites in 42 key locations nationally, within each ICB area and across the 7 NHS regions, each with a focus on specific medical conditions or health needs. This mirrors the successful approach adopted in the VGC programme. This PCN will act as a test bed for the development of group consultations as an access improvement tool for Primary Care and will be able to share their learning across the ICB. The support they access will be flexible, depending on their level of maturity and previous experience of using group consultations. These PCNs can potentially provide a network to support research and development of group clinic practice in partnership with academics. An indication of the costs involved in this national implementation approach can be seen in **Appendix Three**.

After the pioneer establishment, it is proposed an induction programme will be provided to the remaining PCNs in the ICB. This package will support the PCN to plan and prepare to adopt group consultations. The PCN or ICB can top up and support practices with further training and support as required, this can be with the support of the pioneer site or using previously issued development funds. It is anticipated that the first practice to go live in the PCN will share its learning with its peer practice teams so they can replicate admin systems and trial locally tested group clinic models. All teams will also be able to attend regular lunch and learn webinars where they can listen to pioneers, sharing their experiences of making the change. These will be organised nationally (via external provider). Frequently asked questions about national implementation can be reviewed in **Appendix Four**.

Toolkits and e-learning to assist in the implementation of video group clinics and establish a wider understanding of the methodologies of group consultations have been fully established and endorsed by the relevant teams across NHS England including information governance and Digital First Primary Care.

Impact on patient outcomes

Group consultations foster a supportive and collaborative environment for patients, empowering them to actively engage in their care. As a result of shared experiences and insights, patients may gain a deeper understanding of their health conditions, leading to improved treatment adherence and lifestyle modifications. Consequently, this patient-centered approach is expected to result in better health outcomes, reduced hospitalisations, and an overall improvement in the health status of our patient population.

Controlled trials show that compared to a control group receiving one to one appointment, group consultations:

- **Improve clinical biometrics – in particular HBA1c and blood pressure (Kirsh et al, 2017)**
- **Result in superior preventative care for those from low-income and underserved communities (Vaughan et al 2019)**
- **Improve patients' knowledge of diabetes (Riley and Marshall 2010)**
- **Result in more patient-initiated behaviour change (Dickman et al, 2011)**
- **Reduce A&E visits amongst vulnerable people with diabetes (Clancy et al 2003)**
- **Improve quality of life for people living with Type Two diabetes (Trento et al 2010)**

UK studies also show that they increase the percentage of patients achieving National Institute for Health and Care Excellence (NICE) recommended eight care processes in diabetes by 18% within 12 months (Gandhi and Craig 2019) and build social capital in the virtual clinic room, empower patients, and embed sustainable personalisation (Lynch, 2022).

Recent systematic reviews reinforce these findings. Wadsworth et al 2019 review focused on how they impact on patient-centred experiences. It concluded that compared to one-to-one appointments, group consultations lead to measurable improvements in patient trust, patient perception of quality of care and quality of life as well as improvements in relevant biophysical measurements. They reported that clinics were more engaging and empowered patients as active participants in their own healthcare, while simultaneously improving access and healthcare efficiency.

Staffing and Training

In their systematic review, Graham et al (2022) found the most cited challenge to implement face to face group consultations was setting up new administrative processes associated with the change. Also, high quality facilitation skills and leadership support enabled success.

Insights from qualitative research with Primary Care teams in England (Papoutsi et al 2022) found that interactive VGC training provided nationally in England was instrumental in capacity building. Lynch (2022) similarly found that interactive group clinic training and clinic-based intensive support proved essential to outpatient teams making the change to group consultations in Wales.

Workforce Impact

Group clinics also have positive impacts for the workforce. They develop individual and teams' skills. (Including digital maturity), amongst Registered nurses and additional roles practitioners as well as the non-clinical staff who support delivery. They support integrated working within practice teams and across community organisations, and impact positively on staff retention and wellbeing. Video group consultations also support flexible home-based working (Lynch, 2022).

On average, introduction of group consultations to the delivery mix can free up 0.5 or more FTE to undertake other clinical operations and improve access. An illustration of clinician time potentially saved by using groups clinics can be seen in **Appendix one**.

Cara-Leigh Hall, Social Prescribing Link Worker – Used GC/VGC with COPD patients.

"We utilise the help of a social prescriber, clinician/Nurse, and a health care assistant across the group session. Massive reduction in the clinician's time and an opportunity to offer a genuine team approach."

Angela Ormrod, General Practice Nurse Lead

"Despite COVID restrictions the team were keen to see patients and VGC has effectively allowed us to do that. Sessions flow well and very natural where the patients are generating the conversation."

Dr Rupa Joshi, GP –
Used GC/VGC with Children's Mental Health

"Great opportunity to reach out and gather parents sharing the same issues at a difficult time. Able to offer advice via in house expertise and other members of the team within the session".

The ask.

Group clinics deliver 'The Triple Aim'. They are a key enabler of patient empowerment that align with the personalisation agenda and the ambitions of Working in partnership with people and communities. They improve quality of care – both in terms of patient outcomes and adherence with guidelines. They are highly efficient and sustainable, making them worthy of consideration and inclusion in future policy and guidance.

We ask that:

- Group consultations are included in ICB access delivery/implementation guidance and future delivery plans for recovering access to Primary Care as one solution to improving access to Primary Care services
- Include group consultations in all relevant Support Level Frameworks that will be used to facilitate continuous review and improvement in Primary Care
- Support provision of help and advice to ICB teams to scope and their group clinic spread plans, building on best practice and recent ICS audit data on PCN uptake of group consultations; both already developed by the Nursing Directorate
- Host a webinar under the pillar "Implementing Modern GP Access" as part of the Delivery Plan for Recovering Access series on group clinics. Recovering Access to Primary Care Webinars - PCNs and Practices Support Hub - Integrated Care (future.nhs.uk)

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Appendix One – Working illustrations of how group clinic implementation can release clinician time (Rural & Urban example)

Region:	North East & Yorkshire						Practice:	Park Parade, Harrogate				
Moving to Group Consultation Model:	Clinician Time Released		*Hours*	**1866.70**			Workforce Released		FTE	**0.74**		
***Across QoF Indicators - 50% useage per annum**	Appointments Released		*Apts*	**11200**			***Ave FTE works 2520 hrs p.a.**					

QoF Indicator	Pats. On Reg.	List Size	Prevalence %	Ave. No. App. Req. p.a. (as NICE or est)	Ave. No. of Reviews Req. p.a.	Total No. App. Generated	Clinician time to deliver these as 1:1 appointments & reviews (based on 10 min. per app & 20 min. per review)	Clinician time to deliver as group clinics (based on 5 min per pat; average 8 pat. per group clinic)	Potential delivery time released (100%)	Clinician time released by switching 50% of patients to group clinics	Total number of appointments released by switching 50% of patients to group clinic
Units	*Patients*	*Patients*	*%*	*Appointments per annum*	*Reviews per annum*	*Appointments per annum*	*Minutes per annum*	*Minutes per annum*	*Minutes per annum*	*Minutes per annum*	*Appointments per annum*
Asthma	484	7320	6.61	4	1	2420	29040	1513	27528	13764	1376
Atrial fibrillation	183	7782	2.35	2	1	549	7320	343	6977	3488	349
Cancer	327	7782	4.20	2	1	981	13080	613	12467	6233	623
Chronic kidney disease	323	6430	5.02	4	1	1615	19380	1009	18371	9185	919
Chronic obstructive pulmonary disease	94	7782	1.21	4	1	470	5640	294	5346	2673	267
Dementia	51	7782	0.66	3	1	204	2550	128	2423	1211	121
Depression	722	6430	11.23	2	1	2166	28880	1354	27526	13763	1376
Diabetes mellitus	291	6500	4.48	4	1	1455	17460	909	16551	8275	828
Epilepsy	43	6430	0.67	2	1	129	1720	81	1639	820	82
Heart failure	53	7782	0.68	4	1	265	3180	166	3014	1507	151
Hypertension	1002	7782	12.88	2	1	3006	40080	1879	38201	19101	1910
Learning disability	35	7782	0.45	1	1	70	1050	44	1006	503	50
Mental health	61	7782	0.78	1	1	122	1830	76	1754	877	88
Non-diabetic hyperglycaemia	465	6430	7.23	1	1	930	13950	581	13369	6684	668
Obesity	790	6430	12.29	2	1	2370	31600	1481	30119	15059	1506
Osteoporosis	20	3081	0.65	1	1	40	600	25	575	288	29
Palliative care	14	7782	0.18	6	0	84	840	53	788	394	39
Peripheral arterial disease	37	7782	0.48	2	1	111	1480	69	1411	705	71
Rheumatoid artheritis	37	7782	0.48	1	1	74	1110	46	1064	532	53
Secondary prevention of coranary heart disease	228	7782	2.93	2	1	684	9120	428	8693	4346	435
Stroke and transient ischaemic attack	136	7782	1.75	2	1	408	5440	255	5185	2593	259
TOTALS	**5396**			**52**	**20**	**18153**	**235350**	**11346**	**224004**	**112002**	**11200**

Region:	London					Practice:	Royal Docks Medical Practice, North East London				
Moving to Group Consultation Model:	Clinician Time Released	*Hours*	**1965.95**			Workforce Released	FTE	**0.78**			
***Across QoF Indicators - 50% useage per annum**	Appointments Released	*Apts*	**11796**			***Ave FTE works 2520 hrs p.a.**					

QoF Indicator	Pats. On Reg.	List Size	Prevalence %	Ave. No. App. Req. p.a. (as NICE or est.)	Ave. No. of Reviews Req. p.a.	Total No. App. Generated	Clinician time to deliver these as 1:1 appointments & reviews (based on 10 min. per app & 20 min. per review)	Clinician time to deliver as group clinics (based on 5 min per pat.; average 8 pat. per group clinic)	Potential delivery time released (100%)	Clinician time released by switching 50% of patients to group clinics	Total number of appointments released by switching 50% of patients to group clinic
Units	*Patients*	*Patients*	*%*	*Appointments per annum*	*Reviews per annum*	*Appointments per annum*	*Minutes per annum*	*Minutes per annum*	*Minutes per annum*	*Minutes per annum*	*Appointments per annum*
Asthma	414	11062	3.74	4	1	2070	24840	1294	23546	11773	1177
Atrial fibrillation	49	11869	0.41	2	1	147	1960	92	1868	934	93
Cancer	143	11869	1.20	2	1	429	5720	268	5452	2726	273
Chronic kidney disease	273	9616	2.84	4	1	1365	16380	853	15527	7763	776
Chronic obstructive pulmonary disease	160	11869	1.35	4	1	800	9600	500	9100	4550	455
Dementia	20	11869	0.17	3	1	80	1000	50	950	475	48
Depression	968	9616	10.07	2	1	2904	38720	1815	36905	18453	1845
Diabetes mellitus	581	11869	4.90	4	1	2905	34860	1816	33044	16522	1652
Epilepsy	41	9616	0.43	2	1	123	1640	77	1563	782	78
Heart failure	50	11869	0.42	4	1	250	3000	156	2844	1422	142
Hypertension	993	11869	8.37	2	1	2979	39720	1862	37858	18929	1893
Learning disability	54	11869	0.45	1	1	108	1620	68	1553	776	78
Mental health	137	11869	1.15	1	1	274	4110	171	3939	1969	197
Non-diabetic hyperglycaemia	574	9616	5.97	1	1	1148	17220	718	16503	8251	825
Obesity	839	9616	8.73	2	1	2517	33560	1573	31987	15993	1599
Osteoporosis	2	2056	0.10	1	1	4	60	3	58	29	3
Palliative care	29	11869	0.24	6	0	174	1740	109	1631	816	82
Peripheral arterial disease	24	11869	0.20	2	1	72	960	45	915	458	46
Rheumatoid artheritis	45	9822	0.46	1	1	90	1350	56	1294	647	65
Secondary prevention of coranary heart disease	156	11869	1.31	2	1	468	6240	293	5948	2974	297
Stroke and transient ischaemic attack	90	11869	0.76	2	1	270	3600	169	3431	1716	172
TOTALS	**5642**			**52**	**20**	**19177**	**247900**	**11986**	**235914**	**117957**	**11796**

Appendix Two – Working examples of group consultation use in clinical practice to release clinician time for wider population health interventions.

We collaborated with a community nurse who supports a case load of four hundred families with a child with sickle cell anaemia. She wanted to improve the care and support she provided to teenagers as often teens neglect self-management, leading to complications. All her time was taken up doing mandated reviews with families with a child less than 12 months. These were home visits. She switched to a group clinic to review the under ones. These ran twice a week, saving her three days of work. Parents found being able to connect with others helped reduce their sense of isolation and started to break down the stigma around the diagnosis of sickle cell. She used her newly found free time to collaborate more closely with her teenage patients (also in groups), with impressive results.

The clinical pharmacist and Advanced Nurse Practitioner in the Brigstock practice in Norwood, South London were spending all their time, doing one to one diabetes reviews. Based in an area of deprivation, they had a diabetes register of over 1,000 patients from diverse community backgrounds. They diverted all patients into group consultations (two 90-minute clinics a week), released 0.5 FTE nurse time, and freed up clinical pharmacist time too. The team invested this time in pro-actively supporting its care home residents; a population whose care they wanted and had previously lacked capacity to improve.

Appendix Three - Group Consultations Economics

Delivering Group Consultations (GC) requires a combination of both group management and clinical skills. A basic knowledge of the methodology and administration is required by all delivering this method of consultation. Only the clinician requires more specialist knowledge of the methodology to ensure the group is effectively engaged and receives advice and guidance they require. Those delivering Video Group Consultations (VGC), require some additional guidance to cover the nuances of the delivery method i.e., additional information governance considerations.

Group clinic training in England and Wales has expanded a modular offer to cover **both video and face to face group clinic models** and include:

- **3-hour live simulation training** where teams can watch an experienced clinician and facilitator run a group clinic

- **3-hour live basic training** that covers the basic process and how to manage known risks and common group scenarios
- **2-hour live advanced group clinic skills training for clinicians** where an expert clinician mentor shares their experiences and supports the group to reflect on how to develop successful group clinic habits that underpin facilitative leadership and ensure that clinicians undertake safe, effective clinical work in the group
- **2.5-hour live advanced group clinic skills for facilitators and clinic co-ordinators** supported by an expert mentor, teams' chunk down the knowledge to simplify introducing group clinic administrative processes to accelerate progress and minimise disruption to existing clinic administration. This includes detailed guides on how to use existing Primary Care IT systems in the United Kingdom to schedule and organise group consultations. Advanced skills training also supports facilitators to explore how to facilitate inclusive, engaging group consultations where patients feel safe and included, and how to support the clinician to undertake and document their clinical work in a timely manner.

Education and Training

- All training and support provided online with a choice of dates on offer every month.
- An initial 90-minute programme orientation session to ensure the team choose the right pathway, the right team, and the right delivery mode (face to face or VGC), understand the key milestones and start to complete their planning template.
- Programme leadership team (n=3) and group clinic delivery team (n=3) complete 3 live modules of training, usually over 2 months
- All five training modules are Personalised Care Institute accredited.
- Basic training is CPD accredited.
- Teams get access to a comprehensive, continually updated toolkit, including tried and tested toolkits for diabetes, hypertension, menopause, cancer care reviews, Long COVID and respiratory group consultations.

- Clinicians get 2 hours of training on how to consult in group consultations with an expert clinician mentor.
- Facilitators and clinic co-ordinators get 2.5 hours training on how to administer and facilitate group consultations, with administrative shortcuts to cut workload, delivered with an expert facilitator mentor.
- Team gets access to 12 months of monthly “drop in advice and peer support” session to facilitate a community of practice and peer learning exchange.

Appendix Four - Group Consultation Frequently Asked Questions

Which pathways work best with Group consultations?

Evaluation (Lynch 2022) provides insights for policy makers and practitioners about the nature of clinical work best suited to group consultations.

Drawing on a framework for classifying clinical work (Christensen 2000), Lynch identified that VGC models self-selected and developed by outpatient teams in Wales deliver “Simple Care,” characterised as being planned and routine, driven by guidelines and protocols and thus relatively low risk, with a high degree of self-efficacy required from patients to improve outcomes. In most cases, these VGC models were nurse or allied health professional led.

This aligns with the group clinic models most often adopted by Primary Care teams in England. Scott et al (2023) found VGCs being used most frequently to support management of Type One and Type Two Diabetes (27%) and weight management (17%). Papoutsi et al (2022) found VGCs, covering a wider range of pathways, including: diabetes, asthma, chronic obstructive pulmonary disease, cancer (acute treatment and long-term survivors), mild COVID-19, anxiety, those with postnatal care needs, and those receiving healthy eating support.

Based on these findings, health system leaders are now able to offer guidance to clinical teams about the care best suited to the group clinic model. Focusing group consultations as

an alternative way to deliver chronic disease management reviews initially is likely to maximise efficiency and quality gains and be acceptable to clinical teams and patients.

How many places has it been running?

Over 700 sentinel practices in England's Primary Care were trained in Video Group Clinic use in 2020. When evaluated 34% of the practices intended to make Group consultations part of their ongoing General Practice Offer.

Does the technology and infrastructure need to change in any way?

The Digital First Primary Care team at NHS England has for many years been an advocate and provider of resources to enable video consultations. The COVID-19 response also accelerated the implementation of the technology that can be used in both 1:1 and group consultations.

Within the VGC toolkit specific advice is offered on the basic requirements, technology platforms and integration with existing admin and electronic patient record systems.

Does there need to be stakeholder/ multi-disciplinary team engagement?

Engagement from all parts of the general practice team is essential. Involvement from the start of implementation ensures the most effective experience and change in delivery method for all.

Is there any additional risk to consider when delivering group consultations?

Face to face group consultations present very few additional risks than other clinical delivery methods. However having scoped the risks associated with delivering care in group consultations, in 2020 NHS England co-created standardised risk management procedures for clinical teams to adopt for both face to face and video group consultations.

Stakeholders & Contributors

Lead Stakeholders: NHS England Nursing Directorate –

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Integrated Care Boards (Case Studies) –

Southeast London Integrated Care Board
Southwest London Integrated Care Board

Case studies can be found at:

https://future.nhs.uk/DigitalPC/view?objectID=24663536
https://future.nhs.uk/P_C_N/view?objectId=14750480
https://www.youtube.com/channel/UC2TlDoAwSzyEkRJbmoi0zGQ/videos