NIHR | Policy Research Unit in Behavioural Science

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Survey of group consultation activity in general practice in the North East and North Cumbria Integrated Care System

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1. Introduction

Group consultations (GC), or shared medical appointments (SMAs), have been promoted in general practice to efficiently deliver care and self-management support to patients with long-term conditions (Clay & Stern, 2015). They involve a group of patients (typically up to 12) with the same condition meeting with their health professional as a replacement for 1:1 routine appointment. Sessions are commonly between 90 –120 minutes and involve a 1:1 consultation for each attendee with others listening in and learning. GC provide an opportunity for patients to ask questions and discuss their condition with both healthcare professionals and peers. GCs have been found to be at least as effective as usual care in terms of health outcomes (Tang et al., 2022). There is a growing body of evidence showing that patients may benefit from GCs, including increased feelings of socialisation, trust with health professionals, enhanced knowledge, and patient outcomes (Booth et al., 2015; Graham et al., 2021, Kirsh et al., 2017). However, concerns raised by patients include confidentiality breaches by other patients, unclear expectations, and the need for good group facilitation. Reported provider benefits include reduced repetition, improved job satisfaction, peer support, and scope for comprehensive patient-led care (Graham at al. 2022). However, practitioners have reported several barriers and facilitators to setting up and running GCs (Graham et al., 2021; Swaithes et al., 2021). This includes uncertainty amongst practice staff over the purpose of the GCs, benefits to patients and practices, and whether they are effective and cost-effective.

There have been local initiatives in the North East and North Cumbria (NENC) region encouraging the use of GCs for long-term condition management in primary care, which have primarily taken the form of training for practice staff funded by Health Education England in 2018. However, it is unclear the extent to which these trained practitioners have been able to successfully incorporate GC into routine care. NECS have worked with the Policy Research Unit in Behavioural Science at Newcastle University on a series of studies on GCs. Previous fieldwork in NENC revealed that only 53% of trained practices spoken to had managed to run one GC, and only 42% had incorporated them into routine care (Graham et al., 2022). The pandemic has restricted the use of face-to-face consultations, but there is some anecdotal evidence from local GP practitioners in the region, that SMAs have been delivered by video-link though the extent to which this common practice is unclear. GC use in general practice is not recorded by Clinical Commissioning Groups (CCGs), Primary Care Networks or the level of the Integrated Care System, nor is there information about whether practices need or desire further support with adoption and implementation. This survey, funded by Research Capability Funding, was designed to assess current practice, in order to identify support and future research needs. This is important to inform policy decisions about the use of GC, and video-group consultations and identify key uncertainties regarding GC use in primary care that warrant further research and future NIHR funding.

2. Aims and objectives

To evaluate current GC activity across NENC to inform research priorities and future use.

The objectives are:

i) To evaluate the use of GC for long-term condition management in general practice in NENC
ii) To identify the most common mode of delivery
iii) To identify key barriers to implementation in general practice

3. Methods

A short self-completion online survey was used to assess the extent of GC use in general practice in the region. Practice managers were asked to report upon past use, planned use, mode of delivery, and to identify key barriers and facilitators to implementation they had experienced or anticipated. Geographical location, deprivation level and size of practices were also recorded. The survey is given in appendix A.

The survey was created using SurveyMonkey (see appendix A) and emailed out to all 273 general practices in NENC in March 2022. Originally the plan was to follow-up practices that did not respond to the email with a telephone call to prompt a response. However, due to the pressures on Primary Care it was decided to send a second follow-up email (2 weeks later) prompting a response. Initial and follow-up emails are given in Appendix B.

4. Results

A total of 45 practices responded to the survey by the end of March 2022, although 6 were only partially completed. This equates to a response rate of 16.5%.

Practices that responded were primarily from five CCGs in the region, namely County Durham (n=12), North Tyneside (n=9), North Cumbria (n=7), Tees Valley, (n=6) and Sunderland (N=5). Six respondents did not identify which CCG they were from. The majority of respondents were those in areas higher levels of deprivation. Practices ranged in size from less than 2,500 patients to over 35,000. See Table 1. All the practices in this sample have a low proportion of non-white ethnic groups, range between from <1% non-White ethnic groups up to 7.4% Asian, 1.2% Black, typical of the NENC region.

Table 1 Characteristics of practices in sample for whom the CCG was identified.(n=39)

CCG (n=39)	
County Durham	12
North Tyneside	9
North Cumbria	7
Tees Valley	6
Sunderland	5
IMD*	
Highest deprivation 1-5	24
Lowest deprivation 6-10	12
Missing data	3
Rurality	
Urban major conurbation	15
Urban city and town	9
Rural town and fringe	4
Rural town and fringe in a sparse setting	2
Rural village	5
Rural village in a sparse setting	1
Missing data	3
Size of practice (no. patients) (n=36)	
<2,499	0
2,500-4,990	8
5,000-7,499	8
7,500-9,999	7
10,000-12,499	5
12,500-14,999	3
15,000+	5
Missing data	3

** Index of Multiple Deprivation (IMD) IMD deciles 1-5= highest deprivation IMD deciles6-10*

Current use of group consultations

Most of the responding practices were not currently using group consultations (n= 37, 82.2%) and had no intention to do so, (n=35, 77.7%), whilst only a small number had plans to use them (n=3, 7%) or were currently using them (n=3, 6.6%). See Table 2.

Practices currently using them or had plans to use them were large practices (between 5,000- 10,000 patients) in Urban major conurbation with mid to high levels of deprivation (IMD 3-7).

Practices that had used GC in the past but were not currently active were mainly Urban, (one was rural), ranged in size from approximately 5,000 patients to 36,000 patients and tended to be in areas of higher levels of deprivation (ranging from 2-7).

Table 2 Current group consultation use by practices in NENC

Current use	No. practices
Not actively using GCs, no intention to use them	21
Not actively using GCs, have intention to use them, no plans in place	12
Not actively using GCs, have used in past	6
Not actively using GCs, have intention and plans in place to use them	3
Actively using GC at present	3

Conditions for which group consultations are in use/have been used

None of the practices reported that they were currently using face-to-face group consultations. Two practices reported they were they were currently using video group consultations for weight management and Long Covid, one also planned to use them for diabetes. One practice reported whilst not using them at present, planned to use video appointments for weight management. Conditions for which practices had run group consultations in the past, currently or planned are shown in Table 3 together with the delivery model.

Delivery of group consultations

Table 4 shows the staff involved in the delivery of group consultations. None of the practices who responded to the survey involved Nurse Practitioners, Pharmacists, or Social Prescribers as wither the clinician or facilitator. The most commonly involved groups of staff were GPs (25%), Practice Nurses (21%) and Healthcare Assistants (21%) and these staff types usually had the role of clinician. Facilitators were most commonly practice managers (33%) or administrative staff (44%). The only staff type who was an invited speaker was a GP.

Type of group consultation

With regards to the kind of group consultations the practices had run, most reported type used in the past or currently being used were single one-off sessions (n=5). Of the three practices currently using GC at present, one reported they were using a series of sessions in combination with recurring sessions, a second practice reported they were using singe one-off sessions. The third practice did not report the type of GC they were running. Data is summarised in Table 5.

Motivation for using group consultations

The 13 practices that indicated they had decided/intended to use group consultation reported their main motivation to use GC was to deliver care more efficiently (n=8), followed by improving quality of care (n=6) and reduce the repetitive nature of one-to-one appointments. The detailed results are given in Table 6.

Table 3 Use of group consultations

Condition	Face to face			Online / video		
	in the past	at present	planned	in the past	present	planned
Asthma (adults)	1					
Asthma (children)	1					
Cardiovascular disease	1					
COPD	1					
Diabetes	5					1
Hypertension	1					
Lifestyle medicine	1					
Chronic Pain	1					
Weight management	2				1	1
Menopause	1					
Long Covid					1	
Not specified					1	

Table 4 Staff types and roles within Group Consultations

Staff type	Facilitator	Clinician	Invited speaker	Total
GPs	0	5	1	6
Nurse Practitioners	0	0	0	0
Practice Nurses	1	4	0	5
Healthcare Assistants	1	4	0	5
Pharmacists	0	0	0	0
Physiotherapists	0	1	0	1
Social Prescribers	0	0	0	0
Practice manager	3	0	0	3
Administrative Staff	4	0	0	4

(Reported by N= 9 practices)

One of the facilitators was a Primary Care Network project manager.

Table 5 Group consultation type used by practices by current GC use

Group consultation type	Frequency of GC type reported by practices by current GC use			
	Inactive, used in past	Inactive, intention and plans	Actively using GC at present	Total
Single sessions	3	1	1	5
A series of sessions	3	0	1	4
Reoccurring	2	0	1	3
Unspecified			1	

Table 6 motivation for using group consultations

Motivation	Frequency of motivation reported by practices by current GC use			
	Inactive, past use	Inactive, intention and plans	Actively using GC at present	Total
To deliver care more efficiently	5	1	2	8
To improve quality of care enabling health professionals to spend more time with patients, and enabling patients to learn from and support each other	5	1		6
To reduce the repetitive nature of one-to-one appointments	4	0	2	6
To overcome pressures in general practice, e.g. long waiting lists, staff shortages	3	1		4
To add variety into practice staff roles, and support career development	2	1	1	4
To make appointments more enjoyable for patients and staff	3	1		4
To reduce waiting lists and meet targets	1	1		2
Project following council grant		0	1	1
To pursue practice and / or staff interests	0	0		0

Common barriers to implementation

Practices were asked to indicate which of the barriers (identified from previous research) were preventing them from running group consultations or were making them difficult to run. The reported barriers to implementation and the number of practices to specify these barriers are given in Table 7.

Of the 39 practices that provided responses regarding barriers, anticipated or experienced, the two most reported were access to training (reported by 25 practices, 64% of practices), and not having enough staff to deliver group consultations alongside usual appointments (reported by 25, 64% of practice). Several practices reported the lack of physical space within the practice being a barrier to running face-to-face GC (n=18), 11 practices reported they needed help with IT to set up online / video group consultations. Several (n=17) reported concerns about confidentiality and privacy as a barrier to running GCs and some reported patient preference for a 1:1 appointment as a barrier to setting them up.

Practices were asked to report the 'main barrier' to implementation they had experienced. Overall, 30 responded and the top three 'main' barriers were lack of staff capacity to plan and set-up GCS (n=8, 27%), followed by insufficient space within the practice to run them (n=5, 17%), followed by practice need of GC training (n=4, 13%). All the 'main' barriers given are shown in Figure 1.

The barriers were also examined with regards to practice activity and plans for group consultations. For practices not currently active and without intention or plans to start group consultations, the most reported barrier to setting them up was '*The practice doesn't have staff with the time and capacity to run them alongside usual appointments' (n=13)*, '*The practice needs group consultations training' (n=10), 'concerns about confidentiality and privacy' (n=10)* and the concern that 'more evidence was needed as to their benefits' (n=10). These practices cited on average over five different barriers to implementation. This suggests that practices view GCs as way of delivering care that will require additional work, rather than a model that could be used to replace usual 1:1 appointments for long term conditions. Findings also reveal a key barrier to those initiating GCs are concerns over

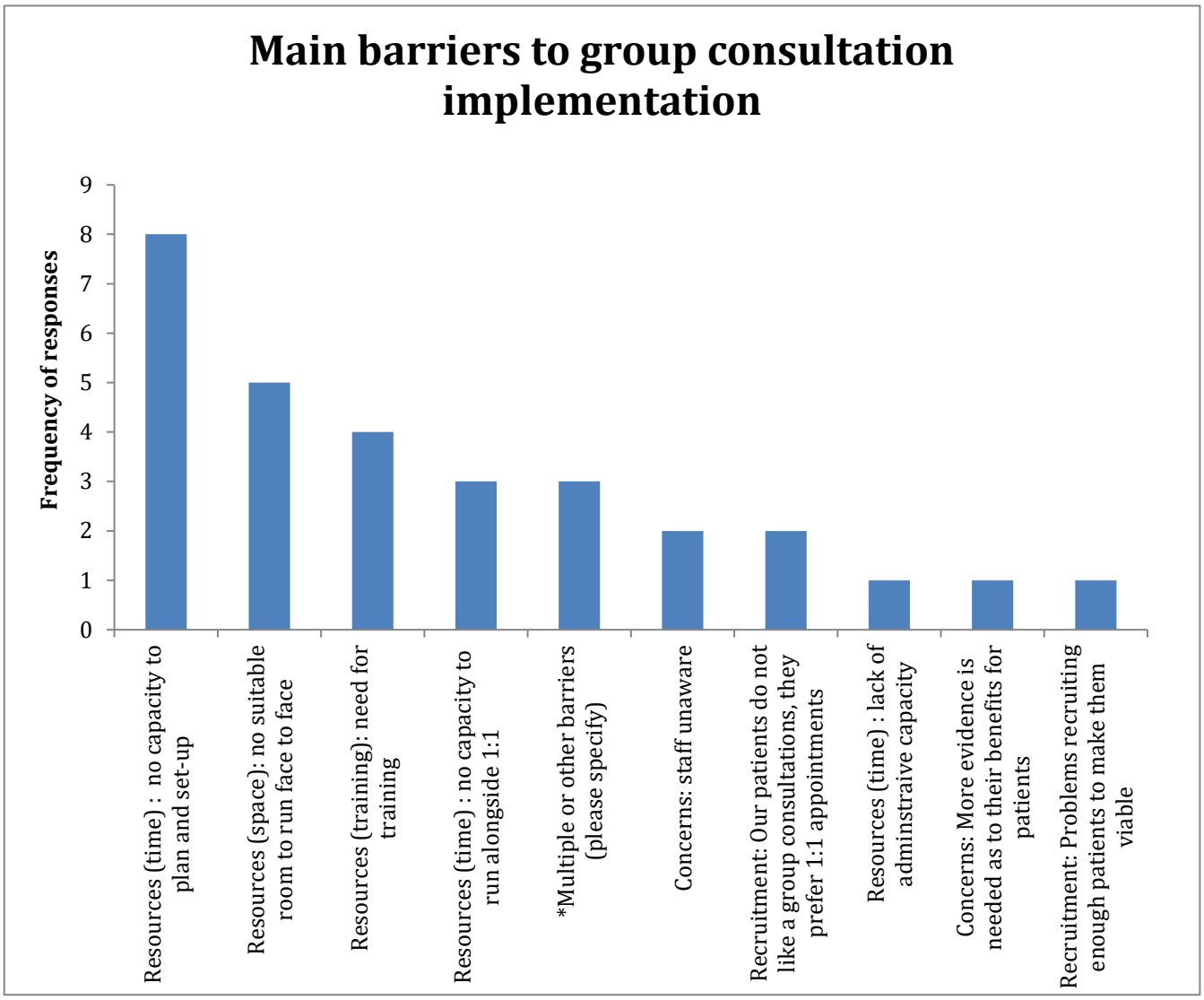
confidentiality and privacy. This, together with a desire for further evidence of benefits, highlights that further information that addresses these concerns and outlines how GCs can be assimilated into routine practice.

For practices who have not yet started CGs but with intention or plans to start them, the most reported barrier to setting them up was *'The practice would need additional funding for resources to set this up ' (n=8) , 'The practice needs group consultations training' (n=7)* and '*The practice doesn't have staff with the time and capacity to run them alongside usual appointments'* (n=7). The average number of barriers cited was six. These findings suggest that those with some intention to use GC have found it difficult to make plans as they lack the training and resources to be able to plan their implementation.

Table 7 Reported barriers to implementation (n=39 responses)

Barrier theme	Barriers	Responses	
		n	% of practices
Resources	The practice doesn't have staff with the time to plan and set-up group consultations	18	46
	The practice doesn't have staff with the time and capacity to run them alongside usual appointments	25	64
	The practice doesn't have the administrative time for set up including recruitment of patients	13	33
	The practice doesn't have a suitable room to run face to face group consultations	18	46
	The practice wants to delivery group consultations online, but need additional IT support to do this	4	10
	The practice needs group consultations training	25	64
	The practice doesn't have staff confident / willing to run a group session	15	38
	The practice doesn't have staff suitable to facilitate a group session	7	18
	The practice would need additional funding for resources to set this up	15	38
Patient recruitment	Our patients do not like group consultations, they would prefer 1:1 appointments	7	18
	Problems recruiting enough patients to make them sessions viable	6	15
Other concerns	Confidentiality and privacy	17	44
	More evidence is needed as to their benefits for patients	11	28
	More evidence is needed as to their benefits to practices and staff	11	28
	Covid: concerns about social distancing and infection control	4	10

Figure 1 Main barriers highlighted by practices



Those practices who were currently or had previously run CGs mentioned 1- 2 barriers each. As this is a small group, further analysis if not appropriate.

Finally, practices were invited to add additional comments, and these are given in Appendix 2. The high pressures on primary care were highlighted, together with some negative previous experiences, and the need for more information and support. The idea of group consultations being run as a CCG or PCN project was also reported, which has been highlighted previously as a possible facilitator for the implementation of group consultations (Swaithes et al., 2021, Graham et al 2022).

5. Discussion

This survey provided insights into the views and experiences of practices about implementing and running group consultations in the region. Only 20% were, or had previously used, GCs, and were mainly in urban areas. However, a further 27% had intentions or plans in place to use CGs, suggesting that this new care delivery model is gaining traction in primary care. However, this must be interpreted with caution given the low response rate and risk of with responder bias - the sample may represent the views of those that already have some interest or knowledge of GCs. There were, however, practices responding from five of the eight CCGs in the region, with a range of settings, deprivation levels and list size.

Practices which had used CGs or had plans to use them were mainly in urban areas with larger practice sizes, and with higher levels of deprivation, and, therefore, long term conditions are more prevalent (NIHR, 2021). The main motivation was to make care more efficient, improve the quality of care and make work less repetitive for health professionals. The greater demand for long-term condition management and larger pool of patients at these practices might make the option of CG seem more feasible in terms of patient recruitment and perhaps more worth-while due to the larger patient group it could serve. It also suggests that there may be benefits from smaller practices working together to consider CGs, perhaps taking a Primary Care Network approach. Although one of the motivators was to make care more efficient, this was not necessarily driven by a motivation to reduce waiting lists, meet targets or reduce other pressures in primary care such as staff shortages.

Whilst many practices reported that they intend to use group consultations, none are delivering them in-person at present and only a very small minority are, or intending to, deliver them online by video GC. The survey revealed that whilst some practices were using in-person GCs to deliver care for a range of long-term conditions previously, they stopped during Covid pandemic. This was primarily due to concerns about bringing groups patients together considering social distancing restrictions but also the broader pressures and changes in primary care, including the move to remote consultations.

Key barriers to the adoption and implementation of group consultations reported were the capacity to run these clinics, and the need for training. There were also reported issues with having the space to run them, the time to plan and set these clinics up, and also concerns regarding confidentiality. This is in line with previous local qualitative research findings (Graham et al. 2022), and shows these barriers are consistent across a higher number and wider range of practices.

The current pressures on primary care are well reported (Fuller, 2022), so it is not surprising that many report that time for the planning and set up of these clinics is the main barrier. The time used for planning and set-up has found to vary across practices (Graham et al., 2022) and there may be benefits to considering central support and guidance to do this, for example from Primary Care Networks or Integrated Care System (place or regionally based), to maximise efficiency and to overcome this barrier. A robust examination of different set-up and running models is required to identify the most efficient methods to use in order to gain the most efficiency savings.

Training is available but this is provided by an external agency so would have to be funded. Previous research highlighted the need for access to ongoing training due to staff turnover (Graham et al., 2022) and also as only approximately 20% accessing centrally funded training back in 2018.

At present, the evidence-base and theory to support this innovative model is still developing. Evidence shows benefits for staff in terms of variety and enjoyment (Graham et al. 2021, Swaithes et al., 2021), and patients in terms of having more time with the Healthcare practitioners, and learning and support from peers (Booth et al.,2015, Graham et al., 2022). However, further research is

needed to demonstrate the clinical and efficiency advantages this model of care has for practices and patients over usual care (1:1 appointments) Tang et al., 2021, Graham et al., 2022, Graham et al., 2022b). In particular, for which conditions they are most appropriate and which patient groups benefit most, and also how they should be organised and run to maximise efficiency and save resources. As reported in the literature (Booth et al., 2015, Graham et al., 2021) diabetes is the condition for which there is most promising evidence for clinical benefits for patients. Yet none of the practices in our sample were using group consultations for diabetes. The most common type of group consultation run has been a single session, which may not be as cost efficient due to the set-up time involved. For in -person GCs to be more efficient than one-to-one care, in the first year after set-up an average of 12 patients per SMA delivered monthly would be needed (Graham et al., 2022b). Nevertheless, the perceived cost-effectiveness of being able to see multiple patients in a single appointment was one of the main drivers of GC use by practices. Further research is needed to confirm whether this model is as at least as cost-effective as usual care. Many practices who responded in this survey were keen to see more evidence regarding benefits for both patients and staff, suggesting they might not be familiar with the existing evidence and / or they are aware of the current 'gaps'. The development and use of an evaluation framework would support practices to more accurately evaluate GC in practice and further add to the evidence base.. The findings ought to be communicated to primary care managers and healthcare practitioners so that they can make informed decisions about implementing CGs using the latest knowledge.

Lack of space to run in-person GCs was the second most common barrier to implementation. Whilst video-group consultations may arguably overcome logical challenges with regards to having space within the practice to hold the sessions, very few practices reported they intended to run GC by video. The need for IT support was only considered a barrier to implementation by very few practices. It is unclear whether this is because primary care teams have all the necessary equipment to deliver video consultations or whether the delivery of GC by video is not something practices have considered. When initially introduced to practices they were to be delivered in person but only in the past two years has there been training and guidance regarding VGC. Further evaluation is needed to better understand the acceptability and implications of VGC use post-pandemic, and what implications the use of video conferencing has on resource use, staff capacity and patient acceptability and outcomes. Findings from early innovator practices suggest embedding VCG in primary care practice may require considerable, organisational, infrastructural and clinical process change (Papoutsi et al. 2022).

Our survey revealed that at present many practices have intention but no plans to deliver GCSs. If practices are to implement GCs (in-person or video) they need to each develop an implementation plan outlining who needs to do what where and when within the practice to ensure GC as delivered according to best practice.

GPs, Practice Nurses, and Healthcare Assistants are the most common ‘Clinician’ involved in the delivery of group consultations, together with a Practice manager or member of the Administrative Staff as the group consultation ‘Facilitator’. Furthermore, the frequency of group consultation delivery to date varies across practices: single one-off GC sessions, a series of sessions and re-occurring sessions. Whilst the flexibility of the model is a strength, allowing it to be adapted and used by practices as per their needs, having additional managerial and administrative support at the level of the practice in identifying specific needs and requirements may help in initiating and embedding GCs are part of routine practice.

Strengths and limitations

Strengths of this survey is that this sample includes practices from a range of urban on rural settings, size range of 2,500 patients to over 30,000 patients and with a range of levels of deprivation. The ethnic diversity of patients belonging to practices in this sample largely reflects that of the Northern region of England. However, only a small proportion of practices responded to the survey, therefore there is a high risk of responder bias- only practices interested in GC may have responded. Improvements in the approach are needed to maximize participation. The survey could be refined, and targeted messages used to encourage responses and / or a representative sample of practices targeted.

6. Recommendations

The findings will be shared with commissioners and researchers, and Healthcare Practitioners, via events, social media and on the NECs Research Evidence webpages.

To support primary care practices with the implementation of GC to help grow the evidence base, the following is recommended:

1. Review and actively disseminate emerging evidence regarding GC effectiveness and efficiency, and best practice in primary care. This should be in a style and format which is accessible to Primary Care staff and commissioning staff.
2. Support staff with implementation planning and operationalization of group consultations in practices and across PCNs.
3. Develop a standardized evaluation framework for practices to assess effectiveness and efficiency of GCs.

There are also a number of specific research recommendations as a result of the survey, as follows:

1. Identify the best approach to assessing the current use of CGs by practices that can be used to determine SMA use across England.

2. Conduct agile evaluations in primary care to assess GC effectiveness and efficiency

3. Further research into the clinical benefits of CGs to add to the growing evidence base.

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8. References

Booth A, Cantrell A, Preston L, et al., (2015) What is the evidence for the effectiveness, appropriateness and feasibility of group clinics for patients with chronic conditions? A systematic review. Heal Serv Deliv Res;3, 1–194. doi:10.3310/hsdr03460

Clay and Stern (2015) Making Time in General Practice. NHS Alliance. Available at https://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/PCF_Press_Releases/Making-Time-in_General_Practice_FULL_REPORT_28_10_15.pdf [Accessed 29/06.2021].

Fuller C (2022). Next steps for integrating Primary Care: The Fuller Stocktake report. Available at https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf [Accessed 14/06/2022].

Graham F, Martin H, Lecouturier J et al., Shared medical appointments in English primary care for long-term conditions: a qualitative study of the views and experiences of patients, primary care staff and other stakeholders, 25 March 2022, PREPRINT (Version 1) available at Research Square [https://doi.org/10.21203/rs.3.rs-1455159/v1]

Graham F, Tang MY, Jackson K*, et al.,* Barriers and facilitators to implementation of shared medical appointments in primary care for the management of long-term conditions: a systematic review and synthesis of qualitative studies. *BMJ Open* 2021;**11:**e046842. doi: 10.1136/bmjopen-2020-046842

Graham et al., 2022b. Policy Brief: Shared medical appointments for the management of long-term conditions in primary care: evidence of effectiveness and efficiency. Available: https://research.ncl.ac.uk/behscipru/outputs/policybriefings/PRU-PB012%20SMA%20Policy%20Brief%20A.pdf

Kirsh SR, Aron DC, Johnson KD, Santurri LE, Stevenson LD, Jones KR, et al. A realist review of shared medical appointments: How, for whom, and under what circumstances do they work? BMC Health Serv Res. 2017;17(1):1–13.

NIHR (2021). Multiple long-term conditions (multimorbidity): making sense of the evidence. Available at https://evidence.nihr.ac.uk/collection/making-sense-of-the-evidence-multiple-long-term-conditions-multimorbidity/ [Accessed 14/06/2022].

Papousti, C, Shaw, S., Greenhalgh, T (2022) Implementing video group consultations in general practice during COVID-19. Br J Gen Pract. BJGP. 2022 https://doi.org/10.3399/BJGP.2021.0673

Swaithes, L., Paskins, Z., Duffy, H et al., (2021) The experience of implementing and delivering group consultations in UK general practice. Br J Gen Pract. BJGP.2020.0856.

Tang MY, Graham F, O'tDonnell A, Beyer FR, Richmond C, Sniehotta FF, et al., Effectiveness of shared medical appointments delivered in primary care for improving health outcomes in patients with long-term conditions: a systematic review of randomised controlled trials. MedRxiv 2022. https://doi.org/10.1101/2022.03.24.22272866.

Appendix A – Questionnaire

Question	Response options
Has your practice ever held group consultations? Please select the most appropriate answer.	No, and we don't currently have any plans to do so No, we would like to but don't have any plans developed yet No, but we have plans to in the future Yes, we have run them in the past but not currently Yes, we are running them currently
For what conditions have you run or plan to run group consultations? Please tick all that apply.	Asthma (adults) - Face to face, in the past Asthma (adults) - Face to face, at present
	Asthma (adults) - Face to face, planned
	Asthma (adults) - Online / video, in the past
	Asthma (adults) - Online / video, present
	Asthma (adults) - Online / video, planned
	Asthma (children) - Face to face, in the past
	Asthma (children) - Face to face, at present
	Asthma (children) - Face to face, planned
	Asthma (children) - Online / video, in the past
	Asthma (children) - Online / video, present
	Asthma (children) - Online / video, planned
	Cardiovascular disease - Face to face, in the past
	Cardiovascular disease - Face to face, at present
	Cardiovascular disease - Face to face, planned
	Cardiovascular disease - Online / video, in the past
	Cardiovascular disease - Online / video, present
	Cardiovascular disease - Online / video, planned
	COPD - Face to face, in the past
	COPD - Face to face, at present
	COPD - Face to face, planned
	COPD - Online / video, in the past
	COPD - Online / video, present
	COPD - Online / video, planned
	Diabetes - Face to face, in the past
	Diabetes - Face to face, at present
	Diabetes - Face to face, planned
	Diabetes - Online / video, in the past
	Diabetes - Online / video, present
	Diabetes - Online / video, planned
	Hypertension - Face to face, in the past
	Hypertension - Face to face, at present
	Hypertension - Face to face, planned
	Hypertension - Online / video, in the past
	Hypertension - Online / video, present
	Hypertension - Online / video, planned
	Lifestyle medicine - Face to face, in the past
	Lifestyle medicine - Face to face, at present

	Lifestyle medicine - Face to face, planned
	Lifestyle medicine - Online / video, in the past
	Lifestyle medicine - Online / video, present
	Lifestyle medicine - Online / video, planned
	Osteoporosis - Face to face, in the past
	Osteoporosis - Face to face, at present
	Osteoporosis - Face to face, planned
	Osteoporosis - Online / video, in the past
	Osteoporosis - Online / video, present
	Osteoporosis - Online / video, planned
	Chronic Pain - Face to face, in the past
	Chronic Pain - Face to face, at present
	Chronic Pain - Face to face, planned
	Chronic Pain - Online / video, in the past
	Chronic Pain - Online / video, present
	Chronic Pain - Online / video, planned
	Weight management - Face to face, in the past
	Weight management - Face to face, at present
	Weight management - Face to face, planned
	Weight management - Online / video, in the past
	Weight management - Online / video, present
	Weight management - Online / video, planned
	Multiple conditions within one group consultation - Face to face, in the past
	Multiple conditions within one group consultation - Face to face, at present
	Multiple conditions within one group consultation - Face to face, planned
	Multiple conditions within one group consultation - Online / video, in the past
	Multiple conditions within one group consultation - Online / video, present
	Multiple conditions within one group consultation - Online / video, planned
	People at risk of long term conditions, e.g. pre-diabetes, familial hypercholesterolaemia - Face to face, in the past
	People at risk of long term conditions, e.g. pre-diabetes, familial hypercholesterolaemia - Face to face, at present
	People at risk of long term conditions, e.g. pre-diabetes, familial hypercholesterolaemia - Face to face, planned
	People at risk of long term conditions, e.g. pre-diabetes, familial hypercholesterolaemia - Online / video, in the past
	People at risk of long term conditions, e.g. pre-diabetes, familial hypercholesterolaemia - Online / video, present
	People at risk of long term conditions, e.g. pre-diabetes, familial hypercholesterolaemia - Online / video, planned
	Other (please specify condition, whether face to face or online, and whether in the past, present or planned)
Which staff have been involved in the delivery of group consultation sessions and what role have they had? (Or, if in the planning stages, which staff will be involved in the delivery of	GPs
	Nurse Practitioners
	Practice Nurses

the sessions and what role will they have? Please tick all that apply.	Healthcare Assistants
	Pharmacists
	Physiotherapists
	Social Prescribers
	Practice manager
	Administrative Staff
	If other staff were involved, or they had different roles to those listed above, please explain who was involved and what role they had.
What kind of group consultations has your practice run (or has plans to run)? Please tick all that apply.	Single sessions, when a patient is asked to attend once only.
	A series of sessions, when a patient is asked to attend a course of sessions over a few weeks or months.
	Reoccurring, when a patients is asked to attend as needed, e.g. for an annual review or regular checks.
	Other type (please explain)
Why did the practice decide to run group consultations? Please tick all that apply	To overcome pressures in general practice, e.g. long waiting lists, staff shortages
	To deliver care more efficiently
	To reduce waiting lists and meet targets
	To pursue practice and / or staff interests
	To improve quality of care enabling health professionals to spend more time with patients, and enabling patients to learn from and support each other
	To add variety into practice staff roles, and support career development
	To reduce the repetitive nature of one-to-one appointments
	To make appointments more enjoyable for patients and staff
	Other reason (please specify)
Are there any specific barriers stopping you from running group consultations (or that are making them particularly difficult to run)? Please tick all that apply.	Resources (time) : The practice doesn't have staff with the time to plan and set-up group consultations
	Resources (time) : The practice doesn't have staff with the time and capacity to run them alongside usual appointments
	Resources (time) : The practice doesn't have the administrative time for set up including recruitment of patients
	Resources (space): The practice doesn't have a suitable room to run face to face group consultations
	Resources (IT support): The practice wants to delivery group consultations online, but need additional IT support to do this
	Resources (training): The practice needs group consultations training
	Resources (staffing): The practice doesn't have staff confident / willing to run a group session
	Resources (staffing): The practice doesn't have staff suitable to facilitate a group session
	Resources (funding): The practice would need additional funding for resources to set this up
	Concerns: Confidentiality and privacy

	Concerns: More evidence is needed as to their benefits for patients
	Concerns: More evidence is needed as to their benefits to practices and staff
	Recruitment: Our patients do not like group consultations, they would prefer 1:1 appointments
	Recruitment: Problems recruiting enough patients to make them sessions viable
	Other barrier(s) not listed above (please give details)
Of these barriers, which is the main barrier?	Response
	Numeric variable for main barrier
	Multiple or other barriers (please specify)
Do you have any other comments, thoughts or views about group consultations?	Open-Ended Response
Please select the CCG area you are within	Response
	CCG numeric variable

Appendix B – Email invites

Good morning,

The Research and Evidence Team at NECS have been carrying out some research with Newcastle University looking at the barriers and facilitators for setting up and running Group Consultations for long term conditions, within primary care.

We are currently asking all practices in the North East and North Cumbria if they have ever run group consultations, or if they might do in the future. We are also keen to know if there are particular barriers to setting up and running this type of appointment. This will help highlight areas for future research or support. So that we get a comprehensive view of their use in the region we would really appreciate it if each practice could reply.

The survey should only take a few minutes to complete, being mainly tick boxes. It is slightly easier to complete on a PC / laptop than mobile phone. It can be accessed by following this link:

https://www.surveymonkey.co.uk/r/groupconsultations

We would be grateful if you could complete this **by close of play on Friday 11th March 2022**.

If you have any questions or would like to know more about our research, please do not hesitate to contact us: Helen.Martin11@nhs.net or Fiona.Graham@newcastle.ac.uk

Thank you in advance for your help,

Helen Martin
Research Manager, NECS

Fiona Graham
Research Associate, Newcastle University

Hi,

We emailed a couple of weeks ago about some research the NECS Research and Evidence Team are carrying out with Newcastle University looking at the barriers and facilitators for setting up and running Group Consultations for long term conditions, with a link to a survey.

We would like to say a big thank you to all those who have already completed the survey. The data shows that it has only taken an average of 3 minutes for people to complete the survey.

If you have not yet completed it we would really appreciate it if you could take a few minutes to do so. This will ensure the findings are more representative of a wider range of practices.

The survey can be accessed by following this link:

https://www.surveymonkey.co.uk/r/groupconsultations

If you have any questions or would like to know more about our research, please do not hesitate to contact us: Helen.Martin11@nhs.net or Fiona.Graham@newcastle.ac.uk

Thank you in advance for your help,

Helen Martin
Research Manager, NECS

Fiona Graham
Research Associate, Newcastle University

Appendix C – Open text responses

No experience, no plans

- Tried them in previous surgery uptake to sessions was poor .
- I think it might be more common for mental health or allied health professionals to lead these kind of consultations? I don't see this as something a GP would do - I certainly have no training in delivering a group consultation. I could see some of our staff e.g. diabetes ANP, mental health practitioner doing this, but I am unsure of their training on this, and they don't currently do it. Patients have mixed views on this in my experience also - some happy, but would say most people want a 1:1 consultation. (not evidence based, just anecdote from patient interactions)
- To make these effective I think requires skilled and competent staff and the time to spend on setting this up and communicating the benefits to patients to encourage attendance. There are huge pressures on General Practice and to be honest in terms of making every contact count this feels a little like a luxury.

No experience, no plans but have intention

- I think they are a great idea and would love to set one up
- Not really aware of any practices running group sessions locally but would be interested to know more about this and how this could be delivered to patients at scale . Where this is working what delivery model are being used . Support with setting up pathways / Standard protocols / IG requirements would be helpful if this was to move forward
- Would like to do it , as long as alternative to 1:1 consultations / QOF FU's.. not in addition
- Lack of clarity around longer-term benefits to staff and practices alike.
- The hospital dietician tried to set up group consultations before the pandemic but did not have enough patients who were willing to participate.

Past experience

- Although these have not been a success in the past, we have discussed future sessions for pre-diabetics but no definite plans made as yet.
- we were doing group consultation for a New diagnosis of Type 2 Diabetes ,until we went into the pandemic . We hope to resume in the autumn when we move into a new Practice building
- As well as this we are still subject to asking patients to wear PPE/face masks and social distancing rules still apply. Practice premises are still an issue and ensuring we comply with the rules in the space we have is difficult. Asking staff to work during extended hours is also challenging.
- this is not something we would be able to look at unless we had an alternative location to use and the session was facilitated by other staff are we have no capacity/trained staff to do so. We like the idea of these and maybe it could be done as a PCN or CCG project rather than down to Practices who have very limited time for proactive workload as we are struggling to meet our reactive patient and non-patient workload.

No experience, have intention and plans for the future

- this is not something we would be able to look at unless we had an alternative location to use and the session was facilitated by other staff are we have no capacity/trained staff to do so. We like the idea of these and maybe it could be done as a PCN or CCG project rather than down to Practices who have very limited time for proactive workload as we are struggling to meet our reactive patient and non-patient workload.