

Brief for DHSC policy teams concerning primary care and the GP strategy: May 2020

Exploring shared medical appointments for the management of chronic conditions in primary care: experiences of practice staff and patients

Shared medical appointments (SMAs), are a new type of consultation in which a group of patients with the same chronic health condition(s) meet with a healthcare professional, or team of healthcare professionals, for routine care. This policy brief summarises patient and healthcare practitioner lived experiences of SMAs based on a review of the literature, as well as information collected through interviews with patients and practice staff with experience of SMAs in the North East and North Cumbrian (NENC) region of England.

Recommendations

- 1:** Develop a standardized evaluation plan for practices to assess the effectiveness and efficiency of SMAs
 - 2:** Ensure there is appropriate training, leadership, coordination and practice-based resource to effectively support SMA delivery (including quality assurance)
 - 3:** Explore under what circumstances and for whom SMAs may be most appropriate
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Introduction

Over 15 million people in the UK have one or more chronic health conditions, with their care accounting for a large proportion of NHS services and budget [1]. Shared medical appointments (SMAs), also called group consultations, have been proposed by the NHS Alliance and Primary Care Foundation as a way of supporting self-management of chronic conditions and ‘releasing clinicians time to care’ [2,3]. SMAs are a type of consultation in which a group of patients with a shared chronic health condition meet with a healthcare practitioner for routine care e.g. medication review, physical examination or other clinical intervention. Unlike peer support groups, SMAs also include a one-to-one consultation with a healthcare professional during the group session [4]. In contrast to the usual ten-minute primary care consultation, patients are in the presence of their healthcare practitioner(s) for longer. In 2018, Health Education England commissioned Experience Led Care group consultations [5] to deliver training in the delivery of SMAs to primary healthcare practitioners. To date, over 200 practices in various locations across the UK have attended this training, yet there is limited understanding of whether and how SMAs have been organised and delivered in practice. Furthermore, there is little robust evidence to indicate whether SMAs are efficient, feasible and acceptable to practitioners and patients in a UK primary care setting.

About the research programme

The National Institute for Health Research Policy Research Unit in Behavioural Science (NIHR PRU BehSci) at Newcastle University, in collaboration with NHS North of England Commissioning Support unit (NECS), undertook some research to examine the effectiveness of SMAs in primary care and to explore the lived experiences of healthcare practitioners and patients involved in SMAs delivered to date. The overall programme of work comprised four work packages (WP). WP1 was a review of the literature to examine SMA effectiveness. WP2 was a costings exercise to examine resource requirements for SMAs delivered in primary care in the NENC. WP3 was a review of literature that reports patient and healthcare practitioners’ views and experiences of SMAs for chronic diseases in primary care. WP4 involved interviews with patient and healthcare practitioners in the NENC to explore their views and experiences of SMAs for chronic conditions in primary care. This briefing presents the findings of WP3 and WP4 and is one of two briefs (the second is due late 2020). The objectives of WP3 and WP4 were:

- To explore practice staff views about SMAs, focusing on barrier and facilitators to implementation
- To explore patient and caregiver views and experiences of SMAs for routine chronic condition care, or for those at risk of chronic conditions

What we did...

We pre-registered our literature review protocol [6] and followed standard methods of searching, study selection and structured data extraction. Our focus was on studies reporting participants' views and experiences expressed following SMAs for chronic conditions in primary care settings.

We recruited health practitioners and patients from practices in the NENC whose staff had attended training in the delivery of SMAs. Interviews were conducted with participants face-to-face or by telephone between October 2019 and January 2020. We audio recorded the interviews, transcribed them and analysed them, to identify key patterns in their experiences of SMAs that were positive and negative.

What we found...

WP3: Key findings from literature review

We identified 18 studies, most of them were conducted in North America (United States, n=10; Canada, n=5). The experiences of patients and practitioners involved in SMAs for diabetes were most commonly reported.

Table 1 Key findings from the literature review

Barriers	Facilitators
<ul style="list-style-type: none"> Limited time and resources Limited availability of (free) training and support for staff Limited communication channels between staff within practice Time commitment (for patients) Lack of accessible room or car parking spaces (for patients) 	<ul style="list-style-type: none"> Informed and motivated staff throughout practice Highly skilled and confident facilitator Informal and relaxed atmosphere during SMAs Patient trust and familiarity with clinician and staff Informed patients who are willing to listen and share experiences with others in SMAs SMA champion within practice leading adoption and delivery

WP4: Interviews with healthcare practitioners and patients

Characteristics of practices involved in study

At least one member of staff from 26 practices attended training on SMAs, out of a total of 382 practices offered the training (uptake rate 6.8%). Of the trained practices, 6 agreed to take part in the study, the characteristics of which are outlined below (Table 1).

Table 2 Characteristics of practices involved in study

Practice	SMA condition(s)	No. SMAs delivered	Still running SMAs	HCP delivering SMA	Approx. no. patients	Setting (deprivation level*)	No. study participants	
							Patients	Staff**
A	Familial Hypercholesterolemia	7	No	GP	7,000	Rural (5)	12	3
B	Diabetes, asthma, high cholesterol	Over 25	Yes	Nurse	10,000	Major urban (8)	1	2
C	Diabetes	1	No	Nurse	13,000	Major urban (10)	0	1
D	Multi-morbidities	6	Yes	Nurse	16,000	Major urban (4)	1	1
E	High cholesterol, asthma, COPD	Over 25	Yes	Pharmacist	20,000	Major urban (1)	1	1
F	Diabetes	1	Yes	Nurse	36,000	City & town (2)	1	1

*Deprivation level 1-lower deprivation, 10 -higher deprivation. **two staff interviewed from other practices that have not delivered SMAs.

WP4: Interviews with healthcare practitioners and patients (continued...)

Participant characteristics

We interviewed 11 primary care staff based at the participating practices (3 GPs, 1 pharmacist, 2 nurses, 4 managers, 1 administrator). The majority of staff had attended SMA training (n=9) and had experience of delivering SMAs in practice; only two staff had no SMA experience. We also interviewed 16 patients (5 men, and 11 women aged between 51-87 years, with or at risk of one or more chronic conditions. The majority of patients (n=14) had attended an SMA in the previous 12 months; two patients had no SMA experience.

Key findings from interviews with patients: SMA benefits and limitations

Support and reassurance: patients found listening to the experiences of others useful, and hearing answers to questions they *'had not thought to ask'* beneficial. Patients realised they were *'not the only one'* with the condition and found meeting people *'in the same boat'* reassuring, particularly those that had been recently diagnosed with a chronic condition.

"It made me realise that, if I manage it well, I could still have full mobility and everything else in 20 years' time" F, 65, attended FH risk SMA, MM

Enjoyable and informal: Patients reported feeling comfortable sharing information about their condition and circumstances with others and to ask questions of clinician in the group setting.

"It was just a bit of banter, in a way, I suppose. Just generally talking about diabetes...[the staff] were having a little bit of a laugh as well" M, 68, attended diabetes SMA, MM

Patients reported that the atmosphere was relaxed and enjoyable and perceived the longer appointment time to be beneficial.

Low confidentiality concerns: Perceived risk of confidentiality breach by other SMA participants was low. Patients reported having anxiety and reservations about sharing personal and/or sensitive information with others prior to attending the SMA but reported no concern of this nature after attending.

"I was worried about my weight being up on the chart, but nobody made any comment on it." F, 71, attended diabetes SMA, MM

Patients recognised or knew each other in SMAs held in 'close-knit' communities. Whilst this was not a concern, it was considered a factor that would influence future attendance.

"I would be willing to talk in a group of people that I didn't know [about my depression]- but where I live, no, I wouldn't want them [to hear]." F, 73, diabetes, No SMA experience, MM

SMAs impersonal: patients expressed the view that SMAs are useful for providing general information about the condition, but some did not feel the information provided was personally relevant.

"I could have met with the GP for 20 minutes myself... It would have been more tailored to me rather than listening to the illnesses that other people had." F, 51, attended FH risk SMA, no CC.

SMAs not for everyone: One practice reported a patient walking-out of an SMA, stating, *'this is not for me'*. Some patients admitted *'switching off'* after their individual assessment or when the comparison of results revealed they were at lower risk than others in the group. It was widely acknowledged that some people would not want to attend an SMA.

Future attendance and expectations: One participant did not feel they received any additional benefit from the SMA therefore would decline a future invitation. However, most patients intended to attend future SMAs for their condition and would recommend it to others in their position. However, many believed it would depend whether they considered the condition appropriate to discuss in a group, including patients with no SMA experience.

"I have no problems attending a group consultation for diabetes, but it's all dependent on what the ailment is...If it was cholesterol, probably yes, fine. But... it's horses for courses" M, 54, unable to attend risk of FH SMA, MM.

F-female, M-male, FH- familial hypercholesterolaemia, MM- multimorbidities, CC- Chronic condition

Key Recommendations

Recommendation 1: *Develop a standardized evaluation plan for practices to assess effectiveness and efficiency of SMAs* Healthcare practitioners were unable to determine whether SMAs reduced demand for one-to-one appointments or saved clinician time. Patient attendance at SMAs, resource and time requirements, healthcare service use, patient satisfaction and health outcomes are important to record in order to evaluate efficiency and effectiveness of SMAs.

Recommendation 2: *Ensure there is appropriate training, leadership, coordination and practice-based resource to effectively support SMA delivery (including quality standard checks)* Practices unable to incorporate SMAs into routine practice following the training explained they did not have the resources and capacity to adopt them and that further staff training was needed. Having a SMA coordinator, external to the practice, to provide ongoing training and share best practice could help smooth adoption and ensure high-quality implementation across the region. They could also help facilitate smaller practices joining with others to run SMAs if the local population was not large enough to warrant regular SMAs.

Recommendation 3: *Explore under what circumstances and for whom SMAs may be most appropriate* Practices reported struggling to recruit patients to attend SMAs. Further research is needed to establish which groups of patients should be brought together in SMAs for best effect. It is important to consider if any inequalities might arise due to differences in the uptake of SMAs in different patient groups based on ethnicity, rurality, health literacy or access to material resources such as transport.

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