Video Group Clinics (VGCs): Evaluation Outcomes, links to Welsh approach to improving health and next steps

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Wales Context

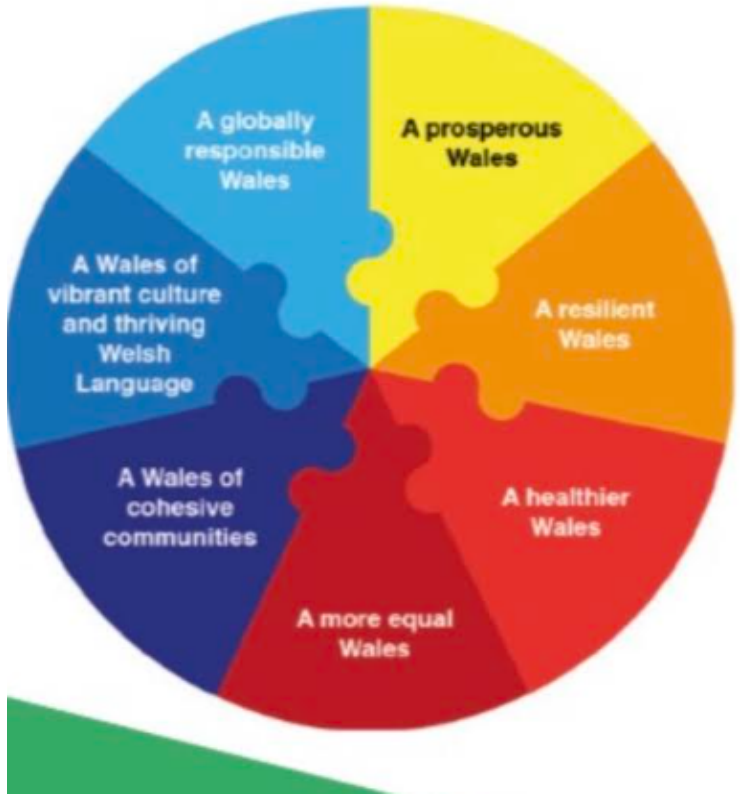
Welsh context 2022 onwards; recovery, transformation and rethinking health and health services

Wellbeing of Future Generations (Wales) Act

Prosperity for All: the national strategy

A Healthier Wales: long term plan for health and social care

A More Equal Wales: the Socio-economic Duty



VGCs in outpatients in Wales

Addressed strategic drivers for improvement, including; reducing waiting times and backlogs in care

Delivers safe, holistic, person-centred care;

Provides support and validation for people waiting to help them feel they were not alone

Builds clinical capacity and saves time; aligns with SOS and patient initiated follow up (PIFU)

Reduces face-to-face follow-ups

Supports self-management and preparation for surgery

Develops sustainable changes in clinical practice and wider service delivery

VGC programme design and evaluation methodology

VGC programme: two phase design

In Phase One, the system was supported to:

- Create the right conditions and governance frameworks
- Develop a VGC delivery toolkit with accompanying help desk
- Provide basic VGC training for participants
- Develop 30 pioneer teams through an intensive support programme
- Produce case studies to show and share what happened and good practice
- Run a national symposium and continue to engage national stakeholders in the design and delivery

Engagement channel	Numbers
Wales only webinar/briefing session	124
Wales only planning session	22
Attendees monthly webinars	364
Lunch and learn sessions	13
Number of people who have registered for a training session (pre and post-voucher scheme)	429
Number of people trained (pre and post-voucher)	339
Number of vouchers allocated	646
National symposium	126
Area Medical Director meetings	34
Overall engaged during programme	1,112

In Phase Two, the programme included:

- A Virtual Joint School spread programme
- Resources to spreading the VGCs beyond the 30 pioneers, using case studies and basic training
- Continued engagement with national stakeholders
- Mapping potential VGC models to support the delivery of planned care recovery in Wales
- Training for up to 234 teams; with up to 1,800 people engaged

Evaluation Methodology

Desktop analysis of the literature and examples of innovations, using virtual remote care, health technology, face to face and video group clinics

Exploration of the context of digital innovation ecology in United Kingdom health systems, and frameworks used to evaluate such work, especially in Wales

Observation and interviews. 15 hours of clinician interviews; four observed training events and provider and commissioner conversations; observation of the project's progress and changes via management meetings and reports, and observation of the delivery and evolution of the VGC programme.

Analysis of evidence of transformation of services and models of care

Topics and questions addressed

1 The implementation and use of VGC systems to support patient access and education in up to 15 settings: what is working and what is not?

2 The preparation and training process: what are the perceived advantages and disadvantages of this innovation for your patients your service and for you?

3 Lessons from implementation: what aspects of VGCs do you wish to continue, stop or add and why?

4 Patient experiences: how have VGCs influenced patient satisfaction, inclusion, safety, continuity of care and communication?

5 Workforce experiences: how have VGCs influenced staff workload, the workforce including satisfaction and stress?

Evaluation findings

Results

3 critical factors:

- Visible benefits and enablers
- Invisible benefits and enablers
- Time as a currency

Visible benefits and enablers

"Changes in patient behaviour, skilled staff, VGC case studies and spread, clarity on where VGCs fit"

Visible benefits and enablers

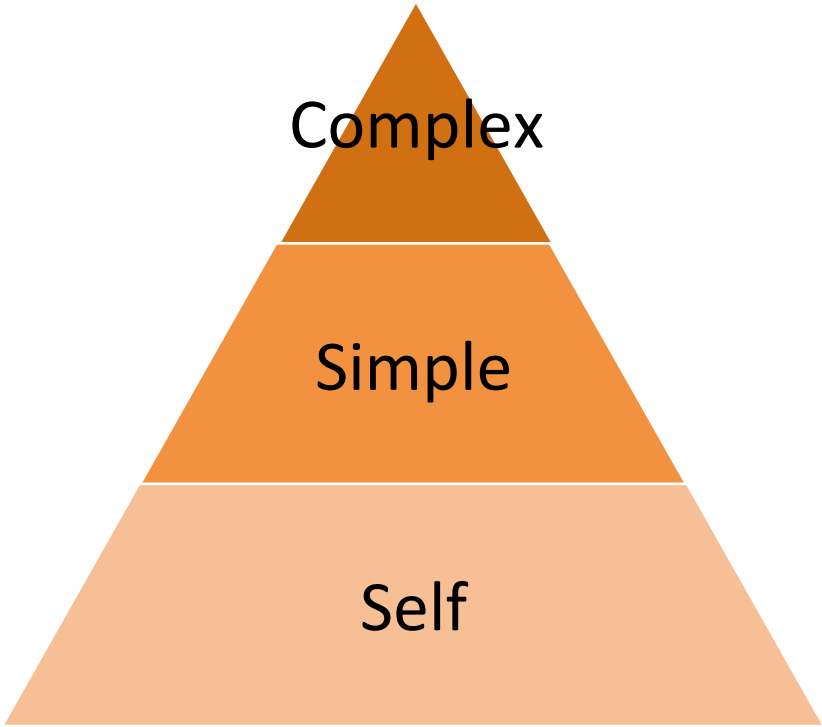
a) Patient behaviour - from past passive to proactive with commitment to self-care

b) Staff skills - a new clinic model is spreading in Wales; case studies available; routine use of VGCs within organisations once confidence, competence and culture has accepted them

c) Clarification of clinical work best suited to VGCs and type of staff best to provide them - VGCs are best suited to addressing **simple clinical interventions** where there is consensus and certainty about the review process and often guidelines and protocols followed with limited variation

VGC's contribution to models of care

	Self care	Simple care	Complex care
Person providing care	Person or peer/ parent provide support	Clinician follows a treatment or review protocol	Clinician manages clinical complexity & medical intervention
Decision support systems	Self managed, peer support AI bot/ app instructions	Protocols, SOPs, treatment guidelines	Clinical expertise, complex decision making and risk assessment
Current Place	Home and virtual **"Empowering"**	Outpatients, primary and community care **"Enabling self management and recovery"**	In patient, outpatients and primary and community care **"Diagnosing and treating"**
Examples	Slimming World Silver Cloud The Maternity Red Book	IAPT groups Pulmonary rehabilitation Midwife led birth **Face to face & video group clinics**	Consultant first appointments CPN or psychiatrist led care Hospital based births



Simple care is high volume healthcare

Invisible benefits and enablers for patients

"Energy, engagement, active participation and connection; culture change and social capital co-created in the virtual clinic room"

Invisible benefits and enablers for patients

a) Patient energy and engagement - staff reported patients' energy within the group, and their willingness to share personal experiences and listen to others. Staff spoke with respect and awe about what they had learnt from listening to patients in their VGCs

b) Moving from passive to active participation - staff noted that patients learnt from each others' experiences. They commented on the shift from patients being passive to active participants who took responsibility for contributing to the group. This shines a light on how VGCs can help change culture by changing the way simple health and care is delivered

c) Social capital co-created in the virtual clinic room - the engagement and community building staff observed, generated by this new clinic delivery model realises the desired change in patient behaviour and the system's approach to health improvement signalled in Healthier Wales. Evaluation suggests that VGCs will encourage prevention, support improved self management and promote well being and thus assure future health for the people in Wales

Invisible benefits and enablers for staff

"Joy in work, joined up services and teams and justice"

Invisible benefits and enablers for staff

a) Joy in work and autonomous clinical practice - staff described VGCs bringing joy to often repetitive, monotonous, simple clinical work through deeper connection to their patients. They described the relief of having the autonomy to improve clinical practices that they understood were not adding value to patient care nor valuing their clinical skills

b) Joined up services and teams - staff recognised that delivering group clinics had brought them together as a team, with administrators and clinicians working more closely together and gaining respect for each others' skills and knowledge. When VGCs supported several clinicians to work together with patients, staff said VGCs supported integrated multidisciplinary working centred around the patient

c) Justice – staff described the improved access available for patients through VGCs and described how working with their patients in VGCs supported them to advocate for what mattered to the person. Staff described how VGCs aligned with their professional values. They also talked about the privilege of meeting people in their own homes

Invisible benefits and enablers for staff

"Improved quality, flexible home working, greater personal commitment and discretionary effort; the bed rocks of recruitment and retention policy"

Invisible benefits and enablers for staff

a) Improved quality - staff expressed pride and joy in the difference VGCs made to patients' experiences and to the quality of their own working lives. They reported VGCs gave them the ability to exert personal influence on the quality of clinical work; something that is key to successful workforce retention and recruitment

b) Flexibility and home working - staff described how working through VGCs meant that they could continue to work rather than shielding at home during COVID, and how the VGC experience meant that they wanted to continue to work when previously they were planning on leaving their post or retiring

c) Personal commitment and discretionary effort - staff invested energy to make VGCs work. They gladly spent their own personal time, doing extra work to make the change happen. This highlights their personal commitment to the VGC cause. VGC work led to high levels of discretionary effort and engagement at work

Invisible benefits and enablers for staff

"Alignment with NHS People Plan "

"It was easier for people to be seen from home, & had help to join"

"I felt privileged to be invited into their homes"

"Because I was trusted to run VGCs, I felt valued"

"This is so much more interesting"

"We were able to hear from patients"

"My ideas were included in MDTs"

"Safety issues were sorted in the training"

"If we needed help, ELC (team) was there."

"I learnt so much on VGCs from patients, & colleagues."

"It kept me nursing even when I was shielding. Now I'm not leaving"

"Working as a team with admin, IT, medical colleagues & patients improved understanding & relationships"

Time as a currency

"Invest to save; embrace an incremental pace of change; recognise personal time and discretionary effort"

Time as a currency

a) Pressure to save rather than invest time - staff reported feeling constant pressure to save time. This is the context in which most NHS staff are working right now. They spoke of needing to invest time in: attending VGC training, participating in discussions about changing how they work. Lack of time was given as a reason for not attending VGC training or participating in evaluation interviews. Although one of the initial drivers for changing to VGCs is to deliver quality care and save clinician time, this is only realised once the switch is embedded

b) Pressure to change more quickly than the change process allows - staff spoke about the time needed to implement the VGC change, sort out problems and have discussions with others. They reported it taking more time than they felt they had. When they took time to discuss and review VGCs with colleagues, interest in VGCs spread; the colleagues they spoke to were motivated and local solutions to operational challenges were generally found. Staff perceived system pressure to make VGCs happen quickly, and recognised that sustainable change usually happens incrementally and much more slowly than those directing the change wish

c) Investment of personal time and discretionary effort - given the pressure to save time now, staff found themselves in a dilemma. They needed to find time in the present to save time in the future. They found this tension hard to balance and reconcile. It led to them wanting to invest their personal time to drive the VGC innovation in the short term. This personal investment and commitment to the VGC cause was evident in all those interviewed. A sense of belonging, autonomy and feeling valued and trusted drove this discretionary effort. Personal time invested is an element of the time currency that is invisible from an organisational and system perspective

NO TIME NOW
NO TIME NOW
NO TIME NOW
NO TIME NOW

Evaluation found the VGC change takes time now to realise benefits later

Key issues are:

- **Invest time now to save clinic time longer term:** the system needs to recognise that to save time by running VGCs long term, it must invest staff time now to attend training and make the change so that discretionary effort becomes paid work
- **Invest clinician and patient time now to empower patients long term:** many VGC models tested proactive care that reaps health improvement in the future
- **Invest time now to improve recruitment and retention long term:** training, sustaining and empowering staff through VGCs saves future recruitment and new staff training costs, and retains experienced staffs' expertise in health boards
- **Time to change public and professional behaviours:** all stakeholders must recognise the VGC change is iterative, and happens over time as personal experience, confidence and trust in the VGC model spreads within an organisation or system

Time as a currency

“Magical moments”

Frustrations with slow progress in some areas were mitigated by magical moments:

- Seeing VGCs start in other departments
- Getting invitations to speak about VGCs at events
- Positive feedback from patients

Magical moments motivated people to keep going and accounted for much of the joy expressed in interviews

Discussion of findings

Discussion

Two themes:

- Understanding the value of VGCs
- Understanding the difference VGCs can make in Wales

Value of VGCs

Value can be seen through two lens:

- **Utilitarian:** “system centred” and focused on transactions and targets, it prioritises evidence on the validity of approaches in delivering what the system needs; saving time and improving care. It often asks, “How many, how much?”
- **Emancipatory:** “person centred,” it imagines people taking responsibility for their own and others’ health and feeling valued and heard. It builds on assets like discretionary effort, community action, personal empowerment. It ensures access is not a wealth issue. “It often asks, “How can we build on strengths?”

Value of VGCs

- The **visible benefits** of VGCs represent their **utilitarian value**
- The **invisible benefits** of VGCs represent their **emancipatory value**

Value of VGCs

Healthier Wales is predicated on building emancipatory value:

and seeks ‘commitment to a cause’; strong relationships and networks; passion and pride that help people in Wales to be more healthy and human

VGCs offer significant emancipatory value:

- VGCs shift roles and responsibilities between nurses and doctors; equalise power and change relationship dynamics within clinical teams
- VGCs equalise power between patients and professionals and challenge the concept of who is the expert and holds knowledge in the clinic room. They have altered whose knowledge is valued so that clinicians' and patients' experiences and expertise are equally valid
- VGCs have changed patient and clinician roles and responsibilities for taking action, with the onus on clinicians and facilitators coaching patients to set goals and change their health related behaviour
- VGCs shift care to the collective, community approach sought in the COVID recovery strategy
- VGCs have built infrastructure and agency (skills) to support a model of care that creates social capital in the clinic room; a key aim of Healthier Wales

VGCs add utilitarian value by creating emancipatory value and increasing social capital

Utilitarian value

VGC infrastructure and care model

Digital platforms

Governance

Social determinants of health

Behaviour change

Clinician time saved

Clinic capacity created

Emancipatory value

Agency, skills, faith, joy, altruism amongst patients and staff

Virtual group connections

Community action

Community networks

Innovation

The difference VGCs can make in Wales

Three levels of impact:

- **Micro:** patient impacts “I am not alone”
- **Mezo:** staff impacts “I get joy from my clinical work”
- **Macro:** system impacts “We have harnessed a new way of delivering care”

Micro: patient impact

Connection: meeting others collectively brings peer education, empathy and role modelling into the clinic experience, and a level of connection and understanding of one's personal health story. Trust built means patients were satisfied. As far possible, the process was fair, with equity of opportunity and access overtly organised

Patients are acknowledged by overtly establishing and addressing what matters to them at the start of the VGC; by building digital inclusion (acknowledging that social determinants of health do not make this an equitable option for all) and by encouraging peer to peer sharing of experiences and expertise and by facilitating the shift towards personal responsibility for health behaviours and wellbeing

Patients feel 'I am not alone' and the opportunity to meet other patients and collectively explore what matters to everyone leads to peer education and learning, reassurance and validation, empathy and role modelling within the clinic setting and a deeper level of connection to peoples' personal health stories

Convenience and savings from appointments online and no need to travel. This also reduces environmental impact and brings efficiency to patient's outpatient attendance process (time and money)

Patient acceptability is key to mainstream VGCs. Patients need to accept the change. This evaluation found patients accept the VGC approach (enrolment), take part in the process of the VGC (engagement) and commit to on-going engagement and actions (adherence)

Mezzo: staff impact

Improved job satisfaction: VGCs brought joy, autonomy and job satisfaction to participating clinical teams, and the wish and willingness to work beyond core hours and beyond their current scope of practice. Staff benefitted through less time spent, repeating the same information in clinic appointments

Staff needs met through a very practical way to work differently: this includes the chance to work remotely and flexibly. This brought new members into the team and aided staff retention, including those who needed to shield and VGCs meant they could still work and contribute

Staff acceptability: when designing future healthcare, staff need to accept the changes they need to make and see the benefit to themselves and to patients. Healthcare staff need to acquire competence and confidence to deliver new services. Within this programme, staff skills improved through VGC training and intensive support.

Credible staff champions: individuals have gone on to lead local awareness-raising, become champions and role models and encouraged others to become involved in VGCs. This energy for change, and effective education to undertake new roles and empower staff is crucial for the successful implementation of new models of care and ways of working.

Macro: system impact

A solution that supports system change: VGCs are established with a clear role within outpatient care pathways. Wales is harnessing VGC innovation in response to the pandemic, service demand and the Recovery Plan to address outpatient redesign and system recovery challenges in Wales

Greater system maturity to enable routine delivery of VGCs: this programme's work means that the Welsh system has increased its readiness to accept, provide and use infrastructure that supports VGCs. Outpatient teams have KPIs that encourage and support adoption embedded in performance frameworks. This is how all innovation evolves

A system culture more open to VGC innovation: outpatient teams are aware of VGCs. There are case studies and they and have permission to innovate. A loosening of transactional controls to support individual teams to innovate and lead the switch to VGCs and to harness the personal confidence and commitment to the innovation will help harness 'commitment to the cause'

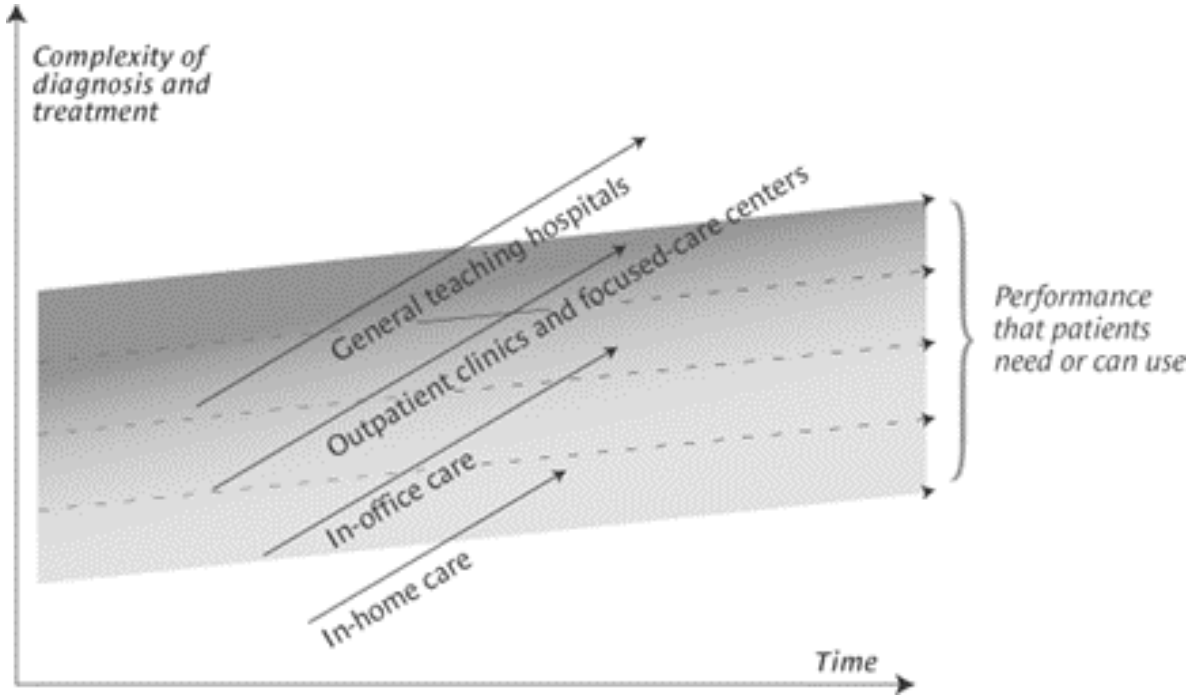
Convenience and savings: convenient and less costly solution that immediately meets the needs of some and eventually can meets the needs of most people, VGCs enable less expensive professionals to provide simple care interventions to groups. Provided virtually in the person's home, they require less outpatient estate and car parking and thus reduce costs and the carbon footprint. They support the switch to specialist care led by nurses and therapists

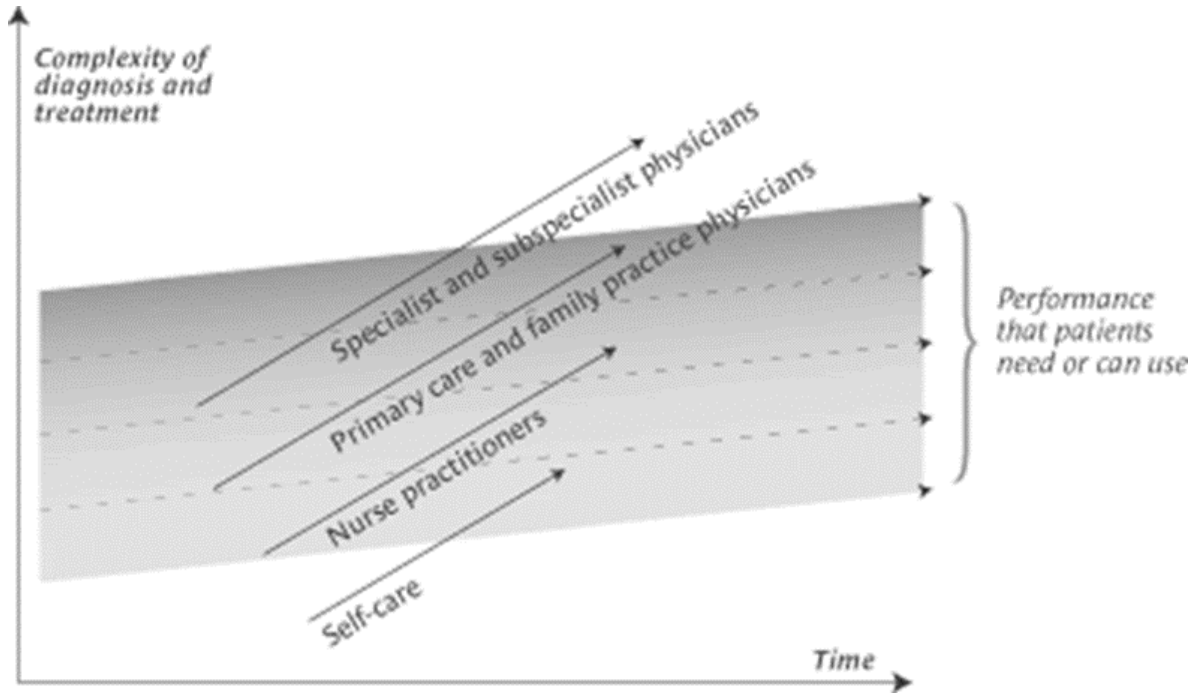
Desired culture change: VGCs have disrupted power and expert knowledge in the clinic room. They have introduced person centred practice and create a way of building social capital within health care delivery, which is a cultural change what Our Healthier Wales demands.

The difference VGCs can make in Wales

"VGCs offer Wales a disruptive innovation that it can harness to support recovery and outpatient redesign"

Disruptive Innovation Theory Supports the Shift. Changing the Design of Outpatients

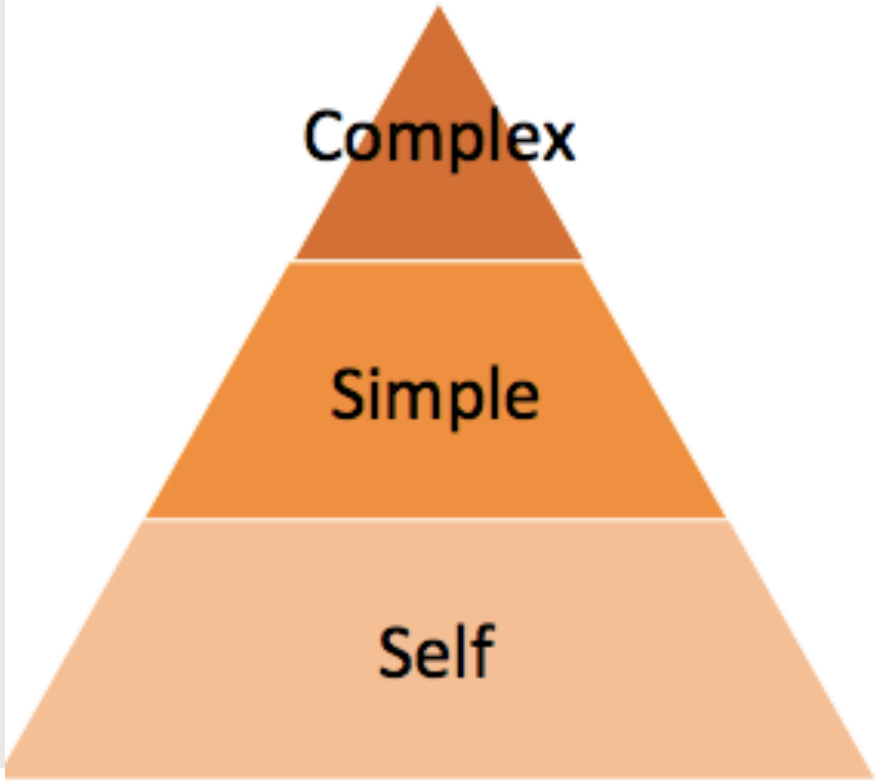




Recommendations

10 recommendations to improve health, workforce development and finances and meet outpatient demand through VGCs

1. Keep it SIMPLE



Identify appropriate clinics that fit the simple clinical work criteria

Clinical work that can be classed as **simple** (Glouberman 2002) and requires information sharing rather than diagnosis or treatment have been successfully and safely managed through VGCs in Welsh outpatient settings to date led by nurses and AHPs

Keep it SIMPLE

Recommend VGCs be used as the system's preferred clinic model to deliver simple appointments

- When considering VGCs, teams should take into account clinical need: the severity of the illness, cognitive function and co morbidities and level of clinical risk associated with management of the patient.
- The reason for the clinic appointment should be clearly defined and inform VGC
- Patients should be offered VGCs as a first contact option, after establishing their ability to use and access technology. Those who have not tried VGCs should be encouraged to give it a go before declining on the basis of personal preference

2. Assure and build digital maturity

Digital maturity scale for healthcare organizations in relation to remote services.	Organizational descriptor How the organization currently uses traditional technology (and new technology (e.g., video, telehealth apps) to support remote consultations
Level 1: Traditional (reactive)	Limited leadership or vision for remote services (there may be a strategic decision and rationale to resist these). Phone is used for triage and call-backs e.g., for demand management and as a response to the pandemic. Patient online access is mostly disabled. Video and telehealth are rarely if ever used and may be actively discouraged. Key infrastructure may not be in place. Digital inequalities either not addressed or addressed by focusing on face-to-face services
Level 2: Traditional with lone innovator (ad hoc, demonstration)	Within a traditional organization or department, one staff member is enthusiastic about remote care, s/he attempts to use novel technologies and engage others in doing so, but has not yet succeeded in getting others to share the vision, influencing practice strategy or changing practice routines or policies. Infrastructure may be inadequate. Digital inclusion not yet a priority issue.
Level 3: Digitally curious (experimenting)	The organization or department has a vision and plans for providing remote care. Traditional and new technologies are used creatively, and adjusted iteratively, to try to improve an aspect of care within the practice. These creative efforts may include measures to overcome digital inequalities. Focus is on technical details and feasibility (i.e., making something work). Infrastructure is adequate but may have limitations
Level 4: Digitally embedded (learning and improving)	Both traditional and new technologies are used creatively and strategically, and benefits and disbenefits are evaluated, with the aim of improving remote care in all relevant areas across the organization, including efforts to meet the needs of digitally excluded groups. Digital capability is high (i.e., many services are successfully delivered remotely). Focus is on quality improvement and organizational learning. Work practices and routines are continuously adapted. Technical infrastructure is good as a result of strategic investment
Level 5: System-oriented (extending and spreading)	Strategy and vision for remote services are strong and extend beyond the organization itself. Reducing digital inequalities is one aspect of a wider vision for an effective, efficient, equitable remote service. Digital capability is high. Staff are actively involved in developing and evaluating remote services beyond the practice—e.g., through inter-organizational benchmarking, quality improvement collaboratives, locality-wide planning, research, national guidelines.

Embed VGCs into Welsh systems that measure and improve digital maturity

An organisation's maturity to manage the introduction of VGCs should be appropriate. Assuring quality and digital maturity is possible, using the five-point digital maturity scale (see opposite). However, to be classed as digitally mature, an organisation needs to have more than a digital platform for VGCs. It needs to also address digital safety and inclusion and have skilled staff

Assure and build digital maturity

Ensure governance aspects of digital maturity are prioritised across the system. This will ensure the unique governance aspects of data sharing in VGCs are consistently understood, managed and shared across Wales and do not become a barrier to spread

Ensure educational support is available. A crucial aspect of digital maturity will assuring the technical skills of those running VGCs (clinicians and facilitators). Skills frameworks should include this competency, and educational programmes should be available

3. Balance patient choice and system pressures; develop information to support behaviour change

VGCs involve a tension between demand management and patient choice:

- Make a system-wide decision as to whether VGCs should be the default for the simple outpatient appointments or an ‘opt in’ or ‘opt out’ choice. This will makes a big difference to time taken to spread VGCs
- Work with communication teams to develop appropriate information for patients and for staff, including the pros and cons to support both staff and patient engagement

Balance patient choice and system pressures and develop information to support behaviour change

Offer alternatives to ensure access for all and digital inclusion is addressed e.g. face to face group clinics

Raise awareness of benefits: to encourage people to engage in VGCs as a preferred way of receiving and delivering care, work with NHS Wales national communications teams to create nudge messages, demonstrating the person centredness of the group clinic approach; the impact on quality (effectiveness, efficiency and equity) and the impact on workload and joy in work. Include these in patient information and share widely amongst staff groups

4. Create infrastructure for transformation; support an innovative organisational culture

Use this evaluation to produce a clear change narrative and context to support organisations making the switch to VGC

Recognise that the supportive, permissive and innovative culture that underpinned the VGC programme was an enabling factor and those involved are the fulcra for future success

Create infrastructure for transformation; support innovative organisational culture

Frame VGCs as a way of delivering the Healthier Wales change agenda in the context of outpatient transformation: The visible and invisible benefits of VGCs are coherent with the Healthier Wales change agenda and Recovery Plan, and move the system towards its ambition; at scale delivery of higher quality, more person centred care

Align VGC spread with service improvement and personal appraisal and revalidation: support service improvement projects or audits linked to personal appraisal and revalidation that show how improving simple care pathways using VGCs can improve quality, save clinical time that can be re-invested in developing the individual's clinical practice, thus supporting clinicians to form clear personalised rationale and development goals for engaging with VGC development

Set health boards up for success: to trigger change at health board level, agree individual action plans and objectives to develop and spread VGC models that deliver simple care and address local environmental and contextual pressures. Describe and support tem to build an innovation culture where VGCs can thrive through: positive clinician - manager relationships, support for VGC champions, and VGC organisational networks to maintain engagement and build momentum for change

5. Create agency for innovation through leadership support for nurses and therapists

Consider a VGC change leadership programme for nurses and therapists

Given their pivotal role in leading VGC spread across Wales, this will help to create a community of practice and provide the support structures needed to spread and sustain the VGC change

Create agency for innovation through leadership support for nurses and therapists

Engage nurses and therapists by sharing the invisible benefits of VGCs work described in this evaluation. Put in place support to make and lead the VGC change. Provide autonomy within an active workplace based leadership role, thus supporting them to create joy in work and building ‘commitment to the cause’

Align VGCs with the “art of nursing and justice”. In line with new ways of working, include the ‘multiple ways of knowing’ outlined by Carper to ensure nursing leadership develops to include the art of nursing and social justice (Rafii 2021)

6. Harness VGCs to transform consultations and create social capital in the clinic room

Put in place clinical education support

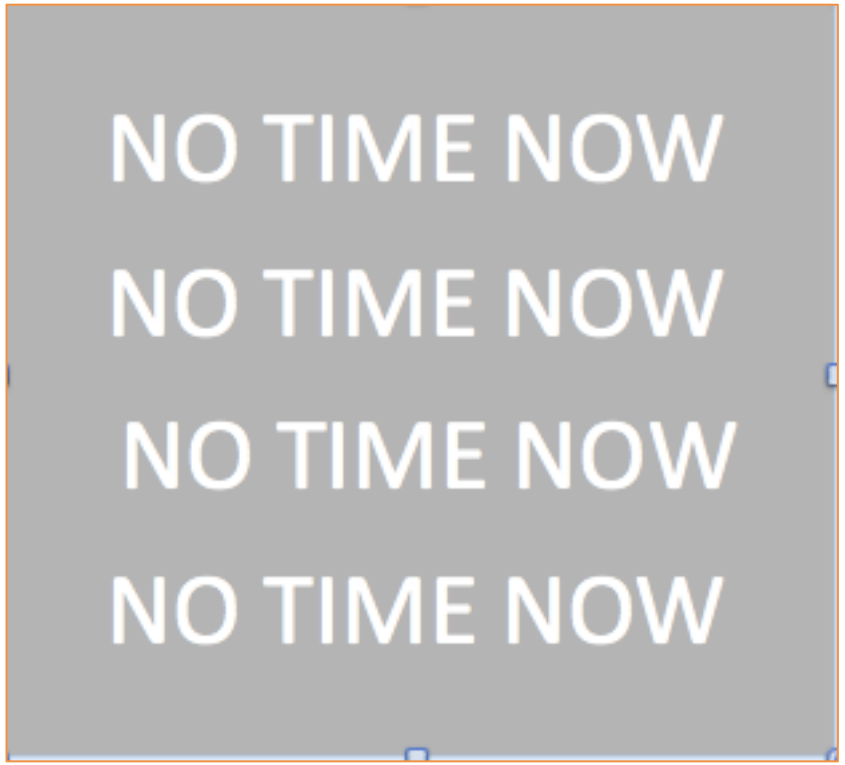
Recognise that VGCs require two new skill sets: virtual consultation and group consulting skills. Working with a group shifts participants towards reflection, collective problem solving, shared decision making and respecting peers' expertise, wisdom and experience as being equal to clinical knowledge. This may require clinicians to work differently and their surrender power, and their current sense of professional identity. Virtual consulting requires even deeper listening and observation of non verbal cues, and the ability to communicate with patients simultaneously through the CHAT column and verbally

Harness VGCs to transform consultations and create social capital in the clinic room

Review Wales' educational approach to consultation skills training: adapting a consultation model such as the Cambridge Calgary Consultation model (Kurtz et al 2003) could help adoption of VGCs. Alignment of clinician training and CPD with group clinic skills will be key

Pilot group clinic educational modules: this needs to involve Deanery and Nursing Schools. Aligning to Ginners (2020) learning objectives may be helpful

7. Reframe conversations about time and staff wellbeing



"This the transformation mind set that health systems seek"

Frame time spent learning as an investment in quality rather than a cost

Ensure teams recognise that time invested in VGC training now saves team time later as it provides best practice and answers to the questions and lead to joy at work

Build in thinking and educational time into work time, or enable people to give themselves permission (as part of wider staff wellbeing initiatives) to take time to pursue their interests and passions for improving care, including through VGCs

8. Provide toolkits, a champion role, networks and a communities of practice

Build on the legacy and develop levers to sustain improvement and spread of the VGC programme:

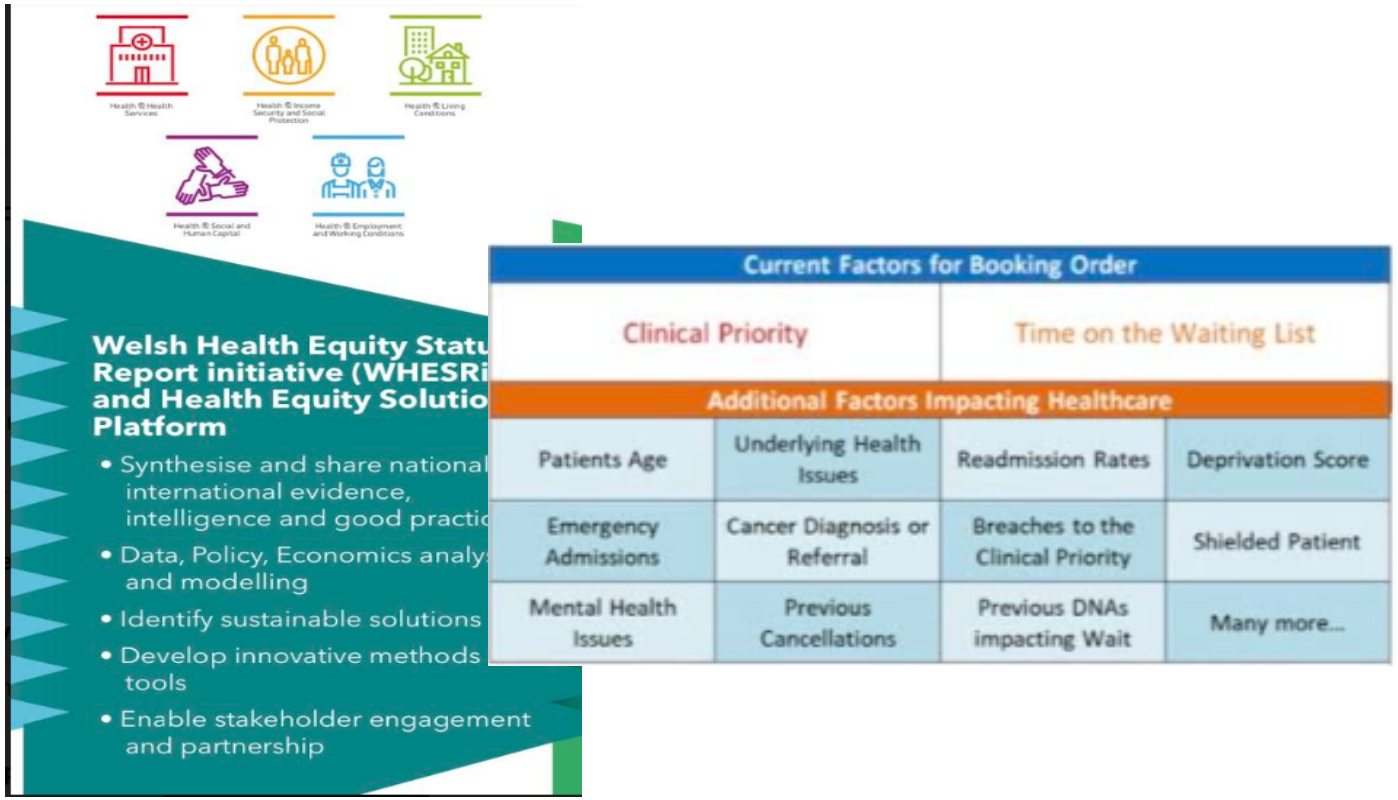
- Create skilled staff, networks and communities of practice
- Identify local champions who can problem solve and sustain others' skills
- Provide the tools to take VGC work forward (toolkits and case studies)
- Recognise good practice overtly and reward those who are already delivering and 'committing to the cause'

Provide toolkits, a champion role, networks and a communities of practice

Support teams to improve health and transform care through VGCs with the following:

- Champions and clinical leaders to spread the word and support uptake across departments or health boards
- Facilitator workforce to support group clinic spread
- VGC consulting skills for clinical staff to communicate with groups and work online
- Communities of practice and networks to share resources and stories of good practice, support current staff and initiate new VGC models
- Co creation of maximum two-page case studies with those committed to leading VGC work on VGC model how has helped deliver simple care in specific outpatient services, noting the benefits to all involved. Share case studies through communications teams and professional networks to highlight the innovation opportunities

9. Review the impact of VGCs on equity and inclusion



Scope VGC equity and inclusion concerns:

- Follow-up with pioneers to ensure that VGCs have been ethical and fair, and digital inclusion is built i into their design
- Utilise Equity Impact tools to ensure this can align with other equity analysis activities within the organisations

10. Consider further evaluation

Consider evaluation of:

- The role of and how the intensive support package adds value. Was this used for confidence building or practical support, or both?
- The next phase when VGCs are framed as a ‘business as usual’ option, and evaluating the implementation of the nine recommendations above
- The impact of VGCs on the invisible aspects of work and care and how the shift in focus of power in the group clinics towards patients influencing patient, clinician and system behaviours manifests itself over time