Harnessing Group Clinics to Deliver the NHS Ten Year Plan

Executive Briefing

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Executive Summary

This Executive Briefing has been produced by the NHS England Group Clinic Task and Finish Group for those tasked with delivering the ambitions of the Government's 10 Year Health Plan.

It sets out what Group Clinics are and importantly, how they will help deliver the three shifts desired by government, namely: hospital to community; analogue to digital; and sickness to prevention.

What are group clinics?

A Group Clinic (also known as Group Consultation or Shared Medical Appointment) is a 90-minute clinical appointment focused equally on delivering planned clinical assessments and reviews and on empowering self-management and lifestyle change. For example, reviewing lifestyle and pharmacological management of high blood pressure and high cholesterol across Core20PLUS populations.

Patients consent to participate and to share medical information, including biometrics, in the group. Group Clinics usually replace one to one appointments. They can be delivered face to face or online. No new investment in digital technology is required to deliver Video Group Clinics (VGCs). Conferencing platforms commonly used in the NHS are safe, secure and effective.

The Group Clinic methodology is grounded in coproduction. A clinician and a non-clinician co-facilitate the group. Patients set the agenda and contribute as equals and valued peer experts. The facilitator shares the group's biometrics to support the clinical assessment or review. A topic board focuses group discussion. Patients compare their results with the optimum range. This helps them to articulate informed questions and concerns. The clinician joins and supports collective discussion of shared questions and concerns. Then they complete a personalised clinical assessment or review with each individual, covering discussion of their biometrics, prescribing of new or adjusting of existing medication, referral where required, and provision of tailored advice and care planning. Everyone in the group listens and learns vicariously from others' one to ones. Following the clinical session, the facilitator supports the group to reflect and set goals. The group then provides feedback for the delivery team to support their continuous improvement and reflective practice.

Group Clinics have been recognised since The GP Forward View as a service innovation worthy of development (NHSE 2016). To date, no sustained national spread programme has been in place. Currently 14 ICBs fund implementation support. The aggregate support commissioned is for a total of 80 GP practices; on average just under 6 per ICB.

How Group Clinics support delivery of the 10 Year Health Plan

The potential of the Group Clinic model to deliver the Ten-Year Plan is set out below.

Shift 1: Hospital to community

- **A vehicle for integrated neighbourhood team working:** Group Clinics enhance and support multidisciplinary working (Graham et al 2021, Lynch 2022). Integrated neighbourhood teams can harness Group Clinics to shift care out of hospital and deliver a range of multidisciplinary, integrated care pathways across neighbourhoods

- **Time efficiencies and productivity gains.** Based on published research (Gandhi et al 2019), in a GP practice with a list of 10,000 patients, switching 50% of planned reviews to Group Clinics would release 1,400 hours of clinician time and over 8,500 one to one appointments per annum

- **Reduced waiting times:** audit of waiting times for community-based specialist Long COVID services at the peak of demand for this pathway in 2022/23 found waiting lists reduced from up to 3 months to less than 2 weeks following the introduction of video group assessments (VGAs). In general practice, introducing Group Clinics for those newly diagnosed with Type 2 Diabetes has reduced waiting times from 2 months to 2 weeks.

- **A way to expand existing capacity:** primary care teams that have embedded Group Clinics report that they have managed a 20% increase in Type Two Diabetes caseload with the same clinician resources.

Shift 2: Analogue to digital

- **A promising way to embed digital care models:** during Lockdown, NHS England's Nursing Directorate led the mobilisation of VGCs across primary care in England. The VGC programme supported teams to: set up digital infrastructure, gain colleague buy in, develop a workforce of patient facing online facilitators and put in place administrative and operational processes to manage known risks, including protecting online privacy and confidentiality (Papoutsi et al 2022). Over 700 teams self-selected to engage and were trained between June - October 2020. Evaluation found that 34% of teams reported that they planned to continue with VGCs (Scott et al 2023). The TOGETHER 2 Study (Papoutsi et al 2024) is further evaluating use of video and hybrid group clinic models for chronic conditions in general practice, with an emphasis on the experience of peer-hood and peer support and the different types of hidden work performed in relation to Group Clinics to understand where and how they could add most value from the perspective of healthcare practitioners as well as patients. Publication is anticipated later in 2025. Furthermore, different virtual group models are emerging, including virtual engagement and virtual group education events where 100+ people attend. As part of the shift from analogue to digital, it will be important to further explore their impact and evaluate their impact and evaluate the different approaches to delivering group models and their use cases. Additionally, to mitigate the risk of digital exclusion and avoid compounding healthcare inequalities, we must understand how to ensure virtual group models can be designed and implemented in an inclusive and user-centric way, and in particular understand user needs and how to best support effective adoption in areas of deprivation, while also ensuring face-to-face (F2F) alternatives are available to meet the diversity of needs.

- **A digital skills accelerator:** VGC independent evaluation and a recent ICB learning review highlight that working in VGC impacts on the whole team's and in particular, upon nurse confidence to undertake virtual clinical work (Lynch 2022, NHS Kent and Medway 2024).

Shift 3: Sickness to prevention

- **An enhanced, more personalised experience for patients** who perceive the Group Clinic experience as validating, higher quality care. They report improved quality of life and greater sense of trust in their clinician after Group Clinics compared to one-to-one appointments (Wadsworth et al 2019)

- **Support health-related behaviour change:** The group dynamic is recognised within behavioural science to support behaviour change. This is supported by in a pre- and post-test quasi experimental design study, authored by Dickman et al (2011) that found a significant increase in exercise time amongst all patients – and men in particular - post Group Clinic compared to pre-Group Clinic achievements.

- **Time for prevention, personalisation and lifestyle change:** Evaluation in English primary care settings found that Group Clinics facilitate prevention, personalised care and a lifestyle medicine approach to clinical practice by creating time for discussion and reflection in the group appointment, whilst saving clinician time overall (NHS Kent and Medway, 2024).

- **An enhanced experience of care for clinicians and their support teams:** preventing burnout and enhancing staff wellbeing is key to the prevention agenda. Staff report that delivering group clinical care is more personalised, less repetitive, that they learn a lot from their patients and that team relationships deepen (Graham et al 2021). There is also emerging evidence of positive impact on nurse retention (Lynch 2022).

Building on the Task Group's knowledge and experience, we recommend that:

- A subject matter expert (SME) is appointed by NHS England. Their role should include: driving pan-directorate and wider stakeholder (e.g. royal colleges, regulators, professional and patient bodies) collaboration, collating evidence and emerging applications of group based care, increasing policy makers' understanding of the evidence and the potential of Group Clinics and other emerging group-based care models to support delivery of The 10 Year Plan, and to advise ICBs on how to spread the model in a cost-effective, joined up way

- The spread model is co-produced with expert patients who shape it through their lived experience

- The spread model is informed by published research and best practice gathered since 2020 into the barriers and enablers of Group Clinic mobilisation within clinical teams, primary care networks and ICBs

- Every ICB nominates a named Clinical Champion to support Group Clinic spread so that the National SME lead can support ICBs to understand the emerging and known benefits of the model and has a clear communication pathway to cascade best practice insights

- ICBs are supported to build quality improvement, change management and leaderships skills to spread, embed monitor uptake of the Group Clinic model across primary, community and specialist care settings as part of improvement work to monitor the realisation of benefits and shift from hospital to community, primary care development and the shift to prevention

- A pipeline of Group Clinic evaluation and research supports and enables the effective spread of Group Clinics and assures a pipeline of innovative applications of the model. This includes, for example, a pipeline to support elective care reform, address inequalities, support return to work, support people being prescribed GLP-1 medication

- A National network of expert peer mentors who have already mainstreamed Group Clinics and an active community of practice is developed and facilitated to support both those already involved in Group Clinics to expand their group clinical practice and to support new adopters to accelerate their progress and embed the model

- Commissioners ensure there continues to be Group Clinic Training available to support knowledge and confidence in clinical, facilitation and administrative processes for capability building for our teams across primary, community and secondary care.

- Group Clinics are encouraged as an exemplar of innovation spread by reviewing historic progress over 10 years, developing the evidence base further and building on the learning to date to accelerate adoption of the Group Clinic innovation as part of 10 Year Plan

- Existing programmes linking to Health and Growth Accelerators, PCN test pilots, integrated neighbourhood pilots and elective care reform pilots include the exploration of Group Clinics as a potential solution

- There is exploration of the use of digital technology to optimise Group Clinics administrative processes and use of Ambient Voice Technologies.

Background

"..We may think that we are spreading the word in the best way, but the patients may not be receiving it the way we would like them to receive it….I felt this was an open way of talking and motivating, energising and empowering - and to see that play out directly in front of us – and having the gift of time … " GP, Kent and Medway 2024

The idea of providing care for patients in a group appointment instead of one-to-one has been around since the 1940's when group therapy and related group methodologies emerged.

In the 1990's, inspired by his personal experiences of group therapy, Noffsinger recognised that the benefits of the group dynamic would hold true in a purely medical appointment and developed the concept of shared medical appointment (SMA) model (Noffsinger, 2013). This term is still widely used in the research literature although not in clinical practice in England where the terms Group Clinic and Group Consultation are the most frequently used terms (Scott et al 2023).

Historical and current policy drivers

Group Clinics have been recognised by NHS England (NHSE) as a valuable practice improvement since the 2016 **GP Forward View**

Making Time in General Practice (Clay and Stern, 2015), a review commissioned to inform the development of Forward View policy, recommended their adoption. Group Clinics were subsequently cited as one of ten high impact actions to transform general practice. Despite this National commitment to the model, no support was provided to enable general practice to adopt Group Clinics until 2020.

In 2020, as part of **A Ten Point Action Plan for general Practice Nursing,** NHSE's Nursing Directorate recognised the value of Group Clinics, commissioned and developed the National Video Group Clinic (VGC) Learning Programme. This was launched as part of the COVID-19 response.

After scoping the risks associated with delivering care in VGCs, NHSE provided Nationally approved processes to manage known clinical and information governance risks. Since 2020 there have been **standardised risk management procedures** for clinical teams to adopt, including: how to gain verbal consent to participate and maintain confidentiality in both face to face (F2F) Group Clinics and VGCs and how to establish patients' location and identity without compromising privacy. These latter two processes are only necessary in VGCs.

The programme team also collaborated with NHS Resolutions to assure indemnity cover for the clinical work undertaken in Group Clinics within the Clinical Negligence Scheme for General Practice (CNSGP). In 2020, NHS Resolutions indemnified clinical work undertaken in Group Clinics (F2F and VGC).

The VGC Programme team addressed critical barriers to the widespread adoption of the Group Clinic model and accelerated the spread of Group Clinics significantly. Between June and October 2019, over 700 GP practice teams engaged with and received training in how to mobilise and run VGCs. The programme was also recognised as an exemplar of best practice, receiving two Health Service Journal Partnership Awards for Best Education Programme for The NHS and Most Effective Service Redesign in 2021.

Furthermore, this programme and others generated well over fifty published case studies of Group Clinic application across a wide range of pathways in English and Welsh primary, community and specialist care settings.

The learning from the VGC Programme has been made available to primary care teams since 2020 here: **Future NHS**. Once logged in, follow this link to the VGC Hub: https://bit.ly/nhsvgchub

A free E-Learning for Health programme was also commissioned as a legacy output. This is available **here** and covers the basics of the VGC process and risk management:

In 2023, Group Clinics were cited within **Modern General Practice** guidance (described as 'shared medical appointments' in the guidance) as an example of improving and personalising care related processes for long-term conditions. As illustrated in Appendix One, and based on published evidence, Group Clinics offer a way of releasing primary care clinician time and improving access to planned care, in particular for supporting improved health literacy and increasing supported co-management for people living with long term conditions where prevention, continuity and proactive care are key to success.

Currently it remains down to individual general practices or primary care networks (PCNs) to invest in and drive the change.

The **Women's Health Strategy** pledges to improve information and access, ensure women's voices are better heard and reduce disparities. The **Women's Health Hub Core Specification** highlights the opportunity to use Video Group Clinics (VGCs) and virtual engagement events (VEE) to improve access and quality to deliver the Women's Health Strategy and person centred women's health care.

NHS workforce wellbeing has a strong women's health focus because those born female at birth account for 75% of NHS workforce. Improving their health and wellbeing ties in with the Retain element of the **People Plan** and supports the 3 shifts that the NHS needs to make over the next 10 years. Furthermore, every £1 invested in women's health services delivers an £11 return (Gorman and Langham, 2024) and every £1 spent on NHS staff treatment results in a £5 in cost saving (NHS Staff Treatment Access Review Data, 2024).

The Workforce Education and Training Directorate has established two cohorts of exemplar organisations that have bundled interventions evidenced to support retention, including support with menopause. This approach is to be scaled up in primary care. The Directorate's Menopause Lead recognises that Group Clinics can hugely support delivery of workforce focused wellbeing programmes. The team sees the Group Clinic model as a highly productive way of improving delivery of NHS staff wellbeing interventions. Giving NHS staff the opportunity to participate in a Group Clinic that aims to improve their own wellbeing will also engage NHS people with this emerging care model so that they recognise the benefits for NHS patients and understand how the process works. This will help to accelerate adoption.

Building on existing menopause group clinical practice developed across England, they would like to see group clinical support and care for NHS women living through menopause put in place initially, with the model scaled to support NHS women across the life course to manage other common conditions such as menstrual health and endometriosis. They anticipate that application of the Group Clinic model will reduce absenteeism, increase presenteeism and improve staff productivity and retention.

Group Clinics also support leadership development, especially amongst nurses, allied health professionals, clinical pharmacists and personalised care practitioners. Those who lead the introduction of Group Clinics report that doing so helps them to develop their leadership skills and make full use of newly acquired coaching and lifestyle medicine qualifications (Lynch 2022, NHS Kent and Medway 2024).

Group Clinics are a key enabler of patient empowerment. They align with the personalisation agenda and the ambitions of **Working in partnership with people and communities**. They reduce social isolation and foster a genuine sense of community. They provide permission and enable patients to co-produce clinical care with clinicians and peers with similar lived experiences. Evaluation has

identified that they build social capital in the clinic room, empower patients and provide a sustainable way to embed personalisation (Lynch, 2022). For these reasons, The People and Communities Directorate is interested in exploring their potential as an enabler of coproduction at scale in line with **Working in partnership with people and communities**.

The Technology Enabled Improvement, Elective Recovery and Outpatient Programme has commissioned 4 ICBs to undertake pilots of group clinic use in outpatient settings and explore the use of Group Clinics as part of initiatives to improve access, reduce waiting times and reform elective care. The team has also developed a resource page on Future NHS:
Group Consultations in secondary care - Digitally Enabled Outpatients - FutureNHS Collaboration Platform

One of the sites is NHS Devon ICB. The Nursing Directorate have also invested in supporting this ICB so that both directorates can collectively explore the benefits of taking an integrated approach to spreading Group Clinics. This collaboration has also enabled the learning and best practice developed by the Nursing Directorate's VGC Learning Programme to be shared with the Technology Enabled Improvement, Elective Recovery and Outpatient Programme so that they could build on existing best practice and accelerate their progress.

The One Devon System Group Clinic Spread Programme is live currently and working with 7 primary care networks and 6 outpatient teams to explore the challenges and opportunities that Group Clinics offer to deliver change and improvement across an ICB. Figure one below summarises the benefits realisation framework for the programme:

Figure one: One Devon System Group Clinic Programme: benefits realisation framework

Independent evaluation of the programme has been commissioned from University of Keele. The South-West Health Innovation Network is also engaged with a view to capturing system learning to disseminate beyond NHS Devon.

The recently published plan **Reforming Elective Care for Patients** highlights the potential of "collective care models" and states that NHS England will set out a consistent clinical model of 'collective care' approaches by September 2025.

Recognising that these are not currently commonplace across the NHS, and can be more convenient for patients and carers and more efficient for staff, as well as providing the opportunity for peer support, it lists several examples:

- Group appointments, where patients with long-term conditions are supported together, either in-person or remotely
- Clinics where patients can be assessed and diagnosed or reviewed on the same day
- 'Super Clinics', where a wider range of clinicians working at the top of their licence are responsible for seeing patients while being overseen by an accountable consultant

NHS South-West Region has recently launched the first pioneer programme to explore the use of Group Clinics on community nursing workflows across five different pathways. Funding for this programme was provided by NHSE's Nursing Directorate. The programme is up and running and due to report in Autumn 2025.

The Behavioural Science Unit is interested in spreading Group Clinics because it understands that behavioural change is really challenging for most people, and that Group Clinics maximises time spent with clinicians, and introduces the design principle of peer-to-peer support, which enhances accountability for change. The team is also supporting an accelerator programme led by the Director of Strategy, which is scoping the NHS's contribution to economic activity. Three ICBs have been selected as **Accelerator sites.** Group Clinics have been highlighted to the Accelerator sites as a potential solution that these ICBs can explore to deliver change and improvement at scale.

The NHSE Obesity Prevention Programme recognises the importance of group-based weight management interventions currently integrated at various stages of the pathway. These interventions strengthen the weight management pathway. Participants often benefit from shared experiences and encouragement from peers. Current examples include: local community groups, locally commissioned services, and online peer support groups via the NHS Digital Weight Management Programme.

Furthermore, NICE guidelines highlight the importance of considering individual preferences when recommending behavioural interventions for overweight and obesity management, whether in individual or group settings. **Weight loss programmes may be best delivered to groups - NIHR Evidence**

The Healthcare Inequalities Improvement Programme wants to explore and understand how Group Clinics empower patients from Core20PLUS groups, and whether Group Clinics offer greater choice and control over how and where disadvantaged communities access NHS support.

This may mean delivering Group Clinics in accessible community venues - not just in clinical settings, and aligning Group Clinics with community language initiatives.

Because they can be delivered in non-clinical settings, Group Clinics lend themselves to the "one public estate" model and approach, and support the development and maintenance of the "community estate assets" that integrated care systems are seeking to consolidate through their emerging infrastructure strategies. Facilitating delivery of services closer to home and in these more familiar settings may contribute to a reduction in inequality by better engaging those who feel uncomfortable in traditional clinics.

To mitigate the risk of digital exclusion and avoid compounding healthcare inequalities, it is important to understand how virtual group models can be designed and implemented in an inclusive and user-centric way, and in particular to understand user needs and how to best support effective adoption in areas of deprivation, while also ensuring face-to-face (F2F) alternatives are available to meet diversity of need in line with **NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion**. The team recognises that further research and evaluation is needed to explore how those who face health inequalities view and engage with the Group Clinic model, and whether Group Clinics could help to overcome mistrust that is a common barrier to engagement with health and other statutory services.

The whole NHS is on a continuous drive to improve productivity. **The Smarter Spending in Population Health Programme** (Smarter Spending) highlights that Group Clinics show potential to become central to this drive, given the efficiency gains they deliver for clinicians and their support teams across all sectors. The Health Economics Unit calculates that allocating 10%, 25% and 50% of the time spent on annual reviews in general practice could lead to 11%, 28% and 56% more people being reviewed respectively (Health Economics Unit, 2023).

The evidence also shows that Group Clinics support multidisciplinary working (Graham et al 2021, Lynch 2022). This makes the model a highly sustainable way to build integrated neighbourhood teams that simultaneously realises productivity gains and builds system capacity and capability to deliver integrated care in primary and community settings.

This overview of historical and current National activity illustrates that there are already many different directorates within NHS England that have recognised the value of the Group Clinic care model and are already independently considering how to further develop and mobilise the approach. The National VGC Learning Programme mobilised during COVID Lockdown clearly demonstrates that Group Clinic spread work that is Nationally enabled and locally led is more efficient, impactful and enables the lessons learnt in one part of the system to be transferred widely.

In recognition of this, The Task and Finish Group was established in December 2024 to improve and accelerate NHSE's impact and provide a forum for an orchestrated approach to Group Clinic spread.

Current state of Group Clinic spread at ICB level

In the absence of a clear National imperative to adopt and a programme of work to support adoption and spread, Group Clinics have followed the Roger's Innovation Diffusion Curve (2003) over the last 10 years. Since 2016, when policy first highlighted their benefit, there has been a gradual spread, mainly amongst general practice innovators and early adopters. Because there is no National imperative, no data is currently collected around general practice activity linked to implementing Group Clinics and so it is impossible to say how many practices are currently using the Group Clinic approach.

One surrogate measure that may provide some insight is tracking whether integrated care boards (ICBs) have historically offered or are currently offering implementation support to general practice or other teams wanting to adopt the model. Figure two summarises in green the ICBs that have offered funded implementation support since 2021. Figure three summarises in green the 14 ICBs who are currently offering funded implementation support in 2025 to primary care teams. The total number of teams that this support covers is estimated at 80 primary care teams.

Figure two: Funded support for primary care teams to adopt Group Clinics 2021 – 2024

ICBs shaded in green have offered primary care teams funded support for at least 1 year between 20/21 and 23/24. Those shaded in yellow did not fund support during this timeframe.

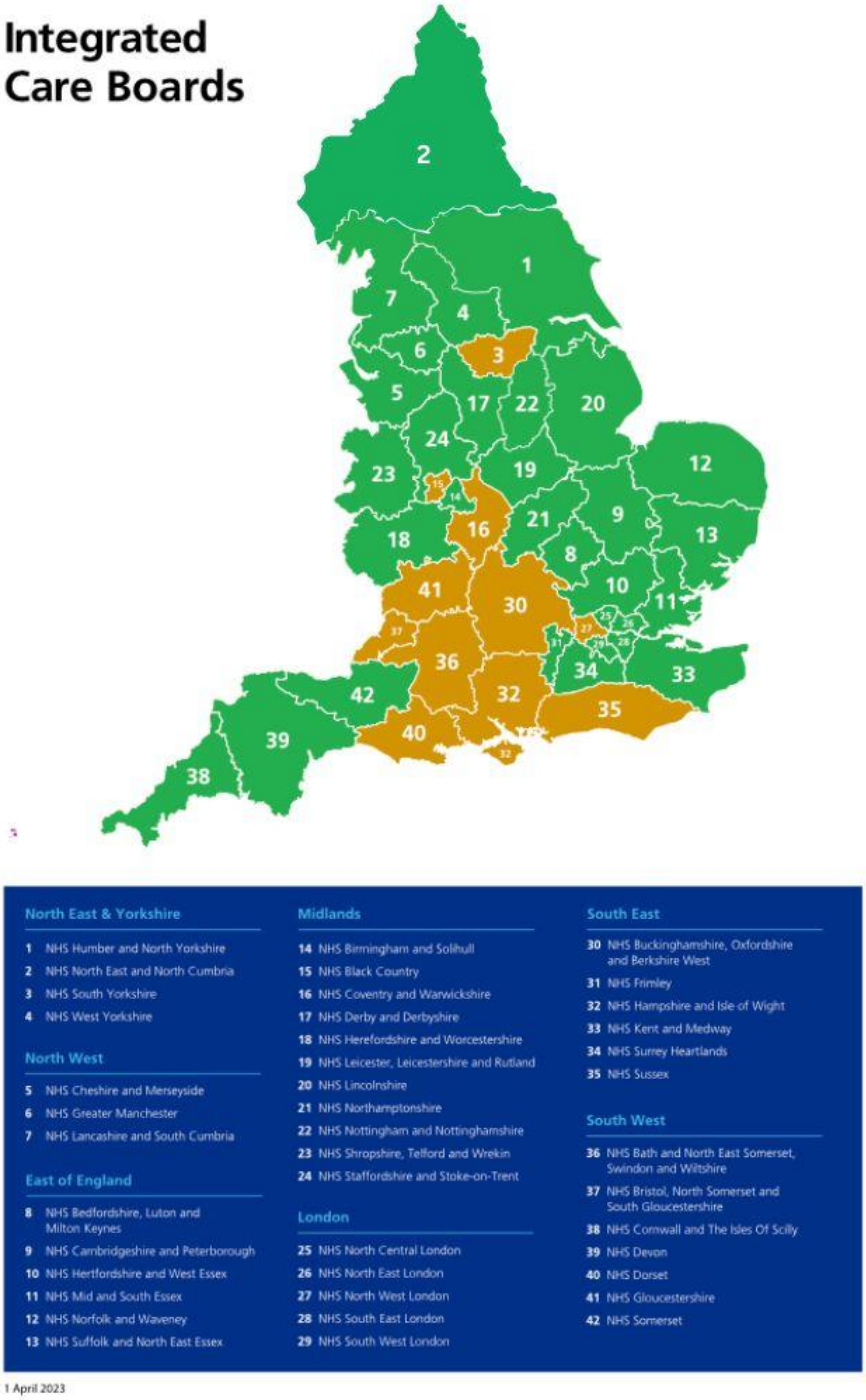
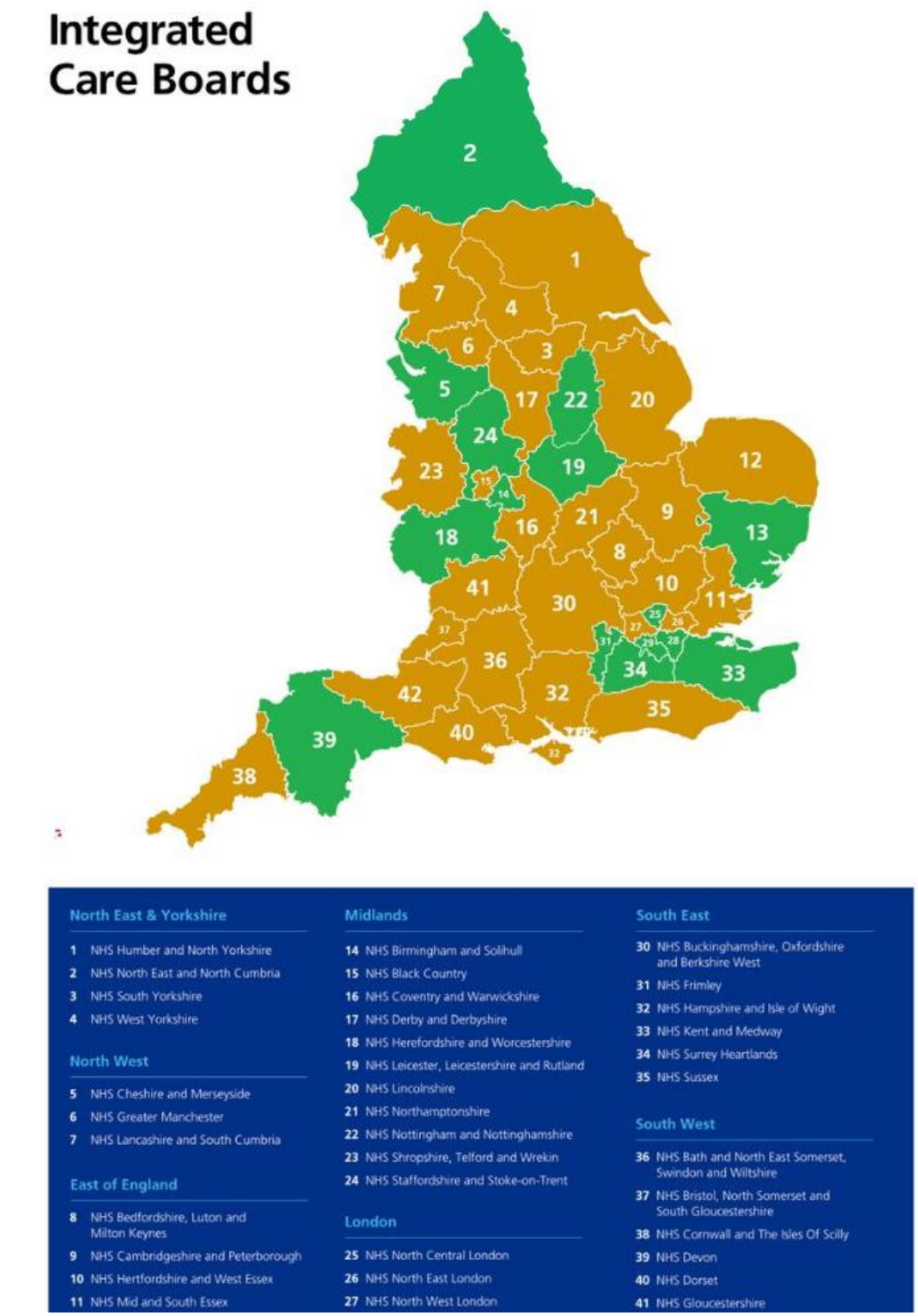


Figure three: Funded support for primary care teams to adopt Group Clinic model 2025

ICBs shaded in green have offered primary care teams funded support in 24/25. Those shaded in yellow have not offered funded support in this timeframe.



How Group Clinics work

"… I mean I love doing Group Clinics because I think as long as we can maintain it, then (when) it comes to the one-to-one sessions and it's 'how have you found it?' In a way, for me, it's like setting up my own group of patients because I can say, 'how's it going? What did you feel? You've done really well'…"

General Practice Nurse, Kent and Medway, 2024

What are Group Clinics?

Group Clinics are an alternative way of undertaking planned health checks, assessments, reviews and follow up appointments in primary, community, and specialist care settings – including outpatient settings. They can be harnessed to support triage, validate waiting lists and provide pro-active care to families in the community and support to those joining long waiting lists so that they wait well.

As well as Group Clinic models led by clinicians, Group Clinics can also be led by personalised care practitioners, including health coaches and social prescribers. Group Clinics help personalised care teams to expand their reach, reduce waiting times, manage case load productively and harness the power of group dynamic to support people to sustain life changes e.g. return to work, weight management, overcoming depression and social anxiety.

A Group Clinic is a 90-minute intervention focused equally on delivering planned clinical assessments and reviews, and on empowering self-management and lifestyle change.
Patients consent to participate and to share medical information, including biometrics, in the group. Group Clinics usually replace one to one appointments.

The Group Clinic methodology is grounded in co-production. A clinician and a non-clinician co-facilitate the group. Patients set the agenda and contribute as equals and valued peer experts. The facilitator shares their biometrics to support the clinical assessment or review. A topic board focuses group discussion. Patients compare their results with the optimum range. This helps them to articulate informed questions and concerns. The clinician joins, supports collective discussion of shared questions and concerns. Then they complete a personalised clinical assessment or review with each individual, covering discussion of their biometrics, prescribing of new or adjusting of existing medication, referral where required, and provision of tailored advice and care planning. Everyone in the group listens and learns vicariously from others' one to ones. Following the clinical session, the facilitator supports the group to reflect and set goals. The group then provides feedback for the delivery team to support their continuous improvement and reflective practice.

Characteristics of the group clinic model in England and Wales

- Replaces a one-to-one appointment
- Team delivery, with a non-clinician facilitating and supporting the health professional with management of the group clinic process, including documenting, and ensuring that all appropriate clinical work is completed.
- Grounded in co-production. Patients set the agenda at the start of the group clinic and are valued as experts in their own care.
- Sharing of key biometrics and prompted key topics so that patients can compare their numbers with optimal levels and with their peers and articulate informed questions and concerns for discussion when the health professional joins.
- Usually a 90-minute clinic, incorporating a 45-60 minute clinical session led by a registered health professional: doctor, nurse, allied health care professional, pharmacist
- Includes clinical intervention or a review including: review of vital signs measures or laboratory results, prescribing of new medication or dose adjustments, and provision of clinical advice delivered through:
    - Group discussion of common concerns and key topics and biometrics, which facilitates exchange of shared experiences and peer to peer advice and learning. Building on what the group already knows, the health professional tops up only when required from their expert knowledge.
    - One to one reviews with each patient within the group so that the clinician can personalise advice and treatment and peers can listen and learn from each other's treatment review, and support with suggestions and lived experiences to enhance self-management.
- Either F2F or VGC, depending on local circumstances, patient needs, preferences, and primary care estate limitations
- A focus on empowering and supporting patients to engage in proactive self-care and self-management.

How do Group Clinics work?

Group Clinics can be delivered both on video (VGC) or Face to Face (F2F). No new investment in digital technology is required to deliver Video Group Clinics (VGCs). Conferencing platforms commonly used in the NHS are safe, secure and effective.

6-10 patients usually attend VGCs. 10-12 and up to 15 patients attend F2F.

A Group Clinic lasts around 90 minutes. The clinician is usually present around half the time (45-60 minutes), depending on the number of patients in the group and how the session unfolds.

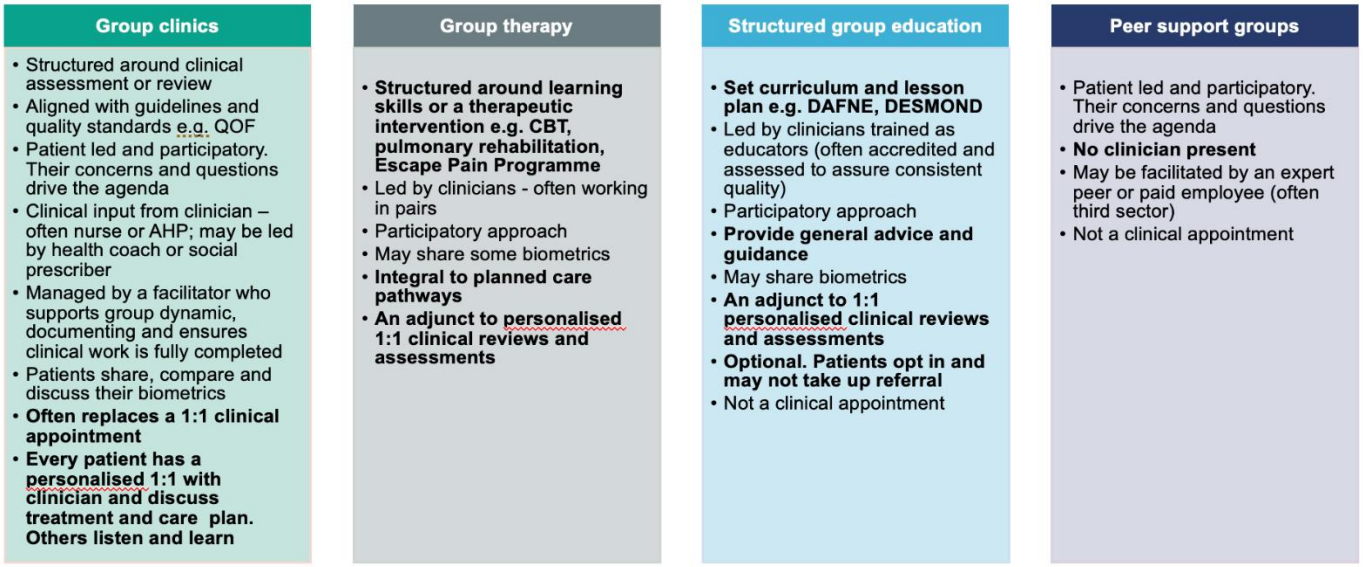
Please watch this video to hear first-hand from staff and patients how F2F Group Clinics in primary care run and stories of impact:

Watch this animation to understand how VGCs flow:

Structured Group Education: is it the same or different?

Often people confuse Group Clinics and structured Group Education.
Figure Four below summarises the key differences in four different approaches to group-based care and support commonly provided in England:

Figure four: types of group-based care in England



How clinical teams harness Group Clinics in England

Hayoe et al (2017) identified a wide range of pathways where F2F group clinics had been trialled. Jones et al (2019) mapped group clinics across the human lifecycle and identified current use from pregnancy through to elder care.

Scott et al (2023) found that the most prevalent applications of VGCs during and after the COVID-19 response in England were: diabetes (27%), weight management (17%), cardiovascular (12%) respiratory conditions (12%), mental health (9%), musculoskeletal conditions (9%), pain management (8%), Long COVID (5%), cancer care (1%) and cardiovascular (12%). Papoutsi et al (2022) found VGCs were used in similar pathways and in addition, noted their application in postnatal care, and to support healthy eating.

In recent years, clinical teams within general practice and specialist settings have explored the use of Group Clinics to support women to explore their symptoms of menopause, to make lifestyle changes and informed decisions about hormone replacement therapy and other medical treatment options. The research supporting the menopause Group Clinic model is emerging. Feasibility of menopause VGCs has been proven (Gibson et al 2022).

Lynch's independent evaluation (2022) examined and stratified clinician activities within the Welsh VGC Programme. She classified the complexity of the clinical work undertaken, using Christensen's framework (2000). The VGC models selected and developed by outpatient teams in Wales fitted within Christensen's definition of "Simple Care". This describes simple clinical work as being planned and routine, driven by guidelines and protocols and thus relatively low risk and where a high degree of self-efficacy is needed from patients to improve outcomes.

In all cases, the self-selected Welsh outpatient group clinic models were nurse or allied health professional led. Lynch's findings and classification aligns with the applications of Group Clinics self-selected by primary care teams during and after the COVID-19 response (Scott et al 2023, Papoutsi et al 2022)

Figure Five:

This insight enables system leaders to understand where the Group Clinic model may work best. They have a clear role in delivering high volume, low acuity clinical care and will add value where there is a need to support prevention, improve self-management and embed lifestyle change. This is the remit of integrated neighbourhood teams.

Innovations in group-based care

Building on the basic Group Clinic model, front line early adopters are exploring hybrid models that combine aspects of both Structured Group Education and Group Clinics.

For example, primary care-based specialist diabetes nurses run Group Clinics for newly diagnosed diabetics that cover many of the same topics included in structured education programmes because doing this in a group reduces repetition for the nurse in one-to-one appointments and creates time for exploration of the challenges around sustaining lifestyle change with peer support. The Group Clinic

deepens everyone's understanding of the long-term implications of the condition, makes patients feel validated and less isolated and more able to come to terms with their new diagnosis.

In some cases, primary care specialist nurses work with diabetes patients over several sessions so they get a head start with their self-management journey and feel empowered to take control early on. This Group Clinic model can also instil hope amongst newly diagnosed people that they can reverse their diagnosis, especially when they get the chance to meet peers who have achieved this.

In City and Hackney, the community-based obstetrics and gynaecology team have used group-based care and support to engage people who are curious to learn more about menopause and thus manage and stem demand for appointments. They have pioneered the concept of Virtual Engagement Events (VEEs). The purpose of the VEE is to provide general education and guidance, answer general questions and signpost resources and services. VEEs are information and advice sessions not clinical appointments. They are conducted without access to the medical records and no attendance records are kept. In City and Hackney, the VEE is the first step in the pathway and addresses concerns about menopause. Clinical leads recognise that VEE could also be used to address other common reproductive health issues that are relevant for a large proportion of the population like: menstrual problems, incontinence and fertility issues. Evaluation found that 82% of patients who attended the VEE self-selected not to attend for a clinical appointment and more individualised care that was on offer in the form of a follow up video group clinic (VGC). This pilot indicates the potential power of VEE interventions as a demand management tool for both primary care and specialist services across a place or neighbourhood.

Other front-line teams have co-created or are currently working on the development of group based first contact sessions within their clinical pathways. These sessions may be scheduled shortly after people join a waiting list or shortly before they attend their allocated one to one appointment. They are different from VEE because people are specifically invited by the service and clinicians have access to the person's medical record.

At these group advice and guidance sessions, clinicians induct people into the pathway and support them to wait well. They share useful tips and techniques for people to practice whilst they wait to help improve symptom management and prevent deconditioning e.g. breathing or physiotherapy exercises. They provide information about what will happen at the first appointment and advice about what to do to prepare. These sessions can help to validate peoples' lived experiences of the condition early on the pathway, prepare them for and reduce fear about what will happen at their first appointment e.g. physical examination and assessment of pelvic floor prolapse. This may reduce "did not attend" rates. The sessions can also help people make sense of the severity of their symptoms so that they feel equipped and prepared for a more focused, empowered discussion at the one-to-one appointment. The model can significantly reduce repetition of advice as what is covered would otherwise need to be shared in each one-to-one appointment. It also accelerates completion of clinical work in the one-to-one as people have time to reflect on what they have heard and want to discuss in advance of the assessment or review. This model has already been successfully mobilised within Long COVID pathways. NHS Devon is also exploring the use of this model to validate waiting lists, reduce waiting times, reduce "did not attend" rates and better prepare those awaiting physiotherapy for pelvic floor prolapse.

In NHS Bedfordshire Luton and Milton Keynes (BMLK), primary care clinicians have combined access to a digital wellbeing prescription and psychological behavioural nudge programme with large scale live virtual group-based support for more than 100 patients at a time. This model is delivering comparable outcomes to NHS Talking Therapies and achieving 80% recovery rates compared to NHS Talking Therapies rates of 52%, alongside a reduction in GP appointments of 2.5-3.5 appointments per user per year. Patients report feeling significantly better and more confident in managing their own health needs. BLMK primary care colleagues also attend and participate in the programme as part of staff well-being support. They report improved wellbeing and increased capacity to remain working in the NHS. Liverpool John Moores University has independently verified and validated evaluation data.

These are just a few ways clinicians are adapting the Group Clinic model and expanding their group clinical practice.

It is still early days and there is a need to explore and test a range of ways in which collective or group-based care can be harnessed and provide all affected directorates across NHS England with the opportunity to better understand how group care can provide more productive ways to deliver time for prevention and the 10 year plan vision by harnessing both face-to -face and digital models of group care, and creating integrated pathways across neighbourhood.

The Evidence Base

"Transformative innovations in care delivery often fail to spread. Consider shared medical appointments, in which patients receive one-on-one physician consultations in the presence of others with similar conditions…… Given the effectiveness of group interventions, why aren't doctors routinely using them to treat physical and mental conditions?"

Ramdas and Darzi 2017

There is a robust research evidence base to support the use of Group Clinics that has been building for over 20 years.

It includes over 13 systematic reviews of randomised controlled trials, with the control group being people who attend one to one appointments. In 2017, Hayhoe reviewed the evidence base in the British Medical Journal (Hayhoe et al 2017) and concluded that the model offered a promising response to escalating demand in healthcare. In the same year, Ramdas and Darzi published The case of Shared Medical Appointments in New England Journal of Medicine. They called for Group Clinics to be recognised as a health service innovation that had been overlooked and was worthy of spreading and provided an enabling framework to spread this transformative innovation (Ramdas and Darzi 2017).

Since 2019, 3 evaluations have documented the spread of VGCs in England and Wales (Papoutsi et al 2022, Scott et al 2023, Lynch 2022) and 3 further systematic reviews of the international evidence have been published (Wadsworth et al 2019, Graham et al 2021, Tang et al 2024). The TOGETHER 2 Study (Papoutsi et al 2024) is further evaluating use of video and hybrid group clinic models for chronic conditions in general practice, with an emphasis on the experience of peer-hood and peer support and the different types of hidden work performed in relation to Group Clinics to understand where and how they could add most value from the perspective of healthcare practitioners as well as patients. Publication is anticipated later in 2025.

A study exploring the feasibility of Group Clinics as a way to deliver Type Two Diabetes reviews documented an increase in the percentage of patients achieving National Institute for Health and Care Excellence (NICE) recommended eight care processes in Type Two Diabetes by 18% within 12 months and a 0.5 full time equivalent reduction in nurse time to manage the practice's diabetes case load (Gandhi and Craig 2019).

The evidence continues to confirm that compared to one-to-one appointments, Group Clinics impact positively on all four elements of the Quadruple Aim.

Given that best practice approaches to safe group clinical practice are now well established, and the strength of the existing evidence base, the time is right to integrate Group Clinics into both National and local delivery planning.

Group Clinics and the Ten-Year Plan

"Based on feedback, patients were extremely happy because we add in the gift of time – time to process, time to feedback, time to ask questions – much more so than in 1:1 appointments… We had very rich conversations with our ladies. One commented, "I wish my mum had something like this (when she was going through menopause), she felt so isolated'"
General Practitioner, Kent and Medway ICB 2024

Group Clinics impact on both quantitative process metrics, including access and waiting times, and on softer quality of care measures such as trust, patient empowerment and staff autonomy.

Since 2020, and despite rapidly growing evidence of Group Clinic impact, there has been no orchestrated approach to build on the evidence and realise the benefits of the Group Clinic model within the NHS. The Ten-Year Plan provides an opportunity to change this.

There are 7 recognised enablers of change to implement the **Ten Year Plan**. The Task and Finish Group has compiled key points for related to each to support those seeking to enable Group Clinic implementation.

People

The NHS needs to consider how to recruit, train and retain a workforce to meet the future needs of the healthcare system; how to support staff to shift work into the community, to work in a digitally enabled way and to focus on preventing ill health and the deterioration of people with long-term conditions.

Group Clinics have proven a powerful workforce development tool. They help specialists to work in community settings. Evaluation has shown that working in VGC builds nurses' digital skills and supports digital maturity of both individuals and the whole team, in particular personalised care practitioners and the non-clinical staff who support Group Clinic delivery. Group Clinics also support closer integrated working within practice teams and across organisations. They impact positively on staff retention and wellbeing. VGCs also support flexible home-based working (Lynch, 2022).

Many clinicians fear the idea of working with a group of patients. Reluctant to relinquish their established power base and sceptical about confidentiality and patient experience, they often need support to make the change. Peer clinician mentors and training are critical to engage them. Graham et al (2022) noted that strong leadership was key to success when introducing Group Clinics. That leadership needs to come from both clinicians and service managers because Group Clinics impact on the mechanics of clinic administration as well as clinical practice. This means that the whole team needs access to training.

During Lockdown, the National Video Group Clinic (VGC) Training programme proved a cost-effective way to support an accelerated spread. Insights from research amongst Primary Care teams in England who participated in the programme (Papoutsi et al 2022) found that interactive VGC training provided nationally in England was 'instrumental in capacity building'. Lynch (2022) similarly found that interactive VGC training and intensive support provided to pioneer clinical teams proved essential to outpatient teams making the change to VGCs in Wales.

Many of those who have successfully implemented Group Clinics have advised us that to mainstream Group Clinics, expert peer mentorship for clinicians and non-clinicians, effective training and change management support for teams adopting Group Clinics will be key to success. There is still emerging evidence to evaluate and understand better for whom and how they work best.

Widespread adoption of Group Clinics will also impact fundamentally on future workforce skill mix. Non-clinical staff facilitate Group Clinics. Taking on this role provides a great opportunity to upskill existing staff and make their work more interesting and engaging. Group Clinics are also a great training ground for those entering clinical practice, including newly qualified clinical staff and students.

Graham et al (2022) documented that building a skilled facilitator workforce was key to successful Group Clinic implementation. Those tasked with planning the future workforce to deliver the 10 Year Plan need to recognise the need for Group Clinic facilitators in the future workforce.

Finance and contracting

The finance and contracting implications of Group Clinics as an NHS service need to be explored.

Based on published evidence that shows Group Clinics support MDT working, creates time for prevention and embeds personalisation, specifying Group Clinics within incentives aligned with the 10 Year Plan's ambitions, in line with emerging evidence about what works, where, how and for whom, could be an enabler to accelerate system and integrated neighbourhood team focus on delivering prevention. Further exploration of how to optimise potential benefits of VGCs and how to harness technology to reduce effort to maximise impact and reach will be important. Teams may wish to use VGCs for specific use cases in appropriate patient cohorts, or through patient choice or convenience, for larger group events and education or to support use of patient-facing technology.

Physical infrastructure

Scaling up Group Clinics requires consideration of how healthcare infrastructure and the NHS estate needs to change to support group-based care models. Lack of suitable estate is currently a barrier to the adoption and delivery of F2F Group Clinic in all settings.

There is a need for more accessible spaces where groups of up to 20 people can meet and clinical care can happen. A growth in group care may mean that there may be less need for individual consulting rooms. The working example provided from Moatfield Surgery demonstrates that as Group Clinics scale, primary care estate needs to be modified to accommodate group clinical practice. Those future proofing the NHS Estate need to consider these potential implications.

Data and technology

The NHS wants to focus its resources to ensure it maximises the impact of data and technology. This includes how we can make life easier and more productive for those who work in the NHS, and use data more effectively to plan, manage and deliver services.

Delivering the Group Clinic model does not require any specific new technology. Existing web platforms accommodate group clinical practice.

When a National VGC learning programme was mobilised during Lockdown, follow up with participating teams found that 34% of teams reported that they planned to continue with VGCs (Scott et al 2023). The TOGETHER 2 Study (Papoutsi et al 2024) is further evaluating use of video and hybrid group clinic models for chronic conditions in general practice to understand where and how they could add most value for patients and staff.

The VGC programme supported teams to: set up digital infrastructure, gain colleague buy in, develop a workforce of patient facing online facilitators and put in place administrative and operational processes to manage known risks, including protecting online privacy and confidentiality (Papoutsi et al 2022). Over 700 teams self-selected to engage and were trained between June - October 2020.

As the Group Clinic model matures and is widely adopted, there are opportunities to integrate the use of technology to support people to self-manage and monitor their health. To date, little work has been undertaken to explore this interface.

Technology can also minimise workload related to administration of the Group Clinic invitation and follow up process. In their systematic review, Graham et al (2022) found the most cited challenge to implementing F2F Group Clinics was setting up administrative processes associated with the change.

SNOMED codes for Group Clinics are already embedded into GP clinical systems. Work in NHS Devon ICB has identified how to adapt EPIC to support delivery of Group Clinics. There is an opportunity to digitalise further elements of the administrative processes to smooth the adoption of Group Clinics across NHS settings.

Data collection at National level, documenting uptake of Group Clinics will also be key to monitor the success of adoption strategies and incentives.

Research, life sciences and innovation

Group Clinics remain early in the innovation adoption cycle. The spread of Group Clinics would be a great test bed for evaluating how effective the Ten-Year Plan proves as a vehicle to speed and scale innovation.

There is 10 years of baseline data to show what has been achieved when adoption is left to the local systems without National leadership and direction.

Professor Lord Ara Darzi, who is co-chairing this working group, published a New England Medical Journal paper in 2018, making the case and setting out a framework for scaling Group Clinics as transformative innovation (Ramdaz and Darzi 2017).

The Task and Finish Group suggests that Group Clinics should be studied as an exemplar of spread. It invites those working on innovation spread to join its work and explore the opportunity to accelerate adoption of the Group Clinic innovation.

Accountability and oversight

Group Clinic governance and indemnity is approved and therefore ready to scale.

To successfully mobilise Group Clinics, it will also be important to create financial incentives to adopt this way of working. Evaluation of the Welsh VGC Programme recognised that time was a currency and backfill was needed to attend training, plan and mobilise the change (Lynch 2022).

It will also be important to recognise Group Clinic appointments as at least equal to one to one appointments within tariff and contracts.

Mobilising change

Those considering how best to mobilise change have the benefit of being able to compare the impact of a Nationally led approach with a locally led approach to spread and adoption. In 2020, a Nationally led Group Clinic programme saw 700 GP practices volunteer to participate in Group Clinic Training between June and October 2020. Since 2020, progress has been much slower and because it is not seen as a national priority, investment in driving the change has been piecemeal, as indicated by Figures 2 and 3 on pages 10 and 11.

Given the potential impact that Group Clinics can have on delivering the three key shifts, it makes sense for the balance to shift away from local and towards a Nationally driven change programme, built on a PDSA cycle. The Group Clinic model already has continuous improvement embedded within it.

The National VGC programme supported teams to: set up digital infrastructure, gain colleague buy in, develop a workforce of patient facing online facilitators and put in place administrative and operational processes to manage known risks, including protecting online privacy and confidentiality (Papoutsi et al 2022). Support covering these same challenges will be important. Expert mentors and a facilitated, vibrant community of practice will also support adoption and exploration of new applications of the Group Clinic model.

Enabling change

Building on the Task Group's knowledge and experience, we recommend that:

- A subject matter expert (SME) is appointed by NHS England. Their role should include: driving pan-directorate and wider stakeholder (e.g. royal colleges, regulators, professional and patient bodies) collaboration, collating evidence and emerging applications of group based care, increasing policy makers' understanding of the evidence and the potential of Group Clinics and other emerging group-based care models to support delivery of The 10 Year Plan, and to advise ICBs on how to spread the model in a cost-effective, joined up way

- The spread model is co-produced with expert patients who shape it through their lived experience

- The spread model is informed by published research and best practice gathered since 2020 into the barriers and enablers of Group Clinic mobilisation within clinical teams, primary care networks and ICBs

- Every ICB nominates a named Clinical Champion to support Group Clinic spread so that the National SME lead can support ICBs to understand the emerging and known benefits of the model and has a clear communication pathway to cascade best practice insights

- ICBs are supported to build quality improvement, change management and leaderships skills to spread, embed monitor uptake of the Group Clinic model across primary, community and specialist care settings as part of improvement work to monitor the realisation of benefits and shift from hospital to community, primary care development and the shift to prevention

- A pipeline of Group Clinic evaluation and research supports and enables the effective spread of Group Clinics and assures a pipeline of innovative applications of the model. This includes, for example, a pipeline to support elective care reform, address inequalities, support return to work, support people being prescribed GLP-1 medication

- A National network of expert peer mentors who have already mainstreamed Group Clinics and an active community of practice is developed and facilitated to support both those already involved in Group Clinics to expand their group clinical practice and to support new adopters to accelerate their progress and embed the model

- Commissioners ensure there continues to be Group Clinic Training available to support knowledge and confidence in clinical, facilitation and administrative processes for capability building for our teams across primary, community and secondary care.

- Group Clinics are encouraged as an exemplar of innovation spread by reviewing historic progress over 10 years, developing the evidence base further and building on the learning to date to accelerate adoption of the Group Clinic innovation as part of 10 Year Plan

- Existing programmes linking to Health and Growth Accelerators, PCN test pilots, integrated neighbourhood pilots and elective care reform pilots include the exploration of Group Clinics as a potential solution

- That there is exploration of the use of digital technology to optimise Group Clinics administrative processes and use of Ambient Voice Technologies.

Working examples from clinical practice

This chapter describes the work of six teams that have mainstreamed Group Clinics.
Five are primary care teams. One is a specialist team, delivering a community-based menopause service hosted in a Women's Health Hub.

City and Hackney Place

In City and Hackney Place, the menopause pathway is delivered by the Women's Health Hub (WHH), which is subcontracted and distinct from the specialist service. To proactively manage and stem demand for appointments in primary care and prevent waiting lists for specialist menopause support developing, the WHH team have used group-based care models to proactively engage women who are curious to learn more about their menopause and support those who are seeking clinical advice and have not yet managed to access it.

Led by Dr Sue Mann, Consultant and Clinical Lead for Women's Health, the team have pioneered Virtual Engagement Events (VEEs). The purpose of the VEE is to provide all women curious or actively seeking support with general education and guidance, answers to general questions and signposting to resources and services. VEE session mirror the VGC process and provide information and general advice only with no individualised care. They are conducted without access to medical records. No attendance records are kept. This means that they are not clinical appointments and larger numbers of women can attend. Women aged 45-55 are proactively identified through GP practice lists and invited to VEE by text.

Since the service launched in 2022, over 3,000 people have attended a VEE. The total invited population for City and Hackney Place is about 27,000. This means that 11% of the eligible population has taken up the VEE invite. Audit and evaluation found that 82% of those attending VEE did not feel that they needed to attend any follow up clinical appointment, including the VGC on offer.

At VEE, all women are invited to a follow up VGC to access more individualised care. At this point, they are registered and followed up and base line symptom and quality of life scores are recorded using the MENQUOL scale.

500 (17%) people have attended a VGC since 2022. On average, this group had had 2.7 primary care appointments related to menopause in the preceding 6 months. Clinical audit at three months found a sustained improvement in menopause symptoms and quality of life, using the MENQOL scale.

As part of the broader WHH model, menopause VEE and VGC interventions have contributed to reduced secondary care waiting times. There are also indications from feedback and audit that the service has reduced pressure on primary care. City and Hackney Place has demonstrated the potential of VEE as an efficient first contact and triage tool as well as its potential as a demand management tool across both primary care and specialist services in a place or neighbourhood. Furthermore, both VEE and VGC have provided a rich learning environment for local clinicians to improve their knowledge of menopause management as they are able to attend and observe the sessions.

The team recognise that the VEE/VGC pathway could also be used to address other common women's health issues that are relevant for a large proportion of the population like: menstrual health, fertility concerns, polycystic ovarian syndrome (PCOS) and incontinence. Pilots have already been run for menstrual health, fertility, continence and contraception. The team has recently applied for

grant funding to support transfer of learning from the specialist led service to a primary care nurse led VEE/VGC pathways addressing menstrual health and PCOS.

Moatfield Surgery, East Grinstead, NHS Sussex

The Moatfield team's group clinical practice is led by Laura Ireland. Laura is a Community Specialist Practitioner and a General Practice Nurse Prescriber. She and leads Moatfield's Nursing and Allied Health Professionals team.

The team have been running Group Clinics since 2019 and started offering Group Clinic to people with type two diabetes. They now run two Diabetes Group Clinics a week. They have 913 patients with type 2 diabetes consultations and in the last clinical year there have been 470 recorded group clinical reviews. The Clinical Pharmacist runs hypertension Group Clinics weekly. Hypertensives with Type 2 Diabetes are reviewed in their diabetes group clinic. 416 have had pharmacist le Group Hypertension Reviews. The plan is to increase to twice weekly hypertension group clinics in April 2025. The team have also introduced groups for people newly diagnosed with Type Two Diabetes. Approximately 75% now have their first appointment in a group setting.

In autumn 2023, the team introduced Chronic Obstructive Pulmonary Disease (COPD) Group Clinics. In 2024 they reviewed 133 (47%) of their 290 patients with COPD in Group Clinics. In 2024, the team started running GP-led Group Clinics for women experiencing menopausal symptoms. Expansion continues, with Group Clinics planned for NDH, and asthma reviews.

The team all report enhanced job satisfaction from group clinical practice, including less repetitive discussions and tick boxing, more meaningful partnership with patients, leading to shared decision making.

On average, the team calculates, every Group Clinics saves 2 hours of clinical time. The practice is now converting their waiting room to accommodate a dedicated private space for Group Clinics. The plan is that they will run at least two a day and to gradually switch most chronic disease management reviews to Group Clinic appointments.

Watch this video to hear what Moatfield's staff and patients think: https://youtu.be/WGY_BeiZ-Ps

Brigstock Medical Practice, Thornton Heath, South-West London

The Brigstock team's group clinical practice is led by Dipti Gandhi. Dipti is a Clinical Pharmacist and a Managing Partner. The team have been running Group Clinics since 2017. They have focused on Type Two Diabetes group reviews. Dipti and her Nurse Prescriber colleague Alyson Saunders each run one Group Clinic a week. Group Clinic is their default appointment for diabetes reviews. They currently see around 30% of all diabetics in Group Clinic.

Dipti published the results of the first 18 months of the switch in 2019 (Gandhi and Craig 2019). This documented: an 18% increase in patients receiving the 8 diabetes care processes and a corresponding rise in Quality and Outcomes (QOF) Framework achievement, a reduction in waiting times for a clinical review from 6 to 2 weeks and in did not attend rates from 11.7 to 5.94%. This equates to a 49% reduction. Whist still maintaining the same number of reviews, the Group Clinic model reduced clinician time sent conducting reviews from 8 x 3 hour one to one clinics (24 hours) to 2 x 90-minute group clinics (3 hours). The team also continued to run a 3 hour one to one clinic for those not suitable for a group. The current Group Clinic pathway requires 6 hours of clinician time and has released 18 hours of clinician time for other clinical work. Since the team introduced Group Clinics, the diabetes case load has increased 20%. Clinical audit conducted in January 2024 suggests that Group Clinics have allowed the team to maintain quality of care without increasing the staffing ratio despite a significant growth in the people diagnosed with Tye 2 Diabetes and other co morbidities. Patients continue to self-report increased knowledge of their condition and high levels of

satisfaction with their Group Clinic reviews. Clinicians' positive experiences and improvements in job satisfaction have also sustained.

Watch this video to hear what Brigstock patient's stories of impact:

Burlington Primary Care, Ipswich, NHS Suffolk and North-East Essex

Burlington's Group Clinic work is headed by Assistant Practice Manager Hollie Hart, supported by Care Co-ordinator Hailey Huynh. The team initially adopted Group Clinics when they recognised that they could not complete 20 minute one to one QOF reviews for their 1,010 asthma patients to switch them all to CFC inhalers.

They introduced F2F Group Clinics initially, shortly followed by VGCs. They have been running their asthma group review pathway ever since. They now review almost all their register of adults over 18 with asthma in either a weekly VGC (scheduled at lunchtime so people can join from work) or a weekly F2F Group Clinic (run in the Church Hall a few doors away in the morning).

The team uses Accurx to collect Asthma Control Test (ACT) scores and complete pre-consent in advance of both VGC and F2F. It is also used to confirm a password that verifies identity and to gather required location and phone contact details so they can contact the person in case of emergency during the VGC.

Whilst there was initially resistance from both patients and clinical staff, everyone is now on board now.

Most patients have had several annual group reviews so they know what to expect. Few patients question the idea of a group review three years on. In the early days, a phone discussion with Hayley who acts as both facilitator and clinic co-ordinator allayed concerns about privacy before their first group review. Knowing Hayley would be at the group was also very reassuring.

Did not attend (DNA) rates were initially high. After patients experienced Group Clinics and with the introduction of reminders, DNAs have dropped. The team also routinely over-invite, knowing a few people will always DNA.

Patients are extremely complementary. Feedback remains consistently positive. They report that the group feels very comfortable and because they get an hour with the team, they feel a lot less time pressure compared to one to one reviews.

They say they learn a lot more about their condition, asthma triggers and medication in the Group Clinic. They also report feeling more confident about managing asthma and preventing complications.

All nurses were trained up and quickly gained experience of running both F2F and VGC. A Group Clinic team WhatsApp group that includes the GP partner champion, Hollie, Hayley, 3 further trained facilitators and all the practice nurses, was instrumental in building team confidence, resilience and in getting sceptical clinicians fully on board. Patient stories were shared, emerging challenges discussed and solutions found. Being involved in co-designing their Asthma Group Clinic model was also instrumental to nurse buy in. They now have a strong sense of ownership of the group review model.

Running Group Clinics has brought the practice team together. It was a steep learning curve and a very big change, especially VGC. The team recognise that through VGC there has been a significant rise in confidence amongst nurses in relation to working with patients online.

During asthma group reviews, the facilitator notes changes recommended to medication and to each person's care plan. Nurses check and agree the changes at the end of the Group Clinic. The facilitator fills in an Ardens template and generates each person's updated care plan, which is then

shared with the patient. This revised documenting process has saved as much if not more nurse time as the switch to Group Clinics. The reduced admin burden has been a significant factor in nurse acceptance of the group model.

The switch has freed up significant nurse time to deal with other long term conditions. Burlington nurses now review 10-12 patients (sometimes as many as 15) in just over 60 minutes in Group Clinic whereas it would have taken them 200-240 minutes previously. Time to write up care plans has fallen drastically as well. The practice now manage their 1,010 asthma patients' reviews in two Group Clinics per week that take up 2-3 hours of nurse time in total, whereas one to one appointments accounted for 7 hours of clinic time a week. This aligns with findings from Brigstock (Gandhi an Craig 2019) who quantified similar clinician time savings generated by Type 2 Diabetes group reviews.

Following the success in asthma, the team has expanded group clinical practice to cover contraception. Counselling pre- and post-coil and implant fitting happens in a Group Clinic. The team have also run statin initiation Group Clinics and they are especially proud of their Dementia Group Clinic, which is attended by both patients and their carers. Alongside clinical reviews, local agencies drop by to connect people with third sector help and support services.

Next, the team is now looking to support those with mental health issues in Group Clinics.

Broxbourne Alliance Primary Care Network (PCN), NHS Hertfordshire and West Essex

Dr Alison Jackson, Clinical Director for Broxbourne Alliance has led the introduction of the VGC model within the PCN's menopause pathway.

The PCN was seeing a dramatic increase in demand for menopause appointments, with clinical staff facing relentless work pressure. The VGC model provided the opportunity to improve access, reduce inequality, build capacity to offer a more holistic, personalised model of care that supports prevention and lifestyle change so that women can age well.
Group Clinics were also recognised as a way to reduce work pressures and prevent staff burn out.

The PCN's comprehensive menopause pathway that centres around the initial VGC appointment has been fully embedded since 2023. It builds in NHS health checks and health and wellbeing initiatives to reduce cardiovascular and osteoporosis risk. It supports healthy weight management and promotes mental health alongside integrated HRT assessments and reviews.

From 31 January 2024 to 20 November 2024, 146 women were seen in a menopause VGC. 76 women (52%) went on to have HRT prescribed. This percentage is likely to be an underestimate as at the time audit was undertaken, some women seen during this period were still awaiting biometric tests, advice and guidance before starting HRT.

All women who had not presented for an NHS health check in the previous 5 years went on to have an NHS health check post VGC. 15 women who were overdue their smear went on to be tested. The VGC team also increased awareness of the importance of attending mammogram screening and responding to bowel screening.

53 (36%) of women booked in a health and wellbeing Group Clinic run by the PCN's Health and Wellbeing team for more support to improve nutrition and physical activity. 12 women booked into a mindfulness group intervention to improve their mental health.
As a result of the switch to VGC and the refreshed pathway, patient experience and quality of care have both improved immensely, with lots of positive feedback from women attending VGCs. The rich learning environment has also enhanced clinician experience of caregiving.

VGCs have helped the PCN overcome estate limitations and improve access. All PCN practices can now offer guaranteed access to appointments and support within 2 weeks for any woman requesting

help with menopause. This guaranteed access also supports and reassures frontline receptionists as they know they have appointments available when requested.

Woodley Centre Surgery, Wokingham, NHS Buckinghamshire, Oxfordshire an Berkshire West (BOB)

The Woodley team's group clinical practice is led by Dr Rupa Joshi. The team have used the Group Clinic model to respond to population health need and improve quality.

Pre-COVID, the team targeted children who were identified through clinical audit as being at high risk of hospitalisation for asthma, who had had 3 courses of steroids in the last 6 months, were over-ordering salbutamol inhalers, being hospitalised or attending the GP practice more than 3 times with respiratory systems over the past 6 months. During the summer holidays, parents were invited to bring their child to a Group Clinic. Asthma questionnaires completed in advance highlighted that the majority of children were experiencing difficulty sleeping and asthma symptoms during the day. They reported that their asthma symptoms were interfering with their usual activities, including school at least once or twice a week. 50% said that they experienced daily interference due to their symptoms.

The Group Clinic explored with the whole family how to manage asthma and prevent symptoms and complications. It was great fun for both the clinical team and the families who reported they learnt a lot and high satisfaction rates.

Average salbutamol inhaler orders fell post Group Clinic from an average of 18 to 8 inhalers over 12 months. Pre- Group Clinic, the group as a whole recorded 12 hospital admissions. In the following 12 months, this dropped to zero. The family's use of general practice also fell from 9 visits to zero.

During COVID, the Woodley team responded to concerns about new parents' ability to cope when there were a number of safeguarding incidents locally. The team joined forces with health visitors and hosted VGCs for new parents to support them to cope during an especially stressful postnatal journey. They also ran VGCs targeted at those with respiratory conditions to reassure them and encourage them to isolate and keep safe. They worked with a Child Psychologist and ran VGCs for parents with children displaying high levels of anxiety.

Following Lockdown, the team continued to run Group Clinics both VGC and F2F.
A particularly popular F2F Group Clinic model that the team currently delivers is the Menopause Group Clinic. These run every second week during extended hours (18.00 – 19.30). The majority of doctors in Woodley refer to the Group Clinic. This releases one to one appointments for other patients and ensures that the quality of menopause care is consistent.

A survey of over 5.000 women suggests that 44% women wait up to a year for treatment and 7% attend over 10 GP appointments before receiving adequate advice and help (Newson and Lawson 2021). Women registered at Woodley get access to comprehensive help, advice and treatment at their first Group Clinic.

Evaluation of 14 Group Clinics and in a sample of over 80 patients found that 80% of patients agree that a Group Clinic is a more effective way to access practice team support. 96% felt the information they got was pitched "just right". 80% felt more confident to self-manage menopause after Group Clinic.

Self-reported confidence levels rose from a baseline of 3 to an end of session score of 7.6 on a 10-point Likert scale. This represents an average 154% increase.

42% said the Group Clinic met their expectations. 57% said it exceeded their expectations. 94% would recommend Menopause Group Clinic to friends and family. 100% agreed or strongly agreed that they felt supported, understood, less isolated and learnt from their peers.

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Appendix One – Working illustrations of how group clinics release clinician time and appointments (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 - Group Clinics Frequently Asked Questions

Which pathways work best for Group Clinics?

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

Drawing on a framework for classifying clinical work (Christensen 2000), Lynch identified that Group Clinic models self-selected and developed by outpatient teams in Wales most frequently 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 models were nurse or allied health professional (AHP) led.

This aligns with the Group Clinic models most often self-selected by primary care teams in England. Scott et al (2023) found the model being used most frequently to support management of Type One and Type Two Diabetes (27%) and weight management (17%). Papoutsi et al (2022) found exemplars, 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.

Focusing Group Clinics as an alternative way to deliver chronic disease management reviews, including prevention, is likely to maximise efficiency and quality gains and be acceptable to clinical teams and patients.

How widespread is group clinical practice?

Over 700 sentinel practices participated in NHS England's Nursing Directorate funded Video Group Clinic Programme in 2020. When evaluated 34% of the 700 practices intended to make Group Clinics part of their ongoing General Practice Offer, it is unknown how many practices have continued to use VGCs. Since then, work has continued to spread both VGC and F2F Group Clinics. No national audit has been conducted. It is estimated that in excess of 1,000 primary care teams have accessed training in group clinical practice.

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

During Covid, the Digital First Primary Care team at NHS England provided a range of resources, funded and assured technology 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 Clinics.

Within NHS England's VGC toolkit, specific advice is offered on the basic requirements, technology platforms and integration with existing admin and electronic patient record systems. Existing web platforms can be used. There is no need to invest in a specific web platform for VGC delivery.

Does there need to be multi-disciplinary team engagement?

Engagement from all parts of the clinical team is essential. This includes management and clinical leaders, as well as those who will work in group clinics. There are three leadership roles and three delivery roles. They all need to be covered. Some people will cover several roles:

Leadership team

- **Clinical lead:** senior clinician who champions the change within the practice or directorate and assures clinical quality and governance; may not be directly involved in delivering Group Clinics with patients
- **Management lead:** senior manager who champions the change within the practice or directorate; oversees changes to clinic administrative workflows and processes and assures information governance risks are managed; may not be directly involved in delivering Group Clinics with patients
- **Implementation lead:** manages the change on a day to day basis; owns the implementation plan

Delivery team

- **Clinician:** undertakes clinical session in Group Clinic; designs Group Clinic framework; supports positive, participatory group dynamic
- **Facilitator:** supports positive, participatory group dynamic; ensures session ends on time; supports documenting
- **Clinic co-ordinator:** ensures that patients receive group agreement in advance and that all biometrics needed for completion of clinical reviews are available

Involvement of the whole team from the start ensures the most effective outcome and a positive experience of change for all.

Are there any additional risk to consider when delivering Group Clinics?

Group Clinics present very few additional risks than other clinical delivery methods. In 2020 NHS England co-created standardised risk management procedures for clinical teams to adopt for both F2F and VGCS.

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Sources of further information and case studies

British Society of Lifestyle Medicine: https://bslm.org.uk/group-consultations/

The Experience Led Care Programme: https://www.elcworks.co.uk/resources/

Shiny Mind:
https://shinymind.co.uk/large-scale-mental-health-virtual-group-consultations

Video Group Clinic (VGC) case studies generated by the National VGC programme:
https://www.youtube.com/channel/UC2TlDoAwSzyEkRJbmoi0zGQ/videos

Future NHS links to resources
https://future.nhs.uk/DigitalPC/view?objectID=24663536
https://future.nhs.uk/P_C_N/view?objectId=14750480