Neighbourhood Group Clinics: a sustainable solution for integrated care systems

Executive Briefing

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Executive Summary

This Executive Briefing has been produced by the NHS England Group Clinic Task and Finish Group to introduce Neighbourhood Group Clinics – a new iteration of the Group Clinic model - to those tasked with commissioning and providing Neighbourhood Health.

It sets out what Group Clinics are and details how the proposed Neighbourhood Group Clinic model will accelerate delivery of integrated care and sustain the Neighbourhood Health model.

What are Group Clinics?

Group Clinics are a medical appointment where clinicians assess, review and treat multiple patients with similar symptoms and health conditions as a group. Group Clinics give patients longer, more in-depth time with the team. Clinicians complete all the usual clinical tasks. The model comes with the additional benefit of peer learning and support, which builds everyone's confidence and supports self-management.

Also known as group consultations or shared medical appointments, Group Clinics are typically 90-minutes long. They are led by a clinician and a non-clinician facilitator. The group discussion agenda addresses patients' questions and concerns. In addition, the clinician completes personalised clinical assessments or review with each individual. These cover everything that would be discussed in a one-to-one appointment. Everyone in the group listens and learns vicariously from others' one-to-ones. NHS England has put in an information governance framework to support their spread.

Neighbourhood Group Clinics

The Neighbourhood Group Clinic methodology – whether face to face (F2F) or virtual - is rooted in coproduction. It should be a core component of the Neighbourhood Health Model because it delivers three key benefits:

1. **Time for prevention and self-management:** By bringing multidisciplinary teams (MDTs) together and reducing repetition and duplication of clinical tasks, Group Clinics create space for clinicians to work with patients to reflect on what matters to them. This embeds personalised care and strengthens prevention and self-management support. Evidence shows patients perceive Group Clinics as offering higher quality, more person-centred care, with greater trust in clinicians compared with 1:1 appointments (Wadsworth et al 2019).

2. **Sustainable integrated working:** Group Clinics support multidisciplinary collaboration more effectively than traditional appointments (Graham et al 2022; Lynch 2022). Combined with measurable productivity and efficiency gains, this creates sustainable capacity to scale integrated care. The model also enables partnership with Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations as co-facilitators.

3. **Stronger agency and improved experience of care:** Patients perceive the Group Clinic model as delivering superior quality of care. People and carers[1] consistently report higher satisfaction, improved communication, and greater confidence and activation following Group Clinic appointments. Clinicians also benefit. The model restores autonomy, fosters empathy, and

[1] Wherever "carer" is used in this publication, it refers to both paid and unpaid carers, however there are key differences between the two. Unlike paid carers (professionals either employed by the individual receiving care, or via NHS or local authority funding or services), unpaid carers can be anyone – including children – who look after a family member, partner or friend who cannot cope without their support. The Care Act 2014 requires local authorities to assess, provide support and promote the wellbeing of unpaid carers.

builds closer team relationships, which in turn improves job satisfaction and professional enjoyment of care-giving.

Policy options for Department of Health and Social Care (DHSC) and NHS England (NHSE)

Neighbourhood Group Clinics offer a practical opportunity to scale an innovation that supports delivery of the six key components of Neighbourhood Health. The model has further potential to contribute to elective recovery by improving access and helping to reduce specialist care backlogs. When implemented effectively, Neighbourhood Group Clinics can enhance quality of care, release capacity, and strengthen staff engagement.

Based on its expertise, The Group Clinic Task and Finish Group recommends the following actions to realise this change:

- **Policy**: DHSC and NHSE support the *appropriate, locally led* use of Group Clinics, including Neighbourhood Group Clinics to deliver personalised care, improve access, patient experience, clinical outcomes and productivity and reduce waiting times where evidence and pathway fit are strong. DHSC and NHSE advocate for the use of Group Clinics to be considered for long-term condition management, in selected specialist pathways, and as part of ongoing clinical care for medicines management.
- **Leadership**: DHSC and NHSE appoint a National Subject Matter Expert (SME) for Group Clinics to increase understanding of the model and support adoption by curating standards, case selection, and model fidelity and updating existing toolkits and implementation guides hosted on Future NHS.
- **Evaluation**: ICBs to be tasked with routinely monitoring the implementation of Group Clinics. Adoption should align with the Model Health System metrics and deliver measurable improvements in access, quality and efficiency and support a pipeline of rigorously evaluated Group Clinic models. These should include Neighbourhood Group Clinics for those living with multiple morbidities. To strengthen the evidence base and case for change, Neighbourhood Group Clinics can be prototyped within neighbourhood health pilot sites in selected ICBs. This will support development of funding projections and quantify potential cost efficiencies that could be realised following adoption. Other priorities for evaluation include: Group Clinics within specialist care pathways, Group Clinics that deliver clinical wrap around care for patients prescribed weight loss drugs, and ongoing clinical care for medicines management and Group Work Coaching models that integrate health and employability professionals in providing personalised care and support for those who are economically inactive
- **Routine data collection:** ICBs to routinely undertake simple, light touch monitoring of the uptake of Group Clinics and their impact, including impact on patient and staff experience. This can be facilitated by a standardised monitoring framework that enables real time data aggregation
- **Provider support:** Commissioners should make available comprehensive Group Clinic training with a strong personalised-care component alongside change management resources so that providers across primary, community and specialist care can adopt Neighbourhood Group Clinics with confidence. This will support teams to embed best practice, build facilitation and clinical skills, and establish the administrative processes needed for safe and effective delivery.

Policy Context

"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

What constitutes an NHS Neighbourhood?

Guidance defines a neighbourhood as a defined geographical area based around a natural community, with boundaries that local people recognise. It is anticipated that neighbourhoods will have between 30 and 50,000 people. This is the population size recognised as optimal for delivering integrated care. Following the publication of the 10 Year Plan, neighbourhoods have become the locus for shifting care into the community, bringing services together to co-ordinate care and wrap support around patients so that they live life to the full for as long as possible. In line with statutory guidance, neighbourhood teams are also tasked with working in partnership with local people and communities, including actively working in partnership with the voluntary, community, faith and social enterprise (VCFSE) sector to transform care and deliver the ambitions of the 10 Year Plan.

What will Neighbourhood Health deliver?

The Neighbourhood Health model aims to:

- Create healthier communities
- Help people of all ages to live healthy, active and independent lives for as long as possible
- Improve people's experience of health and social care
- Increase people's agency in managing their own care.

The government's health mission, encapsulated in the three key shifts in the 10-Year Plan, underpins the delivery of the Neighbourhood Health model. By embedding these three shifts at scale, health and care systems will be more connected, enable smarter co-ordination of care and optimise the use of health and care resources.

Places will coproduce Neighbourhood Health

Neighbourhood Health Guidelines set out that Places will lead development of the Neighbourhood Health model. Key tasks include:

- **Defining community needs.** They will start by clearly defining their target population and geography and, using both data and insights.
- **Developing a "Localised Neighbourhood Health Model".** Each Place's model needs to be tailored to local needs and focus on addressing inequity and on empowering frontline teams. They will involve all system stakeholders in this, including, primary care, social care, community health, mental health and VCFSE organisations. Together, these stakeholders will co-create a shared vision, define outcomes and accountability frameworks, and embed a collaborative high support - high challenge culture.
- **Assuring care co-ordination.** Neighbourhood Health will assure care co-ordination, continuity and personalised care. Group Clinics excel in delivering care co-ordination,

continuity and personalised care because they provide a forum and a scalable process that enables front line teams to coalesce around people and their families.

Guidelines identify 6 core components of a Neighbourhood Health model:

A. **Population health management:** Neighbourhoods define their population health needs and areas of inequity using data and insights and respond with personalised services

B. **Modern general practice:** ICBs are asked to continue to support general practices to deliver modern general practice model and improvements in access, continuity and overall experience for people and their carers[2] in response to increasing demand. This is a foundational step to enable general practices to move from a model of reactive to more proactive care.

C. **Standardised community services:** ICBs and providers should use Standardising community health services publication to ensure funding is used to best meet local needs and priorities. It covers NHS-funded specialist support for people with physical health needs and neurodevelopmental services for children and young people. For people with both physical and mental health needs and those living with drug or alcohol dependency, Neighbourhood Health means joined up support across community, primary care and mental health services.

D. **Neighbourhood multidisciplinary teams (MDTs):** the Fuller Stocktake clearly defined how to establish integrated neighbourhood teams. There is detailed guidance on neighbourhood MDTs for children and young people. In best practice models, a core team is assigned for complex case management, with links to an extended specialist team as needed. The composition of teams varies, depending on the population's needs. MDTs could include GPs, specialist nurses or consultants (specialist dementia nurses, paediatricians and geriatricians), district nurses, GP nurses, acute hospital consultants, allied health professionals, health visitors, mental health professionals, social prescribing link workers and social workers, home care staff, residential care home and nursing home staff, as well as wider system and community partners (such as from public health and the VCFSE sector). Every person or their carer should be assigned a care co-ordinator so that they have a clear point of contact to improve both their experience and continuity of care. The default is proactive, planned and responsive care.

E. **Integrated intermediate care with a "Home First" approach:** short-term rehabilitation, reablement and recovery services (integrated intermediate care) need to take a therapy-led approach. Rehabilitation and reablement care needs to be overseen by a registered therapist working in integrated ways across health and social care and other sectors, working closely with urgent neighbourhood services and applying a 'Home First' approach so that assessments and interventions are delivered outside hospital where possible.

F. **Urgent neighbourhood services:** this requires standardised urgent neighbourhood services for people with an escalating or acute health need. It means ensuring urgent community response and hospital at home (virtual ward) services align to local demand and work together, with access through a single point of access to deliver co-ordinated care.

In 2025/26, guidelines ask systems to focus on 4 things. These form the foundation for scaling Neighbourhood Health over the coming years. They are to:

[2] Wherever "carer" is used in this publication, it refers to both paid and unpaid carers, however there are key differences between the two. Unlike paid carers (professionals either employed by the individual receiving care, or via NHS or local authority funding or services), unpaid carers can be anyone – including children – who look after a family member, partner or friend who cannot cope without their support. The Care Act 2014 requires local authorities to assess, provide support and promote the wellbeing of unpaids.

1. **Standardise the 6 core components of existing practice** to achieve greater consistency of approach. These are outlined above.
2. **Bring together these 6 different components into an integrated service offer** to improve coordination and quality of care, with a focus on people with the most complex needs.
3. **Scale up** and enable widespread adoption.
4. **Rigorously evaluate** the impact of new ways of working and enablers - both in terms of outcomes for local people and effective use of public money.

This means that in 2025/26, systems are focused on preventing adults, children and young people with complex health and social care needs, who are supported by multiple services and organisations, from spending unnecessary time in hospital and care homes. This community accounts for 7% of the population, and around 46% of hospital costs.

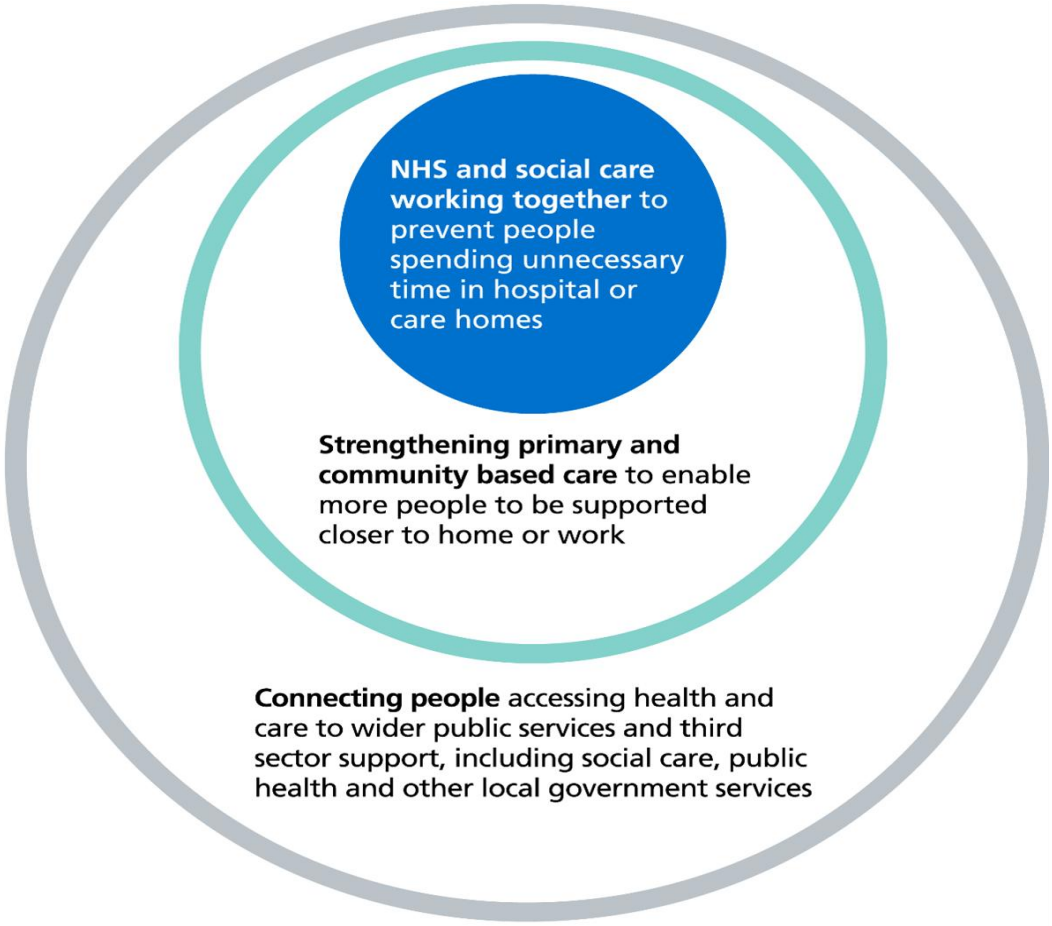
Systems will prioritise specific population groups who are most in need of support to maintain and improve personal independence to reduce reliance on hospital care and long-term residential or nursing home care.

It is likely that systems will focus in 2024/25 on 2-4% of the total population. For the very specific population group they select, Neighbourhood Health systems are expected to achieve measurable improvements in three areas in 2025/26:

- Timely access to general practice and urgent and emergency care
- Prevention of long and costly admissions to hospital, and
- Prevention of avoidable long-term admissions to residential or nursing care homes.

Figure One provides an infographic representation of the Neighbourhood Health transformation journey over the next 5 -10 years.

Figure One: the aims of all Neighbourhood over the next 5-10 years



To achieve this, waves of Neighbourhoods are to be supported by a permissive implementation framework. The framework will accommodate local needs and define a clear action plan. Neighbourhoods will also be supported to test and learn through a National coaching programme, aligned with existing NHS quality improvement frameworks, including Triple Aim and “Improving Patient Care Together” (IMPACT).

How Group Clinics work

"You feel comforted by fellow people that also suffer with the same affliction you have… the effect of the collective group is more than the sum of its parts… you feel supported and empowered… I'd join again without hesitation..."

Group Clinic Participant
Moatfield Surgery, East Grinstead

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 and outpatient settings. They can deliver planned care, support triage, validate waiting lists and provide pro-active care that pre-empts the need for urgent care, and support those on long waiting lists to wait well.

Group Clinics add most value where there is a need for holistic, preventative clinical care aimed at improving self-management, maintaining independence and supporting lifestyle change because they build agency to self-manage health issues (Lacgnina et al 2020). They align with NHS England » Supported self-management. They create time for staff trained in shared decision-making, health coaching and "what matters to you" conversations - skills that have been shown to build patient activation and sustain lifestyle change - to make full use of these skills (NHS Kent and Medway, 2024).

The common characteristics of the Group Clinic model are summarised in Figure Two below.

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.

Group Clinics in the English NHS

While the benefits of Group Clinics have been recognised historically in NHS primary care policy, most notably The GP Forward View where they were highlighted as a high impact change, the model currently lacks the support of a National implementation strategy. Consequently, their use has been driven primarily bottom-up by enthusiastic clinical leaders and their teams. Group Clinics exist and have been trialled inconsistently in places and within pathways rather than the innovation being spread systematically, in line with strategic direction set by DHSC and NHSE.

The notable exception was the National Video Group Clinic (VGC) Programme, which was funded by the Nursing Directorate in 2020 as part of its COVID Pandemic response. This led to a spike of 500 primary care teams engaging and being trained between June and October 2020. This programme was independently evaluated (Papoutsi et al 2021; Scott et al 2023).

Routine data on Group Clinic use and spread is not being collected. Proxy data suggests that currently 15 ICBs are funding some implementation support for an estimated 100 clinical teams in total.

This includes 3 NHS England funded programmes: one in Devon supporting spread across primary and specialist care; one for community nursing pioneer teams in 5 ICBs across the South-West region, and one in primary care, supporting employment retention amongst adults aged 45-67 in South Yorkshire Health and Growth ICB in 20 primary care networks.

The evidence base for Group Clinics

There is robust and growing evidence supporting the effectiveness of face to face (F2F) Group Clinics, with 3 systematic reviews of the international evidence published since 2019 (Wadsworth et al 2019, Graham et al 2021, Tang et al 2024).

A 2017 review in the British Medical Journal concluded that group clinics offer 'a promising response to escalating demand in healthcare' (Hayhoe et al 2017). In the same year, Lord Darzi asked, given their effectiveness, "why aren't doctors routinely using them (Group Clinics) to treat physical and mental conditions?" (Ramdas and Darzi, 2017).

Roth et al (2020) demonstrated that F2F Group Clinics impact positively on all four elements of the Quadruple Aim (Sikka et al 2015, Bodenheimer et al 2014), namely:

- Improved population health
- Lower healthcare costs
- Improved patient experience
- Better work life for healthcare providers.

There is also evidence that F2F Group Clinics generate significant productivity gains for health systems and providers. These stem mainly from improved clinician productivity, improved access and reduced waiting times. For example, evaluation in an English GP practice with a list of 10,000 patients, showed that switching 50% of planned Type 2 Diabetes reviews to Group Clinics released 1,400 hours of clinician time and over 8,500 one-to-one appointments annually (Gandhi et al 2019).

Evidence also suggests that when compared with one-to-one appointments, F2F Group Clinics maintain quality of clinical care (Tang et al 2024). Studies in people living with Type 2 Diabetes suggest that compared to 1:1 appointments F2F Group Clinics improve HBA1c and blood pressure (Edelman et al 2015), improve quality of life (Trento et al 2010) and self-efficacy (Ridge 2012).

Patient feedback about F2F Group Clinics is consistently positive. Participants report improved satisfaction, perceive F2F group clinical care as higher quality than a one-to-one alternative, and report higher levels of trust in clinicians who review them in group appointments (Wadsworth et al 2019).

Both F2F and VGC Group Clinics are popular with frontline staff who report that working in Group Clinics restores their sense of autonomy, leads to deeper connection and empathy with their patients, enables them to add value to routine clinical work and thus increases their job satisfaction and subsequently retention (Wadsworth et al 2019, Lynch 2022).

Video Group Clinic (VGC) practice has accelerated since the pandemic. Three evaluations have assessed their spread across England and Wales (Papoutsi et al 2021; Scott et al 2023; Lynch 2022). The VGC evidence base is less robust. Over 50 case studies generated by the NHS England funded VGC spread programme since 2020 suggest that they deliver similar access, productivity and quality gains.

The TOGETHER 2 Study (Papoutsi et al 2024) is further evaluating use of video and hybrid (video combined with face to face) Group Clinic models for chronic conditions in English general practice. Evaluation is exploring the experience of peer support and documenting the types of 'hidden work' performed linked to Group Clinic delivery to support understanding of where and how the model might add most value from the perspective of healthcare practitioners as well as patients. Publication is anticipated in late 2025.

Figure Two: characteristics of the traditional Group Clinic model

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.

Group Clinics and the 10 Year Plan

The three shifts described in the 10 Year Plan (NHS England, 2025) will underpin the delivery of Neighbourhood Health model. Figure Three below sets out the three 10 Year Plan shifts and how Group Clinics align with each.

Figure Three: Group Clinics and the 10 Year Plan Shifts

Hospital to Community

- **Care closer to home helps people stay independent and minimises hospital bed use. Group clinics support this shift by:**
  - Creating a practical, grassroots vehicle for MDTs to build collaborative practice, cement clinician to clinician relationships and facilitate integrated neighbourhood working
  - Releasing clinician capacity and increasing productivity by up to 80% (Gandhi et al 2019)
  - Reducing waits for planned care within months
  - Reducing hospital admissions and emergency room attendance (Scott et al 2004)
  - Freeing one to one appointments and clinician time for people with the most complex needs (Birrell et al 2018)

Analogue to digital

- **Greater use of digital solutions improves care quality and productivity. Video group clinic support this shift by:**
  - Offering a digital appointment option that releases clinician capacity and increases productivity by 80%
  - Building the full team's confidence and acting as a digital skills accelerator for the whole team (Papoutsi et al 2021)
  - Offering an engaging and sustainable way of switching to digital care compared to 1:1 video consultations

Illness to prevention

- **Prevention happens because neighbourhood health teams support health literacy and early intervention, reduce health deterioration and avoidable exacerbations of ill health. Group clinics support this shift by:**
  - Integrating peer to peer learning into routine clinical appointments that increases people and family carers' understanding of and ability to self manage chronic health conditions
  - Creating time for people and carers to work with clinicians and others on lifestyle change, personalised and anticipatory care planning (NHS Kent and Medway 2024)
  - Offering an enhanced, more personalised experience of care for people and their family carers that improves communication and builds trust (Wadsworth 2019)
  - Having a greater impact on people's progress with behaviour change (Dickman et al 2011)
  - Increasing activation and confidence scores (Moore 2021)
  - Enhancing. staff wellbeing and caregiver experience, especially nurses, allied health professionals and additional primary care roles (Lynch 2022)

Neighbourhood Group Clinics

"Working this way has been inspiring and reconnected me with the fundamentals that underpin my philosophy about person centred care. To see and experience the energy within the Group Clinic environment for people, families and carers, and also the team wrapped around them has been energising and motivating…."

Dr Matthew Dolman, Complex Care GP North Sedgemoor PCN Somerset
Clinical Lead NHS England South-West, Digital Neighbourhood Programme

Given that best practice approaches to group clinical practice are now well established, the strength of the existing evidence base, and the paucity of scalable care models available to expand clinician capacity and deliver personalised, relationship-centred care outside hospital, it is time to explore whether making Group Clinics integral to Place-based implementation plans accelerates Neighbourhood Health system progress and supports sustained change.

The Task and Finish Group proposes that a novel iteration of the Group Clinic model - Neighbourhood Group Clinics - offer promise.

Neighbourhood Group Clinics offer Places a scalable, evidence-based care process that embeds sustainable personalised care and unites teams to address population health needs and coproduce improved outcomes with affected people and their carers. A key gain is that they offer an alternative to 1:1 clinical care.

Neighbourhood Group Clinics will be especially effective at addressing population health needs through the following components of the Neighbourhood Health model:

- Modern General Practice
- Standardised Community Health Services
- Neighbourhood integrated MDT care
- Intermediate care.

By delivering proactive care and by permitting patients and carers who are concerned and need reassurance to 'drop in,' Neighbourhood Group Clinics will also potentially impact on demand for urgent care and pre-empt crises.

How A Neighbourhood Group Clinic is this different to an MDT?

Multidisciplinary teams (MDTs) have existed for many years. An MDT is a group of healthcare professionals from different disciplines who come together to discuss patients' treatment and care. MDTs use case conferences to pool clinical expertise, review people's test results, clinical care and future treatment, revise care plans and to agree how they co-ordinate and work together. The patient and their carers are usually not present and thus unable to share decisions about proposed changes to treatment, care and support plan. The case conference is an adjunct to the 1:1 care professionals provide for the patient cohort. An MDT thus requires additional capacity from all participating professionals and offers no productivity gains.

The Neighbourhood Group Clinic retains the aims and strengths of the MDT model and brings professionals together with a group of patients and their carers under their care who have similar challenges and needs. There is no need for a separate case conference. Professionals and patients are equal partners and coproduce the Group Clinic. Patients and carers determine its focus. Clinicians ensure necessary clinical tasks, reviews and assessments are completed. The Group

Clinic provides time and space for everyone to explore and discover together what matters most and how best to keep everyone well. The infographic below summarises the key differences.

Multidisciplinary Team	Neighbourhood Group Clinics
• Led by the team of health and care professionals who are collectively supporting the person • Biopsychosocial model leading to balanced decisions about treatment • Review and discussion of care and treatment plans • Supports collaboration and integrated working • **Patients and carers are not present** • Limited opportunity for shared decision making with patients • No productivity gains. As well as attending the MDT, each professional meets with the patient to update them about changes being made to their care plan	• Led by the team of health and care professionals who are collectively supporting the person • Biopsychosocial model leading to shared decisions about treatment • Review and discussion of care and treatment plans • Supports collaboration and integrated working • Enables shared learning drawn from observation of peers' clinical practice • **Patients and carers are present and coproduce their care and support plans with the team** • Productivity gains. No need for a separate MDT case conference. No follow up 1:1 appointments required

Whilst the Neighbourhood Group Clinic model still needs to be fully evaluated in the context of integrated neighbourhood working, it is likely to realise productivity gains and ensure people and their carers are involved in decisions about their care plans from the outset.

Characteristics of The Neighbourhood Group Clinic model

The Neighbourhood Group Clinic model:

- Proactively supports people with complex care needs who require support from a multidisciplinary team, including those living with multiple health conditions and their supporters to keep well; sees both as equal partners in care
- Takes place outside of hospital - either face to face or online in community settings
- Delivers proactive, preventative, personalised care aimed at building knowledge, skills and confidence to self-manage and maintain independence
- Is scheduled frequently, with people and carers attending weekly, monthly or even daily as their need requires
- Offers a 'drop in' facility for those who are becoming concerned that they are becoming unwell and need reassurance
- Supports the care co-ordination process and are organised by care co-ordinators
- Is delivered by a multidisciplinary team who provide a range of clinical interventions and tasks at the Group Clinic, and contribute their particular expertise to support the target community of patients and carers
- Funds VCFSE as partners in Neighbourhood Group Clinic delivery e.g. as Group Clinic facilitators.

North Sedgemoor Primary Care Network has piloted and audited the impact of a Neighbourhood Group Clinic model.

WELLbeing Works: a data-driven Neighbourhood Group Clinic in North Sedgemoor, Somerset

"I can now walk to the park with my grandchildren. That's a big achievement."

Community partners across North Sedgemoor have moved away from one-to-one, condition-focused care and towards community-led, whole-person focused Group Clinics that are helping people with heart failure to live better lives in ways that truly matter to them.

North Sedgemoor Primary Care Network (PCN), Somerset NHS Foundation Trust, Somerset Activity and Sports Partnership (SASP), supported by the local GP Support Unit, and The Experience Led Care Programme, have codesigned and delivered a prototype Neighbourhood Group Clinic model that combines clinical assessment and review with exercise and behaviour change coaching, digital innovation, and social prescribing WEllbeing Works - Somerset Activity & Sports Partnership.

The team aimed to:

1. Systematise personalised care and support planning (PCSP) and embed sustainable personalisation
2. Improve patient activation, physical activity, and wellbeing
3. Optimise medication
4. Reduce risk of preventable admissions
5. Deliver care closer to home with fewer travel costs and net zero impact
6. Free up clinical time by reducing repetitive 1:1 reviews
7. Achieve better outcomes at equal or lower system cost
8. Build a successful INT model that optimises use of NHS workforce and VCSEF partners so that patients see the right clinician at the right time.

Patients, families, and carers re-named their planned group medical appointments "WELLbeing Works". They are equal partners in designing and shaping the monthly sessions.

Population health management: using Somerset Eclipse prescribing data, the team identified people living with congestive heart failure in need of medicines optimisation. Using an AI risk stratification tool, the team predicted their risk of hospital admission in the next 12 months.

Modern general practice combined with proactive integrated MDT working: patients and carers joined the WELLbeing Works Groups monthly for planned primary care combined with coaching, exercise practice, reflection and goal setting. A topic board framed discussions about what matters. Topics included: getting moving, my medicines, my people & pets, my hobbies & interests, sleep and fatigue, money, housing & environment, asking for the support I need, and 'Anything else that matters'.

Clinicians optimised medication and addressed treatment related concerns. SASP and clinicians worked together to improve wellbeing and motivation to keep moving and mobile.
Participants tracked progress, using the "4Ms" covering Movement, Mood, Motivation scores and "Matters to Me" outcomes. To make these metrics accessible and meaningful, the team intentionally de-medicalised their labels. The Warwick Edinburgh Mental Wellbeing Scale became their "Mood Score". An Activation Measure where an one-point increase translates to a reduction in primary and secondary care resource utilisation of £327 (National Association of Primary Care, 2024) became their "Motivation Score".

Initial impacts

In December 2025, the programme was awarded The South West Integrated Personalised Care Award for "Using Our Money Well". Watch this video to see and hear the impact on patients and frontline staff: WEllbeing Works - North Sedgemoor Group Clinics 2025 - YouTube

Person centred metrics: changes measured at three months include:

- **Grip strength:** 80% (9 patients) increased grip strength. On average, the group's grip strength scores increased by 11%
- **Physical activity:** 54% (6 patients) increased their physical activity measured in minutes of physical activity per week
- **Motivation:** 45% (5 patients) reported a one-point increase in their Motivation scores. 4 self-assessed themselves as being at the highest level of activation at baseline and remained there. 2 patients reported no change. This indicates that future NHS cost savings of £1,665 were generated by the activation co-created through this Group Clinic
- **Mood** The average Mood score at baseline was 28. The average at three months was 29.5 on the Short Warwick-Edinburgh Mental Wellbeing Scale. Scores improved in 64% (7) of people. Across the whole group of 11 people, scores rose on average by 5%. The average rise scale amongst the 7 people whose scores increased was 2 points on the scale
- **Confidence:** self-reported confidence managing their condition rose in 45% (5) patients. 45% self-reported the highest confidence score at baseline – 10 on a 10-point Likert Scale. They remained there. 1 dropped 1 point.

Tracking mood proved particularly motivating for participants. It sparked discussions of what was working, engendered a sense of pride, and reinforced behaviour change. Patients also set and reached personalised goals. For instance, one person gained so much confidence that they now volunteer as a Park Ranger.

Clinical care quality: the team have optimised medication for all patients. This, combined with improved self-management and increased physical activity is reducing individuals' predicted risk of unplanned admission.

Social capital: the intervention has built community cohesion. Participants report that they no longer feel alone because their lived experience has been validated through peer connection. Participants are starting a peer support group, and set up a What's App group. They have asked for a carers space to run alongside the group clinic. Some have met socially outside the group. A "marketplace" in month 3 connected local community organisations with WELLbeing participants. This has opened the door to addressing social isolation through ongoing support from social prescribing and connection with local VCSEF organisations.

Productivity gains: The Neighbourhood Group Clinic model has improved clinical efficiency and freed up 1:1 appointment capacity. Collaboration across partners is delivering a flexible, scalable, sustainable MDT model that delivers both the NHS Comprehensive Model for Personalised Care and the NHS 10 Year Plan vision of neighbourhood-based, digitally enabled, proactive care. The model aligns with The Allied Health Professionals Strategy for England 2022 to 2027 and is providing a sustainable way to deliver INT workforce plans that assure the "right clinician at the right time" in community settings. North Sedgemoor now has a blueprint for neighbourhood transformation that is data-driven, human-centred, and supports collaborative delivery.

Workforce development and staff experience: Staff satisfaction has improved, with psychological safety assured through collaborative leadership. People have stopped seeing themselves as separate agencies and started seeing themselves as one team. The programme is leading to workforce transformation. Group care is creating joy and permission to push boundaries. It has freed team creativity and restored autonomy to team, tasked with wrapping care and support around WELLbeing Works patients.

The team is planning to expand their Neighbourhood Group Clinic model to other patient groups with complex needs, is and are working on further formal evaluation to dive deeper into impacts and outcomes.

The benefits of the Neighbourhood Group Clinic Model

As this case study illustrates, the Neighbourhood Group Clinic methodology is grounded in coproduction. It offers three specific benefits to health and care systems and providers:

Time for personalised care, supported self-management and secondary prevention

Because Neighbourhood Group Clinics are highly effective at uniting MDTs, they build the interprofessional relationships essential to cut out repetition, support continuity and create time for effective self-management support and prevention (NHS Kent and Medway 2024).

By facilitating peer-led learning, they build knowledge, skills and confidence, improve self-management and increase people's agency in managing their own care. They improve patient activation scores and confidence (Moore, 2021) and quality of life (Trento et al 2010). They reduce reliance on urgent care (Scott et al 2004).

Patients make more lifestyle related behaviour changes when they attend Group Clinics compared to one-to-one appointments (Dickman et al 2011). Systematic reviews have found that compared to one-to-one appointments, people living with Type 2 Diabetes achieve bigger reductions in HbA1c, BP when followed up in Group Clinics (Joseph S et al 2022).

Group Clinics empower individuals and their families in line with NHS Universal Personalised Care standard. They do this because the Group Clinic process shares key biometrics with the group and encourages patients to reflect on their personal concerns and elicits their questions prior to the clinician joining. This provides headspace for both people and their carers to reflect and explore what matters to them. The Group Clinic always ends with goal setting.

Both clinicians and patient perceive Group Clinics as delivering superior quality, more person-centred care that elevates trust in clinicians compared to one-to-one appointments and improves communication between the person and their carer (Wadsworth et al 2019).

A drop in element to Group Clinics is a well-established feature (Noffsinger 2009, Hodge 2017). If people or carers are concerned about deterioration in their health or unexplained symptoms, they can drop into their local Neighbourhood Group Clinics for advice and support. This will further enhance prevention.

Sustainable integrated working processes

If Neighbourhood Health is to sustain and thrive, the systems and processes underpinning it need to quickly deliver significant productivity gains and a replicable, relationship-centred care model.

Patients perceive Group Clinics as a convenient one stop shop (Scott et al 2004).

Care delivered in Group Clinics equals the quality of clinical care observed and measured in one-to-one appointments (Tang et al 2024). Delivering reviews for 50% of their Type 2 Diabetes case load (n=500 patients) as Group Clinics releases a 0.5 full time equivalent advanced nurse (Gandhi et al 2019).

In a recent pilot hosted in Royal Devon University Healthcare NHS Foundation Trust, post discharge rehabilitation Video Group Clinics (VGCs) for stroke patients led to 100% increase in daily therapy received by patients (from 1 to 2 hours), and released 11 home visits (7 hours clinical time plus 13 hours of travel time) and saved 404 miles of travel, with a subsequent positive impact on service delivery costs and carbon emissions.

Evidence shows that working together in Group Clinics strengthens multidisciplinary team working compared to 1:1 care (Graham et al 2021, Lynch 2022). This advantage, combined with increased productivity and efficiency gains, means that Neighbourhood Group Clinics provide a tried and tested care process that will help to optimise scarce clinical resources and system capacity outside hospital

without compromising quality of care, and offer a scalable delivery platform for neighbourhood teaming.

A wide range of professionals can unite to wrap care around a defined population of patients and support them in Group Clinics. Neighbourhood Group Clinics provide a locus for community health and care. Care co-ordinators will play an instrumental role in Neighbourhood Group Clinic delivery. Group Clinics will support them to effectively undertake their co-ordination role and sustain continuity of care. VCFSE partners can co-deliver, share their expertise, signpost their resources and take on a paid role as Group Clinic facilitators, thus expanding the workforce and sustaining local VCFSE infrastructure.

A Neighbourhood Group Clinic might include: general practice, social care, community health professionals, mental health services, voluntary, community, faith and social enterprises (VCFSE). In England and Wales, Group Clinics are already being used to bring together dietetics, occupational therapy, physiotherapy, primary care, and specialist clinicians to co-deliver care to patients.

Whether delivered online or face to face, when multiple clinicians input, Neighbourhood Group Clinics will enable teams to jointly assess, support and review multiple patients efficiently. This will enrich assessment and review processes as each MDT member is trained to focus on different aspects of care. Most importantly, working together in Group Clinics will strengthen relationships, build empathy, understanding and mutual respect between MDT professionals and their patients.

Evidence supports the use of Group Clinics to deliver this kind of proactive care (Scott et al 2004, Wadsworth 2019). Scott et al (2004) evaluated monthly proactive care delivered as Group Clinics for frail older adults. Their target patient population mirrored the priority group recommended in the Neighbourhood Health Guidelines. They found reduced hospital admissions (*P*=.012), reduced emergency visits (*P*=.008), reduced use of professional services (*P*=.005) and lower overall care costs compared to one-to-one care.

Neighbourhood Group Clinics will also impact on wating times. An audit of waiting times for community-based specialist Long Covid services at the peak of demand for this pathway found waiting lists reduced from three months to less than two weeks. In general practice, introducing group clinics for those newly diagnosed with Type 2 Diabetes reduced waiting times from two months to two weeks. Similar reductions can be anticipated when Neighbourhood Group Clinics are in place.

Improved agency and experience of care for everyone

Communities, people, carers and front-line teams all gain agency and an improved experience of care through Group Clinics.

Healthy communities

The Neighbourhood Health model is seeking to build healthy, connected communities. Group Clinics build community resilience and connection in line with Working in partnership with People and Communities. They provide a highly efficient way to connect patients with local community assets and voluntary sector support, thus strengthening the neighbourhood networks. Building peer connection between people with similar lived experience and their carers strengthens communities and personal resilience, thus combatting social isolation. In this way, Group Clinics create social capital in the clinic room (Lynch 2022).

People

Group Clinics can support people across the whole life cycle – from pregnancy through to end-of-life care. Group Clinics can be co-designed with affected people, communities and clinicians to assure they reflect their values and cultural diversity.

Compared to one-to-one care, frail older adults report higher satisfaction with their primary care physician, feel more supported and less isolated when they are followed up in a Group Clinic (Scott et al 2004).

People and carers also report high satisfaction and experience of care scores compared to usual care models, and Group Clinics improve patients' perception of experience and quality of care (Wadsworth et al 2019).

Measures of agency such as confidence and patient activation measure (PAM) scores rise following Group Clinics (Moore 2021).

Carers

The 2024 Darzi Investigation concluded that there is under-recognition and lack of support for England's 4.7 million unpaid carers. Darzi reported that carers feel "invisible, misunderstood and unsupported". The investigation linked lack of engagement and support for carers to poorer outcomes for both carers and their loved ones, citing that 60% of carers with a substantive caring role were not being involved in discharge planning. The investigation called for a fresh approach that recognises unpaid carers as individuals with their own needs and equal partners in care and support.

There is a considerable body of evidence that demonstrates that carer stress and wellbeing is a key factor in hospital admissions, readmission and delays in the transfer of care (Bebbington et al, 2001). Castleton et al (1998) found that 20% of those needing care were admitted to hospital because of the breakdown of a single carer on whom the person was mainly dependent. Conochie et al (2011) similarly found carer-related reasons for admission to nursing or residential care were common and concluded that targeting support at people over 75 who are dependent on one carer would reduce healthcare episodes. Where a frail person is reliant on one family carer, the risk is especially high.

The Neighbourhood Health model need to urgently re-engage with carers as equals because they will be critical to maintaining independence and achieving reduced hospital and care home admissions.

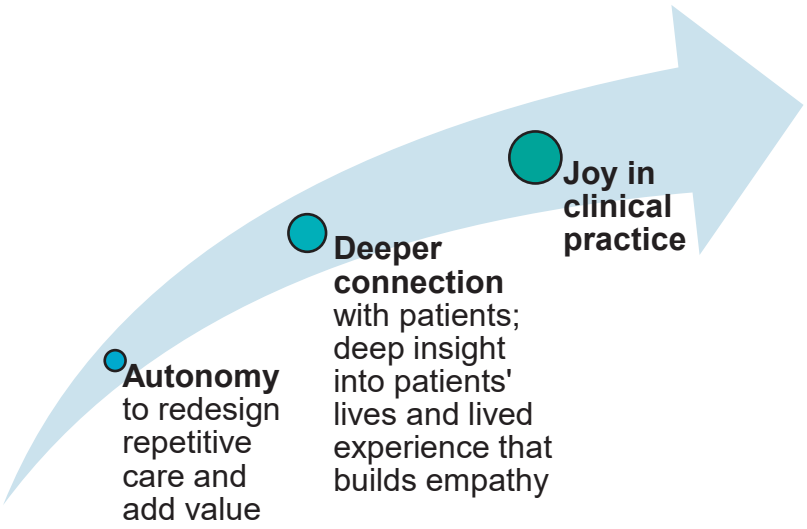
Carers specifically report that communication with their loved one improves after attending Group Clinics (Wadsworth et al 2019). Group clinics provide a highly productive way of re-engaging carers. They create the right conditions for carers to regain agency and become equal partners in care.

Frontline teams

Neighbourhood Health will only work when new systems and processes improve staff wellbeing and restore autonomy to front line teams. Evaluation has found that because clinicians perceive that Group Clinics add value to repetitive clinical tasks and processes, they often invest significant discretionary effort to get Group Clinics going (Lynch 2022). Designing Group Clinics restores autonomy to frontline teams. This, combined with deeper empathy and connection with people and carers (because they better understand people's lives and personal context) restores joy to clinical practice and improves job satisfaction.

Frontline teams report that working together in Group Clinics builds closer working relationships and mutual respect. They report learning from each other as well as from patients and their family members, which leads to more cohesion and team resilience.

Figure Four: How Group Clinics Impact on Frontline Staff



Furthermore, clinicians and facilitators working in Group Clinics need to develop skills in shared decision-making, health coaching and “what matters to you” conversations so that the group setting genuinely delivers personalised care and supports behaviour change. Front line teams can tap into accredited personalised care training, including Group Clinic training via The Personalised Care Institute.

Group Clinics also provide a rich learning environment that accelerates exposure to a diverse case mix of patients for clinicians who are new to practice or in training because they can act as the facilitator, observe and work alongside more experienced or specialist colleagues and witness repeated consultations in a short time. This builds knowledge and expertise, supports professional skills development and enhances their job role.

Recommendations

Neighbourhood Group Clinics offer a practical opportunity to scale an innovation that supports delivery of the six key components of Neighbourhood Health. The model has further potential to contribute to elective recovery by improving access and helping to reduce specialist care backlogs. When implemented effectively, Neighbourhood Group Clinics can enhance quality of care, release capacity, and strengthen staff engagement.

Based on its expertise, The Group Clinic Task and Finish Group recommends the following actions to realise this change:

- **Policy**: DHSC and NHSE support the *appropriate, locally led* use of Group Clinics, including Neighbourhood Group Clinics to deliver personalised care, improve access, patient experience, clinical outcomes and productivity and reduce waiting times where evidence and pathway fit are strong. DHSC and NHSE advocate for the use of Group Clinics to be considered for long-term condition management, in selected specialist pathways, and as part of ongoing clinical care for medicines management.
- **Leadership**: DHSC and NHSE appoint a National Subject Matter Expert (SME) for Group Clinics to increase understanding of the model and support adoption by curating standards, case selection, and model fidelity and updating existing toolkits and implementation guides hosted on Future NHS.
- **Evaluation**: ICBs to be tasked with routinely monitoring the implementation of Group Clinics. Adoption should align with the Model Health System metrics and deliver measurable improvements in access, quality and efficiency and support a pipeline of rigorously evaluated Group Clinic models. These should include Neighbourhood Group Clinics for those living with multiple morbidities. To strengthen the evidence base and case for change, Neighbourhood Group Clinics can be prototyped within neighbourhood health pilot sites in selected ICBs. This will support development of funding projections and quantify potential cost efficiencies that could be realised following adoption. Other priorities for evaluation include: Group Clinics within specialist care pathways, Group Clinics that deliver clinical wrap around care for patients prescribed weight loss drugs, and ongoing clinical care for medicines management and Group Work Coaching models that integrate health and employability professionals in providing personalised care and support for those who are economically inactive**.**
- **Routine data collection:** ICBs to routinely undertake simple, light touch monitoring of the uptake of Group Clinics and their impact, including impact on patient and staff experience. This can be facilitated by a standardised monitoring framework that enables real time data aggregation
- **Provider support:** Commissioners should make available comprehensive Group Clinic training with a strong personalised-care component alongside change management resources so that providers across primary, community and specialist care can adopt Neighbourhood Group Clinics with confidence. This will support teams to embed best practice, build facilitation and clinical skills, and establish the administrative processes needed for safe and effective delivery.

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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/

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