

Shared medical appointments in English primary care for long-term conditions: a qualitative study of the views and experiences of patients, primary care staff and other stakeholders

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Abstract

Background

Shared medical appointments (SMAs) or group consultations have been promoted in primary care to improve workload pressures, resource-use efficiency and patient self-management of long-term conditions (LTCs). However, few studies have explored stakeholders' perspectives of this novel care delivery model in the English NHS context, particularly patients' views about consultations involving other people with similar conditions.

Method

This qualitative study was conducted with 21 patients, 17 primary care staff, 2 commissioners, and 2 SMA training providers in the North East and North Cumbrian region of England. Semi-structured interviews were used to explore the perspectives of stakeholders with and without SMA experience from a range of geographical and socio-economic backgrounds. Thematic analysis was conducted to examine perceptions around impact on patient care and outcomes and barriers and facilitators to implementation.

Results

Three main themes were identified: 'Value of sharing', 'Appropriateness of group setting', 'Implementation processes'. Patients and staff with SMA experience enjoyed the novelty and informality of SMAs, with some patients reporting that they felt less isolated and more motivated to self-care. Concerns were raised about the appropriateness of SMAs for sharing personal information, particularly in close-knit communities where the risk of breaching confidentiality was perceived to be greater. Patients and staff were uncertain whether the group setting benefitted all, believing SMAs suited some patients more than others. Whilst staff anticipated that SMAs could deliver high quality care more efficiently than 1:1 appointments, none of the practices had evaluated the impact SMAs had on patient outcomes or staff time. Staff reported difficulties 'selling' SMAs to patients and low patient attendance at subsequent SMAs.

Conclusion

Newly diagnosed patients and those with limited SMA experience could enjoy and benefit from the added value that peer presence provides during SMAs. Patient intention to attend an SMA appears to be influenced by their existing level of interest in self-care, social support, group work anxiety and the presence of known others in the group. Further research is needed to clarify which patients, health conditions and circumstances are most appropriate for SMAs, and what implications they have for health inequalities.

Introduction

Innovative care delivery models to support patient self-management of long-term conditions (LTCs) are at the centre of government healthcare policies worldwide, including National Health Service in England and Wales (1). One model of care proposed to improve resource use efficiency in primary care and patient self-management are group consultations, also known as shared medical appointments (SMAs) (2,3). A recent systematic review of SMAs in primary care found they are at least as effective as usual care with regards to health outcomes and showed potential in improving self-efficacy which may enhance self-care (4). To support the adoption and implementation of this model, it is important to understand whether patients and providers consider them acceptable and feasible in practice.

SMA s are an alternative to 1:1 appointments whereby groups of patients with the same LTC(s) share an appointment and receive clinical management, patient education and peer support. SMA s can be delivered face-to-face or online (video SMA s) and are usually co-delivered by a clinician(s) (usually GP, Nurse Practitioner or Pharmacist) alongside a facilitator (non-clinical member of practice staff) and typically last up to 90mins. Practice staff have reported SMA s offer advantages over 1:1 appointment for the patients including peer support and accountability, as well as practice benefits in terms of efficiency and the longer appointment time enabling the opportunity to provide comprehensive patient-led (5). Patients have reported some benefits include vicarious learning, though some patients report that they dislike group setting, and report access issues due to the longer appointment time. However most evidence to date is from North America and focuses on provider perspectives and the views of low-income patient groups that may have less relevance to other health systems or patient population(5,6).

In England and Wales, there have been local initiatives encouraging the use of SMA s in primary care for LTC management that have primarily taken the form of training for practice staff. Training programmes provide primary care teams with a standardised SMA s model format that can be adapted according to local needs and resources. Whilst it has been reported that over 100 practices across England have attended SMA training(3), the extent to which practices have successfully used the model is unclear. A review of the wider literature identified several barriers to implementation including administrative and resource challenges, patient resistance and suitability and role adjustments and uncertainties(7). Factors identified as supporting successful implementation in primary care include having leadership, teamwork and communication, alongside staff skilled in group facilitation (7). The experiences of adopting and delivering SMA s in English primary care requires further investigation to understand how best to optimise the adoption and implementation of SMA s in primary care. Exploring the views of those involved in commissioning and delivering the training will help to better understand the readiness of the NHS to adopt and embed SMA s in primary care and what resource and support is needed. This qualitative study explored the views and experiences of patients, practice staff, commissioners and SMA training programme providers about using SMA s in primary care.

Methods

Study design

This was a qualitative study using semi-structured interviews.

Setting and sample

The study was conducted in the North East and North Cumbria region of England that covers a wide range of geographical settings from major urban to rural, with a lower percentage of ethnic minorities than the English average, and higher levels of deprivation in 13 out of 18 local authority areas(8). In 2018, Health Education England commissioned in-person training for primary care teams. The training was primarily for practice staff who will be organising (practice administrators and managers) and delivering SMA s (nurse practitioners and GPs) and SMA facilitators (non-clinical practice staff- usually administrators/ managers). When this study commenced, staff from a total of 67 (19%) general practices in this region had attended SMA training.

To obtain a broad range of perspectives about SMA s, a purposive sampling strategy was used based upon SMA experience. This included patients with LTCs (registered with practices who had attended SMA training) who had either accepted or declined an invitation to attend an SMA; people with LTCs with no SMA experience that could be invited to attend an SMA in future; primary care staff (practice-based and commissioners) who had no prior awareness of SMA s; staff who had attended SMA training in 2018; staff who had run SMA s in general practice for LTCs and senior members of the SMA learning support programme (trainers).

Identification and recruitment

North of England Care Support (NECS) identified practices whose staff had attended SMA training in 2018. Practices were purposively selected based on their geographical location and area deprivation level to ensure the sample included a broad range of perspectives including participants living and working in urban and rural locations in both socio-economically deprived and affluent areas. Managers of these practices were approached with information about the study by email, followed up by telephone calls and face-to-face meetings to request their support with recruitment of practice staff and patients to the study. Managers were asked to identify and forward study information to practice staff involved in the delivery of SMAs or who could be involved in their delivery in future. Staff interested in participating in the study contacted the research team to schedule the interview. Commissioners involved in supporting the use of SMAs in the North of England were identified through local networks.

Participating practice staff identified eligible patients through a search of their records of patients invited to attend an SMA and from personal recollection. Study invitation packs were posted or handed to participants attending the SMA. Patients willing to participate in the study contacted the research team. Patients were then screened for eligibility and interviews were arranged. To recruit people with LTCs without SMA experience, PPI representatives affiliated with the Policy Research Unit in Behavioural Science at Newcastle University were asked to share the study invitation with people in their networks and obtain their consent to be contacted by the research team. SMA trainers were identified from their website and invited by email to participate in an interview.

Data collection

Interview guides were developed to explore stakeholder views of SMAs and their impact on patient care and patient outcomes, experiences of delivering this mode of care, and barriers and facilitators to attendance/delivery (See Appendix 1). Interviews were conducted in-person, by telephone or via the video conferencing software Zoom as per patient preference. Recruitment stopped when the study team felt data adequacy was reached i.e. there was enough data and commonalities across codes to meet the aims of the research (9).

Researcher characteristics and reflexivity

Interviews were conducted by two researchers (FG interviewed patients, NHS staff and SMA trainers, HM interviewed NHS staff) who were of the same nationality and ethnicity as most participants (White British).

Analysis

All interviews were audio recorded, transcribed verbatim and then anonymised. The data were analysed thematically following the six-phase reiterative process outlined by Braun and Clarke (2006). In brief, this included reading and re-reading the transcripts to familiarise oneself with the data. From reading the transcripts, data pertinent to the research questions were coded inductively line by line. These codes were grouped into themes and then into subthemes where appropriate. All the transcripts were first coded by one researcher (FG) and 20% were independently double-coded (JL/HM). The wider research team also met to discuss and agree the final themes, sub-themes and definition of each theme. Nvivo version 12 (10) was used to support the organisation of the data during the coding process.

Results

A total of 39 interviews were conducted either in-person (n = 19), via Zoom (n = 11) or by telephone (n = 9), between October 2019- October 2020.

The sample included 21 patients with LTCs, 13 women, 7 men, 1 transgender person, with an age range between 38–87 years (See Table 1). Patients were from a range of socio-economic backgrounds, residing in areas with the lowest and highest levels of multiple deprivation (indices of multiple deprivation decile 10 and 1, respectively). Most patient

participants were retired, White British and had experience of SMAs. The condition for which most patients attended an SMA was high cholesterol with risk of familial hypercholesterolemia. Patients with SMA experience had attended a single, one-off SMA, were mostly female, and retired. Of the seven participants without SMA experience, five had not been invited to attend an SMA, and two that had been invited but were unable to as the time was unsuitable.

Table 1
SMA participant characteristics (patient/people with LTCs)

Patient participants (n = 21)	
Age (yrs)	
Range	38–87
Mean (SD)	64 (12)
Gender	
Men	7
Women	13
Transgender	1
Index of Multiple Deprivation (n)	
Decile 1–5 (Highest deprivation)	10
Decile 6–10 (Lowest deprivation)	10
Missing	1
Ethnicity	
White	20
Mixed	1
Marital Status	
Married	14
Widowed	3
Single	4
Occupation	
Retired	12 (57%)
Full-time employed	2 (10%)
Part-time employed	3 (14%)
Self-employed	2 (10%)
Long term sick	1 (5%)
Carer	1 (5%)
Highest educational qualification	
Level 2 (GCE, GCSE, O-levels)	4
Level 3 (AS level, A-Levels)	4
Level 4 (CertHE, Higher National Certificate)	3
Level 5 (Diploma of higher education, High national diploma)	0
Level 6 (degree apprenticeship, degree with honours)	5

Patient participants (n = 21)	
Level 7 (Master's degree, post-graduate certificate)	1
Level 8 (PhD or DPhil)	3
Number of chronic conditions	
0 (at risk)	4
1	4
2	3
3 or more	10
Chronic conditions	
High Cholesterol/ Risk of Familial Hypercholesterolaemia (FH)	10
Diabetes /prediabetes	9
Hypertension	4
Asthma	2
Depression	2
Chronic pain/ Fibromyalgia	2
Hyper/Hypothyroidism	2
Osteoporosis	1
Arthritis	1
Parkinson's Disease	1
Chronic Fatigue Syndrome	1
SMA experience (attended SMA)	14
Women	10
Men	4
Retired	9
Full-time employed	3
Part-time employed	1
Carer	1
No SMA experience	7
Not invited	5
Invited -unable to attend	2

[Insert Table 1 here]

A total of sixteen NHS staff were recruited, thirteen had SMA experience: seven had attended SMA training and subsequently delivered SMAs; two had attended training but were not involved in SMA delivery; and two had delivered

SMAAs but had not attended any formal training. Seven staff had no SMA delivery experience, this included: two GPs; two practice manager; two commissioners; and one social prescriber. See Table 2 for provider characteristics; note that the details of the training providers have been omitted from the table to retain anonymity.

Table 2
Provider characteristics

NHS staff (n = 16)	
Gender	
Men	5
Women	11
Ethnicity	
White	16
NHS staff role	
GP	5
Practice Manager	3
Administrator	2
Nurse Practitioner	2
Commissioner	2
Pharmacist	1
Social prescriber	1
SMA experience (n = 13)	
Attended training and delivered SMA	
Practice manager	2
Nurse practitioner	2
Pharmacist	1
Administrator	1
GP	1
Attended training (no delivery experience)	
Practice manager	1
Commissioner	2
Social prescriber	1
Delivered SMA (no formal training)	
GP (1 female, 1 male)	2
No SMA experience (n = 3)	
Did not attend training:	
GP (2 male)	2
Practice manager	1

Practice-based NHS staff in the sample worked in eight different general practices in the NENC, characteristics of these practices and their SMAs use are outlined in Table 3. Most practices had run at least one SMA but had since stopped. Only two of the practices that took part in this study had successfully set-up and were regularly running SMAs to deliver routine care. These practices were replacing 1:1 annual review appointments for patients with LTCs including asthma, high cholesterol, diabetes and COPD with SMAs.

Table 3
Characteristics of SMA and their use in practices

Practice	SMA condition(s)	No. SMAs delivered	SMA status at interview	Staff delivering SMA		Practice list size (patients)	Setting (deprivation level ^{**})
				Clinician	Facilitator		
A	risk of familial hypercholesterolemia	7 as part of project	not running	GP	practice manager/ administrator	7,000	rural (HD)
B	diabetes, asthma, high cholesterol	> 25	routine practice	nurse	medications manager/ administrator	10,000	major urban (LD)
C	diabetes	1	not running	nurse	administrator	13,000	major urban (HD)
D	multi-morbidities	6	routine practice	nurse	healthcare assistant	16,000	Major urban (HD)
E	high cholesterol, asthma, COPD	> 25	routine practice	pharmacist/ GP/nurses	unclear	20,000	major urban (HD)
F	diabetes	1	just started	nurse	healthcare assistant	36,000	city & town (HD)
G*	chronic pain	> 25	yes – now running VSMA(s)	GP/ pharmacist/ nurse	unclear	12,000	major urban (HD)
H*	multimorbidity to include: overweight / obesity / hypertension, pre-diabetes / type 2 diabetes	6	not running	GP	healthcare assistant	12,000	city & town (HD)
GP = general practitioner							
*Interviewed during height of pandemic							
**HD = Higher deprivation (Indices of multiple deprivation deciles 1–5), LD = Lower deprivation (Indices of multiple deprivation deciles 6–10)							

Three overarching themes were identified that captured stakeholder views and experiences of delivering/attending SMAs for LTCs. These were: 'Value of sharing'; 'Appropriateness of group setting'; and 'Implementation processes. These themes and associated sub-themes are illustrated in Table 4. The following abbreviations are used from here: S = Staff (includes practice-based staff and commissioners), P = patients and T = training providers, MM = Multimorbidity, SE = SMA experience, NSE = No SMA experience, HD = High deprivation, LD = Low deprivation.

Table 4
Themes and subthemes

Theme	Subthemes
Value of sharing	Overcomes feeling of isolation and supports self-care Enjoyment of the novelty and greater informality Time for learning
Appropriateness of group setting	Confidentiality and personal concerns Patient preference and suitability
Implementation processes	Training Capacity and resource Leadership and 'buy-in' from colleagues Engagement and attendance Evaluating efficiency

VALUE OF SHARING

This theme captures perceptions and experiences about the benefits that the presence of other patients adds to the appointment in terms of the impact upon the delivery and quality of patient care.

Overcomes feelings of isolation and supports self-care

All patients and practice staff anticipated that SMAs would provide an opportunity for patients to speak to others with the same condition. This would benefit the patient by helping to validate feelings and experiences of living with an LTC and feel emotionally supported, as described by one patient:

"...I think unless you've been there and you've experienced chronic pain for however long, you can have all these skills and all the qualifications but you don't really understand what it's like to live with a chronic illness day in, day out. So, I think for that aspect, I think people experiencing the same problem, it could be quite supportive." P20, F, 50-59yrs, NSE, LD

Patients in this sample who had attended an SMA reported experiencing little direct conversation with other patients during or after the session. However, they described that after listening to the conversations between staff and other patients, they felt less isolated having encountered 'people in the same boat' (P2, P5, P12). Practice staff reported that patients were able to identify with others with the same condition and therefore engage more with their care. One primary care staff member reflected upon a children's asthma SMA:

"...they may not have another person within their friendship group who has asthma, but when they come to the group clinic there are other people in their age range who have it. They're able to identify that and.... get a better understanding of what's happening and realise they're not alone." S6, SE, Urban, HD

GPs without SE expressed reservations about providing individualised results in a group and felt it might require a sensitive discussion with a patient outside the group on a 1-2-1 basis.

"People may or may not understand what different results mean. For example, diabetes. They may just see that a rising HbA1c... is just due to poorly controlled diabetes, but actually it could be due to something else, which is quite a sensitive discussion with a patient and potentially breaking bad news." S11, GP, NSE

However, patients with high cholesterol who had attended an SMA for those at risk of Familial Hypercholesterolemia, reported that despite having some concerns about sharing personal information in the group, they found comparing individual blood cholesterol results with others helpful in understanding their own risk of the condition. A small number also reported that comparing their results with others made them more proactive in the management of their condition.

“it did make me realise...I should make sure I do get my blood test done and checked... If somebody ... 20 years older than me, can have [their cholesterol] brought down to a really low level then I could obviously get mine down and make it less harmful to my body.” P10, F, 60-69yrs, SE, LD

At the same time, there were other instances where patients reported that once they realised their risk of FH was low, they disengaged from the discussion and felt the SMA was a waste of time.

“I could have met with the GP for 20 minutes myself... It would have been more tailored to me rather than listening to the illnesses that other people had.” P13, F, 50-59yrs, SE,

Time for learning

Patients without SE anticipated the longer appointment time would allow them more time with the clinician to discuss their condition in greater depth than they could during their usual 10-minute appointment. This anticipated benefit was confirmed by those with experience of attending an SMA, especially newly diagnosed patients who described the longer appointment as a “life-line” (P5) because it was less rushed, and they had time to “reflect and think”(P5) about their health and it provided them ‘a chance to focus and feel you could do something about it’ (P11). GPs that did not attend the training but were using, or intended to use SMAs, believed that the SMA model provided them the opportunity to spend longer with their patients enabling a more holistic approach to patient care. GPs also reported that having the opportunity to listen to patients sharing their personal experiences of living with the condition enhanced their understanding of the patient and the challenges they faced.

Enjoyment of the novelty and greater informality

Most patients and providers who had been involved in SMAs reported that they had enjoyed the experience, and found the session more relaxed than traditional 1:1 consultations. In addition to benefitting patients, practice staff reported that they enjoyed delivering care via SMAs as they were ‘less repetitive’ than one-to-one appointments and liked the variety they added to their daily routine. One manager reported there being a ‘buzz about it in the practice after a SMA session’ (S1, Practice manager, SE, Rural, HD) and another said they felt invigorated (S10, Nurse, Urban HD). Practice administrators involved in the delivery of the SMAs (facilitator) reported that they particularly enjoyed being in a different role that enabled them to connect with patients on a more personal level. Training providers reported that part of enjoyment of SMAs comes from the experience of teamwork with colleagues within their practice.

Appropriateness of Group Setting

This theme encapsulates participant views about the limitations of SMAs use, and their perspectives on which types of patients and conditions they best suit.

Patient preference and suitability

Most patients reported that they were happy to participate in a group appointment but some expressed concern that group work might not be appropriate for all patients including those who are shy or have social anxiety. This was exemplified by one participant with autism who reported that they would find the group situation too anxiety provoking:

“I’d feel overwhelmed because of the six to ten people in the room, but also... when it was my turn, everyone’s eyes on me, and watching me... I’d probably forget key things that I need to discuss. ...” P20, F, 50-59yrs, NSE, LD

Individuals past experiences of group work/ SMAs underpinned their intention to attend an SMA in future. Most attendees said they would attend a future SMA as they believed they would benefit from the social support of others in the group. However, this view was not shared by all. One patient felt that main benefit of the group setting was the potential for social interaction which she did not require:

“.. . if you were struggling with an illness and, say, you were isolated or lonely. There may be benefits to being in the group for that, in those circumstances, but for me, I’ve got a good group of strong, loyal friends... I don’t think I’d benefit.” P13, F, 50-59yrs, FTE, HD

Practice staff also reported that the group setting suited some patients more than others. They described instances where patients had asked if they could be seen first in the group so they could leave early, and where a patient had walked out of the session upon realising it was delivered as a group. Whilst others, reported they were pleasantly surprised when patients they anticipated would not participate in and SMA. Training providers emphasized that SMAs were not intended to be suitable for all, but felt that if implemented widely in the NHS, they would help to reduce demand for individual GP appointments. Training providers also believed that patients who attended would benefit even if they did not share their experiences with others in the group. However, some practice staff expressed doubts that all patients benefitted, implying that those who were already self-managing their LTC well may not necessarily benefit from hearing from others. As one nurse practitioner reflected upon and SMA for diabetes:

“I think there were three there who were well-controlled and three who weren’t, and it was good for the people who weren’t controlled, but whether the other people learnt much from it, I don’t know” S5, Urban, LD.

Training providers recommended that all patients should be invited to attend an SMA, though there may be some groups they are not suitable for e.g. people with advanced dementia. They also reported that a ‘common sense approach should be taken’ when it comes to children and families and recommended that groups of patients of similar ages should be seen together. One staff member reported that in her experience, SMAs for asthma did not work well with groups of teenagers as they are adversely influenced by others and less likely to share:

“We did find the teenagers we couldn’t do as a group consultation, because they’re very difficult...[in terms of] attitudes... You only needed one to throw the group off and so we felt it was better still to be one-on-one with those patients” S6, Urban, HD

At the same time, trainers cautioned against practices inviting only patients they anticipated would ‘get on’ with others. Yet two providers in this study reported that they spent time screening out patients deemed unsuitable, including those they thought would be ‘disruptive’. The implications this has for health inequalities requires further examination.

Confidentiality and personal concerns

Some patients with SMA experience particularly in rural settings, noted that prior to attending they were concerned that they would recognise other people in the group but were relieved when this was not the case. Whilst attending an SMA for identification of Familial Hypercholesterolemia was considered acceptable by most, future attendance depended upon the condition or personal information that might be divulged during the session.

“The problem is with such a close-knit community, you just have to say your name and people know who you are. If it had been anything a bit more personal, I don’t actually think it would work” P13 F, 50–59 yrs, SE, FTE, HD

SMA participants reported that there were no confidentiality breaches to their knowledge, but some expressed scepticism about the extent to which the information would remain in the group.

One GP without SE believed that SMAs were inherently problematic in their nature given the high risk of confidentiality breaches by other patients in the group and wanted to know how this would be circumvented before proceeding.

“A [confidentiality agreement] form is a form. Unless it comes with a legal follow-up then it’s just someone’s name on a paper. [If] I break confidentiality, I could be in front of the General Medical Council or in front of the courts.” S11, Male, NSE, Urban

Several staff with SMA experience reported that they were initially concerned that patients would be reluctant to attend group appointments over confidentiality concerns. However, after having run the SMA where patients were asked to sign confidentiality agreements, they did not consider confidentiality to be an issue and reported that patients appeared content to share their test results, family history and medical experiences in front of other patients.

Implementation Processes

This theme relates to the key requirements and challenges predicted or experienced, primarily by providers in setting up and delivering SMAs.

Training

Practice managers believed some staff without SE were reluctant to engage with SMAs as they lacked the confidence to consult in a group, particularly those who had not received training first-hand. SMA trainers and commissioners identified lack of time and capacity of staff to attend and high workload and pressure in primary care as key reasons for low attendance at SMA training:

“It is much easier to get teams of people, in secondary care, together for the training. They can cancel their clinics for an afternoon, and it’s the whole team there...In primary care, there’re just not enough people. There’re just not enough GPs, they’re always covering for someone, they’re always under pressure. It’s constant.” T2

With regards to training needs, training providers and practice managers were of the view that the facilitator (non-clinician) required the most training, given that their role was vital to ensuring the SMA ran to time and that the facilitator role was very different to their current job role. However, reflections by clinicians in this sample suggest that they too would benefit from SMA training, as delivering care to a group of patients is a new experience:

“I was somewhat petrified...I’m very much comfortable with that one-on-one, face-to-face scenario. To be put in a roomful of people was very much out of my comfort zone.” S14, SE, Urban

Capacity and resource

Several challenges to setting-up SMAs in practice were reported by practice staff and echoed by commissioners and training providers. Reports of insufficient time, resource, and space in the practice to hold the group sessions were commonly reported by practice staff. Clinicians and managers reported having a lack of time and “headspace” (S4) after the training to think through the set-up work required, which was the reason they had yet to implement SMAs in their practice. Training providers recognised that SMAs require a significant amount of work to set up but believed that the work required to sustain the SMAs would reduce over time. Alongside initial set-up time, practice staff reported that high staff turnover, specifically the loss of trained staff, were additional key barriers to implementation and sustainability of SMAs. Practice managers reported they had insufficient funds to create a new role to support SMA coordination which has meant

that implementation relied upon the 'goodwill' of staff to take on the extra work. Both trainers and staff recognised incentives may be helpful to encourage the use of SMA in practice through the provision of money and resource. Commissioners and staff suggested training opportunities for wider practice staff and additional resource by way of enhanced Primary Care Network link workers and Care Coordinators taking on role of SMA facilitators in practices.

Leadership and 'buy-in' from colleagues

Practices that have successfully embedded SMAs in routine care reported that having staff in senior leadership positions with a personal interest in SMAs was key to their success. This was echoed by commissioners:

"... what has been key is that there have been one or two people in the practice who are really keen... They've almost kind of stepped forward and nominated themselves as aclinical lead in their practice..." S15, NSE

Convincing colleagues to support the adoption of this new approach was a common implementation barrier reported by practice staff who reported colleagues were resistant to change, did not understand the benefits of SMA or were uncertain about what was expected of them. Training providers also reported that the beliefs of health professionals was often a barrier to implementing SMAs successfully:

"Many clinicians, even to this day, will say, 'I can't understand why patients would like to be seen in a group'... Their thinking like that was meaning that ...they weren't being successful because [their mind-set] this was getting in the way for them." T2

Both training providers and practice staff believed that witnessing an SMA in practice would greatly help with 'buy-in' from colleagues. However, trained staff reflected that they had limited capacity, and often no occasion, in which to communicate what they were doing to colleagues in their practice, or other practices.

Engagement and attendance

Patients reported they attended the SMA as they were curious about whether they had the condition for which the practice had organised the group session (those at risk of hypercholesterolaemia). Several newly diagnosed patients reported that they wanted to learn how to manage their condition, they attended without realising the SMAs were novel. Patients in this sample that did not attend an SMA were full-time employed or carers and did not attend because the SMAs were arranged at a time that was unsuitable for them.

Several staff reported that patients had declined an invitation to participate for various reasons including: expressing preference for 1:1 appointments; that they disliked the change to routine care or group work or that they had insufficient time to attend or it was not convenient. Staff reported they had tried to organise SMA at times they thought would be more suitable for patients to attend, for example after school or work, or during the school holidays, but found this unsuccessful and attendance remained low.

Staff in practices running SMAs recommended advertising widely, providing reassurances to patients, setting expectations, and having enthusiastic staff communicating SMAs effectively:

"you've got to have the right dedicated person actually selling the group consults to patients. They're easily sold, don't get me wrong, but, if you don't have that right attitude behind that, there'll be a big struggle." S2, SE, Urban, LD

Managers of practices that were running SMAs frequently also reported having familiarity and trust in the clinician helped encourage patients to attend. Training providers reported that uptake is most effective when the practice staff are enthused and informed about how best to invite patients and SMAs are offered as a default appointment option:

“If you go to patients and give them a choice, it’s like, ‘I don’t want to go to a group.’... What we say to healthcare professionals is, “Keep it really simple. It’s the three key messages, you get to spend longer with your clinician, you get connected with people who’ve got similar challenges or conditions as you, and people that attend group consultations do better” T2

Of the practices using SMA routinely, one reported it was difficult to get the same patients to attend a second group appointment. In some instances, patients attended only the preliminary information gathering appointment (e.g. when bloods were taken by a healthcare assistant), and did not attend the subsequent SMA (where results are reviewed by the clinician). They also reported that they struggled to get children patients back for a second asthma SMA session, assuming the patients and families felt there wasn’t a need.

Evaluating efficiency

When exploring stakeholders’ perceptions of the benefits of SMAs, several patients regarded them as a positive way of saving the NHS time and money by enabling the clinician to see several people at once. The potential time and costs saved by SMAs was described as a key reason that practice staff had decided to attend SMA training. Providers anticipated that SMAs would help to address some of the practical and resource related challenges they faced in primary care, including limited availability of GPs appointments in relation to the large numbers of patients with LTCs. SMAs were also viewed as a way to avoid the large numbers of repetitive 1:1 appointments (S6) that currently reduces their job satisfaction. However, none of the practice staff in this sample had formally assessed the impact of SMAs on their own time, or on the demand for 1:1 appointments in general, so were unable to confirm time or cost savings. Nevertheless, almost all staff with experience of SMA training believed that with time and experience SMAs would become cost-effective, as more patients attended. As one nurse reported:

“we didn’t get a benefit at all when we [ran an SMA for diabetes] because it didn’t save money for us because we only saw six people. So, I mean, in an hour-and-a-half... It took two people to see them.. where I could’ve just done that myself. If the group had been bigger, then there would’ve been a cost saving for the practice there” S5, SE, Urban, LD

Trainers felt that a large scale, national evaluation of SMAs in primary care was required but were concerned that lack of funding and the additional burden the evaluation work would have on practice staff was a key challenge, though were in the process of developing tools to support practices to evaluate their SMAs.

Discussion

The application and use of the SMA model varied across practices, with few providers reporting they had successfully embedded them as part of routine care. Whilst patients and staff experiences varied, the consensus was that SMAs have the potential to deliver care that is enhanced by the presence of peers and the longer time spent with the clinician. SMAs were also perceived to be a more efficient way of delivering care, yet few practices were using SMAs regularly enough to provide insights about their efficiency and use long-term. Accounts suggested that patient engagement with SMAs depended on an individual’s enjoyment or anxiety about group work based on past experiences and their beliefs about the personal gains, (whether they would benefit from the socialisation and peer support), the condition for which the SMA was being held, (whether it was too private or personal to discuss in a group setting) and how comfortable they felt sharing information with people that they may already know.

Concerns regarding the legal aspects around confidentiality of SMAs were expressed by GPs without SMA experience highlighting a potential barrier to SMA implementation that requires clarification. Concerns about the appropriateness of sharing and discussion results that might be of a sensitive were also raised by staff without SMA experience. Whilst perceived SMAs to be an effective way of delivering holistic care, none of the practice staff interviewed were able to confirm whether patients’ conditions had actually improved since attending the SMA. Staff running SMAs relatively

frequently struggled to get the same group of patients to attend subsequent SMAs despite efforts to hold the sessions at times they perceived to be more suitable.

Strengths, limitations and challenges

This study provides various stakeholder views and experiences of SMAs in North East and North Cumbrian region of England, an area that is under-represented in the wider SMA literature(5). A key strength of the study is that we have incorporated the views of patients who live in areas with the greatest and lowest levels deprivation in the country and patients with one or more LTCs. In addition, our sample includes the perspectives of staff without SMA experience that are missing from previous studies(5,7). This has helped to identify preconceptions about SMAs which may represent potential barriers to system wide implementation. This study would have been strengthened had the views of patients that declined an SMA been captured. However we were unable to recruit this group to our study. Data was collected before and during the COVID-19 pandemic during which the delivery of care in primary care changed dramatically and remote consultations became the default, thus perceptions of SMAs may have changed.

Comparison with existing literature

The value of peer presence reported in this study confirm the experiences previously reported (11), whereby the patients feel supported by other group members, enjoy the informal atmosphere the group creates, as well as the additional time it provides with their clinician. Furthermore, our findings support the middle range theories of Kirsh et al. (2017)(12) that group exposure combats isolation, which in turn helps to remove doubts about one's ability to manage illness and that SMAs help patient feel inspired by seeing other who are coping well. Our findings suggest this is particularly true for newly diagnosed patients with or at risk of LTC.

With regards to impact on care provision, practitioners highlighted the reduced repetition and added variety that SMAs provided to everyday practice which in turn has increased work satisfaction; a benefit reported in previous studies (5,6). However, our findings do not support the theory of Kirsch et al. that providers feel increased appreciation and rapport towards colleagues leading to increased efficiency(12). On the contrary, several practitioners reported frustration when experiencing reluctance from colleagues to support their endeavours. This discrepancy may be because these theories were generated from evidence from primary and secondary healthcare settings in other countries, which may not translate to NHS primary care context.

Challenges to implementation of SMAs reported by providers and SMA trainers in this study echo the findings of Swaites et al.(7), which reported key challenges to the initiation and operationalisation of group consultation in primary care related to the amount of time and resource required to set-up the SMAs in practice. We also found that practice-wide 'buy-in' was needed to successfully adopt and support this model, and that staff understanding and attitudes underpinned success. Staff in our study also reported difficulties 'selling' SMAs to patients and reported low attendance at subsequent appointments by the same group of patients highlighting uncertainty around the use of SMAs long-term. This echoes the conclusions of Booth et al. (11) that suggests once patients feel that they have obtained information, their motivation for attendance wanes. Whilst most patients in our sample reported they would attend another SMA, further exploration of their use over time is needed.

Implications for future research and clinical practice

Practice staff and patients raised concerns about the suitability of SMAs for some patients and believed that some patients benefitted from attending SMAs more than others. Practice staff also reported instances where they invited patients based upon who they anticipate would attend an SMA or who would work well in a group. These findings highlight important implications for health inequalities. It is important to consider if any inequalities might arise due to

differences in the uptake of SMAs in different patient groups based on ethnicity, rurality, health literacy or access to material resources such as transport or digital technologies. The approach taken by practices to identify and invite patients also requires consideration to ensure this does not worsen health inequalities. Further research is needed to establish which groups of patients should be brought together in SMAs for best effect. Guidance about how to make SMAs more inclusive or tailor them for patient groups is needed, along with consideration of the additional resource this incurs.

Healthcare practitioners were unable to determine whether SMAs reduced demand for one-to-one appointments or saved clinician time. Authors recommend that a standardised evaluation plan is developed for use by practices. This would involve the development of standardised measures of SMA effectiveness and efficiency for LTC, such as patient attendance at SMAs, resource and time requirements, healthcare service use, patient satisfaction and health outcomes. Once agreed, these measures ought to be embedded in routine data collection systems, such as patient medical records to enable natural experience and more agile evaluation.

Practices that were unable to incorporate SMAs into routine practice following the training explained they did not have the resources and capacity to adopt them and that further staff training was needed. As recommended previously(7), implementation planning at the practice level is needed to ensure there is appropriate training, leadership, coordination, and practice-based resource to effectively support SMA delivery. This planning ought to also include quality standard checks to ensure that SMAs are arranged and delivered as planned with consideration of the potential implications for health inequalities.

Conclusion

Newly diagnosed patients and those with limited SMA experience could enjoy and benefit from the added value that the presence of peers provides during SMAs. However, SMAs were only deemed appropriate for patients that enjoyed sharing with others and for common conditions that were not 'too personal'. An individual's intention to engage in an SMA appears to be influenced by their existing level of interest in the care, social support, group work anxiety and the presence of known others in the group. Further research is needed to clarify health conditions, circumstances and for whom SMAs are most beneficial and appropriate. Barriers to implementation include lack staff capacity, resource availability, senior support and leadership required for implementation planning. Needs assessment in practices to identify appropriate training, leadership, coordination and resource are needed to effectively support SMA delivery, including by video-link following the pandemic. Practice staff were unable to confirm whether the SMAs are as effective and efficient as initially thought, in part due to lack of evaluation planning. Standardised evaluation plans for practices to use are needed to inform future use.

Abbreviations

COPD- chronic obstructive pulmonary disease

GP- General practitioner

NHS- National Health Service

NECS- North of England Care Support

NIHR- National Institute of Health Research

LTC- long term condition

SMA- shared medical appointment

Declarations

Ethical approval and consent to participate

Research methods were performed in accordance with the Declaration of Helsinki and ethical approval was granted by North East – Newcastle & North Tyneside 2 Research Ethics Committee (19/NE/0241) and the Health Research Authority (IRAS number: 262964) on 16/09/19. Non-substantial amendment was granted on 27/07/20 to allow interviews to be conducted by telephone or over Zoom during the COVID-19 pandemic. Informed consent to participate in the study was obtained from participants.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated during the current study are not publicly available as consent to share the data in this way was not obtained from interview participants. Data may be available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Author contributions

EK, KJ, HM, AOD and FG conceived and designed the study. FG and HM undertook the data collection. FG, JL, HM conducted the analysis. All authors contributed to the interpretation. FG drafted the manuscript that all authors contributed to and approved. All authors have agreed to be personally accountable for the author's own contributions and to ensure that questions related to the accuracy or integrity of any part of the work are appropriately resolved and the resolution documented in the literature.

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References

1. NHS England. The NHS Long Term Plan. 2019. www.longtermplan.nhs.uk [accessed March 2022]
2. Clay H, Stern R. Making time in general practice: freeing GP capacity by reducing bureaucracy and avoidable consultations, managing the interface with hospitals and exploring new ways of working. 2015.
3. Jones T, Darzi A, Egger G, Ickovics J, Noffsinger E, Ramdas K, et al. Process and Systems: A systems approach to embedding group consultations in the NHS. *Futur Healthc J*. 2019;6(1):8–16.
4. Tang MY, Graham F, O'Donnell A, Richmond C, Beyer F, Sniehotta FF, et al. A systematic review of shared medical appointments delivered in primary care for patients with one or more long-term conditions to improve health outcomes and reduce healthcare service use. *prep*.
5. Graham F, Tang MY, Jackson K, Martin H, O'Donnell A, Ogunbayo O, et al. Barriers and facilitators to implementation of shared medical appointments in primary care for the management of long-term conditions: a systematic review and synthesis of qualitative studies. *BMJ Open* [Internet]. 2021 Aug 24;11(8):e046842. Available from: <https://bmjopen.bmj.com/lookup/doi/10.1136/bmjopen-2020-046842>
6. Lavoie JG, Wong ST, Chongo M, Browne AJ, Macleod MLP, Ulrich C. Group medical visits can deliver on patient-centred care objectives: Results from a qualitative study. *BMC Health Serv Res*. 2013;13(1).
7. Swaites L, Paskins Z, Duffy H, Evans N, Mallen C, Dziedzic K, et al. The experience of implementing and delivering group consultations in UK general practice. *Br J Gen Pract*. 2021;BJGP.2020.0856.
8. Lawlor J, Hambleton D, Joint SRO Mental Health. North East and North Cumbria (NENC) Mental Health ICS Programme 2018-19 Progress Report [Internet]. 2018. Available from: <https://cemind.org/wp-content/uploads/2020/04/North-East-and-North-Cumbria-Mental-Health-ICS-Programme-2018-19-Progress-Report.pdf> [accessed March 2022]
9. Konstantina Vasileiou, Julie Barnett, Susan Thorpe, Terry Young. Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Med Res Methodol*. 2018;18(1):1–18.
10. QSR International Pty Ltd. Nvivo (version 12) [Internet]. 2018. Available from: <https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home> [accessed March 2022]
11. Booth A, Cantrell A, Preston L, Chambers D, Goyder E. What is the evidence for the effectiveness, appropriateness and feasibility of group clinics for patients with chronic conditions? A systematic review. *Heal Serv Deliv Res* [Internet]. 2015;3(46):1–194. Available from: <http://dx.doi.org/10.3310/hsdr03460>
12. Kirsh SR, Aron DC, Johnson KD, Santurri LE, Stevenson LD, Jones KR, et al. A realist review of shared medical appointments: How, for whom, and under what circumstances do they work? *BMC Health Serv Res*. 2017;17(1):1–13.

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