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COMMENTARY

Scaling group consultations – the fourth healthcare revolution: A call to action to save primary care

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Abstract

Compelling arguments support scaling of group consultations across the National Health Service (NHS) and globally. We need to recognise self-care is the most important type of care for people with long-term health problems. Healthcare systems like the NHS are essential for diagnosis, acute care and initiating optimal therapy but people are on their own over 99.95% of waking hours. We must accept and encourage the contribution that other people with the same long-term health problems can make and enable both types of care through face-to-face and virtual group consultations. Patients and communities need agency and choice to implement and access these patient-centred and codesigned care models. This can bring system benefits, mapped to healthcare's quintuple aim, to those electing to use group consultations and even those who do not. The process of both training and delivering group consultation models can create and sustain compassionate communities and this 'Fourth Healthcare Revolution' may be exactly what is needed to save primary care.

1 | INTRODUCTION

Abel and Kellehear recently outlined a vision of reimagining public health in this journal.[1] As a patient co-designed care model group consultations support that vision, inherently supporting, developing and maintaining compassionate communities, as well as creating time and space for *Lifestyle Medicine*.[2] During the challenges of the pandemic, increased virtual networking, training and delivery of virtual group consultations have been a silver lining.[3] This article will give an overview of the inherent codesign, their value and how scaling might be achieved using place-based partnerships. We will conclude group consultations are an integral part of any solution to current record waiting lists globally (over 7.2 million in the United Kingdom, for instance) and the only one allowing existing staff to deliver more care at the same or higher quality.[4]

2 | EVIDENCE BASED

There is an abundance of evidence that group consultations deliver high-quality care, which meets healthcare's quintuple aim: good outcomes, high satisfaction for patients and staff, good education and cost-effectiveness.[4] That evidence is based on systematic reviews of large randomised controlled trials in antenatal care as well as for people with chronic diseases like diabetes[5] and hypertension.[6] What is less readily appreciated is how many services have seamlessly transitioned group consultation care into virtual delivery, with attendant benefits. This includes agile practice-based models,[7] whole system implementation of diabetes virtual group consultations across the whole of Northwest London Integrated Care System, but also National Health Service (NHS) programmes like the Diabetes Prevention Programme (Harry McMillan, personal communication 2022). Furthermore,

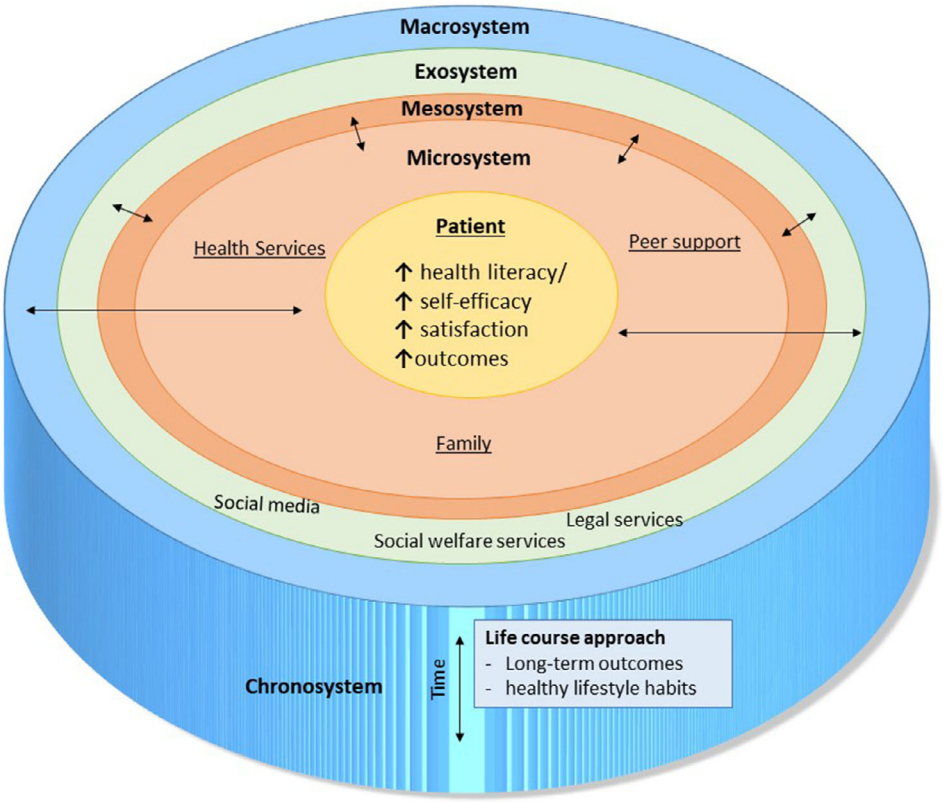

FIGURE 1 Ecological systems theory: Insights into (virtual) group consultation models.

several effective models for healthcare issues like menopausal symptoms and providing broader support for women's health have been developed. These have impressive outcomes both published[8] and, unsurprisingly given pandemic pressures, some of it unpublished. This includes the powerful engagement virtual group consultation model, which gets hundreds of people with a condition onto the chosen virtual platform at scale and enables triage into smaller group consultation sessions.[9]

3 | A MODEL TO UNDERSTAND GROUP CONSULTATION IMPACT

The ecological systems theory model is a longstanding model widely used in North America.[10] It can be applied to understand the impact of virtual and face-to-face group consultations (see Figure 1) unpacks the effects of an intervention into a number of levels, including the individual, family unit (microsystem), friends and close community (mesosystem – which could include your own primary care provider/surgery practice), wider community (exosystem – we might think of integrated care system level but also includes the primary care network delivery) and national perspective (macrosystem – covering the whole NHS). This can also be extended to consider the impact over time (chronosystem), and we would encourage healthcare leaders and decision-makers to include this in longer term planning.

4 | VIRTUAL NETWORKING AND TRAINING

Shared challenges have certainly encouraged the lifestyle medicine community to join up globally, notably through the virtual group consultation webinar series (https://bslm.org.uk/vgc/). This collaboration between the leading UK, USA and Australian lifestyle medicine organisations has engaged clinicians and academic alike in sharing best practice in this space.[3] There have now been 15 webinars with more than 3500 registered attendees from over 60 countries and videos watched over 5000 times on catch-up. Different virtual training models have been tried, and some are very light-touch. For example the NHS England Video Group Clinics initiative trained 700 primary care team members but would appear to have had limited impact with no data published or presented on delivery and outcomes.[11] In contrast, we know that effective training and support delivered virtually across Northwest London Integrated Care System has had measurable impact, including 248 out of 348 practices (71%) trained actually delivering at least one diabetes virtual group consultation session (or 42 out of 45 primary care networks successfully implementing, equating to 93% engagement). They were on track to deliver virtual group consultation care to 7.5% of their diabetic population by year end – over 11,000 patients. So this is an effective training model which is scalable at the integrated care system level, that is a population unit of ~1 million, for delivery within constituent primary care networks.

Reorganisation of the NHS England healthcare system into integrated care systems from 1 July 2022 has arguably aligned the system better with Health Boards in NHS Wales and Scotland. These structures present a real opportunity to view service development through a 'community lens' rather than 'relief' or 'reform' lenses.[12] We can expect to see these integrated care systems take positive steps to address both the need and demand for support for people with long-term conditions and waiting lists in the 100,000s for their local populations. Given NHS resource constraints, especially of pandemic-affected clinical staff, further demotivated by the perceived injustice of public sector wage restraint, it is highly likely that integrated care systems will embed successful, scalable virtual group consultation models. This will likely include the Northwest London Diabetes Virtual Group Consultation model but may also include targeted waiting list initiatives providing immediate, novel intermediate level care through virtual and in-person group consultations. Sharing these new models should leverage better care nationally. This will alleviate pressure on both primary care teams and specialist services. It is clear that the key constraint is now staff time, not finance and that expecting primary care teams to do more is unrealistic. Furthermore, it is now recognised that other people who are facing the same challenge know a great deal about their condition, often more than primary care professionals with their need to cover the whole spectrum of problems necessarily limits their experience with any one problem. In addition people with a particular problem often have experience of dealing with the NHS which they are willing to share with other people, so this peer support can lead to smarter and fairer access.

5 | SYSTEM CHANGE

Pre-pandemic, the vision was articulated to embed group consultations across the NHS using a systems approach, with benefits (including shorter waits and better choice) accruing to all, not just those who attend group consultations.[13] Many factors have pushed the system into a state where change is now necessary to reintegrate the personalisation and continuity of care for which the NHS has previously been renowned. These include the near doubling of the waiting lists, deferring of much routine care, default phone triage in primary care, proven models for both virtual group consultation care and training, not to mention the financial shocks from the war in Ukraine and Brexit. While many of these issues are considered from a UK perspective, the anticipated NHS scaling will consolidate the United Kingdom as the global leader in group consultation care and support a phase of knowledge exchange with the international community.

6 | PATIENT PERSPECTIVE (FROM DENIS COLLEN)

As a person living with type 2 diabetes and heart failure for 10 years, the pandemic impacted me negatively through being on the shielding list and positively through the introduction of virtual group consultations being the delivery method for several patient health programmes in Northwest London.

Over the last 3 years, I have seen that when patients meet other patients in a group environment they share experiences and issues with their long-term conditions and want to connect for peer-to-peer support. I have also observed and attended virtual group consultations (VGCs) in the evening after 7 PM as part of a 12-month diabetes programme called Rewind (https://www.knowdiabetes.org.uk/blog/rewind-my-motivation/) and found that patients can commit to these as they do not have to travel, and it allows them not to take time off work to attend mid-afternoon clinics. These appointments can be managed and handled by healthcare professionals and surgery support teams and colleagues and free up time for general practices (GP's) who are time poor.

I have also observed that healthcare professionals find a benefit in creating a community-based peer-to-peer support network through local practise-based patient participant groups where activity, diet, sleep and mental well-being are supported in Northwest London with local diabetes community clubs.

During the last 3 years of the pandemic, I have had all my diabetes appointments and group support via the flexible approach of VGCs and not felt as if my care has been impacted, unlike so many others (see https://www.knowdiabetes.org.uk/blog/rewind-my-motivation-pt-2/). So I am keen to see this model more widely available.

7 | COMPASSIONATE COMMUNITIES

A key point about group training and care delivery is that it embeds development of supportive social relationships at multiple levels, as illustrated in the ecological systems theory model in Figure 1. The transformative impact of the compassionate communities created can be seen in the work of Julianne Holt-Lunstad[14] and the outcomes from Frome, including reduced hospital admissions and cost.[15] This is also supported by the plausible mechanisms described by Slavich et al.[16] The impact of good social relationships is often left out in the consideration of management of chronic disease. These data show that not only it is possible to improve the efficiency of healthcare but using social relationships as a therapeutic tool can dramatically improve patient outcomes. This approach urgently needs to be built into the planning of the delivery of healthcare and the group consultation training and delivery is a key tool to achieve this.

8 | CONCLUSIONS

Compelling arguments support scaling of group consultations across the NHS and globally. We now need to recognise that self-care is the most important type of care for people with long-term health problems (see Figure 2). Healthcare systems like the NHS are essential for diagnosis, acute care and initiating optimal therapy but people are on their own over 99.95% of waking hours going forwards. We must accept and encourage the contribution that other people with the same

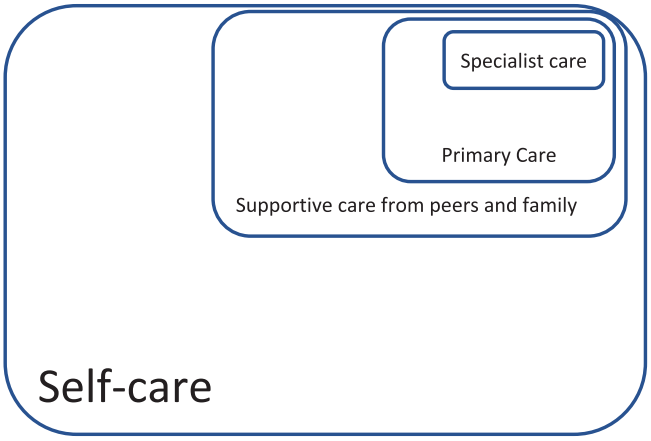

FIGURE 2 Care settings for long-term conditions.

long-term health problem can make and enable both types of care through face-to-face and virtual group consultations. The latter offers a number of advantages. Patients and communities need agency and choice to implement and access these patient-centred and codesigned care models. This can bring system benefits, mapped to healthcare's quintuple aim to both those electing to use group consultations and those who do not.

The UK chief medical officers have rightly called for secondary prevention, for the use of the face-to-face consultation to identify undiagnosed disease and risk factors and then offer support and guidance[17], but the impossibility of doing this was quickly highlighted[18] based on evidence about the time constraints of primary care clinicians.[19] After the first three healthcare revolutions (comprising sanitation; technology; and citizen knowledge and the Internet, respectively). We are now entering a fourth healthcare revolution, where patients can be empowered by learning from each other. This corresponds directly to Sir Anthony Seldon's Fourth Education Revolution, where learners learn more from other learners than they do from the teacher. Embedding group consultation models through a national training programme and offering them as a routine care option can achieve this.

The NHS should support the revolutionary impact of virtual group consultation and communities to enable the survival of primary care.

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CONFLICT OF INTEREST STATEMENT

Editor-in-Chief and Director of Science & Research for the British Society of Lifestyle Medicine Fraser Birrell is also one of the authors. Both Fraser Birrell and Dennis Collen work closely with Group Consultations Ltd. who collaborate on the Sir Jules Thorn Trust National Training & Evaluation Centre at Newcastle University and the NIHR CRN-adopted National Group Consultation Project.

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