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Harnessing new models of care for chronic disease: co-design and sustainable implementation of group clinics into UK clinical practice

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Aims

- Demonstrate group clinics can be sustainably implemented in UK primary and secondary care.
- Identify enabling themes and promoting factors to support scaling up.
- Show efficacy and efficiency, compared with usual care.

Methods

Mixed methods

Prospective observational cohort study, qualitative focus groups and interviews plus a non-inferiority randomised controlled trial in osteoporosis: primary outcome measure – mean possession ratio of bisphosphonates over 12 months.

Group clinics studied:

- mixed early and chronic inflammatory arthritis group clinics in two community hospitals 2010–17
- pharmacy-led osteoporosis group clinics in three general practices 2012–13
- early arthritis group clinic at one further community hospital, 2016–17. Thematic analysis on inflammatory arthritis (n=15) triangulated with patients attending primary care osteoporosis group clinics (n=11).

Results

Two-thousand four-hundred and ninety-eight patient attendances for both early and chronic inflammatory arthritis at 145 group

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Table 1. Five main enabling themes

Enabling theme	Details	Impact on patient care and satisfaction
Efficiency	Reduced waiting times More streamlined administration More effective use of time	'It's very helpful and if there's anything that you're concerned about, it's easier than waiting … for an appointment.'
Empathy	Shared problems Shared understanding Group support	'We are all in the same boat.'
Education	Learning from team Learning from peers	'I've got a much better understanding of how my disease works.'
Engagement	'Appropriate' personality, benefits of a trained educator Individualisation in a group setting Positive physical and emotional environment	'Well he's very good in that he talks to the group, but also he acknowledges that you're an individual.' 'You can have a laugh, and it's more relaxed and you probably get a bit more out of this than you do from a one to one.'
Empowerment	Agency, autonomy, advocacy Focus on personal impact Promoting behavioural change – physical wellbeing	'It's made me realise I am not that badly off but need to take more control so not to get worse.'

clinics at two hospitals and 45 early inflammatory arthritis patients attending group clinics at a third hospital. A mean of 17 patients attended each mixed group clinic (rising from 15 in 2010–11 to 18 in 2016 and 20 in 2017) and reported very high satisfaction (median 10/10, interquartile range 9–10,10). Seven-hundred and ninety-four (40%) of 2,009 patients with disease activity score (DAS) data reached low disease activity (DAS <3.2) or remission (DAS <2.6). In the early arthritis cohort, 82% of patients reached low DAS / remission and 57% reached remission by 6 months. Group clinics were implemented without additional resources beyond brief training on the job and were highly efficient for cost and quality.

Seventy-five patients attended one of four 90-minute primary care osteoporosis group clinics. Eighty-three attended usual care for a 1:1 appointment lasting 15 minutes. Ten-year fracture risk for major osteoporotic/hip fracture was 26/14% for group and 23/10% for usual care. Mean possession ratio was 0.62 for group and 0.54 for usual care (confirmed as non-inferior). All three models delivered 200–300% efficiency for the same or better outcomes compared to usual care.

Qualitative data analysis identified five main enabling themes: efficiency, empathy, education, engagement and empowerment (Table 1). Five promoters to translate these themes into clinical practice were articulated: prioritisation, personalisation, participation, pedagogical approach and personality.

Conclusion

Group clinics are a sustainable, clinically effective and efficient method for chronic disease care in the UK and can be led by different clinicians after brief training on the job. By engaging patients in co-design and evaluation, robust, patient-centred models have been implemented and enabling themes and promoting factors have been identified. These can be used to support the delivery of effective training for clinicians for chronic disease group clinics as a routine care option in both primary and secondary care. ■

Conflict of interest statement

None declared.