iDEAL Insights for Diabetes Excellence, Access and Learning

Best Practice Guide for Conducting Group Consultations within Diabetes Care

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Group Consultations in Diabetes Care Executive

Summary

This Best Practice Guide details the opportunities and complexities of designing and implementing group consultations in diabetes care. The evidence and feedback from Health Care Professionals (HCPs) and People with Diabetes (PwD) to gain a 360^0 opinion is detailed within this Best Practice Guide as this informs decision making and key factors for your consideration of this service redevelopment.

Within diabetes care, group consultations are being encouraged aiming to promote working more proactively. Aiming to increase communication in the group, reduce backlogs of patient assessment and annual reviews caused by lockdowns and services reshaping due to Covid-19. Group consultations are being promoted as being efficient and effective and lean in thinking, whilst aspiring to promoting six sigma methodologies across diabetes care (Kutz et al, 2018). Much literature has been published promoting group consultation approaches for people with type 2 diabetes (Group Consultation, 2020, NHS England, 2019), but little has evaluated the realities of implementing group consultations into routine practice, especially for people with multi-morbidities

or type 1 diabetes. Examples do include DAFNE and DAFNE reunions, but these are educational in purpose (Hamilton et al, 2021).

Diabetes care can be multi sized and have a variety of specialist clinicians involved at any one time. Inequalities in access to health is seen across the spectrum of healthcare, including diabetes (Barnard-Kelly & Cherñavvsky, 2020). Health inequalities are defined as the 'preventable, unfair and unjust differences in health status between groups, populations or individuals' (NHS England, 2020).

The challenges of inequality and healthcare, particularly in the context of diabetes are undoubtedly complex, and there is no one-size-fits all solution (Barnard-Kelly & Cherñavvsky, 2020). This is an essential consideration of undertaking a group consultation and who this service might suit?

Pockets of published evidence from clinicians undertaking group consultations have been evaluated, with much evidence relating to group education opportunities, but not actually group consultations, where confidentiality and personal biochemical results and examinations are often required. Experience and feedback has been gathered to inform this best practice guide from both multi-disciplinary (MDT) specialist diabetes care and people living with diabetes. Both have offered their considerations of the potential for and concerns about undertaking effective group consultations either digitally or face to face.

The backlog of diabetes reviews created by the pandemic, has caused HCPs to be under considerable pressure (Lewis et al, 2020) and many are struggling to deliver the current 1:1 consultation model (Carr et al, 2021) so perhaps the time is right to consider new ways of working (Wilkinson, 2021). Potentially group consultations could increase access and reduce clinic backlog without increasing clinic time (i.e., more people can be seen in the same amount of time) and potential learn from one another's experience living with diabetes.

Feedback from this group of MDT members (as below) all working in primary or secondary care have shared their guidance and feedback for this best practice guide.

Dr Patrick Holmes – GP

Dr Shafie Kamaruddin – Consultant Diabetologist

Anita Beckwith – Type 1 Specialist Dietitian

Paul Pipe-Thomas – Community Diabetes Dietitian

Charles Odiase – Consultant Pharmacist

Dr Elizabeth Cooper – Diabetes Specialist Psychologist

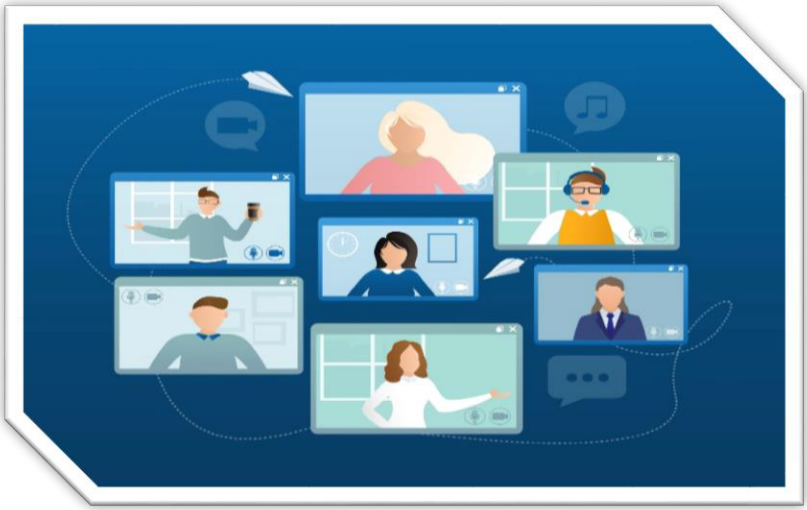
Jane Diggle – Diabetes Specialist Practice Nurse

Jayne Robbie – Senior Podiatrist – Diabetes
Dr Anne Phillips & Kate Walker – representatives of people with type 1 and type 2 diabetes

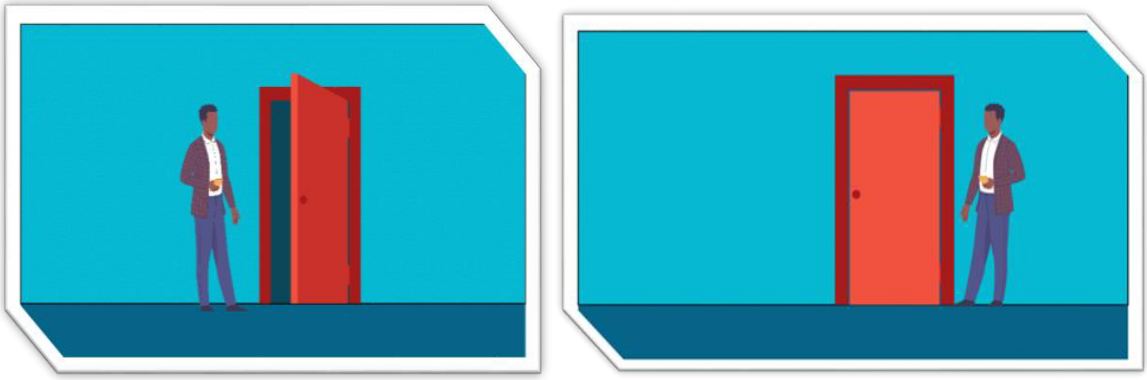
Themes to consider:

Environmental

Feedback from the MDT group have highlighted special considerations for setting up group consultations in terms of ergonomics and environment. These considerations need attention to promote professionalism and inclusion.

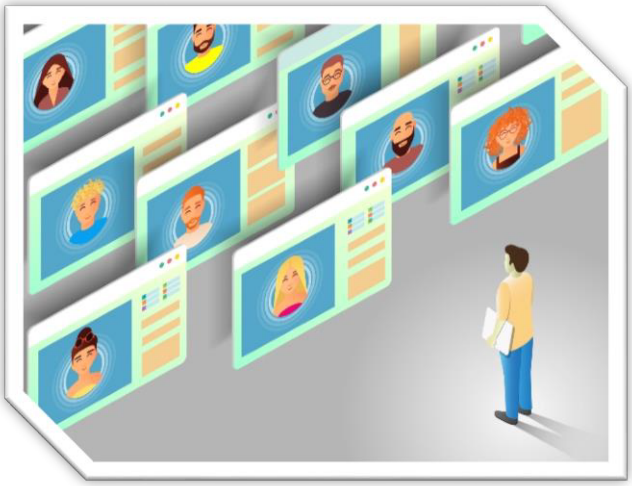


- Aim for a small group – maximum 15 including the clinicians.
- Access to medical records needs to be available as required.
- Video consultation from the HCPs side – use a standardized neutral background to ensure privacy.
- Ensure patients included are in a safe place to hold the consultation (e.g., not driving) or not with other family members (unless pre agreed with the group).
- Remote prescribing e.g., clinics conducted using GP's platform such as System One allow for ease in group consultations.
- This medium is not suitable for improving subjective health outcomes and experience as such environment drive equality NOT necessarily fairness.
- Saves on practices finite resources and expedite a change in practice management of diabetes based on the virtual consultation discussions, however this could simply be an outcome of 'groupthink' which might not reflect individuals mibndsets and decision making.
- Especially for the most deprived, virtual group consultations could lead to further expansion of discrimination and inequality in healthcare outcomes gaps.



Service delivery

This aspect has been identified as fundamental relating to whether a move to adopt group consultations in diabetes care practices is required or possible for individual diabetes services.



Opportunities:

- Group consultations work well for diabetes education and information sharing.
- Confidentiality and Governance need to be acknowledged and protected.
- Grouping similar individuals together will shorten waiting lists and facilitate more people to be seen earlier.

- Clear consent process and written information about the way the consultation will work, discussion about how information will be shared needs to be sent before the consultation to allow people to have choice to opt out.

Potentially time-saving for HCPs and PwD, in terms of sharing common themes for education in particular.

- Clear boundaries and ground rules (making best use of the time and ensure it is a safe and constructive space) must be identified during the set-up process and then agreed by group members.
- Can promote objective improvement in health outcomes and experience from effective use of medicines and understanding of diabetes.
- Competition in doing well depending of gender of participants. This is particularly evidenced in weight loss groups in the Diabetes Prevention Programme (Sauder et al, 2021).
- Peer support enabled with similar groups of people involved.
- Declaration of HCPs and their roles present at each group consultation.
- Use platform that is approved by your relevant trust – governance issues
- Group consultations can be very useful for educational only purposes in terms of improving objective health outcome goals such as: (1) general lifestyle enhancement interventions, (2) general introduction to diabetes medications used in diabetes, (3) discuss the importance of structured diabetes education, (4) general peer discussion on dealing with diabetes distress and other emotional challenges.

Complexities

To reduce inequalities, requires forming groups of individuals that share a similar culture, speak a similar language, share similar social economic status and have the same diagnosis.

- If the attendee numbers are low then more clinician's time would have been wasted as compared to 1:1 consultation.
- A digital virtual group consultation would offer more room to increase group numbers that may not have been feasible in physical premises, however this is restrictive as requires a high level of digital illiteracy and access.
- Sharing information with strangers can be uncomfortable and this must be respected.
- Group consultations do not suit everyone and this needs to be respected so individual choice can be provided without delay.
- Equality in healthcare delivery doesn't consider key contributing factors to poor outcomes such as difference in culture, socioeconomic status, health literacy levels, personal choices where individual consultations or educational opportunities need to be promoted over group consultations.
- Virtual group consultations may not be ideal for improving subjective health outcome goals such as (1) discussing diabetes blood test results, (2) discussing lifestyle behaviour to a heterogeneous group that differ in language, socioeconomic status and are strangers.

- Group consultations would not work for dietetic consultations due to the personal and sensitive nature of information shared dietary intake
- Can be difficult to build a rapport especially with new patient consultations in a group.
- Video recording – both HCPs and PwD need to declare if recording.
- PwD examination may be sub optimal.
- PwD maybe unfamiliar with technology and get flustered.
- Difficult for PwD with hard of hearing or who are partially sighted.
- Can take longer to conduct compared to a face-to-face consultation. Unable to order blood or radiology tests during a clinic unless able to access Systomone.
- However, sharing of inaccurate or unsafe information in the group by group members needs facilitation to prevent.
- Group consultations are not suitable where the clinical scenario is more complex and less stable and a 1:1 review is more appropriate.

HCPs Training Needs

- **Consideration of the training and ongoing support for conducting group consultations needs to be available for clinicians wishing to provide this service to support the organisation, provision, enablement and evaluation of group consultations in diabetes care. This also includes PwD being invited into this process (Bombard et al, 2018).**

- Training of HCPs will be required, consideration for who funds this is in terms of the course and the time required needs to be built into the service set up considerations?
- A cost-benefit analysis of the lean thinking and six sigma outcomes of group consultation set –up and delivery needs to be included (Kutz et al, 2018).
- Clarity of HCPs roles if a diagnosis or treatment prescribing decision is potentially needed during a group consultation?
- Facilitators need to be able to manage group dynamics.
- HCPs will need appropriate training to deliver group consultations – currently few will have the skills or confidence to do so.
- To work, HCPs will need access to training and thereafter on-going support for implementation.
- Two facilitators are recommended to be required ideally especially remotely as connection problems do occur.
- Co-learning of HCPs to support skills sharing across facilitators.
- There is a risk of virtual consultation facilitators intentionally or inadvertently injecting their personal biases into the group exchange of ideas, this is a major issue in heterogeneous groups (Patel et al, 2021).
- Training/packages of how to make virtual groups function need to be available.

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- Could potentially require a number of HCPs need few staff to facilitate – e.g. a consultants, a DSN, a Dietitian a Psychologist so cost-effectiveness can be compromised.

HCPs considerations

If group consultations are going to be introduced for diabetes care the following factors have been identified by the MDT team.

- Group consultations can be cost effective, time efficient and less resource dependent that 1:1 reviews.
- Excellent for routine diabetes education, and has potential for breaking down barriers/hesitancy to access further group education.
- Group Consultations, also known as Shared Medical Appointments (SMAs), are a new way of engaging individuals in self-managing their chronic diseases.
- Virtual group consultations lend itself well to the ease in measuring how a cohort of
  your practice diabetes population manage their diabetes in the real world, it offers an opportunity to share peer learning.

- Encourages peer learning with less resource burden such as clinician's time.
  If using your own mobile phone – switch off call identification to protect your privacy.
- Consent is needed from each PwD as they may discuss their condition generally in the presence of other PwD.
- Formal letter to go out to manage the PwD expectations when they attend the clinic with clear agenda.
- Make a distinction between group consultation and group education though as they are different.
- HCPs need training to build the skills in controlling the flow of the discussions and ensuring everyone is engaged and opinions valued in a group consultation situation.
- Many clinicians have acquired many of the skills required to successfully undertake remote consultations
- HCP's need to debrief at the end of the group consultation and reflect on anything that could have done better and also identify PwD from the group that needs more assistance.

Person with diabetes considerations

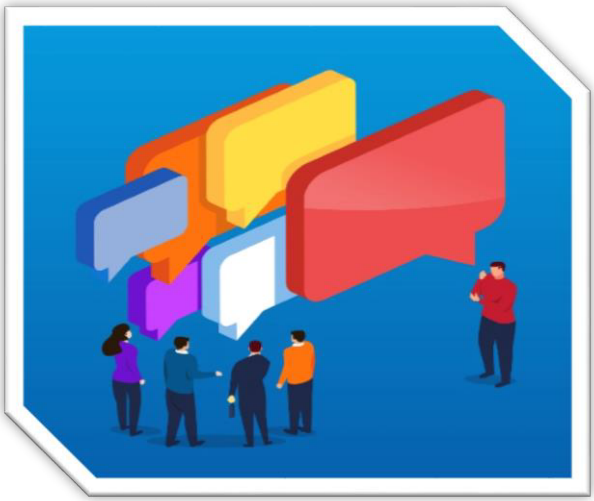
To undertake a change in routine diabetes care for PwD with long standing diabetes might be more problematic than introducing this service delivery with people more recently diagnosed. Also group consultations may be less suitable for people with type 1 diabetes potentially with specific complexities in insulin and glucose management complexities. Distinction between the difference of group education and group consultations needs careful consideration given the evidence of sub-optimal national uptake to group structured educational opportunities in type 2 diabetes across diabetes care in general (Poduval et al, 2020$_a$) and type 1 diabetes (McDonald et al, 2021). Type 1 diabetes structured

- **education however has improved marginally since becoming virtual (McDonald et al, 2021), however type 2 structured education virtually remains sub-optimally attended (Poduval et al, 2020$_b$).**

Feedback from HCPs and PwD about group consultations include the following considerations:

HCPs

Opportunities



- PwD will need encouragement on how to ask a question if their confidence is low and they are unused to group situations.
- This does dependent on people's time management/arriving on time.
- With on-going concerns about the spread of infection, many PwD can feel anxious about spending any length of time face-to-face in a group setting therefore virtual group consultations may be the preferred option.
- Group consultations can promote vicarious learning through modelling of self-management behaviours from peers ‘people like me’.

The condense nature of virtual group consultation mean there is an opportunity to solicit a quantity of lived experiences, opinions, feedback on multiple aspects of the topic discussed.

- Social support in the group and possibly the development of a network.
- Record keeping- needing to be very clear about how that is managed and how records are stored for the PwD and HCPs involved.

Complexities

- Group norms of support, non-judgement and caring creating a safe space for people to explore their barriers and potential strategies however this requires forming groups of individuals that share a similar culture, speak a similar language and share similar social economic status.
- Challenge from other members of the group
- Access to IT – IT skills - fluctuations in connection causing stress.
- May be worried over confidentiality.
- Reduced therapeutic relationship: particularly important for those requiring emotional/mental health support

- Such a time-limited slot provides little opportunity for important conversations and time to address the things that matter most to the person living with diabetes.
- Disengagement of individuals who feel different culturally, in socioeconomic status and intellect. Having a holistic, culturally competent, self-aware, and widely knowledgeable facilitator may help mitigate this risk.

- Group consultations will not suit everyone (one size does not fit all) and may be inappropriate in certain situations (e.g. in those with severe mental health problems, learning disabilities, social anxieties, where more sensitive and personal issues need to be addressed).
- May not be appropriate if: PwD is not happy to participate, PwD is unwell and needs prompt diagnosis and management, physical examination is required, PwD has dementia or acute confusional state, the PwD is deaf (unless signer available or able to lip read in video consultation), the PwD has difficulty understanding or speaking English unless interpreter.

PwD

Opportunities

- This can offer opportunity for peer support/connection with peers and potentially improve PwD outcomes/experience.
- Problem solving can occur across the group.
- Promotes benefits of altruism (helping and supporting others) on mental health and happiness.
- Offers opportunities to share and normalise of people's experiences. Shared understanding facilitates reduction in isolation 'there are other people like me'.

Complexities

- Inappropriate challenge from others who make it sound easy or have been able to engage in a particular behaviour and lack awareness of the other person's challenges.
- May be inappropriate in certain scenarios (e.g., where sensitive or very personal and private issues need to be addressed).
- Fear of judgement or actual judgment by group members.

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- Some people may feel afraid to disclose information in a group for fear of being judged.

  Confidentiality breaches in the group.
- Fear/threat messages – disclosed and their impact on other participants (e.g. negative experiences of other or their family/friend that are shared)
- Tricky group dynamics more challenging to manage the person who talks too much or doesn't allow others time to talk.
- Using a home or work setting – finding a confidential space for the consultation.
- In a virtual group consultation, there is likely to be a silent development of 'comparisonitis', with many often not expressing deeper concerns, worries, while others proud of their achievements.
- Post consultation – isolation as maybe at home – in the same space and this can make it difficult to distance yourself or decompress afterwards
- Misinformation shared in the group.
- It doesn't offer maximum depth on improving an individual group member way of tackling their diabetes in their own world; it doesn't lend itself well to personal revelations.

Conclusions

Group consultations do have their place but careful consideration in the organisation especially in terms of time efficiency and sharing of education. The training of HCPs and group set ups needs careful thought and attention. This is not a one size fits all scenario and reflecting 'No decision about me without me' (Department of Health, 2012), the same considerations need to be applied in the PwD's decision to potentially not engage with this service development.

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