An evaluation of Shared Medical Appointments (SMAs) to improve Self-Management in COPD.



A shared medical appointment (SMA) model or 'Plus Appointment' for Chronic Obstructive Pulmonary Disease (COPD) was developed to promote and embed self-management support and planning between healthcare practitioners (HCPs) and COPD patients. The purpose is to improve healthcare outcomes (e.g. improved COPD symptom management, improved health-related quality of life) and optimise healthcare utilisation (e.g. reduce unnecessary attendances at A&E). The intervention was underpinned by findings from previous work that identified barriers and facilitators to self-management of COPD, and generated ideas and solutions to address these barriers. The SMA intervention is currently being implemented and evaluated and early findings indicate some promise although there are practical and logistical challenges that will need to be addressed.

# Can SMAs provide an effective opportunity to get off the rapid paced treadmill of individual consultations whilst also improving clinical outcomes in COPD?

## The Case for Change

Self-management is recognised as a critical component in the care of COPD and evidence has demonstrated that self-management interventions (SMIs) are effective in improving health-related quality of life and reducing healthcare costs related to frequent acute exacerbations and unnecessary hospital admissions. Evidence from research and practice has however shown that implementing and normalising this in everyday practice can be difficult to achieve.

Suggestions from the COPD self-management research project at Newcastle University suggest that a prototype intervention should address self-management issues from a patient level (e.g. motivation, knowledge and understanding), practitioner level (e.g. behaviour change communication, shared agenda-setting) and organisational / system-level (e.g. organising/mobilising access to community resources). While it is recognised that there cannot be a ‘one-size-fits-all' intervention, an opportunity arose to develop an approach that could tackle many of these key issues in the form of a Shared Medical Appointment (SMA) model.

SMAs are currently being trialled as a method of care delivery / annual reviews for people with long-term conditions in some primary care practices in Newcastle Gateshead CCG. Findings from our larger programme of work (systematic reviews, qualitative interviews and participatory workshops) were used to develop the content and structure of a SMA model to deliver a COPD SMI in general practice. A qualitative evaluation of the SMAs is being undertaken to examine the acceptability and engagement of the intervention.

## Overview of Innovation

The SMA model consists of two components; 1) a group session of 4 – 7 COPD patients (lasting 60-90 minutes as oppose to a GP appointment which typically lasts 10 minutes) that comprises of individual patient assessments, medication support, and a clinical consultation session with the GP, facilitated by a practice nurse; 2) a one-on-one follow up session held with a practice nurse or healthcare assistant (HCA) within 2 – 4 weeks after the group session with a focus on social prescribing. COPD patients are invited by the surgery, following the usual procedure, to attend their annual medical review. The SMAs are run by the usual clinical team; the GP, practice nurse, pharmacist and/or HCA.

The SMA group sessions were structured and directed by a template covering key topic areas such as; living well with COPD (e.g. physical activity, breathing exercises and diet), emotional/psychological management, and social support networks. Patients were also provided with a template/worksheet to take notes and/or use tick boxes during the group session to help inform their personalised plans that would be discussed at their one-on-one follow-up session.

The one-on-one follow-up session was led by a HCA trained in social prescribing or the practice nurse. The agenda at the follow-up session was structured using the SMA template completed by patients at the group session. This aimed to ensure that discussions were personalised to meet the patients' unique support needs. The details of the discussion were recorded as would be done in usual care, i.e. using the care plan/self-management plan. There was potential for a telephone follow-up where a face-to-face visit was not possible.

The SMA templates include a social prescribing element, allowing practitioners and patients to access community-based resources to support their personal goals (e.g. activity groups, peer support). The SMA intervention was underpinned by behaviour change strategies including personalised action planning, goal setting, problem-solving and follow-up.

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Early findings show Shared Medical Appointments has significant promise in improving COPD self-management

Progress to Date

There are currently three GP practices in Newcastle trialling SMAs, each using a slightly different approach; this particular type of SMA has been designed and implemented within one GP practice.

This was a small evaluation, accessing the feasibility of the SMAs. The data from this evaluation is currently being analysed.

## Impact

Data on patient invitation, attendance and follow-up were collected. Data on patient self-management behaviours were collected using Patient Activation Measure (PAM) scores. The ongoing qualitative evaluation with patients and healthcare practitioners is focused on patient recruitment, attendance, engagement and satisfaction with the intervention.

Early findings from both patients and practitioners indicate that SMAs have significant promise in improving COPD self-management. It has however experienced implementation difficulties such as practitioner training and confidence in delivering a group appointment and the additional administration and organisational burden for practice staff. It is also recognised that this intervention cannot reach all patients (e.g. the housebound) and the group setting may not be suitable for some patients.

"The SMA provides an enjoyable and novel approach to efficiently addressing many of the key issues affecting the self-management of COPD that are important to both patients and primary care practitioners alike."

Dr Paul Netts, Benfield Park Medical Group

Next Steps and Plans for the Future

The qualitative evaluation is ongoing and a report will be presented to the CCG. Funding is being sought for a larger scale evaluation.

## Contact

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