

GPs' and staff views of a 'telephone-first' approach to demand management: qualitative study

Authors

Jennifer Newbould¹, Josephine Exley¹, Sarah Ball¹, Jennie Corbett¹, Emma Pitchforth² Martin Roland³

¹ Cambridge Centre for Health Services Research, RAND Europe, Westbrook Centre, Cambridge CB4 1YG, UK

² Primary Care Group, University of Exeter Medical School, Smeall Building, St Luke's Campus, Magdalen Road, Exeter, EX1 2LU

³ Cambridge Centre for Health Services Research, Institute of Public Health, University of Cambridge, Forvie Site, Cambridge CB2 0SR, UK

Correspondence to: J Newbould newbould@rand.org

Abstract

Background To better manage patient demand, some general practices have implemented a 'telephone first' approach in which all patients seeking a face-to-face appointment have to speak to a GP on the telephone first.

Aim To understand the views of surgery staff of the 'telephone first' approach and to identify enablers and barriers to successful adoption of the approach.

Design and setting Twelve general practices using the 'telephone first' approach and two practices which had tried the approach but reverted to their previous system.

Method 53 qualitative interviews with GPs and practice staff.

Results Staff in the majority of practices felt the approach an improvement on their previous system. However, all practices had experienced challenges, especially where the new system led to a major increase in demand for telephone consultations without capacity to meet that demand. Staff were also aware that the new system suited some patients better than others. Adoption of the 'telephone first' approach could be very stressful with a negative impact on morale – especially in interviews with the two practices that had tried but stopped the approach. Interviewees identified enablers and barriers to the successful adoption of a 'telephone first' approach in primary care. Enablers to successful adoption were; understanding demand, surgery staff as pivotal, making modifications to the approach and educating patients.

Conclusion Practices considering adopting, or Clinical Commissioning Groups (CCGs) considering funding, a 'telephone first' approach should consider carefully a practice's capacity and capability before starting such an approach.

How this fits in

At a time when primary care is under pressure, some GPs have adopted a 'telephone first' approach in which all patients seeking a face-to-face appointment have to speak to a GP on the telephone first. Whilst the approach was working well in some practices for othersthere were real challenges. Practices considering adopting, or Clinical Commissioning Groups (CCGs) considering funding, a 'telephone first' approach should consider carefully a practice's capacity and capability before starting the approach. Practices should understand practice demand, have adequate and well trained staff and be able to make appropriate modifications to the system to meet patient need.

Introduction

General practitioners (GPs) in the UK are increasingly challenged to meet demand for care. This is due to rising demand, more older patients with increasingly complex problems and difficulties recruiting to the workforce.^{1,2} Some GP practices, looking for a way to better manage patient demand, have implemented a 'telephone first' approach in which all patients seeking a face-to-face appointment have to speak to a GP on the telephone first. This differs from a 'traditional booking system' in which a patient telephones the GP surgery and requests a face to face appointment with a GP and is given the time and date of the appointment. **In the UK appointments are normally booked by receptionists who do not have any medical training apart from that required to identify immediate medical emergencies.**

Under a 'telephone first' system the problem is either resolved on the telephone, the patient is seen by another health professional or the patient is booked a face -to- face consultation with a GP, usually on the same day (for more detail of the approach please see figure 1). In the UK two commercial companies, GP Access and Dr First, provide support to practices adopting this approach and claim benefits for the system, including better access, improved patient and staff satisfaction, and reduced work stress.^{3,4} Some of these claims have also been reproduced in NHS England literature.⁵

An independent evaluation of the 'telephone first' approach, conducted by the authors, found wide variation in its impact on staff workload, from greatly reduced to significantly increased, but no net reduction in 59 practices using the approach.⁶ We also found a wide range of positive and negative views expressed by patients. While telephone consultations have been used in general practice for many years, the 'telephone first' approach is a more radical method which aims to substitute many face -to -face consultations with telephone consultations. In this paper, we explore the views and experiences of GPs, practice managers and reception and administrative staff of the 'telephone first' approach. We present factors staff identified as enablers and barriers to the successful adoption of a 'telephone first' approach in primary care.

Methods

Sampling

Twelve general practices across England using a 'telephone first' approach were recruited as part of the study, described in detail elsewhere (hereafter 'active practices').⁶ The two commercial companies provided lists of practices known to be running the 'telephone first' approach for more

than six months. Practices were approached in batches with the aim of including practices with a range of practice characteristics. In addition we recruited two practices that had tried the approach but reverted back to their previous appointment system (hereafter 'reverter practices'). Practices varied in the population served, list size, number of GPs and geographical location (see appendix 1).

Data collection

Semi-structured interviews were conducted by JN, SB, JC, JE and EP with up to five members of staff from each practice. Purposive sampling was used to include a range of health professionals, usually two GPs, a practice manager and a receptionist/administrative staff member were interviewed. The practices selected staff to participate based on who they thought was most appropriate to talk about the 'telephone first' approach.

Face-to-face interviews were conducted usually at the practice apart from three interviews which were conducted by telephone. Participants gave written consent to be interviewed. A common interview guide informed by the literature was used for each interview. The interview explored the reasons for switching approach, the setting up process, perceptions of quality of care and safety as well as impacts on the doctor-patient and intra-practice staff relationships. The advantages and disadvantages of the 'telephone first' approach were also discussed. With participants' permission interviews were audio-recorded, transcribed verbatim and anonymised. For one practice audio recordings were unavailable, due to technical problems and detailed notes were taken.

Data analysis

Data analysis proceeded in parallel with data collection and informed the iterative development of the interview topic guide. As an example, the initial topic guide for GP interviews is shown in Appendix 2. Thematic analysis of the data was conducted based on the principles outlined by Boyatzis⁷. Transcripts were read and re-read with coding done by SB, JC, JE, JN and EP. As analysis progressed codes were organised into overarching or organising themes using NVivo 10 software. Data within themes were scrutinised for confirming and disconfirming views across the range of participants. Emerging findings were shared and discussed regularly within the study team.

Results

53 staff interviews were undertaken in 14 practices. Practices varied in the commercial provider used, the size of the practice (from around 2000 to over 16,000 patients) and the length of time the practice had been using the 'telephone first' approach (from 1 to 4 years) (see appendix 1 for additional information and a summary of practice characteristics). The results are presented in themes from the data. We start by examining why practices chose to implement a 'telephone first' approach, their experiences of the system and staff perceptions of the impacts on patients and on patient safety. The final section of the paper explores the enablers and barriers to the successful adoption of a 'telephone first' approach.

Why adopt a 'telephone first' approach?

Many interviewees identified problems meeting demand as a key reason for changing to a 'telephone first' approach, including patients having to wait a long time to see a GP under the previous appointment system;

So, you know, it was getting up to, sort of, three or four weeks, you know, before people would get a routine appointment we were finding that was getting incredibly onerous and stressful for the duty doctor because he might get, oh I don't know, 70, 80 sometimes even 100 calls in a day. (Practice Manager 5001, Practice 105, Active practice)

A couple of interviewees described circumstances which brought the situation to a head, for example a staff member leaving or patient harm attributed to a long wait to see a GP. For others Clinical Commissioning Groups (CCGs) – national NHS bodies that plan local health care services -- funding support from the commercial companies gave the opportunity to adopt the approach, other GP surgeries had paid the commercial companies from their own funds.

Staff experiences of the 'telephone first' approach

Interviewees' experiences of the 'telephone first' approach were varied – with strong opinions both praising and criticising the approach. For all staff, the 'telephone first' approach led to a changed way of working. All GPs reported they were speaking to more patients than under a traditional appointment system but seeing fewer patients face-to-face. A number liked the flexibility that the 'telephone first' approach gave them to arrange their workload and felt that it gave them more control over their day. Conversely, a few GPs found the system harder in terms of balancing the call backs with other tasks such as supervising students and home visits. A handful of GPs commented that they felt more isolated under the 'telephone first' approach as they spent more time on their own in their rooms making telephone calls rather than seeing patients face-to-face. A few surgeries had introduced measures to try to mitigate against this, for example joint coffee and lunch breaks for GPs to increase the feeling of teamwork.

Reception staff often spoke of greater enjoyment in their role being able to offer patients appointments rather than frequently having to tell patients no appointments were available, as under the previous system. Practice managers frequently spoke of improved running of the surgery, for example fewer patients missing appointments (DNAs) and more patients being seen or spoken to. Morale in some practices was reported to have improved;

... the admin staff like it in the fact that they don't have patients shouting at them now, like, 'What do you mean you haven't got any appointments? It's only, you know, 8:45am and how can you have run out of appointments already?' (Practice Manager 5001, Practice 102, Active practice)

All practices reported some challenges in adopting the approach and many highlighted that it had taken a while for practices and staff to adapt, sometimes up to two years.

Despite these challenges, the vast majority of interviewees preferred the 'telephone first' approach to a traditional booking system. At one surgery an interviewee felt the approach had a large impact; less stress, reduced workload and shorter working days;

We definitely go home earlier, definitely..... three years ago, I used to work a Monday evening and, in theory, we should finish at six thirty, I was still here at 8 o'clock most Monday evenings. Now, our Monday evening team, by a quarter to seven, they are gone, and all the patients have been managed and seen. (Administrator/Reception (Admin) 5001, Practice 114, Active practice).

In contrast, interviewees from a few practices reported being overwhelmed by demand and working longer hours than with the previous system as the demand for appointments exceeded the supply.

In the two practices which had followed a 'telephone first' approach and then reverted back to a traditional appointment system interviewees reported a very traumatic time for the operating of the practice and impacts on individuals;

I didn't want to say anything because I felt like everybody else was probably fine and it was just me and then I had one of those unintended conversations with one of the other partnersso I said to her (that I wasn't coping with 'telephone first') and I just saw this kind of massive sense of relief and she said, 'do you know I hate it and I think I'm going to have to leave if it carries on'. (GP 5001, Practice 201, Reverter practice)

Patient safety

Much of the grey literature surrounding the 'telephone first' approach has focused on concerns about safety. The majority of GPs in the practices using it, felt that a 'telephone first' approach was safer than a traditional booking system as all patients wanting an appointment with a GP would at least speak to a GP on the same day;

... the doctors who are saying, "Well, we don't think it's safe," well, they've got four week waits to be seen. And you don't know what's wrong with them, so how's it safe to have them waiting four weeks? (GP 5002, Practice 104, Active practice)

Several GPs spoke about the importance of 'safety netting'; for example saying they had a low threshold for bringing patients in for a face-to-face consultation if anything concerned them. A few GPs spoke of individual attitude to risk as being particularly important when using a 'telephone first' approach. Factors identified as influencing the level of comfort with risk included how long the doctor had been a GP, how well they knew the patient and how much telephone consulting they had done previously.

Staff perceptions of implications for patients

Interviewees were asked about the effect of the 'telephone first' approach on groups of patients that might be adversely impacted by the approach including patients for whom English was not their first language, older people, deaf or hearing-impaired people and patients without telephones. Two practices in deprived areas identified population groups who were challenged by the 'telephone first' approach;

The population which it really doesn't work with is our immigrant population, our asylum seekers and refugees. Sometimes there's language problems and problem with expectations - we have a low threshold for calling them in. The only (way) it helps is that we can arrange an interpreter for them rather than them booking an appointment and turning up without an interpreter. (GP 5001, Practice 108, Active practice)

Interviewees also spoke of arrangements that they had made for individuals such as those with hearing impairment who found it challenging to navigate the 'telephone first' approach;

.... some of them we have a flag on (the clinical system) saying if this person rings up for a consultation just book them in because sometimes, particularly when we have say hard of hearing, deaf patients, vulnerable, learning difficulties, we just book those in (for a face-to-face appointment). (GP 5004, Practice 101, Active practice)

The majority of staff interviewed felt that elderly patients liked the system once they had experienced it. However, a few GPs noted that elderly patients missed the contact that a face-to-face consultation afforded and that there were difficulties for patients who relied on family and friends or public transport and so were less able visit the surgery at short notice if a face-to-face consultation was thought necessary.

Enablers and barriers to the successful adoption of a 'telephone first' approach

Table 1 draws together the enablers, under four themes, and barriers to the successful adoption of a 'telephone first' approach in primary care as outlined by practice staff in interviews. Interviewees often articulated these barriers and enablers as factors which had assisted in successful adoption or presented challenges.

Table 1 Enablers and barriers to the successful adoption of a 'telephone first' approach in primary care

| Enablers to the successful implementation of a 'telephone first' approach | Barriers to the successful implementation of a 'telephone first' approach |
|--|--|
| <p>Understanding demand:</p> <ul style="list-style-type: none"> • Understanding patterns of demand • Matching capacity to demand <p>Staff as pivotal:</p> <ul style="list-style-type: none"> • Reception staff well trained and supported • Identified member of staff leading the approach • GPs all using the approach consistently <p>Making modifications to the approach:</p> <ul style="list-style-type: none"> • Making modifications to the approach to overcome challenges | <p>Insufficient capacity:</p> <ul style="list-style-type: none"> • Insufficient capacity to meet demand – e.g. not enough GPs or reception staff to take calls <p>Staff challenges:</p> <ul style="list-style-type: none"> • Reliance on locums and registrars not familiar with the approach <p>Patient characteristics:</p> <ul style="list-style-type: none"> • Characteristics of the patient population which may make negotiating the system a |

| | |
|--|---|
| <ul style="list-style-type: none"> • Confidence in using the approach flexibly <p>Educating patients:</p> <ul style="list-style-type: none"> • Clear and updated guidance for patients about the ‘telephone first’ approach | <p>challenge (e.g. poor English, unable to take calls at work)</p> <p>Practical problems:</p> <ul style="list-style-type: none"> • Poor mobile coverage in the surrounding area |
|--|---|

The barriers outlined above were factors practices were often unable to overcome. Conversely the enablers outlined by interviewees present elements practices can aspire to incorporate in their implementation of a ‘telephone first’ approach. In the remaining section of this paper we explore in more detail the four areas identified as enablers to the successful adoption of a ‘telephone first’ approach; understanding demand, surgery staff as pivotal, making modifications to the approach and educating patients.

Understanding demand

In a number of practices, interviewees described understanding patterns of demand at the surgery as an important element in the success of the ‘telephone first’ approach. This was conducted through interrogating a practices computer system and enabled a practice to see how it was meeting patient demand on a daily, weekly or monthly basis. In a few cases the surgery had already been monitoring demand prior to the adoption of a ‘telephone first’ approach, but in most cases the input of commercial companies had assisted staff in understanding the nature of demand. In several practices interviewees described how they continued to monitor demand and made changes to the appointment system as necessary in one case on a daily basis;

... on a busy day we might think actually we’re running out of calls, we’ll start booking into another day and we’ll change some of our booking slots into phone call slots to increase our phone demand, so we can be flexible there ... I mean it’s a continual sort of tweaking process through the day really. I mean our duty doctor will tend to be just keeping an eye, our practice administrator sort of has a look ... you’re kind of maximising your efficiency really. And some days you’ll have more calls and less people want to be seen, other days it’s the other way around, but it’s a very flexible system. (Practice Manager 5001, practice 101, Active practice)

Surgery staff as pivotal

Surgery staff were often seen as an important component of the ‘telephone first’ approach; having a member of staff leading the approach and guiding and supporting colleagues, GPs working together to implement the system consistently and reception staff who were well trained and supported. One feature of the ‘telephone first’ approach advocated by the two commercial providers is for reception staff to take a brief note of the patient’s problem to allow the GP to respond to more serious complaints first. In some practices reception staff took a more active role by triaging patients with particular complaints to other sources of information, for example the pharmacist. This eased the number of calls a GP had to take. In practises without such an approach a few GPs felt patients having direct access to them could be a challenge;

My main worry about this is that demand has increased and continues to increase because we are so accessible and there is no barrier there. (GP 5004, Practice 117, Active practice)

Problems with staffing could be a challenge to the approach. In particular reliance on locums who were not familiar with the 'telephone first' approach and therefore could only see patients face-to-face, which impacted on the system for other GPs who had to do more telephone calls. A few practices had struggled with GPs leaving and this meant there were not enough GPs to meet patient demand. In the two practices that had tried the 'telephone first' approach and reverted to a traditional booking system lack of staff was a large problem, one practice had lost two partners and four salaried GPs in a year and in the other two partners had left at a similar time.

Making modifications to the approach

Interviewees reported various opinions on making modifications to the 'telephone first' approach, as it had been originally outlined by the commercial companies. A few saw the commercial companies' guidance as something which should not be changed. For others however the system was something which was often modified and changed. Staff in such practices were confident in offering flexibility around the approach when it was deemed necessary. Where this occurred it often facilitated the successful adoption of the approach, with practices adopting modifications which overcame challenges in their practice or with their particular practice population;

so if you ring in today and the system is overwhelmed you might be told, in some practices I know; "sorry we can't deal with this today please ring back tomorrow", but we won't say that to our patients we will say; "really sorry we can't deal with this today but I will put you on the list for tomorrow and you'll get a call tomorrow" ... so we do do that which can help. (GP 5002, Practice 102, Active practice)

Other examples of modifications included asking patients if they had a preferred time to be called back, some patients being able to directly book face-to-face appointments at the reception or GPs being able to book follow up appointments in advance.

Educating patients

Prior to launching the 'telephone first' approach practices had communicated the change to patients in a variety of ways, often using material provided by the commercial companies. There was variation in the extent to which this was done, some practices had written to every patient registered with them whilst others had put notices up in the practice. Several respondents stressed the importance of patient education about the 'telephone first' approach to enable patients to smoothly navigate the approach.

Discussion

Summary of findings

Staff in the majority of practices felt the approach was an improvement on their previous system and receptionists particularly valued their increased ability to offer patients an appointment (albeit a

telephone appointment). However, all practices had experienced challenges, especially where the new system led to a major increase in demand for telephone consultations without capacity to meet that demand. Staff were also aware that the new system suited some patients much better than others. Adoption of the 'telephone first' approach could be very stressful with a negative impact on morale – observed especially in interviews with staff from the two practices that had tried but stopped using the 'telephone first' approach. Interviewees identified enablers and barriers to the successful adoption of a 'telephone first' approach in primary care. Enablers to successful adoption were; understanding demand, surgery staff as pivotal, making modifications to the approach and educating patients.

Strengths and limitations

This in-depth qualitative study was undertaken as part of the first independent evaluation of a 'telephone first' approach to demand management in primary care. The sample included a range of practices in terms of location, deprivation, size, ethnicity and how the 'telephone first' approach was funded. A large number of interviews (n=53) were conducted. A limitation of the study was that practices and practice staff voluntary took part in the study. However the sample did include both those who felt the 'telephone first' approach had worked and those who had experienced challenges.

Comparison with existing literature

Previous studies have shown that there is considerable potential to use telephone consultations in general practice and they have become commonplace over the last 20 years.^{8,9} However, using telephone consultations to reduce workload is not always successful. For example a recent randomised trial of telephone triage for patients requesting same day consultations (ESTEEM) found that telephone triage produced a significant increase in workload over the subsequent 28 days.¹⁰ The approach evaluated in this paper was more radical in that all requests for appointments were offered a telephone consultation but also, as we reported elsewhere⁶ the new approach was associated, on average, with an increase in workload. However, as with the ESTEEM trial the way in which the new approach was introduced had a profound effect on how well it worked and the impact on staff.¹¹ Concerns about the safety of telephone consultations previously reported^{12,13} were not in general borne out in our study, with most GPs believing that being able to speak to patients without long delays improved safety.

Implications for practice

As GPs continue to struggle with increased demand in primary care increasing numbers of practices are looking to the 'telephone first' approach as a way to manage demand in general practice.

This research shows the adoption of a 'telephone first' approach has major implications for practices and practice staff, with some GPs particularly feeling the strain of the different way of working. Whilst the approach was working well in some practices for othersthere were real challenges.

Practices considering adopting, or Clinical Commissioning Groups (CCGs) considering funding, a 'telephone first' approach should consider carefully a practice's capacity and capability before starting such an approach. Practices should have a thorough understanding of the nature of

demand and the problems they are trying to overcome, staff should be trained and encouraged as enablers of change and , related to both of these, appropriate modifications to the system should be made locally to meet patient need. The successful implementation of a 'telephone first' approach was also dependent on having sufficient workforce, capacity, infrastructure and resource to implement changes. We are aware that some CCGs have funded practices to adopt a 'telephone first' approach in the hope it will change the fortune of struggling practices. Our findings suggest that implementing a 'telephone first' in a practice which is already experiencing challenges is unlikely to help the practice and may cause additional problems.

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Ethical approval.

The study was approved by the West of Scotland NHS Research Ethics Service (7th May 2015, REC reference 16/WS/0088).

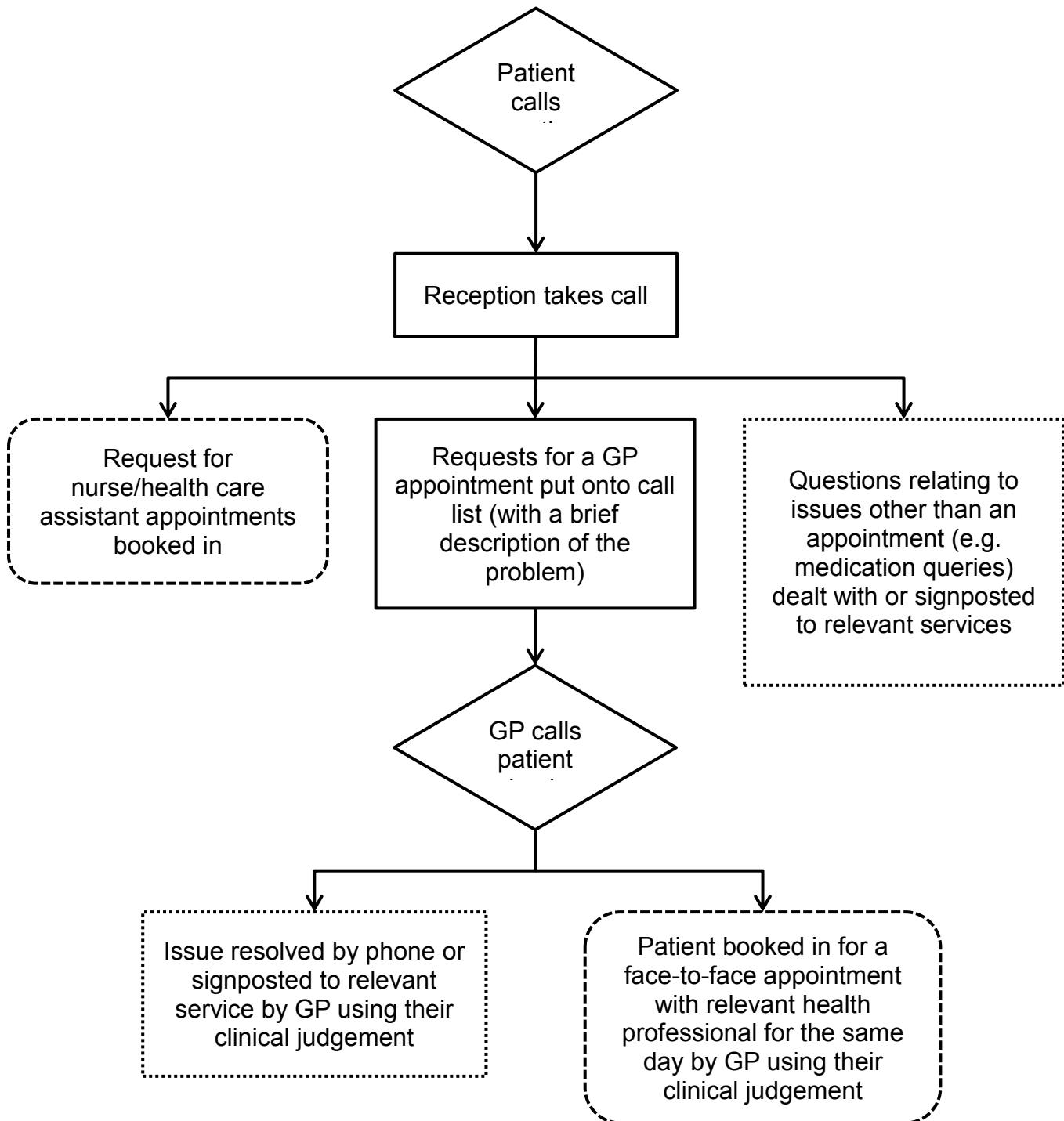
Competing interests

All authors declare that they have no competing interests.

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Figure 1 Flow diagram of a typical 'telephone first' approach



| Practice ID | Provider* | Practice size | Payer of the 'telephone first' approach | Length of time using 'telephone first' approach (years) | Rurality | Deprivation (more or less deprived) | Ethnicity above or below average % of population that are white) | Number of staff interviewed per practice | | | | |
|-------------|-----------|---------------|---|---|----------|-------------------------------------|--|--|------------------|-------|------------------|-------|
| | | | | | | | | GP | Practice manager | Nurse | Reception /Admin | Total |
| 100 | GPA | 8,093 | self-pay | 1 | urban | less | above | 2 | 1 | 1 | 1 | 5 |
| 101 | GPA | 6,672 | self-pay | 3 | urban | less | above | 2 | 1 | 0 | 2 | 5** |
| 102 | DF | 2,347 | CCG | 2 | urban | less | above | 1 | 1 | 1 | 1 | 4 |
| 103 | DF | 7,312 | CCG | 2 | urban | more | above | 2 | 0 | 0 | 2 | 4 |
| 104 | GPA | 4,913 | self-pay | 4 | urban | less | below | 1 | 1 | 0 | 2 | 4 |
| 105 | DF | 11,484 | self-pay | 2 | urban | less | above | 2 | 1 | 0 | 1 | 4 |
| 106 | DF | 16,072 | self-pay | 2 | urban | less | above | 2 | 1 | 0 | 1 | 4 |
| 108 | DF | 4,913 | CCG | 2 | urban | more | above | 2 | 1 | 0 | 1 | 4 |
| 110 | GPA | 8,639 | CCG | 1 | urban | more | above | 2 | 1 | 0 | 1 | 4 |
| 112 | DF | 7,934 | CCG | 1 | urban | more | below | 1 | 1 | 0 | 1 | 3 |
| 114 | GPA | 8,364 | self-pay | 2 | urban | less | above | 2 | 1 | 0 | 1 | 4 |
| 117 | DF | 7,888 | self-pay | 2 | urban | less | above | 2 | 1 | 0 | 1 | 4 |
| 201 | DF | 8,397 | CCG | n/a | urban | more | above | 1 | 0 | 0 | 0 | 1 |

| | | | | | | | | | | | | |
|-----|----|-------|----------|-----|-------|------|-------|---|---|---|---|-----|
| 202 | DF | 4,494 | self-pay | n/a | urban | more | above | 2 | 0 | 0 | 2 | 3** |
|-----|----|-------|----------|-----|-------|------|-------|---|---|---|---|-----|

**Appendix
1.**

Summary of practice characteristics and number of staff interviewed

*GP Access or Doctor First. **Two interviews in these practices were joint interviews between two members of staff

Appendix 2. GP interview guide

1. How long have been with surgery?
2. So you are a GP are you a partner/salaried/locum?
3. How long has the practice been using the telephone triage system?
If new to practice had they used it elsewhere?
4. Does the practice use the telephone triage system alongside other initiatives such as an online platform enabling patients to communicate with GPs?
5. What were practices' reasons for change to telephone triage system?

Setting up of systems

6. Please can you describe the setting up process. How was the setting up process for you?
Time it takes to set up?
What did it entail?
7. Where there any barriers or enablers to the setting up process?
Process of clearing backlog?
Role of/support provided by company in process?
Cost implications? (including company fees, new phones, telephone bills etc)
Infrastructure implications? Have they had to change the practice to accommodate changes?

Process of TT and working day

8. Please describe how the telephone triage system works.
9. How has your working day changed since the system of telephone triage started?
How many patients do you now compared to before?
How much time do you spend on phone?
How has the day to day atmosphere changed in the practice?
How busy is the practice now? How does this compare with before?
10. How has the role of receptionist changed since the introduction of telephone triage?
Has it freed up more time for them to do admin tasks?

Questions to GP – telephone consultation

11. How do you feel about new way of practising, what are the pros and cons?
How has it changed your ways of working with other colleagues (more time to discuss or less time?)
12. How comfortable do you feel using the telephone to communicate with patients?

Do you feel you have received adequate training to consult by phone rather than face-to-face?

13. Do you feel you're able to adequately address patients concerns over the phone? Do you feel patients can adequately express themselves/describe symptoms etc.?
14. Are there challenges with certain groups - both negatively and positively (disabled/non-English speakers/elderly etc)
15. Do you have any concerns over patient safety?
If yes in what ways?

Overall

16. What do you think patients like/dislike about the system?
17. What are the advantages?

*Are the appointments being made are more suitable,
able to talk to a lot more people
able to prepare better for appointments as know why patient coming in
spend longer with those patients that need it?*

18. What are the disadvantages ?
*Spending the day on phone,
missing interaction with patients,
patient safety implications?*
19. If you had the choice would you go back the old system or keep the new system?
Why would you make that choice?

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