Oxford Primary Care 2015

Cutting-edge research in the consulting room

18 May 2015
@OxPrimaryCare

In partnership with:

National Institute for Health Research
Clinical Research Network Thames Valley and South Midlands
New research in telephone triage

Tim Holt
Senior Clinical Research Fellow
Oxfordshire GP

18 May 2015
Background & Introduction

Telephone triage widely used in general practice

Previous research on nurse triage
  – small samples
  – limited numbers of practice settings

Department of Health needed evidence
Research question

For patients requesting same day appointments in general practice, how do...

(1) nurse-led computer-supported telephone triage
(2) GP-led telephone triage and
(3) usual care

...compare in terms of their impact on primary care workload, NHS costs, and patient reported satisfaction, health status and safety?
Methods

Exeter  
Bristol  
Warwick  
Norwich

Pilot Study (2010)  
6 practices, 1200 patients

42 practices (2011/2012)  
21000 patients

GP triage  
Nurse triage  
Usual Care
Inclusion & exclusion

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Practices not already operating triage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients telephoning to request a same-day, F2F consultation with a GP</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Urgent/emergency care</td>
</tr>
<tr>
<td></td>
<td>Communication problems</td>
</tr>
<tr>
<td></td>
<td>Temporary residents</td>
</tr>
<tr>
<td></td>
<td>12-15 year olds</td>
</tr>
</tbody>
</table>

Outcomes

- **Primary:** Number of primary care contacts (GP, nurse, WIC, OOH, A&E) within 28 days of initial same-day request

- **Secondary:**
  1. NHS resource use & costs within 28 days of initial same-day request
  2. Patient satisfaction
  3. Health status
  4. Safety (deaths & emergency hospital admissions within 7 days, A&E contacts within 4 weeks)
**Patient telephone call**

- **Eligible for ESTEEM**
  - **Receptionist** handles call as per procedure for intervention
  - **Clinician**
    - Triage (or see pt in UC)
    - Clinician Form
    - Verbal consent to case notes review
  - **Practice admin staff**
    - Study Read code applied to pt’s record
  - **Questionnaire**
    - sent to pts at 4 weeks (written consent to case notes review on last page)
  - **Case Notes Review**
    - Performed for consenting pts at 12 weeks

- **NOT eligible for ESTEEM**
  - Dealt with according to practice usual protocol

---

**Trial outline**
Results
Recruitment - practices

388 approached

103 interested

71 meetings

54 agreed & randomised

42 in trial

129 no response
133 declined
23 ineligible

27 declined
5 ineligible

13 declined
4 ineligible

12 withdrew
Recruitment - patients

22,261 requesting SD appt
(target: 21,138)

20,998 eligible and sent Q

16,279 consented to notes review

16,219 in final analysis of case notes
(target: 11,253)

752 12-15 year olds
511 withdrawn

8 withdrawn after Q

60 notes not reviewed
Primary outcome

![Graph showing the proportion of patients based on the number of contacts for different outcomes: UC, GPT, NT. The x-axis represents the number of contacts, ranging from 0 to 10+, and the y-axis represents the proportion of patients, ranging from 0% to 60%. The graph indicates that a higher proportion of patients have more contacts.]
Primary outcome – primary care contacts in 28 days following a same-day consultation request

<table>
<thead>
<tr>
<th></th>
<th>GPT v. UC</th>
<th>NT v. UC</th>
<th>NT v. GPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of primary care contacts over 28 days</td>
<td>↑ 33 %</td>
<td>↑ 48%</td>
<td>↑ 4%</td>
</tr>
</tbody>
</table>

Sensitivity Analysis (combining all index-day practice contacts into one)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Rate of primary care contacts over 28 days</td>
<td>↑ 10%</td>
<td>↑ 12%</td>
<td>↑ 1%</td>
</tr>
</tbody>
</table>
### The index day

<table>
<thead>
<tr>
<th></th>
<th>UC N = 5572</th>
<th>GPT N = 5171</th>
<th>NT N = 5468</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contact on index day</td>
<td>5%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>after consultation request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F2F appointment only</td>
<td>87% (GP)</td>
<td>5% (GP)</td>
<td>8% (GP)</td>
</tr>
<tr>
<td>3% (nurse)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triage only</td>
<td></td>
<td>46% (GP)</td>
<td>22% (nurse)</td>
</tr>
<tr>
<td>Triage + F2F appointment</td>
<td></td>
<td>36% (GP f2f)</td>
<td>55% (GP f2f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9% (nurse f2f)</td>
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</table>

*Other pathways taken by very small numbers of patients*

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#### On index day

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<tbody>
<tr>
<td>Rate of GP telephone AND GP F2F contacts</td>
<td>↑ 49%</td>
<td>↓ 28%</td>
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<tr>
<td>Rate of GP F2F contacts only</td>
<td>↓ 55%</td>
<td>↓ 31%</td>
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</tbody>
</table>
### Duration of practice contacts on index day

#### First management/triage contact (mins)

<table>
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<th>Mean (SD)</th>
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<tbody>
<tr>
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<td>GPT</td>
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#### GP F2F contacts following first management/triage (mins)

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<tr>
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No evidence that telephone triage reduces the duration of subsequent F2F contacts.

### Estimated total patient-clinician contact duration on index day (mins)

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</table>
Economic Evaluation

Is there a difference in the cost of care (primary outcome contacts) over 28-day follow-up?

<table>
<thead>
<tr>
<th></th>
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<th>GPT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean 28-day cost (SD)</strong></td>
<td>£75.41 (57.19)</td>
<td>£75.21 (65.45)</td>
<td>£75.68 (63.09)</td>
</tr>
</tbody>
</table>

No significant difference in mean 28-day costs
<table>
<thead>
<tr>
<th>Patient Experience Item</th>
<th>Compared to UC...</th>
<th>Compared to GPT...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GPT</td>
<td>NT</td>
</tr>
<tr>
<td>Getting through on phone</td>
<td>✓</td>
<td>--</td>
</tr>
<tr>
<td>Receiving Prompt Care</td>
<td>--</td>
<td>×</td>
</tr>
<tr>
<td>Ease seeing a GP or Nurse</td>
<td>--</td>
<td>×</td>
</tr>
<tr>
<td>Ease getting help/advice for medical problem</td>
<td>--</td>
<td>×</td>
</tr>
<tr>
<td>Convenience of care</td>
<td>--</td>
<td>×</td>
</tr>
<tr>
<td>Improvement in problem</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td>--</td>
<td>×</td>
</tr>
</tbody>
</table>
## Safety

Compared to usual care is there evidence of increased risk of...?

<table>
<thead>
<tr>
<th></th>
<th>Within 7 days</th>
<th>Within 7 days</th>
<th>Within 28 days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GPT</strong></td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td><strong>NT</strong></td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>
Process Evaluation

10 practices (4 GPT, 4 NT, 2 UC)

54 staff interviews (19 GPs, 9 nurses, 9 PMs, 17 receptionists)

45 patient interviews (20 GPT, 19 NT, 6 UC)
Process Evaluation: themes

• No predictable patterns
• No strong and compelling narrative about what works and what does not work
• GP practices are complex adaptive systems
• Telephone triage in many contexts can be a positive experience
Conclusions

Should I introduce triage?
Summarising ESTEEM

Triage and clinician workload

• Introducing triage, whether GP or nurse led, is likely to lead to an increased rate of patient contacts in the 28 days following a same day consultation request when compared with usual care (GPT 33%; NT 48%).

• If the within-practice management on the index day is considered as a single contact, the rate of contacts increased by 10% and 12% respectively.

• Introducing GP-led or Nurse-led triage does not reduce overall clinician contact time on the index day, but Nurse-led triage does reduce GP contact time.
<table>
<thead>
<tr>
<th>Category</th>
<th>GP triage vs Usual Care</th>
<th>Nurse triage vs Usual Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E attendance rate</td>
<td>→</td>
<td>→</td>
</tr>
<tr>
<td>Admission rate</td>
<td>→</td>
<td>→</td>
</tr>
<tr>
<td>Mortality rate</td>
<td>→</td>
<td>→</td>
</tr>
<tr>
<td><strong>Patient experience of care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td>→</td>
<td>(↓)</td>
</tr>
<tr>
<td><strong>Health economics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per patient</td>
<td>→</td>
<td>→</td>
</tr>
</tbody>
</table>
Publications

• Campbell JL et al. Telephone triage for management of same day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis. *Lancet* 08/2014; DOI: 10.1016/S0140-6736(14)61058-8


• Tim Holt, Emily Fletcher, Fiona Warren, Suzanne Richards, Chris Salisbury, Raff Calitri, Colin Green, Rod Taylor, David A Richards, Anna Varley, John Campbell. Workload implications of telephone triage systems in UK general practice: analysis of consultation duration during the index day in a pragmatic randomised controlled trial. *In preparation.*
Exeter:
John Campbell
Emily Fletcher
Nicky Britten
Linnie Price
Colin Green
Rebecca Kandiyali
David Richards
Sue Richards
Rod Taylor
Raff Calitri
Fiona Warren

Bristol:
Chris Salisbury
Kat Chaplin

Norwich:
Val Lattimer
Jamie Murdoch
Anna Varley

Warwick:
Tim Holt
Vicky Bowyer
Julia Roscoe
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Kirsten Peck – South West 2 REC
Trudi Simmons – Department of Health
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Research Officers – PCRN South West, West Midlands (South), East of England
R&D teams – Peninsula, Western, West Midlands (South), Norfolk & Suffolk CLRNs

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The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HTA Programme, NIHR, NHS or the Department of Health
Thank you for listening
Email for consulting with patients – concern or opportunity?

Dr Helen Atherton. 18 May 2015
What is an email consultation?

- Two-way clinical communication.
- Via software designed to facilitate messaging.
- Or via standard email accounts.
- GP or patient initiated.
Policy situation

• Encouraged by policymakers - Prime Ministers Challenge Fund.

• Linked to the issue of access.

• Assumptions made about the potential that do not draw on evidence.
Current evidence

• Evidence base is growing.
• Good trial evidence lacking in primary care.
• Still a massive gap when it comes to research into the things UK GPs want to know about; impact on workload, safety issues and equity.
Current evidence

• Several studies conclude that the main barrier once a GP decides to use email is the lack of regulation and protocol.

• Also differences in expectations between GPs and patients, due to lack of clarification as to what email consultation is best used for.
Who is doing it?

• Nationally approx. 25% of GPs report say they have done an email consultation.

• Recent survey in Oxfordshire indicated that levels might be higher in this area.
Scoping survey

• Sent 573 surveys across the 81 practices in Oxford CCG.

• 193 responses (34%) from 69 practices (88% represented).
Who is doing it?

How often do you personally conduct consultations with patients via email?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>18%</td>
</tr>
<tr>
<td>Rarely</td>
<td>39%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>19%</td>
</tr>
<tr>
<td>Most working days</td>
<td>15%</td>
</tr>
<tr>
<td>Every working day</td>
<td>9%</td>
</tr>
</tbody>
</table>
Who is doing it?

Does your practice plan to provide email as an alternative to face to face consultations?

- No plans to use this: 47
- Tried to in past, less so now: 6
- Plan to sometime in the future: 25
- Definitely within next three months: 1
- Already do this frequently: 21
AltCon study

‘The potential of alternatives to face to face consultation in general practice, and the impact on different patient groups’
Support for GPs

• Is lacking…with lots of contradiction.

• No clear rationale for this given email is such a mainstream technology used in several sectors.
Support for GPs

• Medical Protection Society in 2014:

‘Only appropriate matters should be dealt with via email exchanges, eg, appointment scheduling, ordering repeat prescriptions and obtaining test results.’
Support for GPs

- BMA

Developing General Practice today: Providing healthcare solutions for the future. 2013 describes the following as an enabler of access:

‘Offering more alternatives to a face-to-face consultation when clinically appropriate, such as dedicated telephone and/or Skype-like surgeries.’
Support for GPs

• BMA survey results

‘Seven in ten (71%) are concerned that using email consultations would increase their workload, and almost two-thirds (63%) are worried about using email consultations due to concerns about clinical limitations.’
Support for GPs

- BMA survey results

‘Only a small minority react positively to email consultations: 6 per cent of all GPs say their experience of using email consultations has already been largely positive, and 5 per cent say their practice is considering offering email consultations in the near future.’
Figure 3.8.2

- I am concerned that using email consultations would increase my workload: 71%
- I am concerned about using email consultations due to concerns about clinical limitations: 63%
- I would not use email consultations due to security and confidentiality concerns: 37%
- I would not use email consultations due to concerns about discriminating against people who are unable/unable to use email: 24%
- My practice has rejected the idea of offering email consultations: 23%
- My experience of using email consultations with patients has been largely negative: 10%
- Technology limitations in my area do not make email consultations practicable: 8%
- My experience of using email consultations with patients has been largely positive: 6%
- My practice is considering offering email consultations in the near future: 5%
- No opinion: 4%

Q36: Which of the following statements reflects your views on adopting email consultations with patients?
Base: All participants giving valid responses (n=15,579), N/A (n=150)
Support for GPs

• RCGP

Patient Online: The Road Map. 2013

‘In view of the separate and unique challenges presented by e-consultation this will not be considered in this document’
Denmark and email consultation

• Mandatory to offer email consultation since 2009.
• Approx. 11% of consultations conducted this way.
• GPs reimbursed £2-3 per consult.
• They do not have any guidance/rules of engagement either…
What next?

• GPs are going to have to take ownership of this use.

• We are working on producing practical advice (AltCon study).

• In the meantime be confident in applying your clinical experience in deciding how you want to use this.
What next?

• Evidence shows us that patients respect the doctor-patient relationship so work within this framework.

• Share experiences with other GPs and practices – strength in numbers.

• Where you can, lobby your professional bodies – they want to hear from you, not from researchers.
Help us?

If you are using this type of communication and want to be part of our existing studies, or have thoughts on where we need to focus our research, then please get in touch.

helen.atherton@phc.ox.ac.uk
Consultations by Skype
The future of general practice or more of the inverse care law?

Professor Trish Greenhalgh. 18 May 2015

Acknowledging wider research team and NIHR funding for VOCAL (Virtual Online Consultations – Advantages and Limitations) study

EARLY report – no definitive data yet!
“We have great things happening here in the UK….like Newham University Hospital that has reduced missed appointments by 11% through use of Skype for diabetic outpatient appointments”

Rt Hon Jeremy Hunt MP, March 2013
Research questions

1. What defines ‘quality’ in virtual consultations and what are the barriers to achieving this?

2. How is a successful virtual consultation achieved in an organization whose processes and systems are mostly orientated to more traditional consultations?

3. What is the national-level context for the introduction of virtual consultations in NHS organizations and what measures might incentivize and make these easier?
Early work at Newham

DAWN study (feasibility) 2011-12
Health Foundation
Proof of concept: can we make it work?

DREAMS study (service development) 2012-14
Health Foundation
Focus on organisational systems / processes

NHS funded clinical service
This is now happening in diabetes care!
Study design

In-depth qualitative study based in two contrasting departments: Diabetes and cancer surgery

**MICRO:** Interactional dynamics via Skype by generating a multi-modal dataset (audio, video and computer screen capture).

**MESO:** Map the administrative and clinical processes that will need to change to embed online consultations

**MACRO:** National policymaker and other key stakeholder perspectives
Interpersonal interaction (micro)

Up to 45 ethnographic cases ($20-30 = diabetes patients$, $10-15 = cancer patients$). Small numbers $\Rightarrow$ depth of analysis.

• **Analysis of Skype consultations:**
  Video, audio and screen capture at both ‘ends’ of a remote consultation

  Analysis of what is said and done, and how the technology shapes and constrains the consultation (using CA)

• **Case narratives:**
  Home visit interviews to explore how the technology affects experience of illness and interaction with service
Map the people and steps to implement and use Skype

Identify how the organisational roles, processes and routines change over time to accommodate and support the service

- **Ethnography**
  Observations and ‘naturalistic interviews’ with Trust staff within using or supporting Skype. Explore significant events.

- **Workshops**
  Bring together key staff to gather feedback and identify opportunity for improvement

- **Action research**
  Do stuff to help get the service set up (e.g. produce SOPs)
Interviews with national stakeholders

Documents recommended or supplied by them

=> The ‘organising vision’ for remote consulting

These data will be used to contextualise statements, actions and interpretations made by organisational actors

Preliminary impression: There is no formal UK policy on remote consulting (but much talk….)
## Next 3-6 months

### Months 3-6: June – August 2015

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit 15-20 patients</td>
<td>Recruit up to 20 patients across case sites (15 diabetes, 5 cancer)</td>
<td>Aug 2015</td>
</tr>
<tr>
<td>Collect data for up to 10 consultations</td>
<td>Collect screen-capture data for 5-10 consultations and pilot method for syncing audio/video data</td>
<td>Aug 2015</td>
</tr>
<tr>
<td>Map people and processes at case sites</td>
<td>Map key people and steps involved in running Skype at an organisational level</td>
<td>Jul 2015</td>
</tr>
<tr>
<td>First consolidating learning workshop</td>
<td>Gathering feedback from all those involved in, or impacted by, Skype appointments.</td>
<td>Aug 2015</td>
</tr>
</tbody>
</table>
Intended outputs

Standard operating procedures for remote consulting (already working with NHS England on these)

Detailed description of ‘what good looks like’ in remote consulting => inform training and quality work

Guidance on what works for whom and ‘red flag’ issues

Ideas for further research e.g. in GP land
Preliminary findings

Based on pilot data

For discussion!!
Patient’s preference

- Likes coming to clinic and finds it accessible
- Dislikes coming to clinic and/or finds it inaccessible

Clinician-patient relationship

- New encounter or poor previous rapport
- Well-established and positive relationship

Anticipated course of clinical examination

- Non-visual physical examination likely
- Non-visual physical examination unlikely

Patient’s care needs

- Complex or unpredictable (e.g. annual review, ‘one stop shop’ for ? cancer)
- Simple and predictable (e.g. monitoring stable conditions, post-op checks)

Anticipated emotional dynamic

- Complex or challenging (e.g. “bad news” / possible conflict)
- Straightforward (e.g. “good news” / conflict unlikely)

Computing environment

- ‘Locked-down’ environment precludes ICT innovation
- Software can be installed and customised easily

Incentives/disincentives

- Financial disincentives to remote consulting e.g. tariff
- Financial incentives to remote consulting

Service pathway

- Systems and processes not optimised for this condition
- Systems and processes optimised for this condition

IT literacy

- Patient or clinician not confident in use of webcam
- Patient and clinician confident in use of webcam

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Thanks for your attention!

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Health technology
Q&A