

## Telephone triage in-hours:

does it work?

*'More than 26 million people in England had to wait for a week or more to see or speak to their GP last year.'*<sup>1</sup>

Those leading the College's campaign for more investment cite this as evidence of a funding crisis in general practice. Others may see it differently but no one disputes our escalating workloads; the number of consultations has risen by over 75% since 1995.<sup>2</sup> Many practices struggle to meet the daytime demand for appointments and innovative 'solutions' have immediate appeal. Many readers will recall the hyperbole that surrounded the Advanced Access initiative. Similar claims for its transformative effects are nowadays being made by those promoting the use of telephone triage.<sup>3</sup> This is potentially big business but what do we know of its impact on workloads? What other consequences follow from large scale adoption of telephone triage to manage routine calls?

### PAST EXPERIENCE

With characteristic prescience, Geoffrey Marsh was promoting telephone consultation as part of the future of general practice a quarter of a century ago<sup>4</sup> but its use is sharply rising. A recent survey of 1148 practices found that 56% used some form of telephone triage; 9% of practices triaged all their patients.<sup>5</sup> There are, of course, many different ways of using telephony for demand management (Box 1) and this variety presents an obvious dilemma for those in search of answers.

Much of the recent research has examined the use of telephone triage out-of-hours, often delivered by nurses. The introduction of NHS Direct was accompanied by evaluation to establish whether it reduced pressure on other services. In essence, this showed that the new service was additive rather than substitutional. While there was a small decrease in the use of GP cooperatives, there was no significant decrease in the use of A&E departments or ambulance services following the introduction of NHS Direct.<sup>6</sup>

A Cochrane review, subsequently published in this journal, concluded that telephone consultations and triage can reduce the numbers of face-to-face contacts and out-of-hours visits by GPs, but the evidence on overall service use and patient satisfaction was inconclusive.<sup>7</sup> It confirmed the dearth of robust research.

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Of nine studies that met the authors' inclusion criteria, five were randomised controlled trials but only one of these examined telephone consultations in the management of same-day appointments in general practice.<sup>8</sup> In general, telephone consultation handled at least 50% of calls and appeared to reduce GP workload. There was no apparent increase in adverse effects or use of emergency services. Levels of patient satisfaction appeared high but most studies were uncontrolled. The only economic evaluation found little difference in cost between intervention and control groups.<sup>9</sup> Predictably, trials of better quality appear to yield more equivocal results.

### ADVANCED ACCESS

The largest ever study of GP appointments focused on Advanced Access.<sup>10</sup> Various strategies were employed to support same-day appointments including telephone triage, booked telephone appointments, e-mail consultations, access to advice on self-management (via leaflets and websites), and delegation to minor illness nurses and healthcare assistants. In other words, this was a whole-system change of which telephone triage was but one

element. It is difficult to assess the impact of these different elements in isolation. Nevertheless, Advanced Access appeared to have little impact on access, or patient or staff satisfaction.<sup>10</sup>

### KNOWN UNKNOWNNS

There remain many unanswered questions. What is the longer term impact of freeing up telephone access on workloads? If removing the traditional barriers to access increases call rates, might overall activity rates rise? Anecdotal reports suggest that many practices come to find wholesale triage burdensome and revert to the way things were before (L Abrahams, personal communication, 2014). Are particular patient groups more likely to use the service than others? The technology itself may constitute a barrier for older patients, minority ethnic groups, and those for whom English is a second language. Those with hearing or speech impairments and people with learning disabilities may also be disadvantaged.<sup>11</sup>

Very little is known about the relative quality of care delivered by phone. On one hand, the management of routine presentations could be more systematic

### Box 1. Models of telephone care: a checklist

- Reception staff book telephone lists followed by:
  - Nurse-led telephone triage
  - Doctor-led telephone triage
- Whole sessions or end-of-surgery appointments
- Whole day or morning only
- Appointments booked by telephone consultant for own/other doctors/other staff surgeries
- Exclusions by patient group, such as children or frail older people
- Exclusions by condition, such as acute or chronic
- Use of protocols
- Use of headphones, landlines, mobile phones
- Training requirements
- Follow-up and evaluation (for example, patient satisfaction, questionnaires, 'conversion rates')

if protocols are being agreed and used. On the other hand, distant and therefore more defensive care could result in lowered thresholds for prescribing, investigation, or referral. How safe is telephone triage, especially at the extremes of life? McKinstry *et al* concluded that telephone consultations may compromise patient safety and be more appropriately used in managing chronic rather than acute conditions.<sup>12</sup>

Hastening access often reduces the availability of appointments for a named doctor. How does telephone triage affect continuity of care? This matters as there is a paradox at the heart of telephone consulting. My confidence in its safety and effectiveness is partly predicated on a familiarity with the callers' consulting behaviour that itself derives from multiple face-to-face contacts. How is that intimate knowledge acquired if those contacts are reduced? And how do faceless contacts, which are generally scheduled to be shorter, affect the potential for opportunistic health promotion or shared decision making? Research suggests variable levels of compliance with nurse triage, but quite how this relates to the appropriateness of management decisions taken is unclear.<sup>13</sup> Different kinds of qualitative research are required involving direct observation and analysis of process to address some of these questions.

Appropriate training ought surely to be mandatory; and not just for teams establishing triaging systems *de novo*. Many Deaneries advise that telephone triage should not be undertaken by registrars until ST3. However, the survey quoted above raised concerns in this area; nearly half (48%) of practices had received no training in telephone triage.<sup>5</sup> Furthermore, 13% of responders said that receptionists without medical training were involved and that many did so with no training or help from nurses or doctors. Where are such triaging teams positioned medicolegally?

## MOVING FORWARD

So how should practices proceed from here? The most telling message from this body of research is that no one size fits all. The search for a single 'right' appointment system is itself futile. Patients have different priorities at different life stages, according to illness and family circumstances. Above all, appointment systems need to be flexible. The need for more, better quality research is irrefutable and the results of trials such as ESTEEM are awaited with interest.<sup>14</sup>

In the meantime, practice teams need to start with a clear understanding of their own patient populations' needs, matching

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resource to demand. Exactly which staff undertake triage may matter less than ensuring that the nurse, doctor, healthcare assistant, or receptionist is properly prepared and supported.

Doctors are easily seduced by interventions that appear to provide short-term relief. Advanced Access was widely promoted following enthusiastic reports from 'early adopters'.<sup>11</sup> Telephone triage is likely to form part of the 'solution' to rising demand for same-day appointments but is not cost-free. Remember also that telephone consultations are probably underused in the management of chronic disease.<sup>15</sup> Similar considerations, notwithstanding ministerial enthusiasm, should restrain impulsive investments in e-mail, skype, and other forms of teleconsulting without prior evaluation.<sup>16</sup>

Finally, and with due deference to our College campaigners, a possibly more unpalatable message for politicians: most patients have no complaints about access to their GP. If immediately necessary, they can see a doctor on the day they call to make an appointment. For many, speed of access is less important than convenient timing and seeing the doctor or nurse of their choice.<sup>17</sup> Austerity, instant access, and continuity are conflicting objectives.

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