Supplementary Table S1: Practices and Participants

Practice and participant characteristics

Practice Identifier	List Size [a]	Deprivation [b]	Round 1 [c] 13 - 27 May	Round 2 28 May - 13 Jun	Round 3 15 Jun - 2 Jul	Round 4 3 Jul - 27 Jul
1	Medium – Large	1	GP1, **PM1**	GP1	GP1	**NM1**
2	Small – Medium	2	GP2, **PM2**	GP2	GP2	GP2
3	Medium	3	GP3, **PM3**	**NM9**	GP3	**NM9**
4	Medium – Large	5	GP4	GP4	GP4	**NM2**
5	Small	1	GP5, **PM4**	0	GP5	**NM3**
6	Very Large	5	GP6, **PM5**	GP6	GP6	GP6
7	Medium	5	GP7	GP7	GP7	GP7
8	Small – Medium	5	GP8, **PM6**	GP8	**NM4**	GP8
9	Very Large	5	GP9	GP9	GP9	**NM5**
10	Small – Medium	5	GP10, **PM7**	GP10	GP10	GP10
11	Small	1	GP11	GP11	GP11	GP11
12	Very Large	3	GP12	GP12	GP12	0
13	Small	5	GP13	GP13	GP13	GP13
14	Medium	5	GP14, **PM8**	GP14	GP14	**NM6**
15	Small	5	0	GP15	GP15	GP15
16	Small	3	0	GP16, **PM9**	0	GP16,**PM8**,**NM7**
17	Small – Medium	3	0	GP17,**PM10**	1 (GP17)	GP17
18	Small	1	0	GP18,**PM11**	1 (GP18)	GP18
19	Small – Medium	2	0	GP19	1 (GP19)	GP19
20	Medium	2	0	GP20	1 (GP20)	GP20
21	Small	1	0	GP21	1 (GP21)	**NM8**
Total interviews			**22**	**23**	**20**	**22**

a) Small: < 10,000; Small-Medium: 10 - 15K; Medium: 15-20K; Medium - Large: 20-25K; Large: 25 - 30K; very large: 30K+

b) 1 = most deprived and 5 = most affluent.

c) **GP** = general practitioner; **PM** = practice manager; **NM** = nurse manager, advanced nurse practitioner or senior nurse.

Supplementary Box S1: Quantitative Data Rules

1. Data extraction and analysis

- ⇨ Data on patient characteristics, consultations and clinical codes for 21 practices were extracted by One Care.
- ⇨ We only extracted consultations added by clinicians. Administrator added consultations (e.g. e-consultations, documents uploaded, SMS messages sent by administrators) were not extracted.
- ⇨ Patient characteristics were extracted for all patients registered in July 2020.
- ⇨ We only extracted consultations for patients who are still registered in July 2020.
- ⇨ To calculate consultations per 1000 patients, we used the July 2020 patient list extracted by One Care as the denominator for the 2020 consultations/SMS data. For the 2019 data, we adjusted this list size based on practice list size data (total list size for all 21 included practices) published by NHS digital. We calculated the quotient of July 2019/July 2020 list size, and used this as a multiplier for the denominator. We used this same method to individually calculate the offset for each practice for the negative binomial models. For the figures presenting consultations per month, we again used this same method but using monthly list sizes on NHS digital to calculate the multiplier for the denominator.

2. Consultation Type

We applied the following rules to identify consultation type:

Face-to-face: If

consultation category= "gp surgery" OR "face to face consultation" OR "face to face consultation with relative/carer" OR "emergency appointment" OR "extended hours consultation" OR "same day appointment" OR "urgent consultation".

Home: If
consultation category= "children's home visit note" OR "home visit note" OR "night visit note" OR "nursing home visit note" OR "residential home visit note" OR "twilight visit note"
OR
Clinical code text contains the words “home visit”.

Telephone: If
consultation category contains the words “telephone call” OR "telephone consultation” OR “[1] OR "enterprise consultation”[2]
OR
appointment type contains the words “telephone” OR “phonecall” OR “phone call” OR “telcon”

[2] These are consultations carried out in a GP surgery which is not the patients own surgery. We identified these as telephone consultation as we do not know anything more about the medium of these consultations and telephone was most likely. If clinical codes for video consultation were identified, this was coded to video instead, in accordance with the data rules shown in the following page.

OR
appointment slot status= "telephone – complete"
OR
Clinical code text contains the word "telephone" OR "telephone and/or video" OR "telephone/video" OR "telephone/ video" OR "telephone / video"

Video: If
consultation category= "consultation via video conference"
OR
Clinical code text= assessed by video consult" OR "consultation via video conference" OR "video consult"
E-consultation[3]: If
consultation category= "online communication" OR "consultation via multimedia" OR contains the word "e-mail"
OR
appointment type contains the words "e consult" OR "econsult" OR "e:consult"
OR
Clinical codes text contains the words "econsult" OR "e-consult" OR "e:consult" OR "e consult" OR "consultation via multimedia" OR "alert received from telehealth monitoring system"

We used the following rank order for determining consultation type: **Video, Telephone, E-consult, Home, Face-to-face** (E.g. if a patient has consultation type as "GP surgery" but has a clinical code for "video consult" then this is coded as video.)

Consultations were excluded as follows:

- ⇨ Non consultation activity (e.g. where the consultation category was "administration note", "inbound document", and "scanned document").
- ⇨ Records which were appearing as consultations but were actually SMS messages. Identified as: *Consultation type*= "Face-to-face" AND *consultation category*="gp surgery" AND the consultation has a maximum of 3 clinical codes associated to it, and one is "patient mobile telephone number" or "patient telephone number", and one is "sms (short message service) text message sent to patient" or "sms text message sent to patient" or "sms text sent to patient"
- ⇨ Consultations which the patient did not attend, or did not answer the phone: Identified by (*Clinical code text* contains the words "did not attend" OR "failed encounter" OR "dna" AND *clinical code text* does not equal "dna studies" OR "dnacpr") OR (*appointment slot status* = "telephone - not in" OR "dna" OR "walked out").

SMS messages

We identified SMS messages using clinical code text containing the words "sms" or "short message service", where the text did not also contain the words "failed encounter", "fail encntr" or "consent given".

[3] Because we only included consultations added by clinicians, not administrators, these only include e-consultations which clinicians added to the patient record. E-consultations added by administrators which covert to a telephone call (added by a GP) or dealt with by a task are not included.

3. Staff type

Codes were mapped for staff type as follows:

GP: Assistant GP, Associate practitioner - general practitioner, General medical practitioner, GP registrar, Locum GP, Salaried general practitioner, Sessional GP

Nurse/Paramedic: Advanced practitioner, Associate practitioner – nurse, Community nurse, Community practitioner, Enrolled nurse, Modern matron, Nurse consultant, Nurse manager, Paramedic, Paramedic specialist practitioner, Sister/charge nurse, Specialist practitioner, Staff nurse.

An Allied Professional Staff Type was also created. However, as the numbers of consultations were very small, this was not used in our analysis.

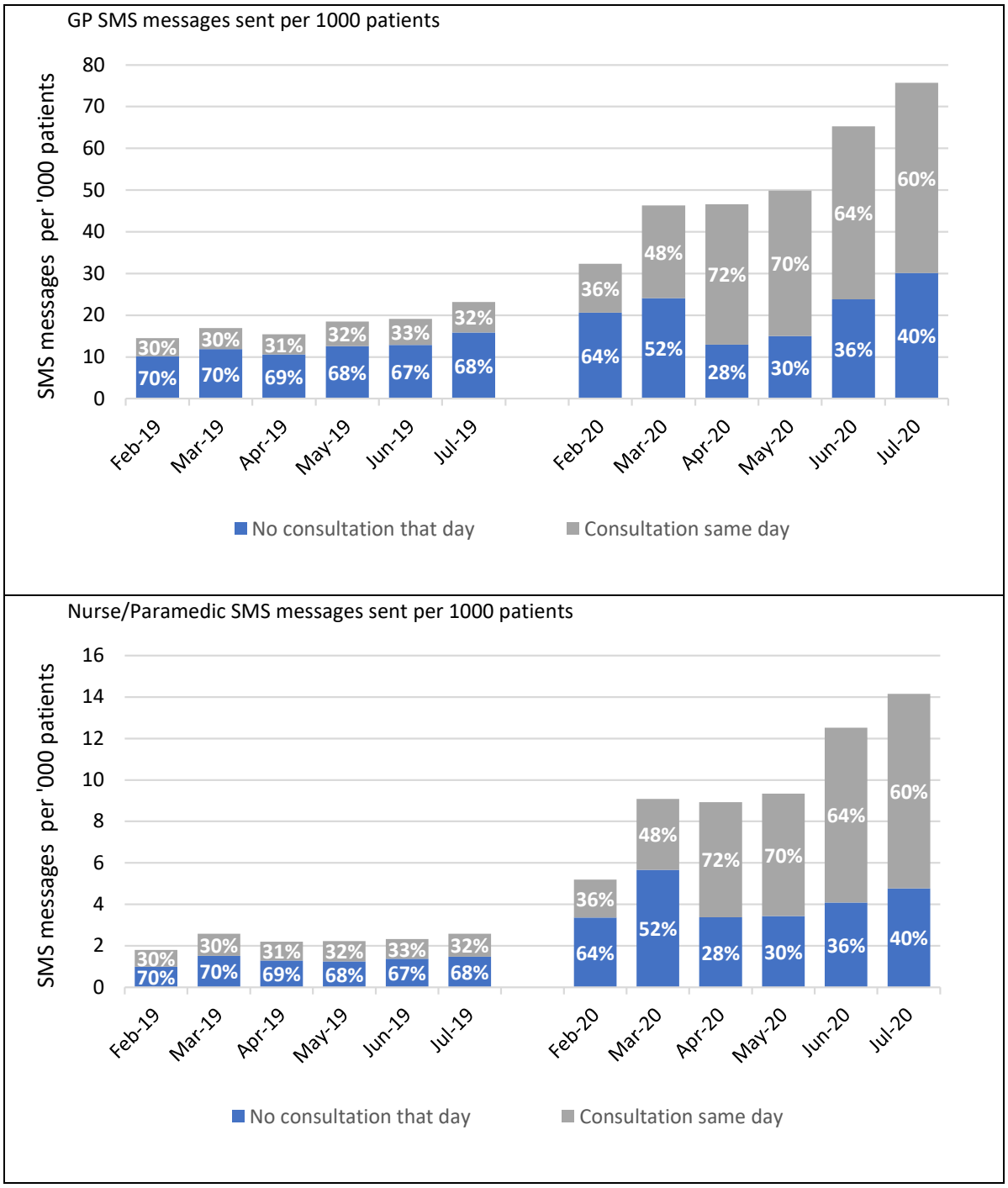
4. Ethnicity

Codes were mapped for ethnicity as follows:

- **White**: 44 different codes. Over 90% of patients were covered by the codes "White British", “British or mixed British” or "other white background."
- **Black/African/Caribbean/Black British**: 36 different codes. Over 90% were coded as “African”, “Caribbean”, “black African", “black Caribbean”, "Somali”, or “black British”.
- **Asian/Asian British**: 49 different codes. 90% of patients were covered by the codes “Indian or British Indian”, “other Asian background”, “Pakistani or British Pakistani", “Chinese”, “Bangladeshi or British Bangladeshi”, “Indian” or “Pakistani”.
- **Mixed/Multiple ethnic groups**: 27 different codes: 90% covered by “white and black Caribbean”, "other mixed background”, “white and Asian”, "white and black African”, “other mixed white”, “black and white”.
- **Other**: 40 codes including: “any other group”, “Turkish”, “Arab”, “other ethnic non-mixed (nmo)”, “Iranian”, "gypsy/Romany”, “Kurdish”, “Latin American”, “Albanian", “other European (nmo)”.

Supplementary Figure S1: SMS Messages

GP and Nurse/Paramedic SMS messages sent per 1000 registered patients, Feb-Jul 2019 and Feb-Jul 2020



Supplementary Box S2: Topic Guide

Staff interview topic guide

(NOTE – this guide evolved over the four rounds of interviews. All questions were not asked in every round.)

Introduction and audio consent

- Introduction – introduce self
- Aim - We are working with BNSSG CCG to rapidly identify the changing demands on general practice, common challenges and innovative solutions that practices have devised to cope with the Covid-19 pandemic. This information will be rapidly fed back to the CCG to improve support for practices.
- Consent – explain voluntary participation, audio record, anonymous quotes
- Switch audio recorder on - For the audio recording, can I check that:
  - You read and understood the study information sheet?
  - You know that taking part in the interview is voluntary and you are free to stop the interview at any point?
  - You agree to our conversation being audio recorded?
  - You understand that quotations from the interview may be used to illustrate our findings, but it will not be possible to trace who said them?
  - You agree to take part in the study?

Covid-19

- On a scale of 1 to 10 how well is your practice coping with the Covid-19 pandemic? (**Round 2-4 option:** Last time when we asked you how you were coping on a scale of 1-10, you said X. What would you say now?)
- Explain why?

Impact of pandemic

- What are the main challenges that your practice is facing due to the pandemic? (**Round 2-4 option:** Last time you said that your main challenges were X, Y, Z. Are these still challenges for you? What new challenges have arisen since we last spoke?)
- What could be done to help them quickly? [note - Link to new challenges]

What creative solutions has your practices come up with to address challenges – what seems to have worked? What would you keep doing post-covid-19? [note - Link to new challenges]

Round 1 question: What about the types of people who consult? Has there been an inadvertent widening of health inequalities due to the sudden change to remote working? How mitigate? Conversely, has it increased access in some areas? What opportunities have been afforded to some areas of the population?

Changing consultations - method, volume, type

- Has volume of consultations changed? How are you dealing with this?
- Has the type of consultations changed? Changes in patients' health seeking behaviour?

How are you managing the move to remote consultations operationally - talk me through your current process for patients accessing care. (**Round 2-4 option:** You talked me through last time how you were managing the move to remote consultations operationally. Have there been any policy or operational changes on this in the last 2/3 weeks?)

Prompts for round 1 only

- *Phone booking [Y/N]*
    - *Online booking [Y/N]*
    - *Online consultation [Y/N]*
    - *Via 111 [Y/N]*
    - *How far in advance can patients book, if at all?*
    - *How is the practice currently operating GP lists?*
    - *What happens if reception triage indicates something urgent?*
    - *How does a patient's first clinical contact happen? (e.g. when, by what means, what duration)*
    - *How are video consultations arranged, if required?*
    - *How is follow up contact arranged, if required?*
- How do you feel about the move to remote consultations? What are the positives and negatives of video consultations?
    - Confidence in dealing with video consultations
    - Able to make an emotional connection? For example, how are you managing COVID-related anxiety/depression via telephone/video?
    - Any issues with the IT equipment for video consultations? – what shared learning?
    - What benefits of remote consultations could be retained post-pandemic
- **Round 2 option:** We talked a bit time about the positives and negatives of telephone/video consultations.
    - How is it going now that you have had more time to get used to it?
    - Are the clinicians confident in being able to use it for most medical enquiries?
    - How is it working with rising workload?
    - Are you still experiencing technical issues (if they were in the first place).
- Have you started doing online triage through AskMyGP/e-consult? How is that going?

Round 1 questions:

- What types of patient, or what types of condition, do you still need to see face to face? What makes you to ask someone to come in?
- *When face to face consultation is required, how is this managed for staff and patients IF:*
    - *Suspected covid patients*
    - *Shielded patients*
    - *Other patients*
    - *When bloods/treatment rooms appointments are needed, how is this managed for:*
        - *Suspected covid patients*
        - *Shielded patients*
        - *Other patients*

(**Round 2 option:** Don't ask this in round 2 – question above asked if there were any operational changes and that should cover this.)
Is workforce safety able to be addressed, separate from their interactions with patients? For example, how is this being managed for BME staff? (**Round 2 option:** We talked last time about workforce safety and how that was being managed through use of PPE and XXX. Have there been any changes in that respect?)

-------In Rounds 1 and 2, if reached 20 min mark, I have a couple of questions on chronic conditions and other activity would you like to carry on or stop --------

What are you not doing?/care of vulnerable patients

- Impact on routine clinical activities, e.g. monitoring, screening, immunisations, contraception? – consequences of these changes? Plans to mitigate consequences?
- Impact on investigations, blood tests, referrals? – consequences?
- Any benefits/opportunities/new ways of working that have arisen?
- How has the delivery of care to vulnerable groups changed during the response to the pandemic? (mental health problems, learning difficulties, vulnerable children) Do you think these changes led to increase in adverse events? Plans put in place to reduce possible negative consequences?
- Is there anything else that we have not covered about your practices response to the pandemic that you think would be relevant for us to know?

Care of patients with chronic conditions/multimorbidity/frailty

- How has the delivery of primary care to patients with chronic conditions/multimorbidity groups changed?
- Impact on management of patients with chronic conditions? – consequences – e.g. missing things due to remote consultations - increase in adverse events? What?
- Impact on continuity of care?
- Shielded patients that you practice has written to and told to self-isolate – what issues are arising caring for these patients? How helping deal with psycho-social burden of isolating?
- How has the delivery of care to patients with frailty changed during the response to the pandemic? Consequences? Plans put in place to alleviate possible negative consequence?
- Gut feel around extended hours, which would help potentially with social distancing/vulnerable/shielded patients?

Supplementary Box S3: Quotes Annex

Contents

Introduction

This supplementary file gives participant quotes to illustrate 1) participants views on the causes of changing volumes of consultations; 2) collective action taken to implement remote consulting; and 3) reflexive monitoring on the use of telephone and video consultations and SMS messaging.

Change in volumes, complexity and health seeking behaviour

Change in volumes, complexity and health seeking behaviour	
Changes resulting in reductions in GP workload	Changes resulting in increases in GP workload
Reduction in viral illness *Viral infection has disappeared off the face of the earth […] Everyone's been shielding each other from each other. Viruses haven't been spreading at all. Lots and lots of illnesses have just gone away. (GP, HC21, Round 2)* ***Reduction in self-limiting conditions*** *What we have noticed is that all the kind of steady self-limiting conditions have just stopped […] All the people with hay fever and itchy eyes and itchy scalp have are I wouldn't get anything anyway or I can go and buy it. (PM, HC18, Round 2)* ***Reduction in home visits*** *The big thing is that visits have fallen off a cliff completely. [...] Literally I think they're just terrified of people coming into their houses. (GP, HC4, Round 1)* ***Initial reduction in mental health problems*** *Although I have spoken to some quite depressed people, on the whole, the majority of our anxious people by and large are finding lockdown suits them much better […]*	***Increase in complexity as lockdown eases*** *So I think life has gone back to normal, so patients are worried about their health, they are wanting to ask us a lot of questions and potentially questions that they might have asked before, but now with COVID in mind, they want to ask them again. They are stored up and sat on things for COVID […] we also have the challenge of them wanting to deal with quite a few things each time and quite complex. (GP, HC20, Round 4)* *Patients are becoming more complex so we have to be careful we don't missing anything in the telephone triage um so it's becoming more focussed I suppose […] it's a little bit more intense I suppose what we're doing now […] so it might be that they have an underlying lung disease and then they might have something else going on and then another problem and we have to rule out that it's nothing to do with COVID, that the lung problem is that and the other maybe pain added to the top we have to make sure it's not COVID related but it could be muscular which we might have thought in the past but we have to go through another layer of questioning to really tease out what's going on and*

Change in volumes, complexity and health seeking behaviour	
Changes resulting in reductions in GP workload	Changes resulting in increases in GP workload
We've seen a massive reduction in the people calling with panic attacks and anxiety, and I think part of it is that everyone is in the same boat, so people who struggle to get out of the house normally are just in the same boat as everyone else. (GP, HC11, Round 1) ***Patients putting off, or deferring issues*** *Patients have opted to probably not contact us with those issues, because they probably feel that they can defer them or they don't want to contribute to what they probably perceive as a demand on our system during these times. (GP, HC6, Round1))* ***Reduction in frequent attenders*** *our frequent attenders all seemed to vanish […] And they're not back yet. (GP, HC10, Round1)* ***Reductions in children*** *I think that families remain very concerned about coming out like I said. Practice Manager, HC5, Round 1)* *We're not seeing the children […] I've been thinking about that as well and wondering whether these viruses are just not spreading because they're not at school together? (Advanced Nurse Practitioner, HC3, Round 2)* ***Reduction in red-flag cancer symptoms*** *My worry is now, in terms of the cancer fast-track pathway, I was probably referring several a month prior to lockdown, and since lockdown I haven't referred anyone. One worries about how much cancer diagnoses we are, not missing, but not seeing because people haven't been coming forward with those problems.(GP, HC6, Round 1)* ***Some GPs found it harder to see a pattern*** *I don't think there is a pattern […] I think it's very dependent on the individual.(GP, HC1, Round 3)* *I think the difficulty is you don't know the ones that aren't consulting, so the more vulnerable ones you think actually they do normally consult a lot or they speak to us a lot, they're not. I think seeing something that's not there is harder to see than something that is there!* (GP, HC2, Round 3)	*whether we need to be worried about the patient or not. (Nurse, H3, Round 4)* ***Increase in shielding calls*** *We haven't really got any potential COVID here and people aren't coming really with respiratory things it's all kind of you know it's you know well I've been told I shouldn't shield and I think I need to shield and my employer wants me to do this and you know.(GP, HC3, Round 3)* ***Increase in mental health later in pandemic*** *I'd say there's definitely more mental health. […]. So people that were managing and their safety net went away, then they kind of felt they had to manage because pandemic, lockdown, now that's coming away, the safety net isn't there but we're not in lockdown any more, so that consultation rate has definitely gone up, has been my experience, and anecdotally speaking to my colleagues I think other people have felt that too. (GP, HC13, Round 4)* ***Stored-up issues*** *Yes as before I think patients were um wanting to try and self-care a little bit for themselves and it's as if they've saved it all up as well now so it's like… and especially if you're doing a face to face consultation even if it's a case of um doing a lady's cervical screening um you know always ask the patient how they are and it's a case of um yeah they've um got a lot of other issues going on as well yeah. (Nurse, HC21, Round 4)* ***Increase in volumes not including COVID*** *We're not seeing a lot of COVID at the moment, we're definitely not, I can't remember seeing a possible COVID case in the last three weeks so I think the amount of COVID or potential COVID we've seen has definitely gone down and a lot of it is normal stuff now. (GP, HC7, Round 3)* ***Increase in non-specific presentations*** *Probably there's a little bit more of the rather nebulous, non-specific symptoms being reported. At the beginning of COVID, hardly anybody dared pick up the phone. So, lots of things where, frankly you think there's probably nothing – non-specific tiredness, non-specific aches, feelings of unease, things like that, which had gone away for quite a few weeks, they're now starting to come back. I would say that's probably more of a feature now than it was. (GP, HC18, Round 3)*

Collective Action

Collective action taken in March 2020
Drop in volumes created time for action: *It was very easy to turn around our system from being very face-to-face to telephone […] with lockdown the patient demand disappeared for various conditions and so that gave us a bit of room to breathe. (Practice Manager, HC18, Round 2)*
Moved to total same-day triage: *We almost immediately moved to a telephone triage service for everything [..] it had to be a same day telephone triage service so you couldn't triage something one day and then book it in three days later because by that time someone could have developed symptoms.(GP, H12, Round 1)*
Closed online booking: *there's no online booking, it's purely for 111. (GP, H11, Round 1)*
Video consultation roll-out: *AccuRx [SMS messaging service] who work alongside EMIS [electronic patient record system] have really put their heads together and come up with a very robust easy way of doing it. We've all bought video cameras and we can do that [video calls]. (GP, HC 21, Round 2)*
Enabled shielding staff to work from home: *We've got two nurses who are shielding, so they're not here at all. […] The HCA, she's doing all the shielding calls. […] Then [the nurse] is just doing all the asthma reviews […] (Nurse Manager, HC8, Round 3)*
Moved to single patient appointment lists: *We moved to one long call list we all shared. We'd pick off that list for the people who are working both in the building and those who were working remotely, who were well but at home for various reasons. (GP, HC10, Round 1)*
No appointment times given: *The receptionist will say that the doctor will call you back and it will be some time this morning, but they're not giving a specific time. […] People have been happy about that. They're locked down anyway, (GP, HC11, Round 1)*
Proactive follow-up of shielded and vulnerable: *Shielded patients have all received calls to see how they are and make sure they're aware of services […] available to them. We've also contacted all the patients on the serious mental health register as well.(GP, HC5, Round 3)*
Slower implementation of e-consultations: *we're just going to do a very soft start and not really advertise it to start […] just try and iron out some of the initial process queries. (GP, H2, Round 2)*
Changes made
Some changed back to individual patient appointment lists: *we were working on this incredibly long, almost, it felt, never-ending list. It's so long. Then if you had five doctors in, there would be approximately 100 slots on that list. You would just be rather soullessly charging through it thinking, will I ever get to the bottom? Are my colleagues working as hard as I am? (GP, H19, Round 4)*
But some stayed on shared patient lists: *I mean, other practices around us have swapped back to an individual list but the strength of the shared list is that it enables people to […] work more as a team. If someone has to see a couple of patients in PPE and gets very behind and the other people are cracking on with calls (GP, HC11, Round 4)*
Re-introduced receptionist triage: *I think a few weeks ago, when we perhaps had more capacity, it was fine for them [receptionists] to just throw everything on the duty doctor list. But now that […] it is getting busier [we are] encouraging reception to book things more routinely, or using our community pharmacist as well. (GP, HC16, Round 4)*
Re-introduced pre-bookable appointments: *in order to avoid seeing things on the day that might have gone away in a week […] we are now just moving to allocate to clinicians their own lists and put in some pre-bookable phone calls for like two-week advance bookings. (GP, H20, Round 4)*
New consultation slot types: *We've got Blue-coloured slots and Purple slots […] They're all telephone slots, um the difference is the Blue telephone slots are just for a new problem […] and the Purple slots are for people that can have a follow-up telephone call after a problem's been dealt with. (Nurse, H3, Round 2)*

Reflexive monitoring

Reflexive monitoring - telephone

Reflexive monitoring – telephone consultations	
Positive	**Negative**
Suitable for the majority of patient problems *We've found again that an awful lot of appointments don't actually require a face to face. I mean the patient might like to come in and see a doctor but it is reassurance but actually clinically, it's not a requirement and not a necessity and a lot of the clinicians I think have found that their triage skills have improved hugely as a result.(Practice Manager, HC1, Round 1)* ***Some GPs find telephone less stressful*** *I personally do, feel a bit more relaxed and not so stressed maybe. In some ways it's less tiring to talk to people on the phone than it is face to face sometimes […](GP, HC6, Round 2)* **Some patients prefer it** *I think they're grateful, obviously, that they're not coming in, they're not being asked to come in […] so they're more relaxed. They haven't got to rush in. I've got them on the phone at a time that suits them. I find them more relaxed […} They've got more of a closer relationship with me on the phone, maybe, in some cases.(Nurse, HC16, Round 4)* **Means F2F time is more focussed** *We are talking to a lot of people on the phone and those who we think there's a problem, we are able to see, and I think as a result of that, those who we see in clinic, we have a much higher rate of some sort of active intervention […] I think the time we now spend with patients is much more focused and probably more productive. (GP, HC18, Round 3)* **Patients less likely to raise multiple problems** *I think patients often come in and go and can you see this, as well? And can you see that as well? And by the way. So that whole surgery thing of having 15 patients with four problems each, that is such a relief to not be doing that, it's so much less stressful.(GP, HC3, Round 1)* **Telephone triage Is a skill, which GPs can learn**	**Less satisfying for most clinicians** *I think people have slightly lost their passion because you feel a bit, I don't know, you're trying to do all your skills and if you've spent your whole life laying your hands on patients and diagnosing them, it's a bit weird to have a disembodied voice the whole time and you're just sort of papering over cracks I think. (GP, HC19, Round 3)* ***Some GPs find phone more intense*** *Doing a lot more telephone triage and telephone calls, I think I and my colleagues find, is a lot more mentally intense. (GP, HC7, Round 2)* **Increased clinical risk** *Today I had someone [on a phone] with a bit of abdominal pain, chest tightness, anxious, pain in feet, PR [per rectum] bleeding, you just think 'Gosh - where do I even start with this' […]Yes, It can be a bit tricky over the phone. (GP, HC16, Round 4)* **Risk in prescribing over the phone** *'Well, it sounds like X.Yeah, lets treat it and if it doesn't get better, you'd better let us know'. So you're almost using the drug to make the diagnosis, which is quite backwards,really, in terms of how we're trained". (GP, HC19, Round 2)* **Missing non-verbal cues** *I'm sure we're missing loads of non-verbal cues and we could probe more deeply, couldn't we, for the hidden agenda or whatever you like to call it? I'm sure there's a load of stuff that's just going under the carpet at the moment. (GP, HC19, Round 2)* **Easier with patients you already know** *It's easier with patients you know, of course. So many patients say, it's nice to hear your voice, or it's nice to hear a voice. (GP, HC4, Round 1)*

Reflexive monitoring – telephone consultations	
Positive	**Negative**
I never particularly liked phone triage in the past and I think in retrospect part of that was because we didn't do that much and I think the more you do it, the more familiar it becomes, so I think we're dealing with it by just learning from it. (GP, HC9, Round 1) **Phone gives GP more control over their time** *Whereas on the phone everything's under control with the Covid because you've had to separate your patients you can pace yourself so you don't have lots of patients waiting, and that has been something that everybody has said that is life-changing. (GP, HC20, Round 3)* ***May improve access*** *Nobody loves telephone consultations in all honesty. I don't think any of my peers love them but I think there is a realisation that it's a very effective way of screening people. It means we're extremely responsive. If we want to see somebody on the day, we have capacity to see them pretty much there and then. In a way, it offers a very good service, very timely service for our patients.(GP, HC18, Round 4)* ***More efficient for simple problems*** *Sometimes you can deal with things more quickly on the phone. Maybe that's why things are feeling more manageable. (GP, HC10, Round 3)* ***More efficient because can take notes without patient seeing*** *I find it quite good that I can write little notes down on a piece of paper as they're talking to me, and then also notes to think about where I need to ask a question, so I don't forget it, so whether that be red flags or such like. Of course, if someone's with you in the room, you can't be jotting notes down, it's not very professional maybe. (GP, HC6, Round 4)*	**Can be more time consuming** *So, for some things it's a quick phone call, it's fine, it's done. With other things, actually it takes much longer on the phone. Much, much longer on the phone, and then you end up bringing them up anyway. I think on balance, it's certainly not quicker. People always think, 'Oh, it'll be quicker, it's a phone call', but it's not. Absolutely not. You have to be so much more careful with your questioning, you have to safety-net so much more. The ring backs, I think you get more return calls than you would if you'd seen someone in person. (GP, HC13, Round 4)* **Potential for inequity** *There's probably some patient groups, those with poor English, those without phones, those without clear accommodation who in the past maybe have just been able to walk down here and book a face to face appointment, they can't do that now. So there probably are some groups who are struggling. Not huge numbers. (GP, HC18, Round 3)*

Reflexive monitoring - video

Reflexive monitoring – video consultations	
Positive	Negative
Video consulting useful and convenient for patients *I think video consultations are going to be here to stay […] there are some real advantages for certain patients, for working patients […] the accuRx platform that we use […] I think it is just brilliant. It is very intuitive. (GP, HC1, Round 2)* *Actually laying your eyes on a patient really helps or if you're worried they're unwell. (GP, HC1, Round 1)* **GPs confident with them and like it** *The positives are our confidence is high, that we're doing them, it works really well […] Patients like it. We like it as well. (GP, HC4, Round 1)* **Useful for relationship building with adults** *Having seen a clinician, even on a video, it feels more human, they feel like somebody's listened to their story and understood what the issue is. (GP, HC3, Round 1)* **Useful for children** *If you can video them and eyeball them, then they would be quite happily sitting there eating their cereal and things like that, that was more reassuring for me.(GP, HC16, Round 2)* **Useful for dynamic assessment** *[I would use video] If I wanted to assess something dynamic, like someone's respiratory rate […] But if it's just a non-dynamic thing like a rash or a bump, a photo is better really.(GP, HC11, Round 1)*	**Less useful when there is not such a drive to not see patients** *When we first started and absolutely not seeing patients and that was very useful, now I think probably if you needed a video, you might just think I might just see them at this point. (GP, HC20, Round 4)* **Potential for digital exclusion** *There's quite a big cohort of people even if they've got a mobile phone often it's not a smart phone and they can't send a picture and they can't you know you can't have a video consultation because they don't know how to do it. (GP, HC3, Round 3)* ***Potential for health inequalities*** *In terms of when it's very positive, it's generally when I'm dealing with a young, fit English-fluent speaking person who is not vulnerable who has a very straightforward problem [...] When I don't like it is when it feels like the patient is complex, vulnerable, or can't really tell me what the problem is, then I just feel like it's not good medicine. (GP, HC5, Round 1)* **Can add layers of screening** *You do your phone call initially, then you did a video phone and it may well be that you need a face to face anyway and then you think, well why did we bother with the second assessment? You're just adding layers of ever-more screening where it would have been simpler just to have got them a face to face straightaway and save ten minutes fiddling around.(GP, HC18, Round 2)*

Reflexive monitoring – video consultations	
Positive	Negative
Useful with patient and allied health professionals on a home visit *If one of those are going out [urgent care practitioners] sometimes what I say is, "While you're there, rather than coming back and telling me about it, why don't you call me while you're there," and we'll do a three-way video conference with the patients. (GP, HC1, Round 3)* **Useful for MDT meetings** *Even MDT meetings um instead of having to travel, I know it's nice to see people face to face but it has just been amazing being able to do MDT meetings through video link and um yeah it's been a lot more time efficient. (Nurse, HC21, Round 4)* **Useful in nursing homes** *We're using it a lot for the nursing home. So we don't have to go to the nursing home very often. That's been brilliant. (GP, HC21, Round 3)* ***"Double-contact" can be reduced by policy on what needs a face-to-face booking*** *So we'd be keen to tell reception that actually abdominal pain, for example, we won't want a video because actually it needs examination […] And that might avoid some of the double contact if actually we know it's going to need an examination. (GP, HC8, Round 2)* ***Works well if IT is seamless*** *Usually the internet is a bit slow – that can be an issue sometimes – the slowness of the IT. It's not a major problem. Sometimes patients can't work out*	**Some patients feel self-conscious** *I think a lot of patients feel slightly self-conscious when we call them up on video phone. I don't know all of them really want it. They all agree to it but I'm not convinced they – it's a bit of a shock for them as well, I think, having the doctor peering at them on the phone.(GP, HC18, Round 2)* **Knowing when to switch to video difficult – people don't always report physical signs** *I: And would you have been able to tell that that person was jaundiced through a video consultation?* *R: […] Possibly, but […] I don't know whether we'd have known we needed to do a video consultation from the history […] Unless we do everyone by video, you might not necessarily know who you need to do and who you don't. You might think it's alright when it's not. (GP, HC8, Round 3)* **Can be distracting for GPs as well as patients** *I've kind of shifted positions slightly […] I think sometimes, if you're not getting anything out of the video, unless it's very, very high quality and you're getting all of the nuanced posture and eye movement and stuff like that, then it's actually a bit of a distraction. (GP, HC21, Round 3)* ***Telephone and SMS picture preferable*** *I kind of thought I would be doing more video by now, but I am not really. I'm still doing mostly phone. I think I'm finding things that I want to see. I want to feel more than see, mostly […] it's easier to get people to send pictures, I think, rather than try and wave the phone around. (GP, HC8, Round 4)*

Reflexive monitoring – video consultations	
Positive	Negative
how to do it. But the quality when you get through is actually really good. (GP, HC4, Round 1) *If the IT works, if you get our side to work and the patient's side to work, it's been very good on the whole. (GP, HC10, Round 1)*	***Can be time consuming*** *You might be familiar with some of the IT, but the patient may not be and that might take some period of explanation to go through that, getting them set up and making sure they have got that connection before the consultation can really get started. (GP, HC12, Round 2)* ***Can introduce governance issues*** *We're having a lot of issues around, again, governance around the webcams and the information we give the patients to make sure that the patient is setting up safely and that they are aware of confidentiality at their end (Practice Manager, HC14, Round 1)*

Reflexive monitoring - SMS

Reflexive monitoring – SMS	
Positive	Negative
Patients like them *I think on the whole the text service that we've been using has proved to be quite a big hit with people, they like the fact that they can just ping us back answers and then that's job done, we also respond with a great, you're well controlled or actually we think we might be able to do more for you, please make an appointment. I think that's a really good way of going forward. (Nurse Manager, HC9, Round 4)* ***Good use of time*** *In terms of time efficiency – it's really time efficient, which means that you've obviously got more time for those patients where you need to focus more time. (Nurse Manager, HC9, Round 4)* ***Useful for conversations with patients around the consultation, often on the dame day*** *I think one of the things I've done a lot more is SMS texting. We've got AccuRx, which I absolutely love, and I'll write quite detailed texts to patients who I've just spoken to, saying, 'You might want to try this website or that website.' You can signpost quite well in a text because all you have to do is cut-and-paste a link and some people then have immediately got the website on their phone, so I quite like that aspect of it. (GP, HC19, Round 2,)* ***Useful for photos*** *Really, it's just transformed the way we work. There's brilliant functions that we didn't have before like patients being able to reply in real time to a text and send you a photo of their skin condition and then that's just in the notes and then you can mail it*	***Photos sometimes poor quality*** *It just completely depends on the quality of the photographer. Yes, most of the time it's enough to exclude anything awful, but not to get a proper diagnosis, I would say. (GP, HC8, Round 2)* ***Potential governance issues*** *There's a lot of governance issues around them, safety for governance as well as clinical safety, there's the information governance around them. Also [inaudible - 0:14:09] as well as being, patients are sending us photographs and again there's huge governance issues at the moment around [inaudible - 0:14:17] photographs. (Practice Manager, HC14, Round 1)* ***Potential for digital exclusion*** *Yeah with the older people and with people who are of lower educational status I think that you know it's fine for the young probably the fitter and healthier ones in general, younger people with chronic disease can manage all of that but if you go could you send a photo of your rash they go well no I can't I have to wait until tomorrow for somebody to come and take a photo of it for me and I'm really meant to be shielding so I don't want somebody to come and take a photo for that so I think it has made inequality more problematic. (GP, HC3, Round 3)*

Reflexive monitoring – SMS	
Positive	Negative
off to a specialist for advice and guidance, it's just amazing.(GP, HC1, Round 1) *We've come to a consensus that we much prefer being sent a picture to video consulting, so the combination of telephone and a picture is fantastically efficient. (GP, HC11, Round 3)*	