Nurse-led Telephone Triage in Primary Care

An Evaluation in South Cheshire

Mona Killey
Catherine Perry
Jenny Jones

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This project preceded National Health Service re-structuring in April 2002, and the subsequent establishment of Primary Care Trusts. For simplicity, names of organisational structures have been left as they were when the work was undertaken.

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Summary

Background

Nurse telephone triage has been present in various health care settings, particularly accident and emergency (A&E) departments, for a number of years. Research has suggested that when planned and implemented carefully, employing experienced and trained nursing staff, nurse telephone triage in either A&E or its more recent primary care context may assist in reducing or reorganising workloads. Given the increased pressure upon primary care staff, the result of increased patient demand and a policy driven shift in health care, nurse telephone triage in this setting may be a welcome addition.

In the summer of 1999, modernisation funding was received by South Cheshire Health Authority to facilitate the modernisation and development of primary care services across the whole of South Cheshire. This funding was used to develop and implement a nurse-led telephone triage service. By April 2002, 54 practices in South Cheshire were recorded as undertaking nurse-led telephone triage.

Aims

The present study was designed to evaluate this nurse-led telephone triage scheme. There were three main objectives to the evaluation, determined by the Steering Group for the project:

- to assess the quantitative effects (impact) of the introduction of nurse-led telephone triage services in primary care within South Cheshire Health Authority;
- to determine the views and experiences of health professionals (for example, triage nurses, other nurses and General Practitioners) on the introduction of nurse telephone triage services in primary care within South Cheshire Health Authority;

- to determine the views of users and carers on the introduction of nurse telephone triage services in primary care within South Cheshire Health Authority.

Study design and methods

In this study a pluralistic approach to evaluation has been adopted, exploring the views of different 'stakeholders', and using both qualitative and quantitative methods in order to give a broad overview of the nurse-led telephone triage scheme. A variety of methods were utilised. These included:

- the collection of quantitative data relating to the number of calls requesting same day contact with a GP and the outcome of these calls from general practices across South Cheshire;
- the selection of two case study practices. At these sites, a patient satisfaction survey was carried out using a postal questionnaire and semi-structured interviews were conducted with practice staff.

In addition, the results from a patient satisfaction survey that was carried out by a third practice are included in this report.

Main findings and conclusions

This evaluation of the nurse-led telephone triage service in South Cheshire has demonstrated that the aims of extending the role of the nurse in primary care and of improving access for patients to a health professional have largely been achieved, accompanied by high levels of patient satisfaction with the service.

However, the implementation of nurse-led telephone triage has not been unproblematic and there are issues raised that may require consideration if the service is to achieve maximum benefit for health professionals and patients. These include:

- a clear definition and understanding of the role of the triage nurse within primary care by staff and patients;

- consideration of the preparation that nurses require in order to undertake triage;
- consideration of the continuing support that may be necessary to sustain triage nurses in their role;
- consideration of the views of nurses regarding the extension of nursing roles and the possible tension caused by the perceived 'medicalisation' of nursing;
- consideration of the impact that the individual characteristics of practices, as well as the populations they serve, may have on the delivery of a nurse-led telephone triage service;
- the education of patients in order that they understand and appreciate changes in the delivery of primary care and learn to use the services effectively and to their best advantage.

Chapter 1

Introduction

1.1 Background to the nurse-led telephone triage service in South Cheshire

At the time this study took place South Cheshire Health Authority (SCHA) was responsible for planning services for 675,000 residents living in Chester, Congleton, Crewe and Nantwich, Ellesmere Port and Neston, Macclesfield and Vale Royal. Prior to April 2002, there were six primary care groups (PCGs) in SCHA, which were responsible for the development of primary and community health services in South Cheshire. These were:

- Ellesmere Port and Neston PCG;
- Chester City PCG;
- Cheshire Rural PCG;
- Central Cheshire PCG;
- Crewe and District PCG;
- Eastern Cheshire PCG.

In the summer of 1999, modernisation funding was received by SCHA to facilitate the modernisation and development of primary care services across the whole of South Cheshire. This funding was used to develop and implement a nurse-led telephone triage service, one of several initiatives outlined in South Cheshire Health Authority's Improvement Programme (April, 2000), with the aim of increasing access for patients to high quality primary care services. In line with government plans for the modernisation of a 'primary care led' National Health Service (Department of Health, 2001) the scheme aimed to:

- extend the role of nurses to make better use of their knowledge and skills, such as making it easier for them to prescribe;
- offer more nurse-led primary care services to improve access for patients to a health professional.

Furthermore it was anticipated that operationally the scheme would:

- reduce unnecessary appointments;
- free up appointments by making better use of time;
- make use of the full range of nurses' skills and increase their expertise;
- deal with patients quicker and more efficiently;
- encourage team working amongst practice staff;
- increase patient satisfaction regarding requests for urgent appointments. (Source: Ellesmere Port and Neston Primary Care Group, 2000, p.2).

Development of the nurse-led telephone triage service was initially led by the Local Medical Committee, in conjunction with the Health Authority, and five of the PCGs in South Cheshire. These were Ellesmere Port and Neston PCG, Chester City PCG, Cheshire Rural PCG, Central Cheshire PCG and Crewe and District PCG. As the scheme evolved, responsibility for implementation was transferred to the respective PCG.

It was envisaged that each practice would run a model of telephone triage best suited to the patient population and current ways of working within individual practices. The models of triage operated differed in terms of the particular day, the time of day, and the number of hours each day that telephone triage was operated. Essentially, all triage models aimed to triage patient requests for same day contact with a GP. Patients telephoning the practice for this purpose had their details recorded by the receptionist, and were subsequently asked to await a telephone call from the triage nurse who would decide the most appropriate course of action in consultation with the patient.

Progression of the scheme was overseen by a South Cheshire-wide steering group, consisting of representatives from the Health Authority, PCGs and NHS Trusts, with the purpose of:

- ensuring the understanding of national policy/initiatives and the connection with local developments;

- facilitating opportunities for sharing good practice;
- performance managing (at a strategic level) the unfolding models of triage across South Cheshire against the quality framework;
- reviewing the quality framework (at least annually).

In October 1999 a workshop was held to devise a shared quality framework for local nurse triage models (see Appendix 1). The principles underpinning the quality framework were that all developments should:

- consider the wider issues and likely impact upon other services, both locally and nationally;
- acknowledge that the only 'right model' is the one which provides the best fit with the needs of the population; the effective use of resources; an effective contribution to the development of primary care services and enhances the patient experience;
- demonstrate value for money and economies of scale (as appropriate in meeting local requirements);
- be supported by all members of primary health care teams;
- secure local ownership and commitment;
- build upon existing skill mix and further develop the integration of primary health care teams and multi-professional working;
- reflect the requirements of professional bodies, for example, U.K.C.C. and professional developments, for example, nurse prescribing;
- be supported by a local (PCG) action plan for implementation and management of the roll out of local models.

(Source: South Cheshire, 1999).

By April 2002, 54 practices in South Cheshire were recorded as undertaking nurse telephone triage.

In February 2001 the steering group changed its name to the South Cheshire Health Authority Nurse Triage Development Group, in order to reflect its

continuing role in assisting development of the newly implemented service. Retaining its membership, it has continued to oversee the development of the nurse telephone triage scheme across South Cheshire. Issues addressed have included continuing professional development (including training), workforce planning, policy connections (modernisation/ NHS Direct), developmental issues and supporting the evaluation.

1.2 The present study

The present study was designed to evaluate the nurse-led telephone triage scheme across South Cheshire, and was commissioned by South Cheshire Health Authority. There were three main objectives to the evaluation, determined by the Steering Group. These objectives reflect the objectives of the nurse-led telephone triage scheme:

- to assess the quantitative effects (impact) of the introduction of nurse - led telephone triage services in primary care within South Cheshire Health Authority;
- to determine the views and experiences of health professionals (for example, triage nurses, other nurses and General Practitioners (GPs)) on the introduction of nurse telephone triage services in primary care within South Cheshire Health Authority;
- to determine the views of users and carers on the introduction of nurse telephone triage services in primary care within South Cheshire Health Authority.

This report presents the findings of the work. In Chapter 2 the study is placed into context by a review of the literature concerning telephone triage. The evolution of telephone triage, its impact within various settings and issues such as training and implementation are considered. Chapter 3 describes the study design for the evaluation. The findings from the empirical work are presented in the following four chapters. Chapter 4 presents quantitative data relating to the

triage service throughout the whole of South Cheshire, whilst Chapters 5 and 6 present findings from work completed within two practices selected as case studies. Findings include views of patients and views of practice staff on the triage service. Chapter 7 reports the findings from a smaller case study, a patient survey that was conducted in another practice. Finally, Chapter 8 serves to bring all the findings together in a discussion of the main issues raised by the empirical work.

Chapter 2

Background

2.1 Introduction

This chapter aims to introduce some of the main areas of existing research in relation to triage in general and telephone triage in particular. It begins by highlighting some of the recent changes in primary care in the UK that have paved the way for promoting the extended roles of nurses in service provision. The evolution of telephone triage is then traced from its roots in the accident and emergency departments of hospitals, to its more recent primary care setting, and research regarding the kinds of health professionals who have traditionally performed triage and the effects of triage in these settings is also examined. Research regarding the views of providers and recipients of nurse telephone triage services is discussed, and gaps in this body of knowledge are highlighted. Finally the chapter concludes with a review of the issues that have been identified by researchers as important for service providers to consider prior to implementation of a nurse telephone triage service in any health care setting.

2.2 Identifying the need for telephone triage in primary care

Health care delivered in the primary care sector in the UK has undergone rapid and fundamental changes over the past decade, with policy developments both influencing and being influenced by characteristics of the health care workforce (Jenkins-Clarke and Carr-Hill, 2001). Demand for primary care services has increased dramatically, in part as a result of the policy driven shift in delivery of health care from secondary to primary settings (Scott and Vale, 1998, in Richards and Tawfik, 2000). Pressures to increase the quality whilst reducing the cost of primary health care delivery has led to the redefinition of health professional roles (Laurant et al, 2000). With a national shortage of doctors, and specific problems around recruitment and retention, both in primary care and acute areas (Jenkins-Clarke & Carr-Hill, 2001), nurses have become a key resource in both

primary and community care, with the creation of new roles such as nurse practitioners, advanced practice nurses and clinical nurse specialists (Laurant et al, 2000).

Practice nurses have already made an essential contribution to increasing the range and quality of services offered to patients within general practice, as well as enabling primary care to keep up with increasing consumer demands and expectations (Koperski et al, 1997). However, the recent government plan for the National Health Service (Department of Health, 2000) has outlined the further development of primary care services as a key component for modernising the NHS. Resources will now be directed at supporting GPs and other primary care staff in improving patient care and multidisciplinary working amongst professionals can be developed further (Department of Health, 2001). Improving access to care is an important feature of the modernisation plan and newly formed Primary Care Trusts (PCTs) are tackling staff shortages by promoting extended roles for nurses (Wilkin et al, 2001). The British Medical Association (BMA) has also recently announced proposals to establish nurses as the 'gatekeepers' to the NHS, a change of policy for the BMA which has traditionally argued that doctors should be the first point of contact in primary care (Dyer, 2002).

One response to the issue of improving access for patients to primary care services has been to develop further the role of nurses by delegating acute disease management to practice nurses (Jenkins-Clarke and Carr-Hill, 2001). Patients with acute minor illness, usually requesting a same day appointment, contribute greatly to general practice workload (Marsh and Dawes, 1995), so not only is this likely to be of importance to the NHS, but as Shum et al, (2000) point out, this might also be welcomed by nurses keen to develop new skills and GPs concerned about their own increasing workload. Research has demonstrated that nurses can do some of what GPs do, often to the greater satisfaction of patients (Shum et al, 2000; Kinnersley et al, 2000; Venning et al, 2000). Thus, in line with modernisation of the NHS, it would seem that primary care nursing is set to

expand as a discipline (Iliffe, 2000). Professional boundaries and role definitions are currently being challenged on a regular basis in primary care with new initiatives such as walk in centres, telephone triage systems, and nurse telephone consultations in 'out of hours' care (Jenkins-Clarke and Carr-Hill, 2001). According to Salvage (2000), this fresh approach to the division of labour places the patient at the centre for the first time.

2.3 The evolution of nurse telephone triage

The telephone has been utilised in the provision of health care for over one hundred years, with the first recorded use being reported in the Lancet in 1879 to assess croup symptoms in a child (Crouch and Dale, 1998). Similarly, the concept of 'triage' has been in use since World War I, where it was used in prioritising the treatment of mass casualties (Edwards, 1994). More recently, triage has been adapted within the accident and emergency (A&E) department of hospitals to describe the process by which a patient is assessed upon arrival to determine the urgency of the problem and to designate appropriate health care resources (George, 1976, in Edwards, 1994).

Triage became an accepted, formalised role in an A&E setting in the early 1980s (Edwards, 1999). Unlike the USA, where triage has been performed by a variety of personnel, triage in the UK within the A&E department has been the responsibility of qualified, experienced nursing staff (Edwards, 1999). For medical staff this marked a shift in their relationship with nursing staff, as it was the triage nurse, acting as gatekeeper, who determined the flow of patients through the department (Woolwich, 1999).

Edwards (1999) states that triage embodies conflicting ideologies and agendas for both nursing and medical staff. He proposes that the initial concept of triage, one that was designed to reduce patient waiting times and ensure therapeutic gains in the A&E department, has since become little more than a nurse-led queuing system. Patients are currently triaged according to clinical requirement and no

longer benefit from the therapeutic effects of triage, like being able to discuss their problem with a health professional in return for sound and sympathetic nursing advice (Edwards, 1999).

This, what might be called medicalisation of triage, has affected the way that triage and telephone triage are both perceived and implemented by health professionals (Woolwich, 1999). In addition, the evaluative emphasis of triage and telephone triage services, on safety, and effectiveness in reducing inappropriate attendees and ensuing workloads (Edmonds, 1997; Lattimer et al, 1998; Gallagher et al, 1998), typically involves comparison of the nurse's decision with that of a retrospective or prospective medical judgement. Edwards (1999) suggests that this serves to reinforce medical dominance in this area. Consequently, the value of designating a nurse to assess the clinical, emotional and psychosocial needs of the patient has been lost (Woolwich, 1999).

In the past, emergency nurses have provided advice over the telephone for patients who call the emergency or A&E department (Rutenberg, 2000). In recognition of this, the Emergency Nurses Association in the USA has taken the position that nurses should refrain from unreservedly giving advice over the telephone 'except to prevent loss of life or limb' (AHFMR, 1998, p.5). The Emergency Nurses Association recognizes that telephone triage nursing services exist, but consider it essential that these services are based on 'clearly defined protocols' which meet the needs of the patient population being served (AHFMR, 1998, p.5). As the delivery of health care has evolved, the concept of providing telephone consultations has gradually taken on a more formalised structure (Janowski, 1995), and nurses, particularly emergency nurses, have been instrumental in the development of sophisticated telephone triage and advice programmes in the USA (Rutenberg, 2000).

Thus historically, telephone triage, essentially an American creation, has its origin within the emergency department of hospitals, with patient care being directed by

telephone as a cost effective response to potentially inappropriate accident and emergency attendees (Glasper, 1993). Telephone triage and advice is currently one of the most rapidly expanding clinical practice areas in the USA (Rutenberg, 2000). Furthermore in the USA, up to a quarter of primary care consultations take place by telephone instead of face to face (Studdiford et al, 1996, in Toon, 2002).

Lack of documentation has meant that few NHS services are able to quantify their telephone workload, although it is estimated that approximately 3 to 5 per cent of A&E patient consultations are by telephone (Crouch et al, 1996a, in Crouch et al, 1997). In some UK primary care practices the rate of telephone consultations could be closer to that of the USA, approximately a quarter of total consultations, although this is not considered to be the same in every general practice (Toon, 2002). It would seem then, there is considerable scope to expand telephone advice in several areas as a means of managing demand for services, workload and waiting times (Crouch et al, 1997).

2.3.1 Telephone triage in A&E

Although in the UK formal telephone triage within a primary care setting is in its infancy, there seems to have always been considerable demand for telephone advice particularly in paediatric and general accident and emergency settings (Crouch and Dale, 1998). The medical information centre at The Hospital for Sick Children, Toronto, universally known as the 'Sick Kid's Hotline', has operated a telephone triage service, staffed by nurses, since 1977, providing parents with reassurance and treatment advice, thus enabling them to care for their children at home (Glasper, 1993). There are clearly benefits to be gained from telephone triage, not least in terms of cost, where the calculated cost per call to the medical centre in Toronto is $10, compared with $100 for a visit to an accident and emergency department. A retrospective telephone survey conducted in Toronto demonstrated that 74% of callers would have attended a hospital if the 'Sick Kid's Hotline' had not been available (Glasper, 1993).

This reduction of 'inappropriate' attendance was also evident in a study of A&E telephone triage undertaken during a five-year period in an Australian teaching hospital (Edmonds, 1997). The policy regarding telephone triage was formalised to ensure advice was received from an appropriate, trained source and was well documented. Following assessment of outcomes, it was calculated that over half of the total number of patients who called the department did not require emergency care and were redirected to more appropriate options, thus reducing not only the costs but also the frustrations for health care staff associated with inappropriate attendees. The author also notes that in the seven years (at time of writing) that the telephone triage policy had been in effect, there had not been a single adverse episode resulting from advice given by the triage nurse (Edmonds, 1997).

2.3.2 Telephone triage in 'out of hours' primary care

In the United Kingdom telephone triage has recently been utilised through provision of telephone advice by nurses from 'out of hours' general practice co-operatives and primary care emergency centres (SWOOP, 1997). In 1992, the demands and expectations of patients for 'out of hours' primary care had outgrown general practitioners' willingness and ability to meet them (Hallam, 1997). Therefore, under these circumstances, there was the potential for greater involvement of nurses and other health care professionals in 'out of hours' primary medical care, as a means of reducing general practitioners 'out of hours' commitment (Dale et al, 1998). Nurse telephone triage has since been employed primarily as an adjunct to cooperatives and primary care emergency centres (SWOOP, 1997). Based on the success of similar nurse-led services in Canada, nurses have been trained to receive, assess, and manage calls by giving advice, or by referral to the general practitioner, or if necessary, the ambulance service (SWOOP, 1997).

Research was undertaken on a substantial general practice cooperative in Wiltshire comprising nearly 100,000 patients, where a new service employing

specially trained nurses to assess and manage 'out of hours' calls had been implemented (SWOOP, 1997). Working from the data collected by SWOOP, Lattimer et al (1998) found that nurses were able to manage 49.8% of the calls received during an intervention period without referral to a GP. All nurses recruited into the project were aided by TAS (telephone advice system), a computer based primary care call management system (Crouch et al, 1997). Lattimer et al (1998) also observed a 69% reduction in telephone advice from a general practitioner, together with a 38% reduction in patient attendance at primary care centres, and a 23% reduction in home visits during the intervention. Thus, nurse telephone consultation (as the authors term it) in this context produced substantial changes in the way 'out of hours' care provision was delivered (Lattimer et al, 1998).

Another evaluation of the effectiveness of this model of service provision in 'out of hours' care, found that following a six month triage period, nurses using the same computerised decision tool as those in the previous study were able to handle 50.8 % (mean for the whole sample) of all calls received, either by advice alone or by advising the callers to see a GP during normal hours (Dale et al, 1998). The authors concluded that although this model of care may not be appropriate for all settings, their findings indicate that nurses using a computerised decision support tool can provide a safe and effective alternative to GP telephone advice provision. However, the main benefit of both these interventions was that the overall workload of GPs within the co-operative was reduced by approximately 50%, whilst providing patients with what the authors considered to be faster and more appropriate access to health information and advice, and convenient access to health professionals (SWOOP, 1997; Dale et al, 1998; Lattimer et al, 1998).

2.3.3 NHS Direct

In recent years, the NHS has promoted the widespread use of nurse telephone consultation services through NHS Direct, a 24-hour nurse-led health help-line (Shekelle and Roland, 1999). The gradual introduction of NHS Direct by the

Government in 1998 aimed initially to offer a more accessible, convenient and interactive gateway to health care for all people (Pencheon, 1998). Four years on, and despite difficulties with meeting call-handling targets, the service now covers the majority of the UK, including all of England (George, 2002). Customer satisfaction with NHS Direct has been consistently greater than 95%, although many professionals have questioned whether the service is value for money (Sadler, 2002). Health Direct, Australia's first large telephone triage project, provides an interesting comparison to NHS Direct, and whilst it has achieved levels of customer satisfaction similar to those reported for NHS Direct, the cost per call is less than half that of NHS Direct (Turner et al, 2002, in Wilson and Turner, 2002).

Concern was expressed at the outset of NHS Direct that providing easy access to telephone services would increase overall demand for care (Shekelle and Roland, 1999). Although reducing demand was not considered a primary objective of NHS Direct (Sadler, 2002), the hope was expressed that a national telephone help line might reduce or limit the demand on other parts of the NHS (Calman, 1997, in Munro et al, 2000). However, in its first year NHS Direct had no visible effect on demand for NHS services overall, although it may have had some impact in limiting increasing demand on general practitioners 'out of hours' services (Munro et al, 2000). As a result of this NHS Direct is set to become the hub of 'out of hours' care, with the hope that reduction in demand might be better achieved by the proposed integration of the telephone advice line with existing general practice 'out of hours' cooperatives (George, 2002).

2.3.4 Telephone triage in daytime primary care

Not only is patient demand increasing for 'out of hours' care provision (Hallam, 1997), but GPs are also finding it increasingly difficult to cope with the demand for daytime primary care, which has escalated during the last decade (Scott and Vale, 1998, in Richards and Tawfik, 2000). Patients requesting same day appointments for self-limiting conditions contribute greatly to GP workload and

are often seen as an inappropriate drain on resources (Marsh and Dawes, 1995). Although the concept of nurse telephone triage is still relatively new within the realm of daytime primary care, research has shown that telephone consultation with GPs appears to be an alternative service for primary care patients termed as 'high users', serving predominantly to reduce practice workload (Brown and Armstrong, 1995).

Little evidence has been published regarding nurse telephone triage in daytime primary care. However, where the effects of telephone triage have been reported, the primary care health professionals involved have begun to realise the benefits that telephone triage can provide in reducing workload, particularly when delegated to nursing staff with appropriate training and experience (Gallagher et al, 1998; Vorster, 1999). Experienced practice nurse telephone triage of patients requesting same day consultations in a general practice setting has been shown to reduce doctor workload by 54% in comparison to the previous three months workload, with 26% of telephone requests for a same day appointment with the doctor being managed by the nurse on the telephone without the patients having to visit the surgery (Gallagher et al, 1998). Similarly, Vorster (1999) found that during a nine month period in general practice, 34% of patients requesting same day contact could be dealt with by telephone advice alone from an experienced practice nurse. The number of patients given a same day appointment was reduced from 76% to 57% and the number of home visits was also reduced from 12% to 6% (Vorster, 1999).

In a study by Elwyn et al (1999), a nurse practitioner operated a telephone triage system for patients requesting 'urgent' same day appointments on two mornings a week. Data were collected for the study over a seven week period and comparisons were made before and after implementation of the scheme. Analysis showed the mean number of calls on triage days to be 11. The nurse practitioner was able to manage 40% of these calls – 17% by telephone advice alone and 23% by providing a same day consultation. This service has the added advantage of

providing immediate access to telephone advice and, where appropriate, urgent nurse practitioner consultation (Elwyn et al, 1999).

Alongside increasing the responsibilities and enhancing the careers of practice nurses and nurse practitioners (Vorster, 1999), patients who need to see a doctor are able to see one promptly, as same day appointments and home visits are allocated according to clinical need (Gallagher et al, 1998; Jones et al, 1998). GPs subsequently have more time to spend with surgery patients. In addition, Vorster (1999) states that improving education in self-help for patients can be seen as a positive investment for the future of primary care. Results of a study by Jones et al (1998) focusing specifically on practice nurse triage of routine house call requests, showed that the triage system reduced the amount of doctors' time spent making daytime house calls. Consequently, approximately three extra surgery-based doctor consulting hours have been made available per day resulting in more surgery appointments being available. Following this pilot scheme the authors were sufficiently convinced of the effectiveness and acceptability of the nurse triage system to establish it as part of the routine service to patients (Jones et al, 1998).

This small body of research would appear to suggest that telephone triage by a practice nurse or nurse practitioner can reduce the number of patients requiring same day contact with a GP (Gallagher et al, 1998; Jones et al, 1998; Elwyn et al, 1999; Vorster, 1999). However, in the studies reported the length of the data collection period varied greatly, from just seven weeks (Elwyn et al, 1999) to 16 months (Jones et al, 1998). All of the studies were described by the authors to be preliminary observations or pilot studies, and in one case a more formal evaluation of the service was underway (Vorster, 1999). Despite this, it was felt that telephone triage in this context is a method of patient management worthy of further investigation for the NHS (Vorster, 1999).

2.4 Views of service providers

The quantitative effects of telephone triage have been researched, analysed and interpreted (Edmonds, 1997; Dale et al, 1998, Lattimer et al, 1998; Gallagher et al, 1998; Jones et al, 1998; Elwyn et al, 1999; Vorster, 1999). However, little is known regarding the feelings and perceptions of health professionals involved in providing triage services.

Research carried out by Foster et al (1999) revealed unease amongst GPs over providing telephone consultations. These consultations were generally considered difficult because visual information was lacking, and concern was expressed about the reliability of information provided by the patient (Foster et al, 1999).

In a survey of GPs views on future provision of 'out of hours' primary medical care (Lattimer et al, 1996), GPs were specifically questioned about the possible involvement of nurses in an 'out of hours' telephone triage service. Only 56% of GPs surveyed were willing to try a nurse-led telephone triage service, despite having conceded the potential benefits of this service as reducing unnecessary and inappropriate calls, therefore reducing subsequent patient contact and levels of stress for the GP. Furthermore only 42% of GPs surveyed were willing to pay for this service, as they perceived that 'out of hours' telephone triage would increase the overall costs of the practice. Other perceived limitations included concerns about clinical responsibility and liability, and concerns about training needs (Lattimer et al, 1996).

Since its launch in 1998, NHS Direct, the 24 hour nurse-led health help line, has provoked debate amongst health care professionals. According to O'Dowd (1999) during an annual GPs' conference held in June 1999 a third of delegates voted to abolish NHS Direct, dubbing it as little more than a public relations exercise. Delegates also voted for NHS Direct to be properly evaluated before it was expanded, claiming it was an inappropriate drain on NHS funds that would only increase patient demand. O'Dowd (1999) also sought the opinion of two

independent nurses on NHS Direct and received two totally opposing answers, one in favour and one not.

Qualitative research has indicated that health care reforms have created 'ambiguous spaces', outside the remit of law, custom and convention (Williams and Sibbald, 1999, p.739). This in turn has created uncertainty in relation to professional identity and aspects of the roles of health professionals which have altered. For example, a specific concern centres around the shift in workload responsibility from doctors to nurses. However, this uncertainty is not limited solely to the shifting of roles between doctors and nurses, but has also had the subsidiary effect of creating tensions between different groups of nurses (Williams and Sibbald, 1999).

2.5 Views of service users

If little is known regarding health professionals' views on telephone triage then relatively nothing is known about consumers' views of telephone triage. In research that has included patients' views of telephone triage services, the emphasis has been on satisfaction with the service (Jones et al, 1998; Gallagher et al, 1998). Consumer satisfaction rates have been as high as 88% (Gallagher et al, 1998) and 80% (Jones et al, 1998). A similar pattern has been established with NHS Direct, where the rate of satisfaction amongst users has been consistently greater than 95% (Sadler, 2002). Despite these satisfaction levels, in another UK evaluation of 'out of hours' telephone services, the majority of patients expecting a home visit were dissatisfied to receive only telephone advice (Hallam et al, 1999, in Shekelle and Roland, 1999). These findings suggest that if telephone services are perceived as reducing access to medical services, or more specifically to a doctor, this may lead to dissatisfied patients (Shekelle and Roland, 1999).

2.6 Implementation of triage

According to Crouch et al (1997) assessing patients needs over the telephone is not straightforward, but despite this, the potential for developing and expanding telephone triage in various contexts, including primary care, is enormous (Crouch et al, 1997). Telephone triage may not yet be the 'panacea envisaged by some', but for many patients it can represent an enhanced quality of service (Glasper, 1993, p.109). It is essential that proposed telephone triage services are planned carefully before implementation, with consideration being given to aspects such as setting, experience and training of staff involved, infrastructure, customisation and use of protocols, liability and costs (AHFMA, 1998). Implementation of telephone triage into a general practice setting in particular has been found to require extensive team working and commitment, alongside good management and planning in order to execute a 'whole systems approach to change' (Richards and Tawfik, 2000, p.45).

2.6.1 Training

It has been argued (Glasper, 1993) that nurse telephone triage should be allowed to develop as a professional aspect of nursing practice, with explicit directives to advise nurses on how to provide such information. However, despite the proliferation of telephone triage services over the last ten years, there has until recently only been limited interest in developing the telephone consultation skills of health care professionals in the NHS (Crouch et al, 1997). As a result of this there has been little research carried out in the UK on telephone consulting skills and the background and training that nurses require (Toon, 2002). Telephone advice has been offered traditionally as an adjunct to the main body of work, particularly in A&E departments, with little thought being given to expertise, skill or training (Crouch et al, 1997).

According to Rutenberg (2000), (an independent consultant in telephone triage in the USA), the experience and training of nurses who perform telephone triage is fundamental. Imparting nursing advice over the telephone has been labelled as

synonymous with nursing with your eyes closed and hands tied behind your back (Glasper, 1993). Therefore, educational preparation, alongside decision support technology, are likely to be essential components in nurse telephone triage in order to ensure the reliability of the advice (Crouch et al, 1997). Telephone triage is emerging as a speciality that requires specialised education and training and it can be dangerous to assume that a nurse with an expertise in a specific area will automatically be competent in performing similar skills via the telephone (Rutenberg, 2000).

In order to enhance and ensure high quality triage and advice skills for nursing staff, doctors in the USA have published protocols so that the best possible advice can be given (Rutenberg, 2000). Research by Crouch et al (1997) in the UK has indicated that both A&E and practice nurses feel a need for training in telephone consultation skills, alongside locally agreed protocols and specifically developed guidelines, in order to assess and advise patients over the phone. This approach to training was subsequently used in a pilot study of nurse telephone triage in 'out of hours' primary care in the UK (SWOOP, 1997). Experienced nurses were trained not only in the skills required for telephone triage, but also in the skills necessary for managing calls through a computer assisted system (Lattimer et al, 1998).

The use of clinical protocols is also incorporated within the training given for NHS Direct, which can range from 5 to 12 weeks, and covers several other areas including telephone communication and information technology skills, clinical assessment, ethical issues and accountability (O'Dowd, 1999). For nurses undertaking telephone triage in general practice, training needs appear to be assessed on an ad hoc basis, with training programmes usually being developed in relation to the need identified by the nurses involved (Jones et al, 1998; Gallagher et al, 1998; Richards and Tawfik, 2000). However, doubts surrounding the quality and quantity of training for nurse telephone triage still remain, not least amongst nurses themselves (Rutenberg, 2000).

2.6.2 Safety of telephone triage

The safety of nurse telephone triage lines has come under much scrutiny recently, in particular with the implementation of NHS Direct (Shekelle and Roland, 1999). Adequate educational preparation is considered to be essential for safe and effective delivery of health care by telephone (Rutenberg, 2000). Preliminary evaluations of NHS Direct have shown substantial variability in the advice given by nurses, despite the use of computer assisted guidance. However, no increase in rates of death or serious adverse events have resulted from the nurses' telephone advice (Munro et al, 1998, in Shekelle and Roland, 1999).

Lattimer et al (1998) reported on safety during their evaluation of 'out of hours' telephone triage in primary care. They emphasise that nurses involved in the scheme were experienced, specially trained, and equipped with advanced decision support software. Thus, although the initial outcomes from this study were that this intervention proved relatively safe, the authors point out that inadequate training of nurses and a different software package may have produced different results (Lattimer, 1998). However, this remains a poorly researched area and further studies of safety and consistency are clearly required, particularly in the UK (Shekelle and Roland, 1999).

2.6.3 Medico-legal aspects of telephone triage

Concerns also exist amongst telephone triage nurses regarding accountability and medico-legal liability, and the need to document calls consistently is acknowledged (Crouch et al, 1997). Participation in telephone triage can involve serious medical and legal consequences for nurses, particularly in the absence of support systems when there is greater risk of making errors (Cady, 1999). According to Cady (1999), a nurse attorney, being aware of potential problems is one way of ensuring the safety of nurse triage systems and avoiding subsequent medical and legal consequences. However, some common errors encountered in telephone triage are listed below:

- failure to evaluate correctly the nature and urgency of the situation;

- failure to speak directly with the patient;
- failure to document the call.

(Cady, 1999, p.157).

2.7 Conclusion

It is evident from the research cited above that nurse telephone triage has been present in various health care settings, particularly A&E departments, for a number of years. However, with the recent proliferation in the UK of nurse telephone triage services in both 'out of hours' and daytime primary care, there would seem to be a greater need to formally and professionally develop nurse telephone triage as a recognised and accepted aspect of nursing practice. Research has suggested that when planned and implemented carefully, employing experienced and trained nursing staff, nurse telephone triage in either A&E or its more recent primary care context, may assist in reducing or reorganising workloads. Given the increased pressure upon primary care staff, the result of increased patient demand and a policy driven shift in health care, nurse telephone triage in this setting may be a welcome addition.

It is within this national and international context that the present study is set. Little research on nurse telephone triage in primary care has been published to date, and it is anticipated that this study can contribute to the body of knowledge surrounding the impact of nurse telephone triage in daytime primary care and the effects this may have for primary care health professionals and patients.

Chapter 3

Study design and methods

3.1 Introduction

This study was designed to evaluate a nurse-led telephone triage service implemented in primary care practices across South Cheshire. As a background to the study, quantitative data relating to the number of calls requesting same day contact with a GP and the outcome of these calls was collected from a large number of practices across the county. Two case studies were then carried out, comprised of a patient satisfaction survey and in-depth staff interviews. In addition, the results of a patient satisfaction survey administered at a third practice have been included in this report.

Numerous approaches to evaluation are possible and according to Beattie (1995, p.465), different approaches 'have been polarised into warring camps', quantitative versus qualitative strategies. However, for an evaluation to be considered meaningful, it is thought to require expertise from a wide variety of fields and so it can be argued that such polarisation is not helpful in evaluative work (Jenkinson, 1997). A multi-method approach can also enhance the validity of data collected (Denscombe, 1998), not in showing the data to be 'correct', but by demonstrating the consistency of meaning across the different methods utilised.

In this study a pluralistic approach to evaluation has been adopted, exploring the views of different 'stakeholders', and using both qualitative and quantitative methods in order to give a broad overview of the nurse-led telephone triage scheme. As evaluation is not only about what changes have occurred, but also about what led to these changes (Bowling, 2002), the study is concerned with process as well as outcome. This is known as 'a mixed portfolio approach' (Beattie, 1995), seeking to compile a range of different kinds of information which can be used in the evaluation of the scheme. This approach also takes into account the

argument that no one approach can be expected to meet all the different interests and requirements of different stakeholders and audiences (Beattie, 1991).

Pluralistic evaluation is an evaluative approach proposed by Smith and Cantley (1985). They argued that the conventional mode of evaluative research was essentially experimental, rationalist and objectivist, and as such was fraught with difficulties. Pluralistic evaluation essentially involves identifying the major groups concerned with a policy and comparing them with each other throughout the research, both in ideological perspectives and in operational strategies. Central to this approach is the perspective that 'Success is a pluralistic notion. It is not a unitary measure.' (Smith and Cantley, 1985, p.173). Thus consideration has to be given to how the different groups involved view success and the strategies they employ to achieve this. Consequently pluralistic evaluation embodies the principles of methodological triangulation with data being collected from different sources (Øvretveit, 1998).

A variety of methods were thus utilised in order to conduct an evaluation of the nurse-led telephone triage scheme in South Cheshire. These are outlined below.

3.2 Retrospective analysis of data

It was agreed with the members of the Steering Group that quantitative information would be collected from every practice in South Cheshire embarking on the nurse-led telephone triage scheme. A data collection sheet was devised by the Steering Group for distribution to all the relevant practices.

The data collected recorded the number of patients requesting same day contact with their GP and the outcome of that call. Same day contact was defined as either:

- request for a same day appointment;
- request for a home visit.

The outcome of the request was categorised as one of the following:

- same day appointment with GP;
- home visit from GP;
- telephone advice from GP;
- routine appointment with GP.

Data were collected in each practice prior to the implementation of the telephone triage service, with the exception of practices in the Crewe and District PCG. This was because information had previously been collected from these practices for audit purposes and the Steering Group felt it inappropriate for these practices to have to repeat the data collection.

Approximately a year after the implementation of triage, practices were requested to repeat the data collection exercise. At this stage the following two 'outcome' categories were added to the data collection form:

- telephone advice from nurse;
- same day appointment with nurse (in practices where a nurse practitioner/clinician was employed).

Collection of pre-triage and post-triage information was to be used to build up a picture of the 'impact' that the nurse-led telephone triage service was having in GP practices across South Cheshire. Data recorded were entered onto a database and analysed using the Statistical Package for the Social Sciences (SPSS).

Data collection in some practices was unsuccessful and few practices had complete pre-triage and post-triage data for comparison purposes. In response to this, practices operating the nurse-led telephone triage service were asked to collect data for a one week (five day) period in April 2002, to give a 'snapshot' of the requests for same day contact with a doctor and the actions taken. A data collection form was designed for this purpose (Appendix 2). Collecting information in this way eliminated some variations, for example, differences in demand at

different times of the year. It did, however, pose other problems, such as the triage nurse being ill or absent during the data gathering period, resulting in triage of calls not taking place for the full five days.

For the 'snapshot' data, practices were asked to define the original request:

- a same day appointment with the GP;
- a home visit;
- a same day appointment with the practice nurse (where this was applicable).

Following triage, the outcome of the request was recorded. These outcomes were:

- a same day appointment with the GP;
- a same day appointment with the practice nurse;
- a home visit;
- a routine appointment with the GP;
- a routine appointment with the practice nurse;
- telephone advice only;
- other.

'Other' outcomes were not defined further; it was noted simply that some other outcome had occurred. All data recorded was entered into a database and analysed using SPSS.

3.3 Case studies

Denscombe (1998) argues that the defining characteristic of the case study approach is that 'it focuses on just one instance of the thing that is to be investigated' (p30). Thus, arguably the strength of a case study approach to evaluation is that it seeks to describe in some detail the inputs, processes and even the outcomes of the evaluated, within a particular social setting (Øvretveit, 1998). However, a major criticism of using case studies in evaluative research is that the findings from one case cannot be generalised to a wider population. This can generally be addressed by conceding to one of the following:

- by choosing a case for detailed examination which, although inherently unique, is also an example of a broader class of things;
- by making clear at the outset that the extent of generalisability, depends upon how similar the case is to others of its type;
- by including sufficient details when reporting case studies in order for the reader to make an informed judgement about how far any findings have relevance to other instances.

(Denscombe, 1998, p.36-37).

For this study two practices were identified by the Steering Group to be used as case studies. In-depth work with practice staff and work with patients (detailed below) was carried out in the practices which are referred to as Case Study 1 and Case Study 2. These practices were selected by the Steering Group as they were considered to provide typical instances of nurse-led telephone triage in an urban practice (Case Study 1), and a rural practice (Case Study 2). A patient satisfaction survey was also conducted in a third, rural, practice, which is referred to as Case Study 3.

3.3.1 Patient satisfaction survey

Stemming from the emphasis on consumerism and accountability in the 1990s, there is a growing recognition of the importance of evaluating health services from a wide variety of perspectives, including the patient's (Bowling, 2002). Self-report measures are considered to be central to health research due to the need to obtain a subjective assessment of patients' experiences of services (Bowling, 1997). Postal surveys are a popular method employed by researchers in order to reach a large number of participants and are considered a quicker and more economic alternative to either face-to-face or telephone interviews (Bowling, 2002). Using postal surveys for evaluative purposes allows the respondent time to think about their response and also to respond anonymously (Øvretveit, 1998). However, with postal surveys, often only a small proportion of the total number of questionnaires distributed are completed and returned as requested. Non-

response can be influenced by factors external to the researcher's control, for example the nature of the respondents and the subject of the research (Denscombe, 1998). In the present study, survey questionnaires were posted to patients who had experienced triage in order to gauge their level of satisfaction with the service.

Following ethical approval by the local research ethics committee, the patient satisfaction survey questionnaire was piloted, face-to-face, with 10 patients attending Case Study 1 for a same day appointment with their GP. All patients had been triaged that day and therefore had relevant and recent experience of the service. The questionnaire, developed in consultation with the Steering Group, primarily asked the patient to rate their satisfaction on various aspects of the triage service. Some socio-demographic data, such as age, gender and employment status were also collected, although patients remained anonymous. A copy of the patient satisfaction survey questionnaire can be found in Appendix 3. The patients perceived the questionnaire to be straightforward and the maximum amount of time taken to complete it was no longer than three minutes. The questionnaire was thus deemed suitable for use in the main survey.

Two hundred patient satisfaction survey questionnaires were distributed to patients from each case study practice between January and June 2002. The records of patients who had experienced nurse triage in one identified week were examined by members of the practice nursing staff. Criteria were identified by staff in the practices which would exclude patients from receiving a questionnaire. Exclusion criteria selected were:

- patients with emergency contraception needs;
- patients with mental health problems;
- patients who may have died since the triage experience;
- patients in nursing homes;
- patients aged under 18 years;

- patients who had rung the triage nurse on behalf of someone else without that person's consent (except in the case of children).

Using the criteria identified the nurse made a decision about whether it was appropriate for the patient to be included in the sample. Selection continued in each practice until the target of 200 patients was identified. The questionnaire was dispatched from the practice by practice staff. An accompanying letter explaining the study was also sent to each patient. Contact details for further information were included in the letter (Appendix 4). A freepost envelope was supplied for completed questionnaires to be returned directly to the Centre for Public Health Research in order to help to retain the anonymity of the patient.

Patient data collected from Case Study 3 were not part of the original study. However, since these data were collected at approximately the same time, it was considered expedient and informative to include them in this report. Data from the patient satisfaction surveys were entered into a database and analysed using SPSS.

3.3.2 Semi-structured interviews

Semi-structured interviews have a 'loose' structure consisting of open-ended questions that define the area to be explored, but will allow the interviewer or interviewee to diverge in order to follow up particular areas in more detail (Britten, 1995). Thus, although the interview topics and questions that led into exploring these areas may have been defined initially, the semi-structured format allows interviewees to express ideas that are important to them and answers can be clarified and more complex issues probed than would be possible using a more structured approach (Bowling, 2002). In the present study semi-structured interviews were carried out with personnel in the GP practice case studies.

3.3.3 Interviews with practice staff

Between January 2002 and April 2002 nine staff were interviewed at Case Study 1 and nine staff were interviewed at Case Study 2. A purposive sampling, or judgement sampling method was predominantly used to select interviewees. This is a deliberately non-random method often used in qualitative research, which seeks to select people who have knowledge which is of value to the research process (Bowling, 2002). In this instance, practice staff were selected by the researcher in conjunction with the practice managers to represent the key staff members involved with the telephone triage service that is, triage nurses, GPs and reception staff. The remaining interviewees were selected at random from a practice staff list by the researcher. Different interview schedules were developed in order to respond to the position of the interviewee and examples of these can be found in Appendix 5.

Practice staff were approached initially by the practice manager who supplied them with a letter from the researcher (Appendix 6), detailing the background of the study and what was expected from them as an interviewee. Staff were given the option to decline. However, all consented to be interviewed. Interviews were taped with the permission of the interviewee and the audiotape transcribed verbatim. Analysis of the interview data was carried out with the data being coded by theme.

Chapter 4

Results from snapshot and baseline surveys

4.1 Effect of telephone triage on GP practices

To investigate the effect that triaging calls has on the outcome of same day requests, 'snapshot' data was collected for a one week (five day) period in April 2002, using the data collection forms (Appendix 2).

Data collection forms were sent to 54 practices across the area covered by the five Primary Care Groups (PCGs). In total, 30 practices returned data, giving a response rate of 54%. There were returns from a wide variety of practices: single and multiple GP practices; large practice population and small; rural, town and city; and with differing lengths of time that the triage scheme had been in operation.

Detailed analysis of the data by PCG, together with an individual breakdown for each practice return follows (see page 33). A summary of all the data received from the 30 practices shows:

- 89% of the original calls requested a same day appointment with a GP; 49% were given a same day appointment and 13% a routine appointment;
- 8% of the original calls requested a home visit; 5% were given a home visit;
- 3% of the original calls requested a same day appointment with the practice nurse; 6% were given a same day appointment and 2% a routine appointment.

In total, of the original calls:

- 60% had their same day request granted;
- 15% were transferred to a routine appointment;
- 20% were given telephone advice only;
- for 5%, some other action was taken.

Baseline data (the pre-triage data that were collected in each practice prior to the implementation of the telephone triage service) gave a comparable picture of the calls received before the implementation of the service. These data were submitted by 16 practices in four of the five PCGs; there were no returns from the practices in Crewe and District PCG.

For calls requesting same day action, baseline data showed:

- 92% requested a same day appointment with the GP;
- 8% requested a home visit.

As alluded to in Chapter 3, collection of the pre-triage data and post-triage data was not complete. Consequently the results presented here refer mainly to the snapshot data, although where available the baseline (pre-triage) data are also reported.

4.2 Analysis of 'snapshot' data returns

30 practices from the five PCGs included in the evaluation returned information. Data have been summarised by PCG.

4.3 About the practices

Table 4.3.1 Response rate from practices in each PCG

	Requests		Returns		Response
PCG	**Number**	**%**	**Number**	**%**	**%**
Central Cheshire	14	26	10	33	71
Chester City	13	24	8	27	62
Crewe & District	10	19	7	23	70
Cheshire Rural	8	7	4	13	50
Ellesmere Port & Neston	9	17	1	3	11
Overall	54	100	30	100	56

Practices had been operating nurse triage for varying amounts of time. This was known for 27 of the 30 practices.

Table 4.3.2 Number of practices by length of time nurse telephone triage service in operation

PCG	Less than one year	One to two years	Two years and over	Overall
Central Cheshire	3	7	-	10
Chester City	-	2	6	8
Crewe & District	-	-	4	4
Cheshire Rural	2	2	-	4
Ellesmere Port & Neston	-	-	1	1
Overall	**5**	**11**	**11**	**27**

There was wide variation in the size of practice and the number of calls received. Not all practices recorded data for the five day period for various reasons, for example, triage nurse on holiday. However, adjusting for the fact that some practices collected data for less than five days, overall there was no significant difference found in the number of requests for same day action between the five PCGs.

After making adjustments where necessary for a five day period, on average, practices received 66 requests for same day action during the five days.

4.4 Requests for same day action

When considering the effect on the practice that telephone triage has, percentages will be used. These have been calculated as the percentage of the number of calls requesting same day action; this includes home visits. One practice triages only requests for home visits and has been excluded from Table 4.4.1 below. (It is included in all other tables and calculations).

Overall, nine out of 10 requests were for a same day appointment with the GP. There was no significant difference by PCG.

Table 4.4.1 Requests for same day action

Same day request / PCG	GP appt. (%)	Practice nurse appt. (%)	Home visit (%)	Total number
Central Cheshire	91	3	6	642
Chester City	88	8	4	427
Crewe & District	92	1	7	488
Cheshire Rural	95	2	3	191
Ellesmere Port & Neston	98	2	-	61
Overall	**91**	**3**	**5**	**1809**

4.5 Comparison of same day requests with baseline data

Baseline data, gathered prior to the nurse telephone triage service becoming operational, showed a similar pattern of requests for same day action.

The data were collected from 16 practices in four of the five PCGs. There were no recorded requests for a same day appointment with the practice nurse. To compare requests before and after the introduction of triage, the numbers of requests have been averaged over a five day period.

Table 4.5.1 Baseline data by PCG

PCG	Number of practices	Same day GP appt.		Home visit		Total number of requests
		Number	%	Number	%	
Central Cheshire	7	449	94	28	6	477
Cheshire Rural	6	378	90	42	10	420
Chester City	2	96	100	-	-	96
Ellesmere Port & Neston	1	76	85	13	15	89
Overall	**16**	**999**	**92**	**83**	**8**	**1082**

The average number of calls for the practices submitting baseline data was 68 over a five day period which compares with 66 calls for the 'snapshot' data. The introduction of telephone triage does not appear to have affected the number of calls requesting same day contact received.

4.6 Outcome of same day requests following telephone triage

Overall, six out of 10 requests for same day action were granted; five out of 10 requests resulted in a same day appointment with the GP, the remainder either being seen by the practice nurse on that day or having a home visit. There was no significant difference by PCG.

Table 4.6.1 Same day action taken (percentages of all calls)

Same day action PCG	GP appt. (%)	Practice nurse appt. (%)	Home visit (%)	Overall %
Central Cheshire	54	3	3	61
Chester City	52	13	3	68
Crewe & District	36	4	10	50
Cheshire Rural	60	3	5	68
Ellesmere Port & Neston	66	3	0	69
Overall	**49**	**6**	**6**	**60**

Overall, for four out of 10 requests (40%), some other action was taken:

- two out of 10 requests (20%) were dealt with by telephone advice only;
- 15% of all calls were dealt with by routine appointment.

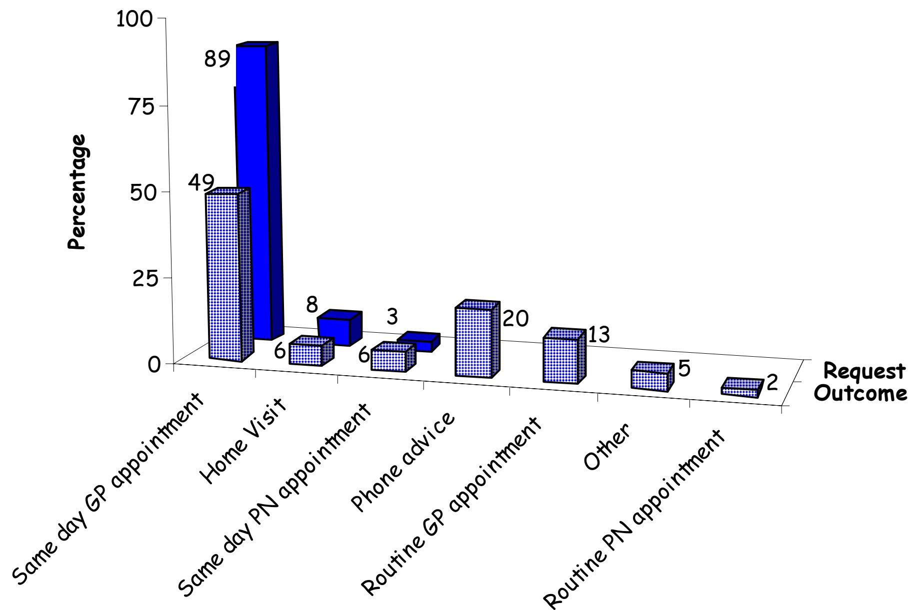
Table 4.6.2 Other action taken (percentages of all calls)

Other action PCG	Routine GP appt. (%)	Routine PN appt. (%)	Phone Advice (%)	Other (%)	Overall %
Central Cheshire	12	1	22	3	39
Chester City	7	2	16	7	32
Crewe & District	17	3	23	7	50
Cheshire Rural	15	1	12	4	32
Ellesmere Port & Neston	28	0	2	2	31
Overall	**13**	**2**	**20**	**5**	**40**

As can be seen from the chart below, telephone triage results in the number of same day appointments with the GP being substantially reduced. The number of

home visits is reduced, whilst the number of same day appointments with the practice nurse increases.

Figure 4.6.1 Percentages of same day requests and outcomes



4.7 Returns from individual practices

Analysis of data from the 30 practices showed that no single factor about the practices was apparently related to how requests for same day appointments were dealt with: PCG, how long triage has been operating or the number of calls. However, the sample size is small and there are many variations.

Tables 4.7.4 to 4.7.9 list each participating practice by PCG. Individual practices have been anonymised and are represented by a letter. They show the original requests and the way these requests were dealt with following triage. Within each table, the practices are listed in decreasing order of the number of calls received.

Since data collection began, the reorganisation of Primary Care Groups into Primary Care Trusts has meant that the participating practices are now part of three Primary Care Trusts. For information only, the data collected has been summarised by Primary Care Trust.

Table 4.7.1 Requests for same day action by PCT

Same day request PCT	GP appt. (%)	Practice nurse appt. (%)	Home visit (%)	Total number
Cheshire West	90	6	4	618
Ellesmere Port & Neston	98	2	-	61
Central Cheshire	92	2	6	1,130
Overall	**91**	**3**	**5**	**1,809**

Table 4.7.2 Percentages of calls having same day action taken

Same day action PCT	GP appt. (%)	Practice nurse appt. (%)	Home visit (%)	Overall %
Cheshire West	55	10	10	68
Ellesmere Port & Neston	66	3	-	69
Central Cheshire	46	4	6	56
Overall	**49**	**6**	**6**	**60**

Table 4.7.3 Percentages of calls where other action was taken

Other action PCT	Routine GP appt. (%)	Routine PN appt. (%)	Phone Advice (%)	Other (%)	Overall %
Cheshire West	10	2	15	6	32
Ellesmere Port & Neston	28	-	1	2	31
Central Cheshire	14	2	23	5	44
Overall	**13**	**2**	**20**	**5**	**40**

Table 4.7.4 Percentages of calls and outcomes by practice in Central Cheshire PCG

Practice	Same day Requests: Number of calls	Same day Requests: GP (%)	Same day Requests: Practice nurse (%)	Same day Requests: Home Visit (%)	Outcome – Same day: GP (%)	Outcome – Same day: Practice Nurse (%)	Outcome – Same day: Home Visit (%)	Outcome – Other: Routine GP appt. (%)	Outcome – Other: Routine Nurse appt. (%)	Outcome – Other: Telephone advice (%)	Outcome – Other: Other (%)
Practice A	228	97	-	3	53	1	2	9	2	30	3
Practice B	137	100	-	-	74	1	-	12	1	7	5
Practice C	90	100	-	-	53	-	-	22	1	22	1
Practice D	69	36	23	41	22	13	22	6	3	30	4
Practice E	47	94	2	4	60	4	2	15	2	13	4
Practice F[1]	28	100	-	-	64	-	7	4	-	25	-
Practice G[2]	22	100	-	-	14	14	-	18	-	50	5
Practice H[3]	13	92	8	-	62	8	-	23	-	8	0
Practice I	5	100	-	-	80	-	-	-	-	20	-
Practice J[4]	3	67	-	33	67	-	-	-	-	-	33
Overall	**642**	**91**	**3**	**6**	**54**	**3**	**4**	**12**	**1**	**22**	**4**

1 2 days calls only.
2 3 days calls only.
3 Not typical week as course cancelled and additional appointments available.
4 Open access surgeries before 11 a.m. every day except Thursday. Small number of calls triaged.

Table 4.7.5 Percentages of calls and outcomes by practice in Chester City PCG

	Same day Requests				Outcome						
					Same day			Other			
Practice	Number of calls	GP (%)	Practice Nurse (%)	Home Visit (%)	GP (%)	Practice Nurse (%)	Home Visit (%)	Routine GP appt. (%)	Routine Nurse appt. (%)	Telephone advice (%)	Other (%)
Practice A	124	98	2	1	70	3	1	10	3	9	3
Practice B	105	80	20	-	30	26	-	7	1	26	10
Practice C[1]	68	100	-	-	68	3	-	6	-	21	3
Practice D	47	98	-	2	40	19	-	2	6	13	19
Practice E	37	54	5	41	51	5	32	-	3	5	3
Practice F	19	100	-	-	63	5	-	16	-	11	5
Practice G[2]	15	27	73	-	7	67	-	-	7	20	-
Practice H[1]	11	100	-	-	45	-	-	9	-	45	-
Overall	**426**	**88**	**8**	**4**	**52**	**13**	**3**	**7**	**2**	**16**	**7**

[1] 3 days calls only.

[2] Does not triage requests for home visits.

Table 4.7.6 Percentages of calls and outcomes by practice in Crewe & District PCG

	Same day Requests				Outcome						
					Same day			Other			
Practice	**Number of calls**	**GP (%)**	**Practice Nurse (%)**	**Home Visit (%)**	**GP (%)**	**Practice Nurse (%)**	**Home Visit (%)**	**Routine GP appt. (%)**	**Routine Nurse appt. (%)**	**Telephone advice (%)**	**Other (%)**
Practice A	117	97	3	-	49	6	-	21	3	21	2
Practice B	113	99	-	1	19	10	1	32	9	19	12
Practice C	100	89	1	10	43	3	9	12	-	32	1
Practice D	90	97	-	3	56	-	2	17	4	20	1
Practice E	55	62	2	36	25	0	22	5	-	18	29
Practice F[1]	46	-	-	100	7	-	65	2	2	24	-
Practice G[2]	13	92	-	8	23	8	-	8	-	38	23
Overall	**534**	**84**	**1**	**15**	**36**	**4**	**10**	**17**	**3**	**23**	**7**

[1] Triages only requests for home visits.
[2] 2 days calls only.

Table 4.7.7 Percentages of calls and outcomes by practice in Cheshire Rural PCG

	Same day Requests				Outcome						
					Same day			Other			
Practice	Number of calls	GP (%)	Practice Nurse (%)	Home Visit (%)	GP (%)	Practice Nurse (%)	Home Visit (%)	Routine GP appt. (%)	Routine Nurse appt. (%)	Telephone advice (%)	Other (%)
Practice A	117	98	1	1	72	-	5	9	1	8	5
Practice B	38	100	-	-	58	11	3	21	-	5	3
Practice C	26	81	-	19	19	8	12	27	4	31	-
Practice D[1]	10	80	20	-	30	-	-	20	-	40	10
Overall	**191**	**95**	**2**	**3**	**60**	**3**	**5**	**15**	**1**	**12**	**4**

[1] 3 days calls only.

Table 4.7.8 Percentages of calls and outcomes by practice in Ellesmere Port & Neston PCG

	Same day Requests				Outcome						
					Same day			Other			
Practice	Number of calls	GP (%)	Practice Nurse (%)	Home Visit (%)	GP (%)	Practice Nurse (%)	Home Visit (%)	Routine GP appt. (%)	Routine Nurse appt. (%)	Telephone advice (%)	Other (%)
Practice A	61	98	2	-	66	3	-	28	-	2	2

Chapter 5

Case Study 1

5.1 Introduction

Case Study 1 is situated in a small town in Cheshire and has a patient list size of 21,200. Although this population is quite mixed, the number of new housing developments in the area has meant that there are a large number of younger families now registered at the Centre. The clinical staff consist of 11 GP partners (10 $\frac{1}{4}$ full time equivalents), 2 trainees, 1 assistant, 1 retainer and 6 practice nurses.

Since December 2000, all patients telephoning the medical centre between 9.00am and 5.00pm requesting same day contact with a doctor have had their calls returned by the triage nurse.

Before the telephone triage service was implemented, emergency appointment audit data collected from the practice showed that, for a 15 day period in June/July 2000, 552 emergency appointments were used.

Following the implementation of telephone triage, data collected for a five day period in April 2002 showed that 228 calls were received, 97% requesting a same day appointment with a GP and 3% requesting home visits. Triage resulted in 56% of calls being given same day action; the GP seeing 53% and the practice nurse seeing 1% of patients on the day. The percentage of home visits was reduced from 3% to 2%. The remainder of calls were diverted either to routine appointments (11%) or by having advice given over the telephone (30%).

In this Chapter, the results of the Case Study 1 patient satisfaction survey and the findings from the staff interviews are presented. A summary of the patient satisfaction survey is followed by a detailed analysis of these results, and the interview findings are at the end of the chapter.

5.2 Patient satisfaction survey - summary

To evaluate patients' views of, and reactions to, the nurse-led telephone triage service, in March 2002 a short questionnaire was sent to 200 people who were recorded as having their request assessed in this way. 107 (54%) of the questionnaires were returned from people ranging in age from 18 to 90 years old, the majority (eight of out of ten) being women. Six out of ten people requesting same day appointments contacted the practice before 10.30 a.m.

Overall, people were positive about the service: nine out of ten people rated their initial contact with the receptionist as either satisfactory or very satisfactory. Likewise, eight out of ten people rated the time taken to return their call as either satisfactory or very satisfactory. However, half of the people who waited more than 30 minutes found this unsatisfactory.

All of the people who replied to the question said they found the nurse spoke to them in a way that was easy to understand. One third of people said they received advice from the nurse and 82% of these people felt the advice was appropriate. Following assessment, seven out of ten people received same day action; for 19 people (18%) advice from a nurse was the only action taken. 85% of people felt the problem they rang the surgery with was dealt with to their satisfaction. People who were unhappy about the way their problem had been dealt with were unlikely to have been given an appointment with the GP. The majority felt they should have seen a doctor. Thirty-nine people, sixteen of whom had been asked specifically to do so, contacted the surgery again with the same problem. Nine of these people said they were dissatisfied with the way their original call had been dealt with.

Although almost eight out of ten people were unaware of the service until they telephoned the surgery, the majority were in favour of keeping the service running (90%). Eight out of ten people felt that the service was 'fine as it is'. Issues raised were a lack of awareness of the system generally and why it was needed; people felt they should be able to see or speak to a doctor without going through the triage nurse.

Five out of ten people made an additional comment, the majority being very positive about the service and its benefits to both staff and patients. There were some concerns predominantly from people who wanted assurance that they would not be denied access to GPs.

5.3 Patient satisfaction survey – detailed analysis

Questionnaires were sent to 200 people and 107 completed questionnaires were returned, giving a response rate of 54%. Not everyone answered all questions.

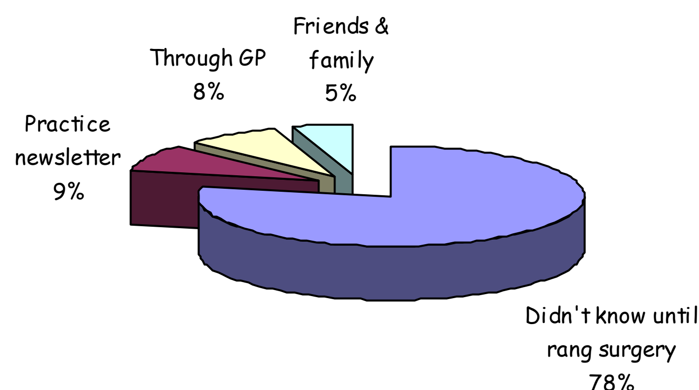
5.4 About the people who replied

- There were more women than men; 78 (73%) women and 27 (25%) men replied; two people did not give their gender.
- They were aged from 18 to 90 years old, the average age being 46.5 years.
- Eight out of 10 people (82) were under retirement age.
- 28 people (41% of men and 22% of women) worked full time, 23 people (one man and 22 (29%) women) worked part time and 52 people (56% of men and 49% of women) did not go out to work.

5.5 How had people learned about the service

100 people replied to this question and of these almost eight out of 10 did not know about the service until they telephoned the surgery. Only women said they had found out from the practice newsletter.

Figure 5.5.1 How people learned about the service



5.6 Who people rang the practice for

- Six out of 10 people (59% of the 96 people who replied) were ringing the practice for themselves.
- 40 people (39%) rang the practice for a child.
- Two women rang the practice on behalf of someone else.

For the 40 people who rang the practice about a child:

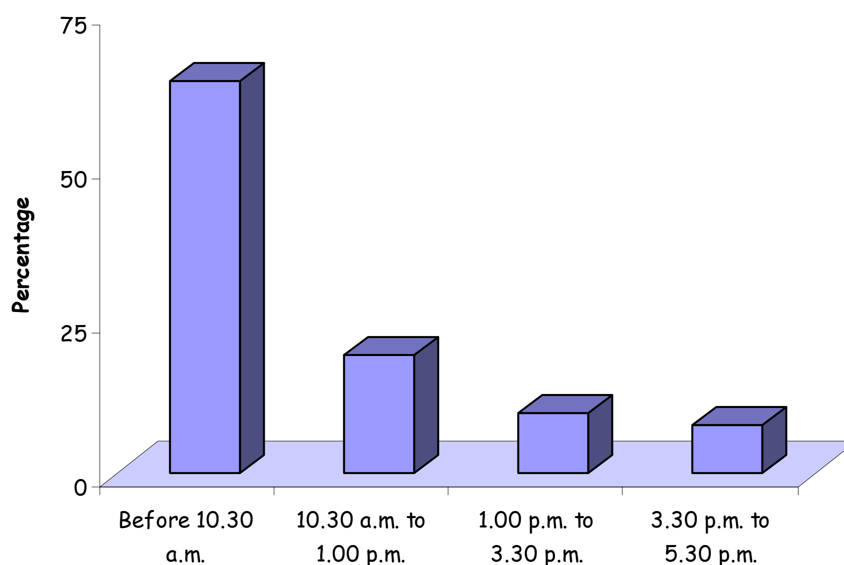
- the majority of these were women (37);
- 25% calls were for children aged under one year;
- 25% calls were for children aged between one and four years;
- 50% calls were for school age children (5 - 16 years).

People with babies aged under one year were more likely to know about the service with 33% saying they knew about the service compared with 22% of those with older children.

5.7 What time did people ring the practice

The majority of people (63%) rang the practice before 10.30 a.m.

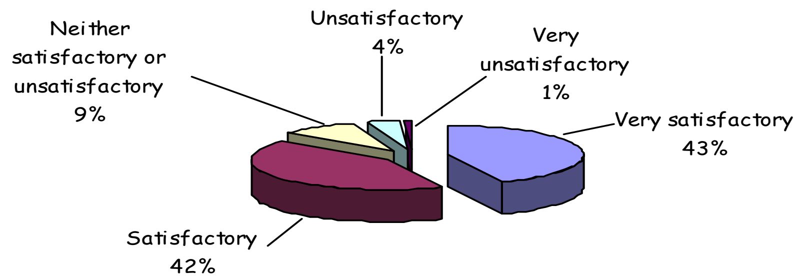
Figure 5.7.1 Time telephoned the practice



5.8 Contact with the receptionist

Almost nine out of 10 people rated their contact with the receptionist as satisfactory or very satisfactory.

Figure 5.8.1 Contact with receptionist



5.9 How long before people spoke to a nurse and how satisfied they were

Almost seven out of 10 people spoke to a nurse within 15 minutes and almost nine out of 10 within 30 minutes.

Table 5.9.1 How long before people spoke to a nurse

	Number	%
Up to 15 minutes	70	66
15 - 30 minutes	22	21
30 minutes to an hour	8	7
Over an hour	6	6
Total	106	100

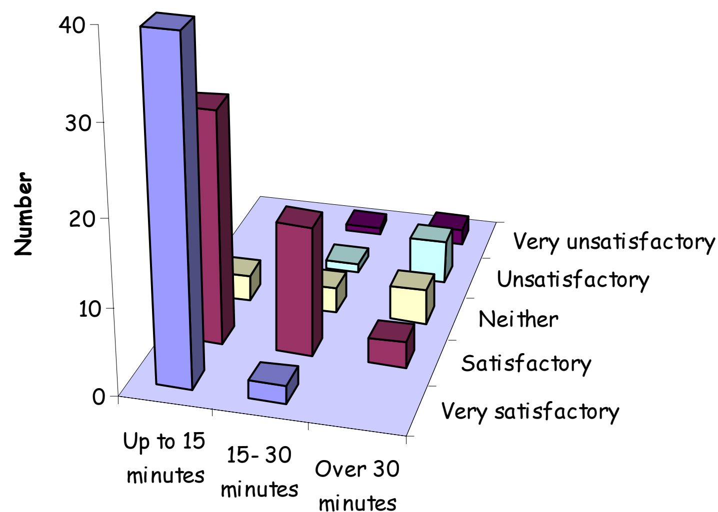
More than eight out of 10 people felt the time they had to wait to speak to the nurse was either satisfactory or very satisfactory. One in 10 thought the time they waited was either unsatisfactory or very unsatisfactory.

Table 5.9.2 Level of satisfaction with the time waited before speaking to a nurse

The time waited to speak to a nurse was…	Number	%
..very satisfactory	41	39
..satisfactory	45	43
..neither satisfactory or unsatisfactory	10	9
..unsatisfactory	6	6
..very unsatisfactory	3	3
Total	105	100

The following chart shows the relationship between the level of satisfaction and the time taken.

Figure 5.9.1 Relationship between level of satisfaction and time taken to return the call



The level of satisfaction decreased with the time waited to speak to the nurse:

- for people waiting up to 15 minutes, six out of 10 people felt this was very satisfactory; nobody felt this length of time was unsatisfactory;
- for times between 15 and 30 minutes, one in 10 people thought this was very satisfactory. One in 10 people found this wait either unsatisfactory or very unsatisfactory;
- for times in excess of 30 minutes, half of the people felt this was either unsatisfactory or very unsatisfactory.

5.10 Contact with the triage nurse

All of the 104 people who replied to the question felt that the nurse spoke in a way that was easy to understand; three people did not reply to the question. In total, 34 people (one third) said they received advice over the telephone from the nurse. For 19 of these, this was the only action taken.

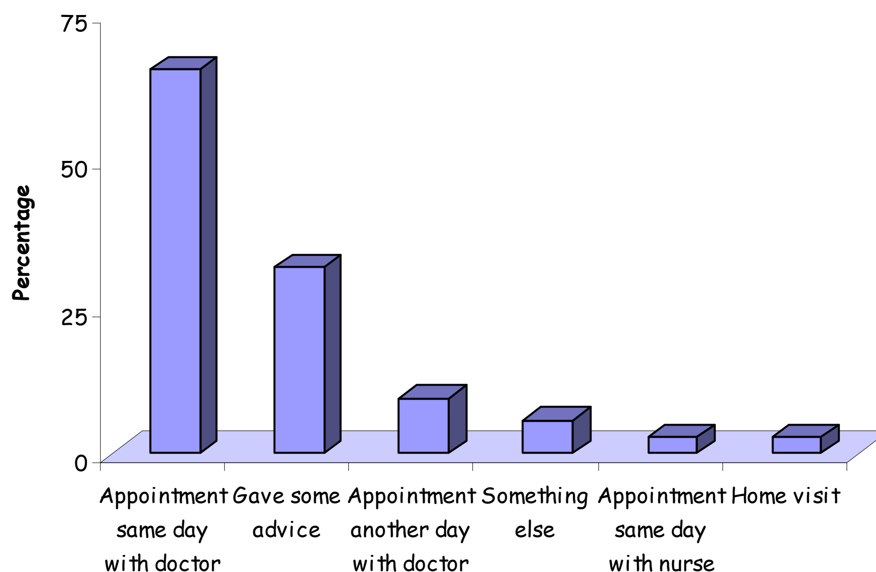
For seven out of 10 people, the nurse arranged a same day action:

- 70 (65%) people were given a same day appointment with the doctor;
- three (3%) people were given a home visit;
- three (3%) people were given a same day appointment with the nurse.

However, for 31 people (29%) triage resulted in same day requests being diverted:

- 19 people received advice only;
- seven people made an appointment to see the doctor on another day;
- one person was given advice and an appointment for another day was made;
- for four people some other action was taken.

Figure 5.10.1 What did the nurse do



(Percentages do not add up to 100% as more than one reply was given.)

Of the six people who replied 'something else':

- one person was given an appointment with the asthma nurse later in the week;
- two people were given prescriptions;
- three people were later telephoned by a doctor.

For 30 of the 40 people who rang about a child:

- six were given advice only;
- 19 were given a same day appointment with a GP;
- four were given a GP appointment on another day;
- for one the nurse arranged for the doctor to telephone.

The remaining 10 people were given advice and:

- six were given a same day appointment with a GP;
- one was given a GP appointment on another day;
- one was given an appointment with the nurse;
- for one the nurse arranged for the doctor to telephone;
- for one the nurse arranged a prescription.

In total, 62% of children received a same day appointment with the GP.

5.11 Was the telephone advice from the nurse appropriate

Of the 34 people who said they were given telephone advice, 28 (82%) said the advice was appropriate and six said it was not appropriate.

For the six women who said the advice was not appropriate,

- one was given a same day appointment with the GP;
- one was telephoned by the doctor;
- the remaining four were given advice only.

25 people, who said the nurse had not given them advice, nevertheless answered the question about the appropriateness of the advice. 22 of these people said the advice

was appropriate. It is possible that the question was interpreted as the *action* being appropriate/ inappropriate rather than the *advice*. The majority of these people were given an appointment on the same day with the GP or a home visit. Three people were given an appointment on another day.

5.12 How well was the problem dealt with

85% of the 103 people who replied felt that the problem was dealt with to their satisfaction. 15 of the 16 people who said it was not gave reasons.

Four people were given a same day appointment with the GP and one a home visit. There were three comments from these patients:

> *You should not have to speak to different people when you feel unwell and need to see a doctor.*
>
> *Telephone call initially made 9.00am to obtain early appointment. Over 1 hour later and 2nd call was given an appointment. Saw doctor, rushed appointment, unsatisfactory help from staff. The Deputy Manger unhelpful and rude. Emergency appointments difficult to obtain with triage nurses often trying to avoid giving emergency appointments.*
>
> *I know my body and I know when I need to see a doctor. Had I a history of wasting the doctor's time, I could understand it but I don't.*

Two people were given a routine GP appointment and they commented:

> *Being a diabetic with asthma, I feel my problem could have been dealt with sooner.*
>
> *I get the distinct impression that the triage nurse's only aim is to dissuade you from bothering the doctor.*

Seven people were given advice only. These patients made the following comments:

> *A doctor's appointment should have been available.*
>
> *I think the child should have been seen - still ill 2 weeks later.*

A diagnosis was made which probably explained my symptoms accurately, but I did not receive advice for all my complaints. I saw a doctor a few days later and he helped me to a cure.

I would have liked to have seen a doctor, but couldn't get an appointment for four days.

I should have asked to SEE a doctor, perhaps the nurse should have offered this given the nature of the problem (child's ear infection).

I should have seen a doctor and I felt I couldn't request to see one after her advice (which didn't help).

I wanted to see a doctor and felt I was being side-lined. I very infrequently call the surgery. I spent another three weeks before I felt well again. It takes me a long time to pluck up courage to ring the doctor.

One person, who was given advice by the nurse, commented:

Doctor should have telephoned at least, I wanted a home visit.

For one person, who the doctor telephoned, the problem was dealt with to their satisfaction, but:

…only after speaking to the doctor and arranging an appointment to examine my child.

Additionally one person commented:

Should have been asked if I was happy with advice or would I still like to see Doctor.

One person said they did not receive advice, but felt they should have been treated with *'a little more understanding'*.

There were significant differences between this group of 16 people who felt their problem should have been dealt with differently and those who felt their problem was dealt with to their satisfaction. Comparing those who were not satisfied with those who were:

- they were significantly older with a mean age of 48 years compared with 37 years;

- 56% rated their contact with the receptionist as satisfactory or very satisfactory compared with 92%;
- 56% said they waited more than 30 minutes before speaking to the nurse compared with 9%;
- 31% felt the time they had to wait to speak to the nurse was satisfactory or very satisfactory compared with 93%;
- they were unlikely to have been given a same day appointment with the doctor. 25% of those who were not satisfied with the way their problem had been dealt with had a same day appointment with the doctor, compared with 75% of those who were satisfied.

5.13 Contacting the surgery again

In total, 39 people (36%) contacted the surgery again with the same problem and of these, 23 (59%) had not been asked specifically to do so.

For these 23 people:

- seven had received advice only from the nurse;
- one had received advice and a prescription;
- 10 had been given a same day appointment with a GP, one a home visit and two an appointment on another day;
- two people were telephoned by the doctor.

Eight of these 23 people were not satisfied with the way their problem had been dealt with.

5.14 Improving the telephone triage service

101 people replied to the question asking if the practice could do anything to make the nurse triage service better and 79% (80) of these said 'No, it is fine as it is'. One other person who did not reply to the question commented here.

All of the 22 people who felt something could be done said what this was:

- five people said they should be able to see or speak to a doctor *'The triage service makes it harder to see a doctor, surely this should not be happening'*; and two people felt triage should not automatically exclude them from seeing the doctor *'Even if they give advice, should always feel at ease to go and see the doctor'*;
- four people said personal circumstances and medical history should be taken into account;
- four people wanted better communication, explanations of why the triage system is used, a more sympathetic approach, not *'so dismissive'*.
- three people wanted more staff to cover triage: at weekends; more than one nurse; triage carried out by a doctor;
- two people wanted to be sure information was passed on to the doctor;
- one person said, *'The system has fallen down since the introduction of the triage nurse at Case Study 1'*;
- one person said *'I feel that the nurse does what she knows very well. I think receptionists take too much on themselves, picturing themselves as doctors, asking what's wrong when all you want is an appointment'*.

5.15 Keeping the telephone triage service

91 (90% of the 102 people who replied to the question) felt the practice should keep the nurse triage system running.

For the 11 people who did not, seven made additional comments. These are reproduced in full.

> *Knowing the nurse triage service is important to the doctors and can help deal with some patients without seeing their doctor. I don't think this applies to all of us.*

I would like to be informed as to when a nurse becomes qualified to make an over the phone diagnosis without even seeing the patient, they don't even tend to do this in casualty!

I do not agree with trying to make a diagnosis over the phone. If you want an appointment with the doctor you should be given one there and then.

Waste of good money. A receptionist could do a nurse's job. More bureaucratic red tape not needed at all.

No statistics of success are shown, nor failures, to provide correct treatment.

Offering two appointment times for choice.

For this service to work well, training in communication skills needs to be given. It is most annoying from a patient's view to wait an hour for the nurse to telephone only for her to say, "Can I help you?" It would be more appropriate for her to explain that she was following up the patient's request for a doctor's appointment and may be able to give advice over the phone, which would negate the need for a visit to the surgery. She could then ask what the patient's symptoms are and take the conversation forward.

5.16 Additional comments

Almost half of the people (50) made an additional comment. These comments have been summarised below. For each of the points below, one comment has been chosen which reflects the point made. All comments can be found in Appendix 7.

37 people praised the nurse triage system, saying it was an excellent, effective, efficient service that prioritised calls:

Since the nurse triage service was introduced, I feel as though I have received a much better service from the practice. I no longer have to compete with others making routine appointments when I feel a same day appointment is necessary.

Two of these people added the proviso, that '*……. when a patient obviously needs to see a doctor for treatment an appointment should be made for that day.*'

Three people mentioned a 'lack of co-operation' from receptionists.

Three people felt the service was good, but:

- one felt they would prefer a 'sit and wait service';
- one felt that for problems involving young children a health visitor would be preferable;
- one felt *'Now get the people who are running the service to sort out the doctors'.*

Three people felt triage created additional problems for patients:

> *It can be a long-winded process just making an appointment to see a doctor. Some problems are personal and only for the doctor to hear and no one else so can be frustrating when you just want an appointment.*

Additionally, two people voiced concerns about being able to see a doctor:

> *If the patient still requests to see a doctor after advice has been given, an appointment should willingly be made.*

Two people felt triage should be unnecessary:

> *Providing the surgery is staffed with sufficient doctors for the number of patients on their books a normal appointment system should be satisfactory.*

One person felt that having used the system only once they were unable to comment and one that access to medical records was important for effective triage.

5.17 Findings from Case Study 1 interviews

Nine staff from Case Study 1 were interviewed regarding their views on the nurse telephone triage service. Staff selected for interview included three practice nurses and a health visitor, all who regularly triage patients, a practice nurse who does not triage, a member of reception staff, two GPs and the practice manager.

Five key themes were elicited from the interview data. These were: anxieties about accountability; escalating patient demand; supporting staff who triage; continuing professional development; and providing a better service. In addition to this a further section has been included that will examine some of the factors that are perceived to have hindered the triage service at Case Study 1. Quotations from the interviews will

be used where appropriate in order to illustrate points made and these are labelled with a transcript number so that the anonymity of the respondents may be retained.

5.18 Anxieties about accountability

Anxiety about being held accountable as a result of 'getting it wrong' or 'missing something' during a triage encounter was a prominent theme to emerge, particularly in the accounts of the nurses. This theme was articulated by respondents in several ways. Many of the nurses felt that by doing telephone triage they were stepping outside the normal remit of a practice nurse and although they felt competent to perform telephone triage due to their training, fears about being held accountable were evident. For GPs accountability was not perceived as a problem, as they felt that whilst nurses followed the protocols developed for telephone triage they were well within their remit. Finally, two further factors added to the nurses' fear of accountability from telephone triage. These were the absence of computer assisted programmes for making triage decisions and also the absence of a call recording system for audio recording telephone triage calls.

Most of the nurses felt that by performing telephone triage they were moving into the realm of diagnosing patients, an aspect of health care they felt was traditionally beyond the remit of a practice nurse. This had led to anxiety for the nurses when performing triage, as this triage nurse explained:

> *'I know the other girls worry about it and I do as well. That is because we are not trained, well we are trained but we are not sort of, that is not within our, do you know what I mean? It is not usual for us and that is a concern.' (TT4).*

Another of the triage nurses felt that telephone triage, was not an appropriate use of practice nurse skills. As she explained, these skills could be better used elsewhere:

> *' I think because of my anxieties about triage, I think really somebody else would be better there while we went to do other things. There is so much going on in practice……really we could spend so much time on that and taking it into a lot more depth and a lot more detail.' (TT3).*

For the practice nurse who did not participate in the telephone triage service, the worry of being held accountable for something she felt to be outside her remit was cited as a reason for choosing not to be involved with the telephone triage service. She commented:

> *'I'm accountable for what I do, and to be honest with you as I said I'm a nurse not a doctor. If I wanted to be a doctor I would have trained right? And I've done triage face to face in the past, years ago and that is totally different from over the phone.' (TT1).*

Although this nurse felt that face-to-face triage was easier to perform, this was another area of anxiety for the triage nurses. The triage nurses had been asked by the practice to triage, on an ad-hoc basis, patients who presented in person requesting a same day appointment. The triage nurses had felt very strongly about this as they had only been trained for telephone triage, and had refused to do the face-to-face triage work. This was on the basis that the chance of being held accountable for a mistake was far greater when doing something they do not have appropriate training for. This triage nurse explained:

> *'It's totally different training, so in a way we're being asked to do something that we weren't trained to do. And you know legally we wouldn't have a leg to stand on……If you're not happy to be say a practitioner, if you're not happy to do something you must say, and we kept saying it. But now we're not doing that anymore so it did get through.' (TT6).*

The GPs and the practice manager acknowledged the anxiety that the nurses had regarding accountability and one of these respondents suggested that concerns were the result of issues regarding triage that had been aired in the nursing press. However, for these respondents nurses performing telephone triage was not a cause for concern and one GP even expressed the notion that nurses may be better than GPs in this role:

> *'I think that the nurses are probably more careful than the doctors are and they do follow usually the protocols. We might make decisions on less information just through experience and possibly knowing the patient. They manage to extract a lot more information. They don't always get it right and that is obvious from the people coming down, but where they don't make a mistake is in the seriousness of it.' (TT9).*

Two aspects of triage within the practice further compounded the anxieties felt by the triage nurses regarding accountability. The first relates to the protocols used when triaging patients. Although some protocols are available for use by the nurses, and more are in development, computer templates which record information and prompt the nurses to ask the correct questions were not in use at Case Study 1. The concern for the triage nurses was that without a decision support tool, such as computer templates, a patient could be unfocused on what the actual problem was during a triage consultation. As a result of this important symptoms pertaining to the patients' condition could be missed, should the nurse not ask the correct questions. Use of computer templates, like those currently in use in the out of hours cooperative, were thought to be helpful in allaying such concerns. One triage nurse articulated:

> *'Well if you did have a template to follow, although you've got your books and your literature, you're there with your pencil following it down the line to the next one saying - 'yes but can I just get back to this', and I think if you had a template to follow it would make recording easier and it would make asking the next appropriate question easier.' (TT3).*

Finally, in conjunction with the use of templates, the audio recording of telephone triage consultations was considered necessary by almost all respondents. This had been explored within the practice but was subsequently deferred by the installation of a new telephone system and worries about cost. It was felt by the GPs that although this may bring peace of mind to the nurses, cost was too great an issue in comparison to the minimal number of critical incidents that had occurred since the inception of the telephone triage service. However, for the nurses this remained a matter of concern, especially as many of the triage cases the nurses had read about that had been brought to court involved calls that had been recorded. This triage nurse articulated the view expressed by all the nurses:

> *'But I think you know, from a legal point of view, I think it would be better if we had our calls taped. At least then we could prove what we'd said and what they'd said, and I don't find it an issue being recorded, because I think you know, if you know you're alright doing your job then you shouldn't have a problem with that. I think from that point of view, it would be better if we recorded all our calls.' (TT8).*

5.19 Escalating patient demand

The theme of escalating patient demand was articulated by respondents in several different ways. Some respondents expressed disappointment that the triage service had not achieved what some thought it would achieve in reducing workload. Conversely, patient demand was perceived by most of the respondents to have increased since the inception of the telephone triage service, with demand being particularly high on a Monday morning. Furthermore, respondents did not always view patient demand for services as appropriate. Finally this increase in patient demand was perceived as having financial implications for the practice, with the GP respondents noticing a marked increase in the practice telephone bill as a result of patient demand for the triage service.

One of the original reasons for the introduction of the triage service at Case Study 1 was to assist with patient demand and reduce the number of patients receiving same day appointments. Many of the respondents believed that the triage service had not achieved this objective, as the following respondent articulated:

> *'I don't think it's actually changed the workload, I mean it's changed the aspect of how we deal with it but its not changed the amount. I think its probably increasingly getting worse, but I think that's just because of the amount of patients we're dealing with and also the way patients see things, their rights, that they want to be seen, they want to be dealt with.' (TT2).*

Some respondents, particularly the GPs, described the fact that the triage service had not reduced the daily workload of same day appointments as a 'disappointment'. In addition there was the perception amongst many of the respondents that the service itself had actually increased the demand over the 12 months it had been in place. This triage nurse explained:

> *'I think the demand is probably we just provided a service, and you provide a service and it just escalates doesn't it. We always say there aren't enough doctors' appointments, but I think no matter how many appointments we put on the computer you never have enough, and I think that is what is happening in triage.' (TT8).*

Furthermore, patient demand was not always deemed appropriate, not just by doctors but also by many of the nurses. Many of the respondents felt that 'changing times' were responsible for the unprecedented demand for GP services, and patients were now less capable of judging the seriousness of an illness for themselves and more reliant on their doctor to provide a panacea. As this nurse explained:

> *'I mean things that are rung up, most of them are coughs and colds. I mean the public of today do not use any grey matter do they. It's easier to pick up the phone and ring the surgery – 'I've got a cold or my child's got this and that' – instead of just thinking and using common sense they don't want to because it's easier to pick up the phone and people are so demanding – 'I want an appointment, it's my right'. You know and you explain to them it's only a virus, antibiotics or whatever will not do, you just need to use your common sense.' (TT1).*

Many of the respondents commented that on a Monday morning patient demand was 'phenomenal' and this could affect such things as nurses' concentration, time taken to call patients back and also the number of appointments available for 'real emergencies'. Many of the triage nurses remarked that some patients could be rude or aggressive if they were not given the appointment they had phoned in for. Subsequently, on many occasions patients were given appointments, often inappropriately, in order to pacify the patient's demand. As this GP articulated:

> *'They still complain you know that they feel there is a block between them and seeing the doctor…….. and all the amount of explaining in the world they never seem to feel that it is reasonable you know. If they want to see a doctor then they should get to see a doctor, and they don't realise that the other 36 people this morning would have also wanted that.' (TT9).*

These patients remained in the minority and the consensus amongst respondents was that the majority appeared satisfied with the service. However, as a result of the perceived increase in patient demand since the inception of the triage service, the service itself had become a priority over the day-to-day practice nurse work. The perception amongst respondents was that telephone triage had 'opened the floodgates' and consequently there was no going back as it was felt the practice would not be able to cope with the workload. The following GP respondent explained:

'I think this is the way medicine is going now because of just the pressures of demand and supply and demand.....its now an essential part of nursing in general practice.' (TT5).

A final aspect of patient demand that could have financial implications for the practice was raised by both of the GPs. Their concern was with the dramatic increase in the practice telephone bill, as this GP explained:

'because people phone in and we then have to phone back it has actually increased our phone bill quite astronomically. Not least because lots of people now have mobile phones that we are supposed to phone them back on. So that's no small nuisance, and that's not NHS money, that's the GP partners, that's our personal money otherwise we have got to take home at the end of the month. It's a slight grievance really.' (TT9).

5.20 Supporting staff who triage

The theme of supporting staff who triage was expressed by respondents in different ways and different categories of the theme could be identified. The nursing respondents talked about good support in terms of peer support from their nursing colleagues. However, support on a daily basis in the form of clinical supervision from their GP colleagues was not consistent and some of the triage nurses felt this was something they were lacking. Support was also discussed in terms of the training and educational support that is provided within the practice for the triage nurses.

Many respondents commented on the strong sense of peer support amongst the nursing group. This also included support and feedback from the nurses who were not involved in the telephone triage service, as this triage nurse articulated:

'There are nurses that don't think it's a good thing, but they choose not to do it and they have got no interest in it. But after saying that, they are still really supportive to those that are doing it, and all the triage nurses are supportive to each other as well. And I think that is another reason that we are lucky being such a big practice, because we have each other to bounce ideas off.' (TT3).

Alongside this peer support respondents also reported good support from some of the doctors in terms of providing a forum, every month, for the nurses to voice any concerns they may have had regarding triage. Continuing training would also be incorporated into these sessions and many commented that this was well co-ordinated

by the nurse manager who shaped the training agenda in conjunction with the issues raised by the triage nurses. However, two of the triage nurses interviewed questioned whether these sessions were being utilised to their full potential, as the following quotation demonstrates:

> *'As far as we're concerned, the in house training can be as good or as bad as we want to make it, we perhaps haven't used it to the best that we should have done.' (TT3).*

In addition to this, one of the non-nursing respondents speculated whether the nurses were actually receiving enough training, although this issue had never been raised within the practice. This respondent commented:

> *' I think they could do with a little more, but I don't know whether they want more or not. They've not said. Nobody's moaning saying we need more training than we've already got.' (TT7).*

Whilst overall support for staff in the practice who performed triage was seen to be acceptable by those involved, problems arose when it came to day-to-day clinical support for the triage nurses. Support in terms of clinical supervision for staff who triage was perceived to be of great importance to the nurses. All respondents, including the GP respondents themselves, acknowledged the difficulty the triage nurses had with obtaining feedback and support from some of the GPs on a daily basis whilst triaging. This triage nurse articulated the problem:

> *'It depends which doctor you're actually linked with. I mean some of them are really good, I mean you've probably got half and half really, and it is a big practice, but it's annoying when you're trying to, it might be just a few people you need to speak to them about and they're gone from 1 o'clock in the afternoon and they don't come back until 5. And you're there thinking I need to speak to the emergency doctor, the duty doctor because that's the one who will deal with it, and sometimes if you go to another doctor they're a bit shirty because they're not the emergency doctor and it should be someone else.' (TT6).*

This was a problem for the triage nurses who all felt that they were often missing out on vital feedback from the GP regarding patients they had triaged. Respondents cited various reasons for this problem such as personalities of staff and did appreciate the time pressures imposed on both the GPs and the nurses themselves. One GP

respondent articulated that due to time pressures the practice did rely a lot on the expertise of the nursing staff to cope with the triage alone.

The issue surrounding daily support by the emergency doctor for the triage nurse had already been raised within the practice. One respondent reported measures that had been taken to combat this problem, such as contact by e-mail and telephone within the building. However, they also conceded that making time for the face-to-face feedback would probably be of more use to the nurses. Finally, another respondent made it quite clear that they felt very little could be done to address this situation appropriately:

> *'Oh, it's come up at every practice meeting, you know with the partners' meetings. It comes up at the staff meetings we have with the doctors. But getting some of the doctors to do what they're supposed to do is like making pigs fly I'm afraid.' (TT7).*

A final aspect of this theme of supporting staff who triage was raised by one of the GP respondents. For this GP one of the difficult aspects of supporting the triage nurses arose during consultations with patients who are opposed to triage:

> *'The problem for us is trying to deal with the patient sympathetically and adequately for the problem they have got and still support the nurses. Because if you rushed it and then go 'what the nurse told you was right', then immediately the patient's back is up and you're not able to perform the consultation adequately, with you know the right rapport. But if you don't actually mention that you did feel that what the nurse did was right, then it only gives the patient something to grumble and hold on to.' (TT 9).*

5.21 Continuing professional development

The theme of continuing professional development emerged from respondents' accounts and some respondents talked about triage in terms of continuing professional development. For the GPs and the practice manager there was no doubt that triage was developmental for the nurses, as this respondent explained:

> *'They're dealing with a variety of complaints and problems that they wouldn't normally come across in their working day, because their working day is through appointments and they are seeing things that the doctor would normally have seen.' (TT7).*

According to these respondents, triage could only serve to develop the nurses professionally by 'adding another string to their bow'.

The issue of professional development was not so clear cut for the nurses interviewed. Some of the nurses claimed only to have gained skills such as assertiveness, better communication and even better computer skills. For one nurse in particular, although she recognised the opportunities that telephone triage could bring as part of professional development, she felt that her skills might be better used in more traditional nursing practices. She stated:

> *'You're stepping up. It has added to the skills, you know you think, yes, I did recognise that or whatever, but I think we're doing so much triage you know, I just want to see some people, you know I want to nurse people.' (TT6).*

All of the nurses talked about looking back on each previous day's triage outcomes and most discussed it as part of their own 'learning process' or 'self-training'. For one triage nurse, the service appeared to have a positive effect in continuing her professional development as a health visitor as this quotation demonstrates:

> *'It can't help but improve my job.....Girls that I work with will often say, 'is that the right advice' and they will look to me because I am being updated all the time, and not necessarily as health visitors, you pick up from the journals, but you are not necessarily always being updated on minor injuries or things like that. So they use me as a bit of a resource as well which is useful.' (TT4).*

5.22 Providing a better service

Providing a better service for patients was another theme that emerged from respondents' accounts. About half of the respondents talked about the triage service in terms of providing a better service for patients. However, there were differences in the ways respondents articulated this theme.

The member of reception staff and the practice manager felt the benefit for patients was that they were now able to speak to a qualified health professional, if they wished, upon ringing the surgery. For reception staff, the intervention of the triage nurse had

'closed a gap' between the reception staff and the doctors. As a result of this, reception staff were no longer faced with the decision about whether a patient should receive an emergency appointment, with the decision instead being made by the triage nurse. This outcome was not only felt to relieve stress from the role of the receptionist, but also to be more acceptable to patients, as this respondent articulated:

> *'A real example of this is that a patient will ask us something that we know can't really be dealt with there and then, but if we are seen to go and speak to somebody, and come back and say, 'I have spoken to the triage nurse and she says such and such', they are quite happy with that. Whereas if they ask us and we just say no, that is unreasonable, it is not possible, well who are you? But they are quite happy about the fact that we have gone off and spoken to a nurse and she has given her professional opinion on it.' (TT2).*

One of the GP respondents talked about the telephone triage service in terms of providing better access for patients to primary care services, as personal experience as a patient had taught them that this was often difficult:

> *'I think for patients it's a much better service and I suppose I would like it, and having tried to ring my GP, so for instance it's not easy. But so we are very available, so I think it is good for the patient.' (TT5).*

The nurses felt that telephone triage provided a way of allowing patients to obtain information with which they could educate themselves about minor illness. One of the triage nurses felt that there was an obvious difference between what was urgent in 'nursing and medical terms' and what was deemed urgent to the patient. Telephone triage was seen as a way of helping patients differentiate between the two through the provision of information and education, ultimately providing a better service. This triage nurse articulated:

> *'I think what it has done is provided a better service. It has eliminated the onus being on the receptionist. It's given patients a service that they have not been used to before in getting information.' (TT4).*

5.23 Factors that hinder the triage

In addition to the five themes above, several factors were identified from respondents' accounts that were perceived to hinder the telephone triage service at Case Study 1.

The first problem felt by respondents to hinder the service was that of inappropriate calls being placed on the triage line for the nurses to ring back. This problem was compounded by the fact that Case Study 1 had two patient lines: one for general nursing advice (the nursing advice line); and the triage line, which was essentially for patients who were requesting same day contact with a GP. For most of the nurses this problem had been a constant source of frustration from the inception of the triage line, with calls such as repeat prescriptions being placed on the triage line.

According to the practice manager some training of reception staff had taken place, usually as a result of a problem being highlighted. However, this type of training was described as 'fire fighting' and it was conceded that patients were still probably being placed on the triage line as this could be seen as a general 'dumping ground' for patients whom the reception staff were unsure how to deal with. This was articulated in the following manner by a triage nurse:

> *' A few of us quite often have days when we feel as though we have just been a dumping ground. 'If it is difficult to deal with, put it on there for the triage nurse', and there is quite often days when you know more than one of us have said that, 'I just felt like a dumping ground today, I haven't felt like a triage nurse.' ....We do quite often get that, we feel like that and I don't think for one minute it is lack of understanding.' (TT3).*

From the receptionists' perspective, it was felt that their lack of professional training resulted in them not always knowing which line was most suitable for a patient's problem. In addition to this, patients were often either reluctant to tell the receptionist what they were calling for, or could be misleading as to what the problem actually was, thus making the decision even harder. However, although it was acknowledged that this could often be difficult for the triage nurses, the reception

staff were reassured that the patient would be dealt with effectively regardless of which line they were placed on. One respondent explained:

> *'But its not a huge problem for us because we're not, they're going to be spoken to anyway so it not as if we are deciding whether they're going to be spoken to at all.' (TT2).*

The final factor that appeared to have hindered the telephone triage service was that of patient understanding of triage. It was felt by many of the respondents that getting patients to understand the purpose of triage had initially been difficult and some had met with resistance from patients who only wished to speak with or see a doctor. Information about the telephone triage service had been circulated around the practice prior to the inception of the service, but it was felt that it would have been very difficult to inform all patients. A respondent explained:

> *'To be fair any changes that are made in the surgery are made well in advance. We usually have leaflets, you know, you are never going to cater for everybody because some people just don't read things or don't pick up leaflets or don't see posters that are right in front of them.' (TT2).*

A couple of respondents felt that the reception staff had spent a lot of time explaining to patients what triage was, both in the beginning and subsequently. The general feeling from respondents was that once patients had experienced telephone triage or understood its purpose they were generally happy with the service, although there were always one or two exceptions. This respondent articulated the problem:

> *'It took a bit of explaining, 'why do I need to speak to somebody else.' But I think that was it, when it first started, 'well I am speaking to you, why do I need to speak to somebody else? I want to speak to the doctor'. But when you explain it to them they are OK about it. I think with anything, if you just explain to people what something is about 99.9% of the population are quite happy with that.' (TT2).*

Chapter 6

Case Study 2

6.1 Introduction

Case Study 2 is a rural practice with two surgery sites. At the time that this study was undertaken the practice list size was approximately 7,850, although this is steadily increasing. The practice population is mixed with both young families and older people registered. The clinical staff consist of 6 GP partners ($4\frac{1}{2}$ full time equivalents), 1 registrar, 1 salaried GP, 2 practice nurses and 1 part time treatment room nurse.

Since February 2001, all patients telephoning the surgery between 8.30am and 10.00am, and 2.00pm and 3.00pm requesting same day contact with a doctor have had their calls returned by the triage nurse.

Before the telephone triage service was implemented, baseline data collected from the practice showed that, for a 10 day period in July 2000, 258 requests for same day action were received. 89% of these were for a same day appointment with the GP.

Following the implementation of telephone triage, data collected for a five day period in April 2002 showed that 117 calls were received, 98% requesting same day appointments with a GP, 1% with the practice nurse and 1% requesting home visits. Triage resulted in 77% of calls being given same day action; the GP seeing 72% of these. The percentage of home visits was increased to 5%. The remainder of calls were diverted either to routine appointments (10%) or by having advice given over the telephone (8%). For 5% of calls some other action was taken.

In this Chapter, the results of the Case Study 2 patient satisfaction survey and the findings from the staff interviews are presented. A summary of the patient

satisfaction survey is followed by a detailed analysis of these results, and the interview findings are at the end of the Chapter.

6.2 Patient satisfaction survey - summary

To evaluate patients' views of, and reactions to, the nurse-led telephone triage service, in March 2002 a short questionnaire was sent to 200 people who were recorded as having their request assessed in this way. 97 (49%) of the questionnaires were returned from people ranging in age from 21 to 87 years old, the majority (six of out of ten) being women.

Overall, people were very positive about the service: nine out of ten people rated their initial contact with the receptionist and the time taken to return their call as either satisfactory or very satisfactory. However, more than half of the people who waited more than 30 minutes found this unsatisfactory.

Almost all (98%) of those who replied to the question said they found the nurse spoke to them in a way that was easy to understand. Just over two out of ten people said they received advice from the nurse and all but one of these people felt the advice was appropriate. Following assessment, eight out of ten people received same day action; for 12 people (12%) advice from a nurse was the only action taken. 93% of people felt the problem they rang the surgery with was dealt with to their satisfaction. For three of the people who were unhappy about the way their problem had been dealt with, it was the outcome of the appointment which they were unhappy with, not the way the triage nurse dealt with their problem. Other people felt they should have seen a doctor. A third of people (28), twelve of whom had been asked specifically to do so, contacted the surgery again with the same problem. Nine of these people said they were satisfied with the way their original call had been dealt with.

Although almost eight out of ten people were unaware of the service until they telephoned the surgery, the majority were in favour of keeping the service running

(90%). More than eight out of ten people felt that the service was 'fine as it is'. Issues raised were from people who did not want the triage system. These were about the time taken to return the call, and triage nurses being more aware of personal circumstances.

Four out of ten people made an additional comment, the majority being very positive about the service and its benefits to both staff and patients. There were some concerns about issues such as what happens when a patient disagrees with the recommended outcome of their call and a lack of information about how the system operates. Five people commented very positively about the triage nurses and the care they give to patients.

6.3 Patient satisfaction survey – detailed analysis

Questionnaires were sent to 200 people and 97 completed questionnaires were returned, giving a response rate of 49%; not everyone answered all questions.

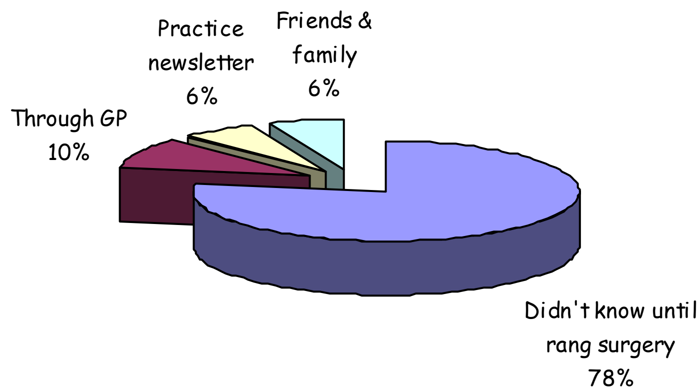
6.4 About the people who replied

- There were more women than men; 57 (59%) women and 39 (40%) men replied; one person did not give their gender.
- They were aged from 21 to 87 years old, the average age being 51.7 years.
- Seven out of 10 (65) people were under retirement age.
- 40 people (53% of men and 35% of women) worked full time, 12 people (one man and 11 women) worked part time and 43 people (45% of both men and women who replied) did not go out to work.

6.5 How people learned about the service

94 people replied to this question and of these, almost eight out of 10 did not know about the service until they telephoned the surgery.

Figure 6.5.1 How people learned about the service



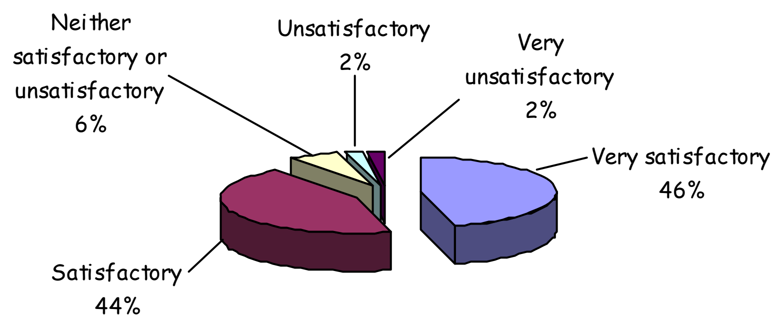
6.6 Who people rang the practice for

- 83 people (91% of the 91 people who replied) were ringing the practice for themselves.
- Five women (6%) rang the practice for a child; these children were aged between one and eight years old.
- Three women (3%) rang the practice on behalf of someone else.

6.7 Contact with the receptionist

Nine out of 10 people rated their contact with the receptionist as satisfactory or very satisfactory.

Figure 6.7.1 Contact with receptionist



6.8 How long before people spoke to a nurse and how satisfied they were

Almost six out of 10 people spoke to a nurse within 15 minutes and more than eight out of 10 within 30 minutes.

Table 6.8.1 How long before people spoke to a nurse

	Number	%
Up to 15 minutes	55	58
15 - 30 minutes	25	26
30 minutes to an hour	10	11
Over an hour	5	5
Total	95	100

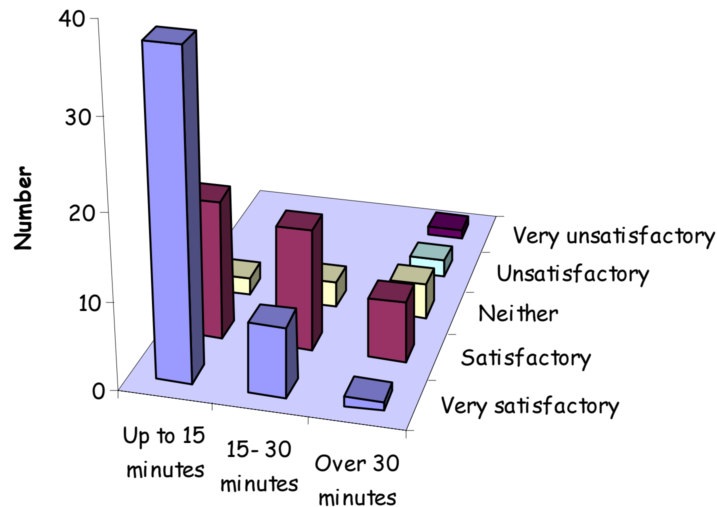
Almost nine out of 10 people felt the time they had to wait to speak to the nurse was either satisfactory or very satisfactory.

Table 6.8.2 Level of satisfaction with the time waited before speaking to a nurse

The time waited to speak to a nurse was…	Number	%
…very satisfactory	47	49
…satisfactory	38	39
…neither satisfactory or unsatisfactory	9	9
…unsatisfactory	2	2
…very unsatisfactory	1	1
Total	97	100

The following chart shows the relationship between the level of satisfaction and the time taken to return the call.

Figure 6.8.1 Relationship between level of satisfaction and the time taken to return the call



The level of satisfaction decreased with the time waited to speak to the nurse.

- 93% of the 80 people who waited up to 30 minutes thought the length of time was satisfactory or very satisfactory. Nobody found this length of time unsatisfactory.
- 53% of the 15 people who waited 30 minutes or more felt this was satisfactory or very satisfactory. Three people were dissatisfied; one of these said she waited over an hour and found this very unsatisfactory.

6.9 Contact with the triage nurse

98% of the 96 people who replied to the question felt that the nurse spoke in a way that was easy to understand. In total, 21 people (22%) said they received advice over the telephone from the nurse. For 12 of these, this was the only action taken.

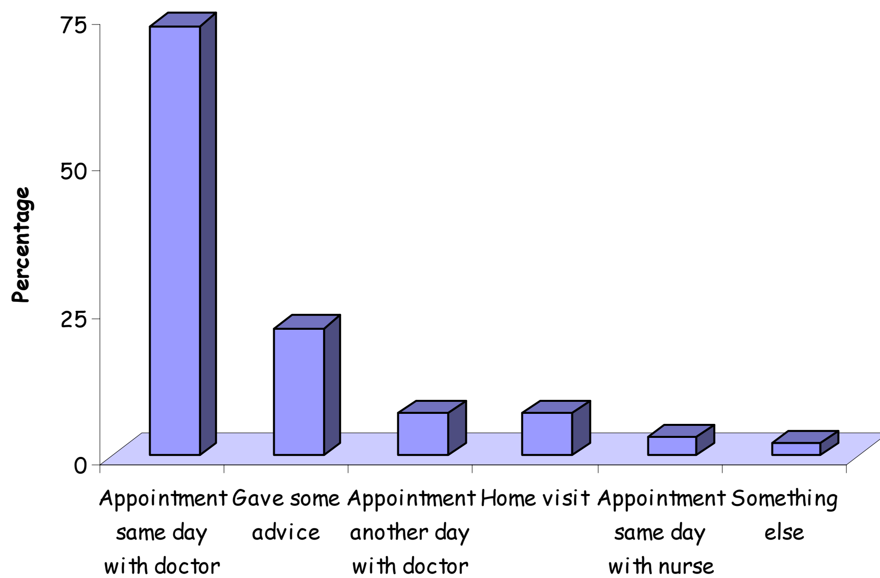
For more than eight out of 10 people, the nurse arranged a same day outcome:

- 71 (73%) people were given a same day appointment with a doctor;
- seven (7%) people had a home visit;
- three (3%) people were given a same day appointment with the nurse.

However, for 19 people (20%, or one in five) triage resulted in same day requests being diverted:

- 12 people received advice only;
- five people made an appointment to see the doctor on another day;
- two people were given advice and an appointment for another day was made.

Figure 6.9.1 What did the nurse do



(Percentages do not add up to 100% as more than one reply was given.)

For the two people who said something else, one person was given an appointment card for further necessary visits and one was sent to hospital.

For the five people who rang the practice about a child, four were given a same day appointment with the doctor, one of these also being given advice. One person was given advice only.

6.10 Was the telephone advice from the nurse appropriate

Of the 21 people who said they were given telephone advice, 20 said the advice was appropriate. One woman, ringing the practice for herself, did not feel the advice was

appropriate. She was given advice only over the telephone and was not satisfied with the way her problem was dealt with and felt she 'should have spoken to a doctor'.

22 people, who said they had not been given advice by the nurse, replied to this question. It is possible that the question was interpreted as the *action* being appropriate/ inappropriate rather than the *advice*.

Only one of these people said the advice given was inappropriate. He was given a same day appointment with the GP, but said he was not satisfied with the way his problem was dealt with. It appears it was the outcome of the subsequent appointment with the GP he was not satisfied with, rather than the advice from the triage nurse (see 6.11 below).

6.11 How was the problem dealt with

93% of the 96 people who replied felt that the problem was dealt with to their satisfaction. Seven people said the problem was not dealt with to their satisfaction.

Four were given a same day appointment with the GP. One person said:

> *The nurse asked some silly questions i.e. do you feel that you should see the doctor?!!!*

For three of these it was the outcome of the appointment they felt was not to their satisfaction:

> *Inadequate time available for appointment making for poor diagnosis.*

> *One problem was with my eyes which she didn't look at, I went to the chemist a few days later and was given some drops.*

> *I was sent to the (name of surgery) and I was wrongly diagnosed. It was said I had a virus. I later had a heart attack.*

Three people, one given a same day appointment with the nurse, one a routine appointment with the GP and one who received advice only, all felt they should have seen the doctor.

Three other people made a comment here:

> *On this occasion it was fine, but on more than one occasion it was not.*
>
> *....I should have been seen by a doctor/ nurse sooner.*
>
> *Should have direct conversation with the doctor.*

No one characteristic defines this group of 10 people who felt their problem should have been dealt with differently. However, four did contact the surgery again with the same problem and three of these had not been specifically asked to do so.

6.12 Contacting the surgery again

In total, 28 people (31%, approximately a third) contacted the surgery again with the same problem and of these 43% (12) had not been asked specifically to do so.

For these 12 people:

- nine had same day action: seven were given an appointment with the GP, and one a home visit. One man given an appointment with the nurse felt he should have seen the doctor;
- two were given advice only by the nurse;
- one woman was given advice by the nurse and a routine GP appointment;
- nine were satisfied with the way their problem was dealt with.

6.13 Improving the telephone triage service

85 people replied to the question asking if the practice could do anything to make the nurse telephone triage service better and 85% (72) of these said 'No, it is fine as it is'.

Of the 13 people who felt something could be done, 12 said what this was and seven people who had not answered the question also made a comment. Quotations have been reproduced below to reflect the points made.

Nine people were opposed to the telephone triage service:

Suspend the service. It is extremely frustrating when you genuinely feel ill or concerned to have someone decide on your behalf whether you can see a doctor. The more fearful or less articulate might find this extremely daunting.

Seven people made suggestions for improving the service, three of these about the need to raise awareness of the service:

Receptionist should remind people how the triage service works.

Four people made suggestions about improving the procedures:

Access records and get fuller details of problem. I had transport, but was very shocked and didn't want to drive. Over 60s would perhaps not be as confident as under 60s.

Perhaps asking date of birth and arranging a local appointment.

Ring back in a shorter time.

If the nurse is 'free' speak to her straight away rather than await a return call.

Additionally, one person felt that the nurse telephone triage service could *'restrict the receptionist to their correct role'*; one person felt she could not comment as she had only one contact; and one that she had been unlucky on that occasion to have been wrongly diagnosed.

6.14 Keeping the telephone triage service

85 people (90% of the 94 people who replied to the question) felt the practice should keep the nurse telephone triage service running.

For the nine people who did not, seven made additional comments which are reproduced below.

Hospital said I should see doctor when I need to but I always have to speak to nurse.

In the end you still need to see the doctor.

As inadequate as hospital A & E triage, if not worse!

Do not think it is necessary to have a nurse triage service. When I ring to see a doctor it is because I need to see one. I am not in the habit of ringing unnecessarily.

I understand that it might 'weed out' those who make demands on doctors' time for trivial reasons, but it's the last thing you want when you feel that your need is urgent.

I think it is a waste of time; a nurse is NOT a qualified doctor. It is a complete waste of time and money.

I have taken my daughter to the receptionist with a rash and asked that the nurse pop out (this was before 9 a.m. and she was in her room). I just wanted to see if my daughter was able to attend school. I was told she would ring me. How can she see a rash over the phone! This led to a delay, a phone call she wouldn't have to make and then when she did call over one hour later there were no appointments left. My daughter was seen that evening by which time the local chemist was shut for her prescription.

6.15 Additional comments

A further 40 people (all of whom felt the telephone triage service should continue) made additional comments. These comments have been summarised below. For each of the points below, one comment has been chosen which reflects the point made. All comments can be found in Appendix 8.

20 people were very positive about the service and its benefits to patients and GPs:

*Before this service was available, it was necessary for **me** to decide about severity of symptoms. This system allows the triage nurse to offer an appointment if needed. This clearly eliminates emergency appointments for trivial complaints - to the advantage of doctors and patients.*

Five people, while appreciating the benefits of the service, expressed some reservations:

What would happen if the nurse decided to give advice to a patient but that patient did really need to see the doctor? I think the nurse triage could be useful at times but only you know if you need to see a doctor or not.

Three people commented about preferring triage to explaining their problems to a receptionist:

> *Should be put through to triage nurse. Unqualified receptionists are not able to decide appropriate measures/ treatment/ advice.*

Four people commented very positively about the triage nurses:

> *I found the practice nurse was very easy to talk to and I was very satisfied with the information she gave to me.*

Three people felt the service needed to be advertised more:

> *Needs to be publicised more/ better. Came over as an apology for the unavailability of an early doctor's appointment.*

Four people suggested improvements to the service:

> *Nurse triage is a welcome step in the right direction. We need more nurse hours put into it e.g. over lunch and in the evening so full time workers can access health care more readily. Also nurse prescribing would be a big help e.g. antibiotics for ear infections, much more scope than they have now.*

Finally, one person praised the service the practice gives to its patients:

> *I would like to say thank you for their care.*

6.16 Findings from Case Study 2 interviews

Nine staff from the Case Study 2 practice were interviewed regarding their views on the nurse telephone triage service. Staff selected for interview included two practice nurses who triage patients on a daily basis, a health visitor, two members of reception staff, three GPs and the practice manager.

The findings are presented in three main sections: initial implementation of triage; putting triage into practice; and reflection upon triage. Within these sections the key themes elicited from the interview data are explored. In the first section the theme of coping with change is presented, and in the second section four themes are explored: going it alone; experience and knowledge; operational problems; and human error. Finally, in the section on reflection upon triage, the themes of managing and improving the patient journey and triage as development are introduced. Quotations

from the interviews will be used where appropriate in order to illustrate key points. Quotations are labelled with a transcript number so that the anonymity of the respondents may be retained.

6.17 Initial implementation of telephone triage

When interviewees spoke about the initial developments leading up to the implementation of nurse telephone triage, it was clear that the introduction of the service meant a certain amount of change for all staff involved in the day-to -day working practices of the surgery. For some staff, changes to their working practices were to be quite marked, for example, practice nurses were increasing their working hours in order to accommodate the service. Related to this, the theme to emerge was that of coping with change. There were two main ways in which respondents expressed this theme: in terms of uncertainty about how telephone triage would contribute to the efficient running of the practice and their own role within the system; and in terms of the development being perceived as threatening.

6.17.1 *Coping with change*

Several interviewees reported that practice staff were uncertain about whether there was a need for the nurse-led triage service and how it would be effectively implemented. The following respondent articulated this uncertainty amongst staff regarding the service:

> *'And I think some people weren't quite as convinced as others and I have to say that I wasn't completely convinced when we started it.' (TT10).*

In addition to uncertainty about the need for the nurse-led telephone triage service as a whole, some interviewees, specifically receptionists and nurses, expressed uncertainty about their own roles within the service and about whether they would have the necessary knowledge and skills to fulfil their new roles. The perception of reception staff was that for them, a lack of enthusiasm for the new service was based on fear as they were not sure what to expect of the new service or what was expected of them. For example, one receptionist commented:

'I mean at first we were a bit dubious about something new coming into the system and oh we've got an extra task and that's what the girls first thought.' (TT13B).

The perception of interviewees was that this apparent uncertainty amongst the reception staff led to problems in the way in which the new telephone triage service was explained and presented to patients ringing the surgery for an appointment with their GP. Reception staff were the first point of contact for patients, and as many of them were uncertain about the function of telephone triage within the practice, they were often unable to explain the service accurately and appropriately to patients. The problems experienced by the reception staff in explaining the service appropriately to patients when it was initially introduced were felt by some respondents to have had an impact on the way patients perceived the service. The doctors and nurses involved in the triage service felt it was essential that the purpose of the service was explained in such a way that patients would not perceive it as a 'barrier' to their GP, but rather as enabling them to be offered the most appropriate care. A triage nurse explained this in the following way:

'It depends very much on how it has been broached with them at first. You know, 'I was told I have to speak to you before you will let me in to see the doctor'. As long as you sort of put it to them , 'this is going to benefit you so I am going to refer you to the appropriate person to make sure you get exactly the care you need.'……..And you can normally defuse the situation' (TT10).

Respondents reported that this initial problem was overcome by providing training and guidance for staff answering the telephone, so they were able to explain the triage service to patients in an accurate way. Reception staff were given a written explanation which they could read from while talking to a patient on the telephone. This training was perceived by some respondents as unnecessary, as they preferred to explain using 'their own words'. However, one of the members of the reception staff interviewed felt that the training had been important in helping to standardise the introduction to telephone triage and manage the calls. This staff member commented:

'When we talked with …….. and she went through it, it didn't seem as onerous as I thought it would be really and it was pretty straightforward and we found that the more we got into it that its part

and parcel of our everyday duties in the practice, that you know between certain times it will be triage and you know what to say, and how to deal with it and pass it on, make sure the correct information is given to the nurse.' (TT13).

As well as the reception staff expressing uncertainty about their role in the service, members of the practice nursing staff articulated uncertainty about their own ability to operate the telephone triage service. This is illustrated in the following quotation:

' Well I suppose it's because I haven't done it before and I wasn't sure that I had enough knowledge to do it.' (TT10).

The second way in which the theme of coping with change was expressed was in terms of the change being perceived as threatening to the role of some staff. There was a perception that some reception staff may have resented nursing staff taking over a role that they had performed informally for years, that is, assessing the urgency of patients' same day requests. It was felt by some respondents that resentment could have arisen from their changed relationship with the patients and the nurses, and that receptionists may have felt that their role was being threatened. One interviewee commented:

'I mean the only thing I can speak for myself, is that in the early days certainly the receptionists weren't all very happy with sort of putting the patients to the nurse. It altered their relationship with the patient and with the nurses to a certain extent.' (TT14).

According to respondents, following these initial problems, telephone triage has become a routine part of the day-to-day running of the surgery. One respondent, a GP, commented that the introduction of telephone triage into 'out of hours' general practice had formalised telephone advice, thus paving the way and making it more acceptable to doctors and patients. Despite this, respondents reported that there were some exceptions. Patients who were reluctant to be triaged often questioned why they could not simply have the appointment or home visit with the GP that they had requested. However, on the whole it was perceived by respondents that the practice staff had worked well together as a team to introduce the telephone triage and ensure seamless delivery of the service.

6.18 Putting telephone triage into practice

Four themes emerged from the interview material when practice staff spoke of their experiences putting telephone triage into practice. The first theme of going it alone relates to the lack of standardised telephone triage training available for the practice to draw upon prior to implementation of the service. In direct contrast to this perceived lack of external support, this theme also describes the strong sense of support the staff within the practice gave each other during this period. The second theme, experience and knowledge, relates to how the experience and knowledge of the practice nurses at Case Study 2 is perceived to have facilitated the smooth implementation and running of the telephone triage service. Finally, the themes of operational problems and human error relate to some of the problematic issues that have arisen since the introduction of the nurse triage service.

6.18.1 *Going it alone*

The first theme, going it alone, became evident as respondents explained that at the time it was agreed within the practice to undertake the telephone triage service, Case Study 2 were one of the first practices in their locality to do so. As a result of this, training and information for triage nurses in the area was scarce. Staff had to rely on the knowledge of colleagues external to the practice who had some experience in nurse telephone triage. The involvement of these professionals was initiated and encouraged through contact from members of staff within the practice, as the words of this GP illustrate:

> *'We did have difficulty getting hold of information and it was really through friends. I've got a couple of friends who are GPs in Chester who share things with us. (Name of practice nurse) had contacts and you know we did it that way really.' (TT15).*

Respondents stated that established protocols for triage of minor illnesses were difficult to obtain and some respondents felt that there should be a centralised resource for these, so that anyone involved in telephone triage service provision was able to access them. However, it was articulated by one respondent, a GP, that this often was not the way in general practice. This individual commented:

'That's typical of general practice, you have lots of practices all doing their own thing on their own and the information isn't shared, we're like little units on our own.' (TT15).

Despite wishing that the initial training could have been more formalised, both the nurses and the GPs alluded to the perception that although training is useful preparation, much of the learning comes from experience. Thus, actually putting the telephone triage service into practice was a useful way to learn. One GP used the analogy of learning to swim.

'You've got to jump in the water sometime. You get swimming lessons on the shore but it's no good if you don't get in and try it.' (TT16).

Whilst many of the respondents felt they were pioneering the telephone triage service with little external help and support, there was also the feeling that the practice staff received much support from colleagues. The triage nurses particularly acknowledged the support that they had initially received from GPs, with the nurses and GPs triaging together, and the ongoing support from GPs despite any initial reservations they might have had regarding telephone triage. Other respondents acknowledged the hard work of the nurses in getting the service established. The following quotation illustrates something of this perception that it was the staff involved, without external support, who had driven the introduction of the service:

'So I think credit goes to the nurses and the doctors here, they've brought it (triage) in quite well.' (TT12).

6.18.2 Experience and knowledge

The experience and knowledge of the practice nurses was a recurring theme in the accounts of respondents, and was explained as being central to the perceived success of the telephone triage service at Case Study 2. In the views of the respondents, experience was an important quality for a practice nurse to have and some respondents suggested that nurse telephone triage should only be performed by more senior, experienced members of nursing staff. One respondent suggested however that the areas in which a nurse had worked, regardless of length of experience, were important. It was thought, for example, that nursing experience in A&E nursing was a better basis for working in nurse triage in primary care than some other specialties.

Another aspect of the telephone triage service at Case Study 2 that was commented upon was that it was performed by practice nurses who had worked at the practice for a number of years and were familiar with many of the patients. Therefore the nurses were using not only their clinical experience but also their knowledge of the patients in order to triage them by telephone, as this triage nurse explained:

> *'You're relying on experience and of course in this practice, knowing the patients, we know the majority of the patients that ring you know anyway. You know their families……..and you know what's going on and who they have to support them.' (TT10).*

This knowledge of the patient alongside the experience that both practice nurses possessed was perceived by respondents as aiding the nurses in managing the triage encounter efficiently, so that patients were directed to the most appropriate care in the least amount of time. A triage nurse explained:

> *'I genuinely think that within 20 seconds of speaking to the patient you know what the outcome is going to be of that call………because you know the conditions that are definitely going to have to be seen.' (TT10).*

It was felt by many of the respondents that an important aspect of telephone triage, particularly for nurses, is being aware of the limitation of their own experience and knowledge. Symptoms being misinterpreted or 'missing something' in a patient was something that nursing and medical staff talked about as being a risk, not just in telephone triage, but in any consultation. A triage nurse commented:

> *'I suppose it is a worry for anybody, but it is a worry, that is the job. It's not just nurse triaging, it is doing nursing per se, you might just miss something one day and that is all part of it. The doctors can easily miss something as well.' (TT10).*

However, the staff at Case Study 2, including the nurses, seemed comfortable that the nurses' knowledge and experience regarding the boundaries of their own competencies, teamed with the fact that patients could always be assessed by the GP, minimised this risk satisfactorily. Consequently the nurses would tend to 'err on the side of caution', referring any patients they were unsure of to the GPs. This GP commented:

'I think they're both very aware of where they are not confident. And obviously they get back to us, who are very happy to, and certainly the surgeries when I am around for triage I always know who it is, they know I'm here and they will pop their head around and ask things if necessary.' (TT15).

6.18.3 Operational problems

The third theme to emerge was that of operational problems. Respondents identified many factors about the way in which the system was organised that could make it difficult to run nurse-led telephone triage effectively and efficiently. Firstly, since the implementation of the service, staff have had a problem with patients presenting at the surgery for an 'on the day' appointment. One respondent reported that this particularly happened at the Case Study 2 surgery as it is situated next to a school. Whilst this had not been a problem previously, with patients either waiting or returning to see the doctor, reception staff were now having to ask patients to return home and await a call from the triage nurse, as it was deemed 'unfair' that these patients were gaining direct access to the doctor without going through triage. One respondent explained:

'But patients that come in, actually walk into the surgery, are actually told to go home and they will have a phone call, which I don't know that patients particularly like that very much.' (TT10).

According to one GP, a further factor hindering the telephone triage service was the current shortage of routine appointments available at the practice. Reasons such as being a GP short, increased patient demand and also longer consultations had led to approximately a two week wait for a routine appointment. It was felt by the respondent that this wait was not only unacceptable for patients but was hindering the triage process, as the following quotation illustrates:

'At the moment we're so short of routine appointments though I think it must be impossible for the nurses in triage because offering somebody a routine appointment isn't an option.' (TT15).

An issue described by one of the nurses that further compounded the problem associated with routine appointments was when the doctors asked for no more patients to be added to their list, or for their patients to be added to another GP's list.

Although it was acknowledged that this was often unavoidable, particularly if a GP had other commitments, it appeared to be causing problems for the nurses, as this respondent commented:

> *'There are different issues all the time, so it's not a criticism, it is just something that is very, it is quite difficult at times.' (TT11).*

An issue raised by most respondents was that the telephone triage was only undertaken for two hours in the working day. Respondents conceded that the amount of time during which triage could be undertaken was restricted by both the funding available, and the practice nurses' time. However, outside of triage time the receptionists revert back to their original role in allocating patients to 'on the day' appointments and this was thought to appear 'inconsistent' to patients. GPs also preferred to see patients who had been triaged, as they could prepare prior to the consultation by reading the triage notes.

Finally, some respondents highlighted the fact that only the two practice nurses had been trained to undertake telephone triage. Consequently, there was no cover available should both nurses be absent from work. Whilst this had only happened once in the 14 months that triage had been running, it was felt by some respondents that this could be a problem in the future and needed to be addressed.

6.18.4 Human error

Fourthly, the theme of human error. A problem that was highlighted by the triage nurses was that reception staff had, on occasion, taken the wrong number from a patient waiting to be triaged and subsequently the nurses had not been able to make contact, or had rang the wrong patient. While it was accepted that sometimes this was the result of human error, it could cause embarrassment for the nurses when they rang the wrong patient. Therefore, reception staff had been taking precautions to ensure these errors were minimised by asking the patient for their date of birth and also reading back to the patient any telephone number, taking particular care with mobile phone numbers.

6.19 Reflection upon telephone triage

The final two themes describe the feelings of practice staff regarding the nurse-led telephone triage service a year subsequent to the implementation of the service. The first, managing and improving the patient journey, refers to the way that the telephone triage service was perceived to have facilitated, both for staff and patients, the patient journey through primary care. The second theme in this section, telephone triage as development, was expressed in two ways by respondents. Firstly, telephone triage was perceived by respondents as a development to service provision not only within the practice but also within the arena of primary care. Secondly, telephone triage was seen as a means of professional development for practice nurses who wished to develop their skills.

6.19.1 Managing and improving the patient journey

Many of the respondents perceived that the original aim of telephone triage, in this particular case study practice, had been to reduce the workload within the practice. However, explicit in many of the respondents accounts was the notion that another aim of telephone triage was ultimately to provide a better service for patients, by allowing patients to have their problem assessed by a health professional at first point of contact. It was therefore felt by some respondents that telephone triage had enabled the practice staff to manage the patient's journey through primary care more effectively. One respondent explained:

> *'Well I think it's a way of allowing patients to talk about their problem with a professional at point of contact rather than having to give that kind of information to a receptionist who may not be, not feel comfortable with that and neither might the patient. It allows for the opportunity of re-direction of the problem either to a routine appointment or just for telephone advice, or for an on the day (appointment) according to someone who has professional sort of training. So you'd hope that really that would be for the benefit of the patient.' (TT14).*

Reception staff no longer having to make decisions of a clinical nature regarding whether or not a patient should receive an 'on the day' appointment was perceived by all respondents as a major advantage of the service. Reception staff reported that

not having to make the decision of whether a patient should be seen by a doctor that day took a lot of the strain away from the role of the receptionist. However, one respondent, a GP, commented that despite this responsibility being lifted from the reception staff, they still had to answer the phone to the patient initially and take patient details in order for the triage nurse to return the call. This staff member commented:

> *'So they (reception staff) are still answering the phones as these problems come in. So in a way you're creating an extra tier of work to go from the receptionist to the nurse.' (TT14).*

Managing the patient journey, described by all of the respondents, was an outcome of the telephone triage service that had not been expected by the staff. As a result of the triage encounter, GPs running the 'on the day' appointment surgeries had found that patients attending for consultation were suitably 'focused' on the problem they rang with and were less likely to present with a 'wish list' of problems for the GP to resolve. One respondent explained:

> *'I think for the patient they are primed if you like to deal with the problem in hand, they know the nature of the appointment because they have had a chance to talk it through with the nurse…..and if they need to bring a specimen like a urine sample or something like that then they have been advised to do that.' (TT14).*

For the GPs, the notes taken by the triage nurse during the triage encounter not only gave them time to think about the problem the patient was attending with, but also served as a natural introduction to the consultation. Whilst this was not perceived to have led to a significant reduction in consultation times, many of the respondents believed that this allowed better management of the consultation and the surgery. In addition, for the GPs it helped reduce the stress of wondering what might present next. This was thought to be ultimately to the patient's advantage, as patients who needed to be seen were seen and their problems dealt with more quickly and more efficiently. One respondent commented:

> *'So it sort of focuses the patient's and the doctor's attention on the condition that they want to be seen for. It does utilise the GP's time better and I think not to see it from a patient perspective you would have to ask them, but I think it doesn't waste their time as much as it*

used to. You know they are being referred appropriately, hopefully to the right professional.' (TT10).

6.19.2 Telephone triage as development

The first way in which the theme of telephone triage as development was expressed was in relation to telephone triage as a development for the practice. One of the reasons for the service being implemented at Case Study 2 was that funding was received from the Primary Care Group (PCG) for this purpose. Many of the respondents alluded to the idea that telephone triage was a development not just within the practice but more widely within primary care. One member of practice staff commented:

'I think it's an important pointer for the future and its developmental.' (TT12).

Whilst all of the respondents perceived the service to be a positive aspect of development, one respondent commented that the consequence of telephone triage was that it left little scope within the practice to develop the nurses in any other area. One area that was highlighted by many of the respondents as the logical extension to the current service was a nurse-led minor injuries clinic. With this development respondents believed practice nurses would be able to see patients they had triaged, leaving the GP time for more complicated cases. The GP respondents saw this as an inevitable development, as illustrated by the following quotation from a GP:

'*I think it has to go that way otherwise it's a lot of effort and money for not much benefit really. I think it's got to go that way. I mean that would leave us longer on the more difficult problems.' (TT15).*

However, it was recognised by respondents that without further resources the telephone triage service at Case Study 2 practice would be prevented from developing further. One respondent commented:

'At the moment it's probably as good as it can get with what we have got.' (TT10).

The second way in which the theme of development was expressed was in terms of professional development for the nurses involved. One respondent explained:

'It's extended their opportunities to develop themselves professionally, to a new area that they may not have considered or have had a chance to work in before.' (TT16).

Despite the service being in place for over twelve months, both the nurses and some of the doctors viewed the professional development for the nurses as continuing. The nurses felt they were constantly learning from their experience of different cases and also from their colleagues. One triage nurse commented:

'We do have clinical supervision meetings, but that is with the other nurses. We have regular clinical meetings every Friday lunchtime so any issues that are brought up around the triage we can bring up there and then. But even at the end of a surgery we can go in to the GP and say, what did you think about this one? Are you sure that I dealt with it in the right way or whatever?' (TT10).

In addition to this the nurses would also 'check up' on the outcome of previous triage calls on a regular basis. Respondents subsequently identified some areas where they felt that their skills had become outdated and there was a need identified for further development around chest and obstetric problems. It was felt that a forum whereby telephone triage nurses could get together to discuss problematic issues would be useful, as would further training. Furthermore, some respondents identified the development of further protocols by the practice, for use by the triage nurses, as something that might be beneficial. One respondent commented:

'Sometimes I sort of think it might be nice just to have a little protocol. If you went into chests…., and you could just ask maybe five or six little questions that would help you for that' (TT11).

Chapter 7

Case Study 3

7.1 Introduction

Case study 3 is a small rural practice in Cheshire. At the time the patient survey was undertaken the practice list size was 6,120. Clinical staff consist of four GP partners, 1 GP retainee, 1 GP registrar, and three practice nurses, which equate to two full time equivalents.

Telephone triage is operated every morning between 9.00 and 10.00am, with the exception of Mondays when the service is extended to 10.30am. In addition to this, calls are also triaged on a Monday, Tuesday, Thursday, and Friday between 3.30 and 4.00pm. Since November 2001, all patients telephoning the surgery during these times requesting same day appointments with a doctor have had their calls returned by the triage nurse.

Before the telephone triage service was implemented, data collected from the practice showed that for an 11 day period in January 2001, there were 164 calls requesting same day action. 93% of these calls were for a same day appointment with a GP and 7% for a home visit.

Following the implementation of the service, data collected for a five day period in April 2002 showed that 38 calls were received, all requesting a same day appointment with a GP. Telephone triage resulted in 72% of calls being given same day action; the GP seeing 61% and the practice nurse seeing 11% on the same day. The remainder of calls were diverted either to routine appointments (21%) or by having advice given over the telephone.

In this Chapter, the results of the patient satisfaction survey undertaken in Case Study 3 are presented. A summary of the survey is followed by a detailed analysis of these results.

7.2 Patient satisfaction survey - summary

To evaluate patients' views of, and reactions to, the service, in July 2002 a short questionnaire was sent to 200 people who were recorded as having their request assessed in this way. A third of the questionnaires were returned from people ranging in age from 16 to 78 years old, the majority (eight of out of ten) being women.

Overall, people were very positive about the service: nine out of ten people rated both their initial contact with the receptionist and the length of time they waited for the return call, as either satisfactory or very satisfactory.

Everybody said they found the nurse spoke to them in a way that was easy to understand. Two thirds of people said they received advice from the nurse and all of these people felt the advice was appropriate. Following assessment, a same day appointment with a GP was made for seven out of ten people; for 12 people (18%) advice from a nurse was the only action taken. All but two people felt the problem they rang the surgery with was dealt with to their satisfaction. Thirteen people, five of whom had been asked specifically to do so, contacted the surgery again with the same problem. However, only two of these said they were dissatisfied with the way their original call had been dealt with.

Although three quarters of people were unaware of the service until they telephoned the surgery, they were overwhelmingly in favour of keeping the service running (95%). Three quarters of people felt that the service was 'fine as it is'. Issues raised were lack of awareness of the service and the time taken to return calls.

Almost four out of ten people made an additional comment, the majority being very positive about the service and its benefits to both staff and patients. There were some concerns; people wanted assurance about the training nurses received and that

they would not be denied access to GPs. Some people said they would simply 'prefer to see a doctor'.

Finally, one person took the opportunity the questionnaire offered to ask for an additional advice service: a 'Well Man' clinic. Four people expressed their satisfaction with the practice and praised the service they received.

7.3 Patient satisfaction survey – detailed analysis

Questionnaires were sent to 200 people and 71 completed questionnaires were returned, giving a response rate of 36%. Three of the questionnaires were returned almost incomplete with the comment that they had never used the service; two of these were from women, both aged 36, and one where neither age nor gender were given. The final number of questionnaires used was therefore 68, 34% of the original sample. Not everyone answered all questions.

7.4 About the people who replied

- Eight out of 10 of the respondents were women; 54 (79%) women and 13 (19%) men replied; one person did not give their gender.
- They were aged from 16 to 78 years old, the average age being 49 years.
- Seven out of 10 (48) people were under retirement age.
- 20 people (30% of both men and women) worked full time, 18 people (one man and 17 women) worked part time and 28 people (62% of men and 38% of women) did not go out to work.

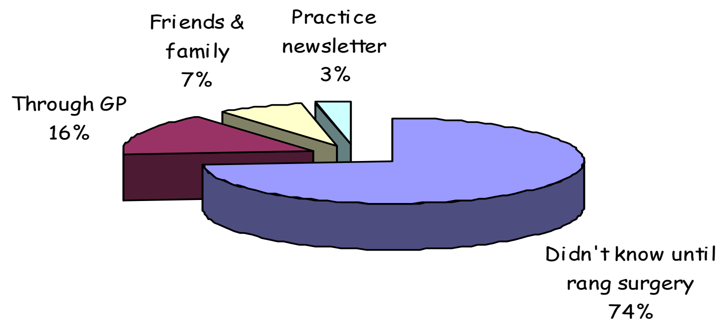
7.5 How people learned about the service

Almost three quarters of the people (74%, 50) did not know about the service until they telephoned the surgery; this applied equally to both men and women. Two of the people who did not complete the remainder of the questionnaire had however commented:

> *It sounds like a very good idea, but I have never been informed that it existed, so I have never used it.*

I didn't know anything about the nurse advice line! I just wanted an appointment with my doctor (you should not have to ask a nurse if you can have an appointment with your own doctor).

Figure 7.5.1 How people learned about the service



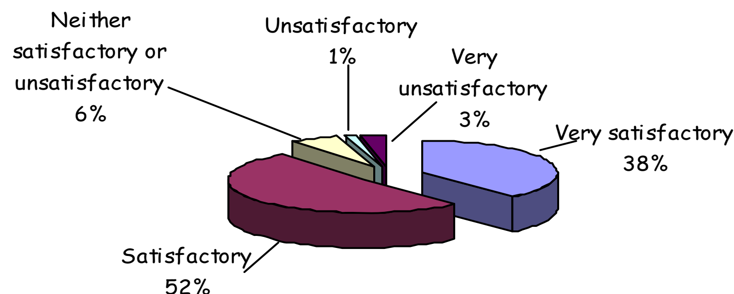
7.6 Who people rang the practice for

- Seven out of 10 people (73% of the 67 people who replied) rang the practice for themselves.
- 14 people (21%) rang for a child: all of these being school children aged between six and 14 years.
- Four people (6%) rang on behalf of someone else.

7.7 Contact with the receptionist

Almost nine out of 10 people rated their contact with the receptionist as satisfactory or very satisfactory.

Figure 7.7.1 Contact with the receptionist



One of the two people who rated their contact with the receptionist as very unsatisfactory and had rung the practice for an appointment for herself said:

> *I find the receptionist staff very rude and unhelpful. They are not sympathetic to one's problems.*

7.8 How long before people spoke to a nurse and how satisfied they were

More than a third of people spoke to a nurse within 15 minutes and two thirds within 30 minutes.

Table 7.8.1 How long before people spoke to a nurse

	Number	%
Up to 15 minutes	25	37
15 - 30 minutes	18	26
30 minutes to an hour	15	22
Over an hour	10	15
Total	68	100

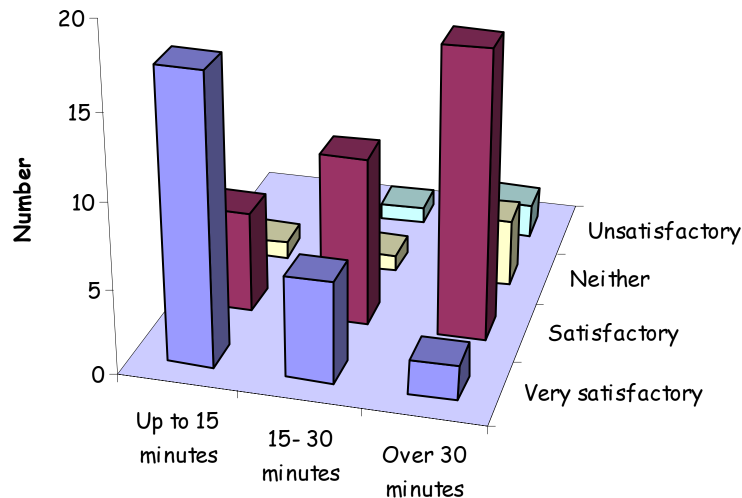
Almost nine out of 10 of the 67 people who replied felt the time they had to wait to speak to the nurse was either satisfactory or very satisfactory. Nobody found the length of time they waited very unsatisfactory.

Table 7.8.2 Level of satisfaction with the time waited before speaking to a nurse

The time waited to speak to a nurse was….	Number	%
…very satisfactory	25	37
…satisfactory	33	49
…neither satisfactory or unsatisfactory	6	9
…unsatisfactory	3	5
…very unsatisfactory	-	-
Total	67	100

The following chart shows the relationship between the level of satisfaction and the time taken. It can be seen that, while the level of satisfaction decreased with the time taken to return the call, nobody found the wait very unsatisfactory.

Figure 7.8.1 Relationship between level of satisfaction and time taken to return the call



The level of satisfaction decreased with the length of time waited to speak to the nurse.

- For people waiting up to 15 minutes, seven out of 10 felt this was very satisfactory; nobody felt this length of time was unsatisfactory.
- For times between 15 and 30 minutes, a third felt this was very satisfactory. However only one person felt this was unsatisfactory.
- For times in excess of 30 minutes, only one in 10 people thought this was very satisfactory, but the majority of these people were not dissatisfied with the time they waited. In total, of the 25 people who said they waited more than 30 minutes for the nurse to contact them, only two people (8%) said they were dissatisfied.

7.9 Contact with the triage nurse and what she did

All of the 68 people in the sample felt that the nurse spoke in a way that was easy to understand. In total, 44 people (two thirds) said they received advice over the telephone from the nurse. For 12 of these, this was the only action taken.

For almost three quarters of the people, the nurse arranged a same day appointment:

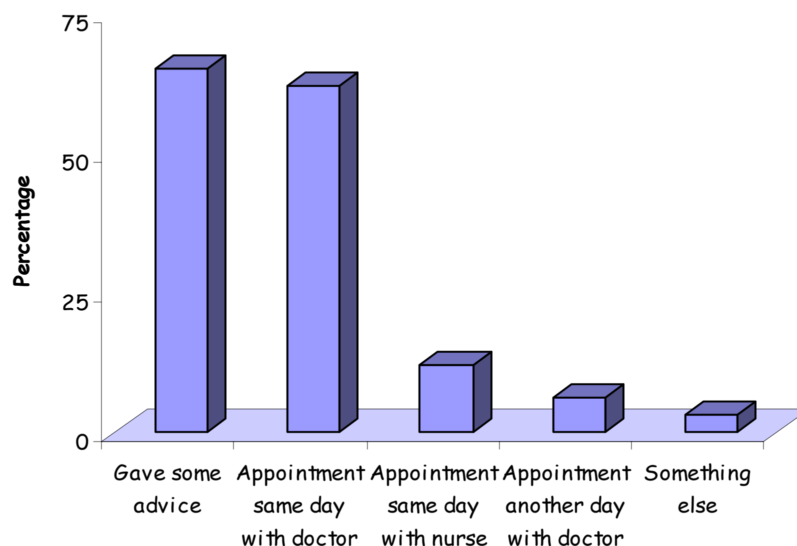
- 42 (62%) people were given a same day appointment with the doctor;
- eight (12%) people were given a same day appointment with the nurse.

However, for more than a quarter of people whose calls were triaged (18), same day requests were diverted:

- 12 people received advice only;
- for four people an appointment was made to see the doctor on another day, three of these also receiving advice from the nurse;
- one person was given advice and said she had been told if she was not happy, she could go in and see someone;
- for one person, a sick note was arranged.

Same day appointments with the nurse were given to eight people with four of these also saying they were given advice. One of these people said that the nurse arranged for the doctor to telephone her.

Figure 7.9.1 What did the nurse do



(Percentages do not add up to 100% as more than one reply could be given.)

For 13 of the 14 people who rang about a child, advice was given over the telephone:

- eight were given advice only;
- four were given advice and a same day appointment with the GP;
- one was given advice and was told if she was not happy, she could go in and see someone.

The remaining child was given a same day appointment with the GP.

7.10 Was the telephone advice from the nurse appropriate

All of the 44 people who said they were given telephone advice by the nurse, felt the advice was appropriate.

Three people, who said the nurse had not given them advice, nevertheless answered the question about the appropriateness of advice. It is possible that the question was interpreted as the *action* being appropriate/ inappropriate rather than the *advice.*

- Two of these people, given a same day appointment with the GP, said the advice was appropriate.
- The third person, who had been given an appointment with the GP for another day, said the advice was not appropriate.

7.11 How was the problem dealt with

96% of the 66 people who replied to this question felt that the problem was dealt with to their satisfaction. For the three people who said it was not:

- one, given a same day appointment with the nurse, said :

  Treatment helped but return visit to GP needed for correct diagnosis and antibiotics.
- one, given advice only, said the problem should have been dealt with by:

  Appointment with GP a.s.a.p., as it was for an eight year old child.
- one, given advice and a same day appointment with the GP, said*:*

  I feel the receptionist could have been more helpful instead of being so abrupt.

Additionally, two people (who said the problem was dealt with to their satisfaction) both added the comment that they would have preferred to see the doctor on the day.

Only one of these five people was given a same day appointment with the GP.

7.12 Contacting the surgery again

In total, 13 (20%) people (two of whom said they were not satisfied with the way their problems were dealt with) contacted the surgery again with the same problem; of these, eight (62%) had not been asked specifically to do so.

For these eight people:

- all had received advice from the triage nurse;
- five had a same day appointment: four with the GP and one with the nurse;
- all felt the advice given was appropriate;
- all but one were satisfied with the way the problem they rang the surgery with was dealt with. This person was given advice for the treatment of a child.

7.13 Improving the telephone triage service

62 people replied to the question asking if the practice could do anything to make the nurse telephone triage service better and 87% (54) of these replied 'No, it is fine as it is'.

All of the eight people who felt something could be done said what this was; these comments are reproduced in full below.

Two were about the time taken to speak to a nurse:

> *It would help if you could speak to the nurse straightaway but she also has her work to do – so it's a catch 22.*
>
> *Make them ring in no more than half an hour. I waited nearly two hours when I was told it would be within the hour.*

There were two comments about being unaware of the service:

If they have publicised this I am sorry but I haven't heard. Perhaps I don't use the surgery enough.

I would have liked to know we had this service before I required it.

There were three comments from people about referral to the GP. Two people said simply they wanted to see the doctor and one person made specific reference to children.

Ambiguous symptoms especially in respect of children should be referred to GP i.e. rash/ temperature/ swollen glands/ painful joints when presenting together.

One other comment about the service was made:

Some nurses need a less abrupt attitude which I experienced the time before last.

7.14 Keeping the telephone triage service

64 people (96% of the 67 people who replied to the question) felt the practice should keep the nurse telephone triage service running.

Two of the three people who said the practice should not keep the service running made an additional comment.

When I ring up for an appointment, I would like to get one. I do not want to be questioned by a nurse as to whether I need one or not. Why has this suddenly come into place? Get more doctors or make them work longer. I feel something should be done about the receptionist staff; they are extremely rude on the phone.

Would rather see the doctor.

7.15 Additional comments

A further 26 people (all of whom felt the service should continue) made additional comments. Some people took this opportunity to reiterate or reinforce comments they had made earlier in the questionnaire. For each of the points below, one comment has been chosen which reflects the point made. All comments can be found in Appendix 9.

Nine people were positive about the service and its benefits:

I think it is a wonderful service and should continue. It is very reassuring to actually speak to a nurse about your particular problem, this can allay any fears you may have and stop you worrying so much until there is an appointment available to see a doctor/ nurse if this is necessary.

Four people wanted assurances about the service:

The advice line is good – providing the nurses are trained to recognise a serious problem and are available when needed.

Six people, while appreciating the benefits of the service, expressed some reservations:

I have only had to use it once and I was given an appointment immediately. I might not have been so satisfied if I had not warranted an immediate appointment and had to wait a few days before seeing a doctor.

One of these people also commented about reception staff:

If you could speak to the nurse straightaway it would be much better. The receptionist (particular one) is very un-cooperative and very unhelpful at times. At times I have had to go into the reasons why I want to see a doctor which I feel I should not have to as it's private.

One other person commented on reception staff:

As I said before, perhaps the receptionist who is the person you first speak to could be more helpful.

One person commented on the fact that they had not known about the advice line previously:

I didn't know about the nurse advice line, it is a very good thing to be able to talk to a nurse when you can't get an appointment with a doctor. This was what happened to me recently, much better for a nurse to decide whether you should see a doctor rather than the receptionist.

One person made a request for:

'Well Man' clinic with prostate screening is the biggest single improvement to public health that could be made.

Finally, four people took the opportunity to praise the services the practice gives to its patients:

I feel that we in this area are extremely fortunate to have such a good GP practice with a courteous and professional practice nurse.

Chapter 8

Discussion

8.1 Introduction

The findings of the study are discussed here in relation to the aims of the nurse-led telephone triage service and in the light of the literature reviewed. Progress towards the two main aims of the service, that of extending the role of nurses in order to make better use of their knowledge and skills and of improving access for patients to a health professional, are explored in turn. The experiences of all three case study practices are included. It should be noted that work with health professionals was carried out in two of the case study practices and patient work was carried out in all three.

8.2 Extending the role of the nurse

Nurses have made an essential contribution to increasing the range and quality of services offered to patients within general practice (Koperski et al, 1997), and evidence suggests that professional boundaries and role definitions are currently being challenged on a regular basis in primary care with new initiatives such as walk-in centres and nurse telephone consultations in 'out of hours' care (Jenkins-Clarke and Carr-Hill, 2001). In line with these developments, an overall aim of the nurse-led telephone triage service in South Cheshire was to 'extend the role of the nurse to make better use of their knowledge and skills' (Ellesmere Port and Neston PCG, 2000, p.2). Respondents interviewed in this study perceived that telephone triage had extended the role of the nurse in primary care, but there was variability in their views concerning the desirability of this extension, with nurses tending to be more hesitant than other practice staff.

Nurses interviewed at both of the case study sites expressed unease regarding the extension of their current role into undertaking telephone triage. At Case Study 1 nurses articulated doubt about whether telephone triage should become part of an

extended nursing role as they felt they were moving into the realm of diagnosing patients, an aspect of health care they felt was traditionally beyond the remit of a nurse. They were concerned about the 'medicalisation' of the nursing role that they perceived accompanied their involvement in telephone triage, an issue that has been raised in relation to nurse triage in the A&E department of hospitals (Edwards, 1999). Nurses in both practices also alluded to the notion that telephone triage would, they believed, almost inevitably lead to further extensions of their role, such as triaging patients face-to-face. This can also be understood in terms of 'medicalising' the nursing role, and was an issue about which some of the nurses had reservations.

However, these same nurses did recognise in their work as telephone triage nurses some of the 'therapeutic' effects of triage as described by Edwards (1999), in that they felt that they were able to supply patients with information that those patients would not otherwise be able to access easily and to give them helpful advice. Thus, the importance of establishing clear definitions of professional roles and maintaining a clear view amongst staff of the purpose of triage in terms of delivering appropriate care is highlighted.

In terms of continuing professional development, the nurses interviewed perceived that their skills at telephone triage had increased during the period telephone triage had been operational, although they felt that they still had much to learn. In addition, development of knowledge through triage had, for some of the nurses, enhanced other aspects of their roles. Although this was of benefit for some nurses, others felt that the time taken up by triage left little scope for any other kind of development in areas that they perceived may have made better use of their time, skills and knowledge *as a nurse*. This again highlighted the tension that was evident surrounding what a nurse's role should encompass.

At Case Study 2, apprehension expressed by the nurses centred around doubts about their own ability to perform telephone triage, felt particularly before the service was implemented and during the first weeks of implementation. Educational preparation

for nurses prior to undertaking telephone triage has been cited as an essential component in ensuring the reliability of the advice subsequently given (Crouch et al, 1997). However, providing appropriate education and training to equip the nurses in the study practices with the skills necessary to perform telephone triage was difficult owing to the absence of any professionally approved training courses at that time. This lack of educational preparation was highlighted as a concern for the nurses at the practices, and added to their concerns regarding their own ability to perform telephone triage. Initially, at the practices studied, the doctors undertook triage with the nurses observing, then the doctors and nurses triaged together until the nurses felt confident enough to triage alone. It is possible that this approach helped to build the confidence of the nurses, allaying some of their fears about performing triage.

Adequate preparation for an extended nursing role such as performing telephone triage is likely to include education and training prior to implementation. However, this study also highlighted the importance of day-to-day clinical support and feedback in sustaining triage nurses. In Case Study 2 doctors were always available to answer queries from the triage nurse, this being cited as important by the nurses and leading to them feeling supported in their work. However, problems were experienced at Case Study 1 regarding day-to-day clinical support for telephone triage nurses. Time pressures and organisational factors within this practice, where nurse-led telephone triage was performed throughout the day, meant that the triage nurses frequently missed out on clinical feedback from the GPs regarding patients they had triaged, as GPs were not necessarily available for consultation. Nurses thus often felt unsupported on a daily basis. However, nurses at Case Study 1 found a training forum provided by the GPs to be particularly useful as continued support for their extended role. Training was conducted on a monthly basis and was guided by issues that had arisen for the practice nurses as a result of triage.

At both practices the importance to the triage nurses of peer support was evident. Nurses at both case study sites reported a strong sense of peer support amongst the

staff involved in implementing the telephone triage service. This was considered to have been important for the nurses in developing their telephone triage roles.

Although some of the GPs interviewed expressed that they had some concerns about nurses performing telephone triage prior to the implementation of the service, the experience of these GPs since the initiation of triage had served to allay these concerns. Medical and administrative staff tended to view nurse telephone triage as a positive means of managing and redistributing the workload within the practices, and the potential development of nurses engaging in face-to-face triage was perceived as another useful tool for managing practice workloads. GPs and other non-nursing staff did not express the same concerns as nurses regarding the role of the nurse and generally perceived professional development, through triage, as positive in terms of the career development of the nurses.

Nurse interviewees identified further forms of support which they considered could be useful to them in their triage work. Research has previously found that practice nurses felt they would require specifically developed guidelines and locally agreed protocols, in addition to training in telephone consultation skills, to enable them to undertake telephone triage (Crouch et al, 1997). This was echoed in the present study as nurses cited the need for computer-assisted protocols in telephone triage in order to standardise the triage encounter. Another issue that was considered to be important by nurses at one of the case study sites was the audio recording of triage consultations. Neither of the practices audio recorded triage consultations and some nurses felt that this would be a useful support for them, particularly if there were ever any complaints made by patients. At both case study sites, as in previous research (Crouch et al, 1997), nurses expressed some concern regarding accountability and the legal implications of performing telephone triage. It was considered by some nurses that audio taping the telephone triage consultations would be a safeguard for them in the event of any legal proceedings resulting from patient complaints.

It is evident that there were different views held by nurses and other practice staff about the implementation of nurse telephone triage at the practices studied. The concerns expressed by nurses would benefit from being addressed as confidence in performing the role is likely to be integral to effective implementation. Adequate support would appear to be essential for the safe and effective implementation of the service, as well as for the nurses interviewed to feel comfortable in taking on an extended role within the practices. The differences in support received by the nurses in each practice could be attributed to differences between the practices such as size, which affect ways of working, and the number of hours during each day that the telephone triage service is in operation. These differences highlight the benefit of considering the implementation of telephone triage on an individual practice level.

8.3 Teamwork

One of the operational aims of the triage service in South Cheshire was to encourage team working amongst practice staff (Ellesmere Port and Neston PCG, 2000). Previous research has indicated that implementation of telephone triage into a general practice setting actually requires extensive team working and commitment, from all staff members, in order to execute a 'whole systems approach to change' (Richards and Tawfik, 2000, p.45). Such teamwork was evident amongst staff at the practices studied. For example, the way in which GPs and nurses undertook triage together when the triage systems were initially implemented indicates a team approach, as does the monthly triage forum set up at one of the case study sites.

8.4 Improving access for patients to a health professional

Improving access to primary care services has been a recurring theme in UK government policy for the past four years and is an essential component of the NHS plan (Wilkin et al, 2001). This was also an important aim of the nurse-led telephone triage service in South Cheshire (Ellesmere Port and Neston PCG, 2000). Staff interviewed at both case study sites perceived that the service did improve access to more appropriate care for patients. Nurse telephone triage was seen as providing fast and efficient contact, albeit by telephone, to a health professional. At Case

Study 1, there was also a perception that the service not only increased access to traditional primary care services, but increased access to information that may not have been available to patients previously. The triage nurses at this practice articulated the observation that some patients were using the service for this purpose instead of 'bothering' the doctor, perhaps an indication of the patients' acceptance of this service.

The survey of patients revealed that at all three case study practices patient satisfaction levels with the nurse-led telephone triage service were consistently high. At least 90% of patients in each practice thought that the service should remain in operation. For the minority of patients who were unsatisfied within each practice, factors which may have contributed to this could be identified. Two of the most important were the length of time a patient waited for the triage nurse to return their call and whether or not the patient received the requested same day contact with a GP.

Patients who had to wait for longer than half an hour to have their initial call to the practice returned by the triage nurse often displayed dissatisfaction with the service. Approximately half of the patients who waited for this length of time in each practice were unsatisfied with the time taken to return their call. Thus it is evident that consideration of how to manage returning calls, particularly at busy periods, is necessary. In addition, the situation arose at one practice whereby patients presented in person requesting same day contact with their GP, and were then not happy to be asked by the receptionist to return home and await a telephone call from the triage nurse. It was perceived by practice staff that this situation arose because the surgery was situated next to a school, so parents would call in on their way to or from that destination. This highlights again the importance of examining the individual characteristics of a practice when considering implementation of nurse-led telephone triage.

The other characteristic that tended to define a patient who was not satisfied with the triage service was not receiving same day contact with their GP. This finding is similar to that revealed by research into 'out of hours' primary care services, which indicated that the majority of patients expecting a home visit from a GP were dissatisfied to receive only telephone advice (Hallam et al, 1999, in Shekelle and Roland, 1999). The importance of educating patients about the purpose of triage, that is, to ensure that patients receive fast access to the most appropriate care, is thus highlighted, as if a patient feels that they have received appropriate care they are less likely to report dissatisfaction. Some patients perceived the nurse-led telephone triage service to be a barrier to primary care services, or more specifically to their GP, rather than regarding it as increasing access. This was a perception that concerned the staff interviewed too. Furthermore, in Case Study 1, people who appeared less satisfied with the outcome of triage were slightly older than those who were satisfied and therefore may have traditionally been used to seeing a GP whenever they so requested. This relates again to the issue of patient education.

It was intended that, in addition to improving access for patients, nurse-led telephone triage should enable patients to be dealt with more quickly and efficiently (Ellesmere Port and Neston PCG, 2000). An unexpected outcome of telephone triage has been to enable better management of some consultations by GPs. The view was expressed that patients who had been triaged and required an appointment with their GP were often clearer about, and more focused upon, their presenting problem than patients who had not been through the triage process. In addition, the triage nurse had often advised them to take any relevant 'samples' to the consultation. Thus, the GP was able to deal with the problem in a shorter time than would have been the case if the patient had not already consulted with the triage nurse.

The reduction of unnecessary appointments was one of several operational aims of the nurse-led telephone triage service in South Cheshire, as patients requesting same day appointments for self-limiting conditions are considered to contribute greatly to the workload of general practice (Marsh and Dawes, 1995). Quantitative data from this

evaluation shows that, overall, for the participating practices in South Cheshire, nurse-led telephone triage was able to redirect 40% of requests for same day contact with a GP. Of these requests, 20% were dealt with by nurse telephone advice alone.

Individual analysis of the case study practices revealed that the proportion of redirected requests varied by practice. As revealed in the 'snapshot' data, the largest percentage of patient requests directed away from a same day appointment with their GP was 44% at Case Study 1, followed by 42% at Case Study 3 and 23% at Case Study 2. At these practices, 30%, 5% and 8% respectively of requests for same day contact were dealt with by nurse telephone advice alone. Variation in these figures is likely to reflect, at least in part, distinguishing factors about the practices, such as differences in size, patient population, and the length of the daily telephone triage period. Nevertheless, it is evident that at all three case study practices nurse-led telephone triage did reduce the amount of same day GP appointments that were issued.

Staff in the case study practices, particularly the GPs, expressed some disappointment at their perception that the telephone triage service had not led to a noticeable reduction in daily workload. Although this was not an expressed aim of nurse-led telephone triage it was evident that interviewees had thought that a reduction in workload might occur. In direct contrast to this expectation, many of the respondents at Case Study 1 perceived that the triage service was in fact fuelling an increasing demand for access by providing easy and convenient contact with a health professional. However, research has shown that the demand for GP services has experienced a dramatic increase in the last decade (Scott and Vale, 1998, in Richards and Tawfik, 2000) and recent government plans to further develop primary care services as a key component of NHS modernisation (Department of Health, 2000) may have contributed to this upward trend in demand. Therefore, the perceived increase in demand for services at Case Study 1 could be a reflection of a national increase in demand for primary cares service. Alternatively, nurse-led telephone triage may provide an easier and more convenient method of access for potential

inappropriate attendees, which could result in a large number of telephone calls and so the perceived increase in demand.

8.5 Conclusion

Government plans to develop primary care as a key component of NHS modernisation (Department of Health, 2000) have highlighted shortages in the GP workforce and one response to this has been the promotion of extended roles for nurses (Wilkin et al, 2001). This is reflected in the establishment of nurse-led telephone triage in primary care across South Cheshire, funded through modernisation monies. The evaluation of the triage service, as described in this report, has demonstrated that the aims of extending the role of the nurse in primary care and of improving access for patients to a health professional have largely been achieved, accompanied by high levels of patient satisfaction with the service.

However, the implementation of nurse-led telephone triage has not been unproblematic and there are issues raised in this evaluation that may require consideration if the service is to achieve maximum benefit for health professionals and patients. These include:

- a clear definition and understanding of the role of the triage nurse within primary care by staff and patients;
- consideration of the preparation that nurses require in order to undertake triage;
- consideration of the continuing support that may be necessary to sustain triage nurses in their role;
- consideration of the views of nurses regarding the extension of nursing roles and the possible tension caused by the perceived 'medicalisation' of nursing;
- consideration of the impact that the individual characteristics of practices, as well as the populations they serve, may have on the delivery of a nurse-led telephone triage service;

- the education of patients in order that they understand and appreciate changes in the delivery of primary care and learn to use the services effectively and to their best advantage.

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Appendix 1

South Cheshire: A shared quality framework for local nurse triage models

SOUTH CHESHIRE

A SHARED QUALITY FRAMEWORK

FOR LOCAL NURSE TRIAGE MODELS

October 1999
CAT/NMG/LNT

BACKGROUND:

A process, led by the LMC in conjunction with the Health Authority and PCGs, determined the area for investment for part of the Primary Care Modernisation Fund as ***Local Nurse Triage***.

In order to arrive at a shared understanding of the ***principles*** and ***quality issues*** a Workshop was held to develop this framework.

Implementation, including, for example, the type of model, roll out arrangements and operational management will be led and owned within the respective PCG. Where appropriate, PCGs may wish to develop collegiate working arrangements for all or some of the operational aspects. However, as agreed, ***all local Nurse Triage models will work within this quality framework***. Any (possible) future developments, along with performance management processes of existing models will be required to provide evidence of the principles and quality statements set out in this framework.

STEERING GROUP:

The Nurse Advisor for South Cheshire Health Authority will establish a South Cheshire-wide Steering Group, formed by representatives from the Health Authority, PCGs and NHS Trusts. The purpose of the Steering Group is to:

- Ensure understanding of National policy / initiatives and the connection with local developments.
- Facilitate opportunities for sharing good practice.
- Performance manage (strategic level) the unfolding models across South Cheshire against the quality framework.
- Review the quality framework (at least annually).

PRINCIPLES:

All developments should:

- Consider the wider issues and likely impact upon other services both locally and nationally.
- Acknowledge that the only 'right model' is the one which provides the best fit with the needs of the population; the effective use of resources; an effective contribution to the development of primary care services; and enhances the patient experience.
- Demonstrate value for money and economies of scale (as appropriate in meeting local requirements).
- Be supported by all members of the Primary Healthcare Teams.
- Secure local ownership and commitment.

- Build upon existing skill mix and further develop the integration of Primary Healthcare Teams and multi-professional working.

- Reflect the requirements of professional bodies, e.g. UKCC, and professional developments, e.g. Nurse prescribing.

- Be supported by a local (PCG) action plan for implementation and management of the roll-out of local model(s) within available resources.

QUALITY STATEMENTS:

National Policy and Initiatives:

Evidence of:

1. Support from the Steering Group to ensure local knowledge and understanding of national policy.

2. Flexibility and adaptability of local models and a connection with national developments as they unfold, e.g. NHS Direct, Walk-In Centres.

Clinical Governance:

Evidence of:

1. Baseline and ongoing audit with I.T.-based recording systems that effectively support the management of the patient and provide consistent, high quality data.

2. Operating within locally agreed and owned guidelines.

3. Significant event reviews.

4. Risk Management Strategy.

5. Sharing and utilising best practice.

6. Measuring patient satisfaction.

Use of Resources:

Evidence of:

1. Identification of existing resources (e.g. money, service skills, premises, I.T.).

2. Value for money – investments are targeted alongside the best use of existing resources.

3. Review of best practice in determining the most effective and efficient model for local implementation.

Education, Training and Continuing Professional Development

Evidence of:

1. Assessment of training needs of all staff directly or indirectly involved in the implementation of the model (e.g. eider Primary Healthcare Team).

2. Effective use of skill mix.

3. Accredited training for triage skills, referral protocols, management of schemes, etc.

4. Individual personal and professional development plans, and team practice professional development plan.

5. Preceptorship, clinical supervision, professional reviews, and appraisal.

6. Ongoing access to training/development of individuals and teams.

Recruitment, Selection and Retention

Evidence of:

1. Use of 'Good employer' practice, e.g. interview process, job specification, person specification, flexible working arrangements, and support for personal development.

2. Good working environment, e.g. safe, supportive, inclusive.

3. Maximising flexibility in use of funding to attract, develop and keep the right people with the right skills.

Performance Management:

Evidence of:

1. Processes which demonstrate measurement of the quality framework against local models (within PCGs and the Steering Group).

2. Processes which support the identification and management of risk.

3. Reference to progress against milestones in PCGs, Primary Care Investment Plans and Clinical Governance reports.

Appendix 2

Snapshot data collection form

Evaluation of Nurse Telephone Triage in General Practice

As part of the evaluation of the Nurse Triage scheme, we need to look at what happens to requests for same day appointments and home visits.

We are asking all practices to monitor ONLY these requests for five days, beginning on Monday, 22 April 2002. We've tried to keep the monitoring as quick and easy as possible and the data collection forms attached require only ticks in two columns.

The first three columns define the original request.
Please tick only one of:-

- a same day appointment with the Doctor
- a same day appointment with the Practice Nurse
- a home visit.

The following seven columns define the outcome following triage.
Please tick only one of:-

- a same day appointment with the Doctor
- a same day appointment with the Practice Nurse
- a home visit
- a routine appointment with the Doctor
- a routine appointment with the Practice Nurse
- telephone advice
- some other outcome. NOTE: We do not need to know what this was, just that there was some other outcome of the call.

If, within your practice, requests for same day appointments with the Practice Nurse are given automatically, i.e. are not subject to triage, please indicate this on the front sheet of the forms. Similarly, if your practice does not have Practice Nurse clinics, please also indicate this on the front sheet.

Thank you for your help. If you have any problems with this data collection, please contact Mona Killey at the Centre for Public Health Research on 01244 375 444 ext. 4795..

Nurse Triage Evaluation

Data collection forms

Practice name ……………………………………………………….

Please tick the following statement(s) if applicable to your practice:

☐ **This practice does <u>not</u> have Practice Nurse clinics**

☐ **Requests for same day appointments with the Practice Nurse are given automatically**

FINAL OUTCOMES OF RECEIVED CALLS 22/04/02 – 26/04/02

PRACTICE NAME: **DATE:**

Please could you place a tick (✓) in the relevant box to indicate both the initial request and the final outcome of each call

Original Request of Call				Final Outcome of Call						
CALL	SAME DAY APPT GP	SAME DAY APPT NURSE	HOME VISIT	SAME DAY APPT GP	SAME DAY APPT NURSE	HOME VISIT	ROUTINE APPT GP	ROUTINE APPT NURSE	TELEPHONE ADVICE ONLY	OTHER

Appendix 3

Nurse telephone triage patient satisfaction survey

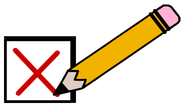
Nurse Telephone Triage Satisfaction Survey

Thank you for taking part in this survey. We would like you to tell us what you think about the telephone nurse triage service you have encountered at (name of practice). We have tried to make the questionnaire as short as possible, and we would be very grateful if you could spare some time to answer it.

The information that you give is anonymous and will not be seen by the practice staff, so please feel free to make any comments either about the service or the questionnaire itself. If you need any further information about the questionnaire, please contact me, Mona Killey either by letter or by telephone.

Mona Killey
Centre for Public Health Research
Chester College of Higher Education
Parkgate Road
Chester CH1 4BJ
01244 375444 Ext. 4795

Answering Questions



Usually you just need to place a mark in the box…

…but to answer some you might need to write in the space provided

…to put the questionnaire in the freepost envelope provided and send it back to us as soon as you have completed it.

Thank you for your help

© Centre for Public Health Research

About You….

1. Are you: male ☐ female ☐

2. How old were you on your last birthday? ………………… years

3. Do you work: full time ☐ part time ☐ I don't go out to work ☐

4. How did you learn about the nurse telephone triage service?

   ☐ Through my GP

   ☐ Through a Practice Newsletter

   ☐ Through friends or family

   ☐ Didn't know about it until I rang

For the following questions, please could you think about the last time that you contacted the surgery and spoke to the triage nurse.

5. Did you ring the practice on this occasion for:

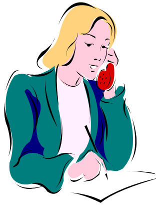
   ☐ Yourself

   ☐ Your child

   How old is the child? …………..years…………..months

   ☐ Someone else (Please state)

   ……………………………………………………………………………………



About the telephone service….

6. At approximately what time did you ring the practice on this occasion?

- ☐ Early morning (Before 10.30am)
- ☐ Late morning (Between 10.30am and 1.00pm)
- ☐ Early afternoon (Between 1.00pm and 3.30pm)
- ☐ Late afternoon (Between 3.30pm and 5.30pm)

7. How would you rate your contact with the practice receptionist?

- ☐ Very Satisfactory
- ☐ Satisfactory
- ☐ Neither satisfactory or unsatisfactory
- ☐ Unsatisfactory
- ☐ Very unsatisfactory

8. After you spoke to the receptionist, approximately how long was it before you spoke to a nurse?

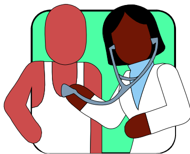
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ 30 minutes to an hour
- ☐ Over an hour

9. Did you feel that the length of time you waited to speak to the nurse was:

- ☐ Very Satisfactory
- ☐ Satisfactory
- ☐ Neither satisfactory or unsatisfactory
- ☐ Unsatisfactory
- ☐ Very unsatisfactory

10. When the nurse spoke to you over the telephone did she speak in a way that was easy to understand?

- ☐ Yes
- ☐ No



About your healthcare….

11. What did the nurse do for you over the telephone?

- ☐ Gave some advice
- ☐ Arranged for an appointment that day with the doctor
- ☐ Arranged an appointment another day with the doctor
- ☐ Arranged a home visit
- ☐ Arranged for an appointment that day with the nurse
- ☐ Something else (please tell us briefly)

………………………………………………………………………………………………

12. If you received telephone advice from the nurse did you feel that the advice was appropriate?

☐ Yes
☐ No
☐ I didn't receive advice over the telephone

13. Was the problem that you rang the surgery with dealt with to your satisfaction?

☐ Yes
☐ No

14. If you said no how do you feel your problem should have been dealt with?

....

....

Did you have to contact the surgery again with the same problem?

☐ No
☐ Yes
↓

Was this because the doctor or nurse asked you to?

☐ Yes
☐ No

15. Do you think that the practice could do anything to make the nurse triage service better?

- ☐ No, its fine how it is
- ☐ Yes (please tell us briefly)

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

16. Do you think that the practice should keep the nurse triage service running?

- ☐ Yes
- ☐ No

17. Are there any other comments you would like to make about the nurse triage service?

………

………

………

………

Thank you for taking the time to fill in this questionnaire. The information you have given will be used to shape future services at your GP surgery.

Please return the questionnaire in the freepost envelope provided.

Appendix 4

Patient information letter

Dear Patient,

At your doctor's surgery, (name of practice), the staff are very keen to ensure that all patients receive the best service possible. This is why they have introduced a nurse telephone triage service. Nurse triage has been introduced in many practices in the area, and South Cheshire Health Authority would like to find out what patients think about it. They have asked the Centre for Public Health Research, a small research unit based at Chester College, to carry out a survey on their behalf, and the staff at (name of practice) have agreed to be involved. You have been contacted because you have experienced the nurse telephone triage service at (name of practice) whilst ringing the surgery for a same day appointment.

Although the Centre for Public Health Research is carrying out the survey, this questionnaire has been sent by the staff at (name of practice) so that no one outside the medical centre has had access to your personal details. We would like to ask you to help us by filling in the enclosed questionnaire and sending it back to the Centre for Public Health Research in the freepost envelope provided. It is important for this research that as many people as possible return these questionnaires, but it is completely up to you whether you want to take part or not. Whatever you decide, it will have no effect on the care that you receive. You do not need to put your name on the questionnaire and the surgery staff will not see it. As the questionnaire is anonymous it will not be possible for anyone to trace your answers back to you.

The information that you give us will be combined with the answers that we get from other people, and a report will be produced that could help the staff at (name of practice), and other practices all over Cheshire, to plan future nurse telephone services.

If you have any questions about the questionnaire, or would like to speak to someone at the Centre for Public Health Research, please telephone Mona Killey on 01244 375 444 Extension 2027 or write to her at the following address:

Centre for Public Health Research
Chester College of Higher Education
Parkgate Road
Chester
CH1 4BJ.

Thank you very much for your help.

Yours faithfully,

Mona Killey, Researcher, Centre for Public Health Research.

Appendix 5

Practice staff interview schedules

Interview Schedule for Evaluation of Telephone Nurse Triage Service

Triage Nurse

Theme 1 – Introduction and Perception of Triage

- How long have you been at the practice, and what does your work involve?
- Have you had any previous experience of triaging patients?
    - *Can you tell me about this?*
- Why did this practice choose to introduce the telephone nurse triage service?
- What impact has being involved with a telephone triage scheme had on your role within the practice?
    - *Workload*
    - *Taking on new responsibilities*
    - *Was enough information made available to you prior to the implementation of the telephone triage service?*
- What do you see is the primary function of telephone triage?
    - *Do you think there are other ways, already existing or not, besides telephone triage of achieving this function?*
    - *Do you see it as an additional/alternative service within general practice?*

Theme 2 – Training

- How much training did you receive prior to the implementation of this scheme?
    - *What did this training involve?*
    - *Who carried out the training (What is their position)?*
- Following the training were you certain about your role and duties as a triage nurse?
    - *Did the training received enable you to undertake telephone triage with confidence?*
    - *Was there anything else you felt could have been included?*
    - *Was there anything that wasn't necessary*
- Did the receptionists undertake any training?
- Did you feel that the training undertaken by the receptionists was adequate?

- *Why/ why not?*
- *Anything that should have been included/ excluded?*

Theme 3 – Provision of Ongoing Support

- What support/ back-up do you have in your role as a triage nurse?
  - *Feedback/regular discussion of cases with GP*
  - *Support from other practice nurses*
  - *Anything else that perhaps should be?*

- Do you think that the telephone triage service has made full use of your skills

- Do you feel that participating in this service has added to your expertise?

Theme 4 – Perceived Benefits

- Have there been any obvious benefits of the telephone triage service this far?
  - *Unnecessary and inappropriate attendees reduced - Benefits to practice?*
  - *Supply patients need for advice and education - Benefits to patients?*
  - *Patient contact with GP reduced - Benefits to GP?*
  - *GP stress reduced - Benefits to GP*
  - *Trained personnel available – Benefits to patients?*
  - *Costs reduced - Benefits to practice?*
  - *Benefits to nurses?*
  - *Benefits to receptionists?*

Theme 5 – Perceived Problems/ Safety Issues

- Have you come across any problems in implementing the telephone triage service?
  - *Need for training protocol development (standardisation)*
  - *Resistance from patients*

- Do you think that triaging a patient by telephone is particularly different to triaging face to face? Why?

- What are your main concerns with performing telephone triage?
  - *Concerns about clinical responsibility and liability*
  - *Are you concerned about the reliability of information received over the phone? i.e. patient could be over/under exaggerating symptoms.*
  - *Over compensation i.e. asking patients to attend just in case*

Theme 6 – Perceived Patient Reaction

- Do you feel that patients were made adequately aware of the telephone triage service?

    - *How?*
    - *When?*

- What do you feel has been the overall reaction by patients to this service

    - *Barrier to GP – Negative reaction?*
    - *More option for treatment – Positive reaction?*

Theme 7 – Perceived Staff Issues

- How do you think that the implementation of this service has affected professional and staff relationships within the practice?

    - *Positively or negatively? Staff Morale? Team working?*
    - *Do you feel that triage is an aspect of nursing care?*
    - *Nurse trying to do same job as a doctor*

- Do you get job satisfaction in this particular role?

Reflection

- Can you tell me about any particularly good or bad experiences you have had whilst being involved in the triage service?

- On reflection can you think of anything that could/should have been done differently?

- Overall do you think the service has been successful?

    - *Why and it what ways?*

Interview Schedule for Evaluation of Telephone Nurse Triage Service

General Practitioner

Theme 1 - Introduction and Perceptions of Triage

- How long have you been at the practice, and what does your work involve?
- Why did this practice choose to introduce the telephone nurse triage service?
- What impact has being involved with a telephone triage scheme had on your role within the practice?
    - *Workload*
    - *Taking on new responsibilities*
    - *Training*
- What do you see is the primary function of telephone triage?
    - *Do you think there are other ways, already existing or not, besides telephone triage of achieving this function?*
    - *Do you see it as an additional/alternative service within general practice?*

Theme 2 - Training

- How much training was available for the nurses/receptionists prior to the implementation of this scheme?
    - *Do you know what this training involved?*
    - *Who carried out the training (What is their position)?*
- Do you feel the training was adequate for the nurse/receptionist to be able to carry out telephone triage with confidence?
    - *Was there anything else you felt could have been included?*
    - *Was there anything that wasn't necessary*

Theme 3 – Ongoing Support

- What support/ back-up has been made available for the triage nurse?
    - *Feedback/ regular discussion of cases with GP?*
    - *Support from other practice nurses?*
    - *Feel anything else should be in place?*
- Do you feel that the telephone triage service makes full use of the nurses skills?

- Do you feel that the triage has added to the nurses expertise at all?

Theme 4 – Perceived Benefits

- Have there been any obvious benefits of the telephone triage service this far?

    - *Unnecessary and inappropriate attendees reduced - Benefits to practice?*
    - *Supply patients need for advice and education - Benefits to patients?*
    - *Patient contact with GP reduced - Benefits to GP?*
    - *GP stress reduced - Benefits to GP?*
    - *Trained personnel available - Benefits to patients?*
    - *Costs reduced - Benefits to practice?*
    - *Benefits to nurses?*
    - *Benefits to receptionists?*

EXAMPLES

Theme 5 – Perceived Problems/ Safety Issues

- Have you come across any problems in implementing the telephone triage service?

    - *Need for training protocol development (standardisation)*
    - *Resistance from patients*

EXAMPLES

- What are your main concerns as a doctor with telephone nurse triage?

    - *Concerns about safety and adverse effects? (clinical responsibility and liability)*
    - *Are you concerned about the reliability of information received over the phone? i.e. patient could be over/under exaggerating symptoms.*
    - *Telephone triage heading towards diagnosis not an aspect of nursing care?*
    - *Nurse trying to do same job as a doctor.*

EXAMPLES

- How would you feel about assessing and advising by telephone?

    - *Is triaging a patient by telephone particularly different to triaging/consulting face to face?*
    - *What are the main reasons for this?*

Theme 6 – Perceived Patient Reaction

- Do you feel that patients were made adequately aware of the telephone triage service?

    - *How*
    - *When*

- What do you feel has been the overall reaction by patients to the introduction of this service?

    - *Barrier to GP – Negative reaction?*
    - *More option for treatment – Positive reaction?*

<u>EXAMPLES</u>

Theme 7 – Perceived Staff Issues

- How do you think that the implementation of this service has affected professional and staff relationships within the practice?

    - *Positively or negatively? Staff Morale? Team working?*
    - *Do you feel that triage is an aspect of nursing care?*
    - *Nurse trying to do same job as a doctor*

Reflection

- Can you tell me about any particularly good or bad experiences you have had whilst being involved in the triage service?
- On reflection can you think of anything that could/should have been done differently?

- Overall do you think the service has been successful?

    - *Why and it what ways?*

Appendix 6

Practice staff information letter

Dear staff member,

As you will be aware a telephone nurse triage system handling requests for same day GP contact is currently being implemented in many primary care settings across South Cheshire. Development of the telephone nurse triage scheme is being overseen by a South Cheshire development group, comprising of representatives from the PCGs and from South Cheshire Health Authority. The Centre for Public Health Research, which is an independent unit based at Chester College of Higher Education, has been asked by South Cheshire Health Authority to undertake an evaluation of this scheme. An important part of this evaluation is to determine the views and experiences of health professionals (triage nurses, other nurses, receptionists and GPs) involved in the implementation of this scheme, which is why you are being asked to take part in an interview.

Some of the staff selected for interview have been selected because the Practice Manager has identified them as having key roles within the telephone triage process, others have been selected randomly to ensure that the different professional groups are represented. I would like to ask you about your work and experiences working at (name of practice). I would also like to tape the interview to ensure accurate reporting of what you have said, but nothing that you do say will be attributed to you as an individual and nobody at the medical centre will hear the tape. If you have any questions, then please do not hesitate to contact me on 01244 375444 ext. 2027.

Thank you very much for your help.

Yours faithfully,

Mona Killey, Researcher, Centre for Public Health Research.

Appendix 7

Case Study 1 – Comments made by patients

Patient Comments (Case Study 1)

If you said that your problem was not dealt with to your satisfaction, how do you feel your problem should have been dealt with?

- A doctor's appointment should have been available.
- I think child should have been seen - still ill 2 weeks later.
- A diagnosis was made which probably explained my symptoms accurately, but I did not receive advice for all my complaints. I saw a doctor a few days later and he helped me to a cure.
- I would have liked to have seen a doctor, but couldn't get an appointment for four days.
- I should have asked to SEE a doctor, perhaps the nurse should have offered this given the nature of the problem (child's ear infection) as it doesn't usually clear up on its own.
- I should have seen a doctor and I felt I couldn't request to see one after her advice which didn't help.
- I wanted to see a doctor and felt I was being side-lined. I very infrequently call the surgery. I spent another three weeks before I felt well again. ………………..It takes me a long time to pluck up courage to ring the doctor.
- Being a diabetic with asthma, I feel my problem could have been dealt with sooner.
- Should have been asked if I was happy with advice or see Doctor.
- I get the distinct impression that the triage nurse's only aim is to dissuade you from bothering the doctor.
- Only after speaking to the doctor and arranging an appointment to examine my child.
- Better by the diagnosis.
- You should not have to speak to different people when you feel unwell and need to see a doctor.
- Telephone call initially made 9.00am to obtain early appointment. Over 1 hour later and 2nd call was given an appointment. Saw doctor, rushed appointment, unsatisfactory help from staff. The Deputy Manger unhelpful and rude. Emergency appointments difficult to obtain with triage nurses often trying to avoid giving emergency appointments.
- I know my body and I know when I need to see a doctor. Had I a history of wasting the doctor's time, I could understand it but I don't.
- Doctor should have telephoned at least, I wanted a home visit.
- With a little more understanding

Do you think that the practice could do anything to make the nurse triage service better?

- I felt as if I was worrying for nothing and that my child's illness was not that bad ...... she should have been able to see a doctor that day.
- By getting you an appointment when it is needed.
- The triage service makes it harder to see a doctor, surely this should not be happening.

- I feel that sometimes the nurse gives advice, rather than make an appointment with a doctor which is what I called for.
- Offer to make doctor's appointment if no full cure for symptoms can be devised over the phone.
- Be aware of patients medical history before commenting on condition.
- The nurse should be aware of the background of the patient.
- To always check records and history of patient so the correct advice can be given.
- When triage nurse is 'sifting' information following a request for a home visit and encouraging patient to attend surgery, possibly ask about personal circumstances, transport, difficulties dressing themselves etc.
- Authority to phone mobile numbers. Having a more sympathetic approach and not behaving with an air of condescending authority.
- They could communicate to the patient much better e.g. explain why they are using the triage system.
- Less abrupt, more understanding, not so dismissive that a doctor ids not required especially for a baby.
- A little more time taken. Perhaps I am being slightly harsh, but I felt that it is felt that most people who ring in don't need to be seen.
- Even if they give advice, should always feel at ease to go and see the doctor.
- Perhaps for problems with young children, there should be readier access to a doctor or a nurse. Triage service should not be used to keep patients at arms length.
- Maybe have more than one nurse. Some things are personal and only for the doctor's ears and require his advice not a nurse's.
- The triage should be a qualified doctor. The advice given over the phone is misleading and derogatory.
- Get a doctor to the phone. Have a doctor available for appt on day you ring. Extra cover over the weekend - people still get ill but do not like to think of themselves as emergencies.
- If doctors can be relied upon supposing they got the message.
- Information given to the receptionist was not passed on to the nurse and then not passed on to the doctor so my conversation had to be repeated three times when I didn't feel well enough to explain it at all.
- The system has fallen down since the introduction of the triage nurse at Case Study 1.
- I feel that the nurse does what she knows very well. I think receptionists take too much on themselves, picturing themselves as doctors, asking what's wrong when all you want is an appointment.

Are there any other comments you would like to make about the nurse triage service?

- Knowing the nurse triage service is important to the doctors and can help deal with some patients without seeing their doctor. I don't think this applies to all of us.
- I would like to be informed as to when a nurse becomes qualified to make an 'over the phone' diagnosis without even seeing the patient, they don't even tend to do this at casualty!

- I do not agree with trying to make a diagnosis over the phone. If you want an appointment with the doctor you should be given one there and then.
- Waste of good money. A receptionist could do a nurses job. More bureaucratic red tape not needed at all.
- No statistics of success are shown, nor failures, to provide correct treatment.
- Offering two appointment times for choice.
- For this service to work well, training in communication skills needs to be given. It is most annoying from a patient's view to wait an hour for 'the nurse' to telephone only for her to say, "can I help you?" It would be more appropriate for her to explain that she was following up the patient's request for a doctor's appointment and may be able to give advice over the phone, which would negate the need for a visit to the surgery. She could then ask what the patient's symptoms are and take the conversation forward.
- Very helpful and supportive.
- As a nurse myself, I feel it is much better dealing with a qualified nurse to assess patients problems and prioritise them over the phone in order to give advice or appointments as appropriate, taking this responsibility of the doctors receptionist at last.
- When my husband rang on my behalf and told them about my illness at first they said they could not fit me in and then after the nurse spoke to me she said I better come and see the doctor on that day. It is not the nurse triage that is good. But please sort out the desk there where the trouble is at times you could die before you get an appointment.
- The triage service works well. They deal with minor things that we can deal with at home making more time for doctors and patients who need to speak to the doctors.
- It is ok to speak to the triage service first as long as appointments are given if necessary. I think it saves the unnecessary people coming to the medical centre, so freeing up time for the more necessary appointments.
- I think having a triage nurse as it helps save wasted appointments and the doctors time so they can deal more effectively with patients who do need to see the doctor.
- I have rang and spoke to the triage nurse on a few occasions lately regarding my daughter and son and every time found it helpful and appointments have been made.
- The triage nurse system is far more beneficial than trying to get an appointment via 'some' uncooperative receptionists.
- The nurse triage service is excellent as you are able to speak to someone qualified. It is far better than when everything is dealt with by a receptionist who has no medical training.
- The triage nurse is better qualified to help with a patients needs in an urgent situation.
- I think the nurse service is much better than a receptionist telling you that no doctor is available to see you. we can now speak with a nurse and have an appointment if she thinks it is necessary. Thank you for thinking of the nurse triage service.

- I think they responded to me very well on a second occasion I was connected to a second Dr. who provided me with a prescription until I see my own doctor next week.
- Seems fine, though one wonders how physical/telephone triage works if nurses are very busy which they always are.
- It was a brilliant service. Within 20 minutes of my initial call our son had been seen by a G.P. who arranged for him to be admitted to Leighton Hospital and he was on the ward within the hour. Thank you to everyone concerned.
- Yes, keep the nurse triage if only for parents that need advice for their children with minor illness. I feel that this would help the doctors at the surgery.
- Any dealings I have had have been exceptionally good.
- It can be very effective and time saving if advice is needed. But, when a patient obviously needs to see a doctor for treatment an appointment should be made for that day.
- The nurse assessed my daughter's condition by asking a number of questions then referred her to see the doctor. She was then prescribed antibiotics for a chest infection. Good service this time.
- A good way of prioritising G.P appointments so that patients needing urgent appointments can receive them.
- The nurse triage service works well. Now get the people who are running the service to sort out the doctors. Most of them are a waste of space.
- The service is very useful as sometimes it saves the doctors time and our time if you don't actually need to see the doctor.
- The idea is fine but I would much prefer to have a sit and wait service somewhere available. Psychologically its much more reassuring to see a doctor than have advice over the phone from a nurse.
- I have been in contact with the nurse triage system on a few occasions and I have at all times found the one at Case Study 1 to be very helpful and quick.
- Excellent work.
- Very pleased and it makes you feel you are in good hands.
- On another recent occasion I used the service for self and another child, and triage nurse was very helpful and service worked very well. We got accurate help and Drs. were freed up for more urgent needs. When both sides know the health problem is, the service is a great help. It's when there's doubt over nature of problem that the service may not be so helpful.
- I think the service provided is excellent, as a full time worker I have to try to get either very early or late appointments, just so I don't have to take time off. I do hope you keep this service on!
- Very satisfactory service. Hopefully takes some of the pressure of GP's.
- It was nice to have someone to talk to when I was concerned about my sons health, especially when you usually have to wait a week for an appointment to see a doctor.
- Communication in my one instance within the practice did not happen, if it is a one off then otherwise it is a good service.
- Always been pleased when I rang with the help I was given and very very helpful.
- The nurse was very courteous, but I got the impression that I could be given a later appointment by the receptionist than the one the nurse obtained.

- Perhaps I am being slightly harsh but felt that it is felt that most people who ring in don't need to be seen. I think the service is backed by good ideas.
- I feel perhaps for young children/babies the health visitors are best suited to deal with things. They are more understanding and always give the option to come in to the surgery.
- Since the nurse triage service was introduced, I feel as though I have received a much better service from the practice. I no longer have to compete with others making routine appointments when I feel a same day appointment is necessary.
- I've used this system quite often having a young child and I've always been satisfied with all aspects of the service.
- I think it's a very helpful service and it stops some people wasting doctors time.
- Has got to be better than speaking to a receptionist.
- I feel that sometimes the nurse gives advice, rather than make an appointment with a doctor, which is what I called for.
- I think doctors should tell you of any news about you test, not nurse. So ask and get answer, what to do, help yourself, the truth.
- Information given to the receptionist was not passed on to the nurse and then not passed on to the doctor, so my conversation had to be repeated 3 times when I didn't feel well enough to explain at all.
- Patients' confidence in the triage nurse system, and hence its acceptability, will only be maintained if the nurse has the patients notes in front of her when discussing a condition (the nurse did on this occasion). Also the return call must be within, say a maximum of, 30 mins (preferably 15 mins).
- Coming from a country where ill people can always receive medical attention on the same day, I find it very bizarre that ill people in UK can often not have a doctors appointment until several days later, and doctors often stop when they have made a diagnosis instead of advising on a cure.
- Having only used it once after an accident, it is difficult to gauge its success on my experience to date.
- It can be a long-winded process just making an appointment to see a doctor. Some problems are personal and only for the doctor to hear and no one else so can be frustrating when you just want an appointment.
- In my view a nurse triage service should only be necessary at times of epidemics or other abnormal circumstances. Providing the surgery is staffed with sufficient doctors for the number of patients on their books a normal appointment system should be satisfactory.
- If the patient still requests to see a doctor after advice has been given, an appointment should willingly be made.
- The only comment I have is that the nurse who attended me at home after being sent home from hospital with a double fracture of my right leg was, being unsociable and did not show interest in patients' problems.

Appendix 8

Case Study 2 – Comments made by patients

Patient Comments (Case Study 2)

If you said that your problem was not dealt with to your satisfaction, how do you feel your problem should have been dealt with?

- On this occasion it was fine, but on more than one occasion it was not.
- Inadequate time available for appointment making for poor diagnosis.
- The problem was of a nature that required immediate attention from the GP.
- My right eye filled with blood - I saw the receptionist in (Case Study 2) at approx 8.50am - but didn't see a doctor at (Case Study 2) surgery until 11.40am. At 64 years of age, I did wonder, if it was serious, the delay might have been an issue. My family thought I should have been seen by the Nurse/Doctor sooner.
- With the doctor.
- One problem was with my eyes which she didn't look at, I went to the chemist a few days later and was given some drops.
- Should have direct conversation with the doctor.
- I should have spoken to a doctor.
- I was sent to the surgery and I was wrongly diagnosed. It was said I had a virus. I later had a heart attack.
- The nurse asked some silly questions i.e. do you feel that you should see the doctor?!!!

Do you think that the practice could do anything to make the nurse triage service better?

- Let more people know about it.
- Receptionist should remind people how the triage service works.
- Possibly advertise the service more - although I was a new patient.
- The nurse can't do anything for my case because I am under three hospitals.
- <u>No</u> triage nurse - a <u>brief</u> conversation preferable.
- To cancel it.
- You should get to see doctor without speaking to nurse.
- Suspend the service. It is extremely frustrating when you genuinely feel ill or concerned to have someone decide on your behalf whether you can see a doctor. The more fearful or less articulate might find this extremely daunting..
- I found you couldn't see the doctor without going through the nurse to see the doctor that morning.
- Access records and get fuller details of problem.
- Perhaps asking date of birth and arranging a local appointment. I had transport, but was very shocked and didn't want to drive. Over 60's would perhaps not be as confident as under 60's. The receptionist did tell me she had seen this before and was reassuring - but I only SPOKE to the nurse when sent home.
- Ring back in a shorter time.
- Sometimes receptionists appear to act out of their role. The Nurse triage system could help to enable the receptionist to be restricted to their correct role.
- If the nurse is 'free' speak to her straight away rather than await a return call.
- Sometimes it is obvious to myself and the receptionist that there is nothing to be gained by the nurse's intervention but red tape gets in the way of common sense!

- Giving medical information to receptionist and then triage nurse is wasting time for everyone
- Didn't understand why the receptionist needed to ask the nature of my 'medical problem' - the nurse had to ring me anyway and would have been told then.
- I feel in my case I was unlucky to be wrongly diagnosed. However in the same situation I would go straight to hospital.
- Having only made one contact with the triage nurse, I do not feel I could make any worthwhile comment.

Are there any other comments you would like to make about the nurse triage service?

- I feel by 'vetting' each caller the doctor's time can be used more effectively for the more serious cases. Good practice-Well done.
- It's very efficient and service quick.
- Very good service, keep it up. It saved my life.
- It is a very good service because it saves a lot of worry, the nurse addresses your problem and then you know if it's an urgent case or not.
- If the service can reduce waiting time to see a doctor, or save the patient time, I would like to see it extended to all practices.
- When my daughter was on holiday from Aberdeen, her 5-month-old son developed a rash. X spoke to a nurse out of hours and was given excellent advice and reassurance. All was well, but if there had been a problem a number was given for contact at any time. My daughter was very impressed with this service. This was done when I gave her our practice number to ring and I too was so grateful for this service.
- It's a very good idea, keep it working.
- Everything is OK the way it is.
- I think it's a really good idea and hope they keep it running.
- If it means that medical conditions are dealt with promptly by doctors then triage can only assist the practice. Receptionists cannot be expected to make medical judgments on the urgency of an appointment request. Often appointments are only available several days after request to see doctors. Triage can alleviate this.
- If not for the nurse I would not have received an appointment that day.
- It seems to be a really useful, responsive service that hopefully cuts down on wasted appointments. I would like to know the outcome/recommendations following the study.
- Before this service was available it was necessary for me to decide about severity of symptoms. This system allows the triage nurse to offer an appointment if needed. This clearly eliminates emergency appointments for trivial complaints, to the advantage of doctors and patients.
- An appointment was made by the nurse with the doctor to take place one hour later.
- I think it is a very good idea, especially if you want some quick advice.
- I think it is a good idea to discuss with the nurse if you need treatment.

- I feel this service is a great idea, as if yourself or children need to see the doctor the same day it can be arranged, rather than time wasters using up all the appointments with the doctor.
- I hope its here to stay.
- I found this service excellent, both administratively and medically.
- No I think it's a very efficient service, particularly as it ensures that when you do have to attend an emergency appointment they generally run to time. This is a breath of fresh air when you are dealing with a sick toddler.
- It's a good idea as long as it's not done in a way that stops you seeing a doctor, as it's hard getting an appointment.
- At 83 years of age, I would rather ring for a Dr. and have a visit right away, but if that cannot be then this arrangement is the next best thing.
- What would happen if the nurse decided to give advice to a patient but that patient did really need to see the doctor? I think the nurse triage could be useful at times but only you know if you need to see a doctor or not.
- I do feel is the nurse qualified enough to make a decision as to whether or not it is important enough to see a doctor!
- I think it needs to be made clear what the escalation procedure is if one does not agree with the opinion/advice of the nurse.
- Should be put through to triage nurse. Unqualified receptionists are not able to decide appropriate measures/treatment/advice.
- It is useful to talk to a nurse rather than tell a receptionist whos conversation can be overheard by others, whereas the nurse is or should be in a private office.
- The nurse triage service seems to me most satisfactory. It saves that awful 'fight' with the receptionist to try to get a same day appointment.
- Very positive experience for me given the urgency of which I needed an appointment - the triage nurse was understanding and very nice!
- I would just like to say I found the nurse was very helpful every time I have had to ring with my injury. This is with giving advice and also appointments with the doctor.
- I found the practice nurse was very easy to talk to and I was very satisfied with the information she gave to me.
- I was a first aider for many years and feel competent to make a judgment. Of the 5 or 6 different nurses that treated me I would say that they were all 'the epitome of dedication, care, consideration and diligence'. Plus they were concerned about my pain and ultimate recovery. Thank you. I couldn't praise them enough.
- Nurse triage is a welcome step in the right direction. We need more nurse hours put into it e.g. over lunch and in the evening so full time workers can access healthcare more readily. Also nurse prescribing would be a big help e.g. antibiotics for ear infections, much more scope than they have now.
- I have only needed the triage nurse when seeking an on the day appointment. However, I think that on many occasions it would be helpful to discuss symptoms with a qualified nurse who could then offer advice or suggest a consultation with the doctor if necessary.
- Nurse prescribing would surely enhance this service.
- I would like to say thank you for their care.

- I would prefer the government to release money to enable everyone who needs to see a doctor to get a same day appointment.
- I have taken my daughter to the receptionist with a rash and asked that the nurse pop out (this was before 9am and she was in her room). I just wanted to see if my daughter was able to attend school. But I was told she would ring me. How can she see a rash over the phone! This led to a delay, a phone call she wouldn't have to make and then when she did call over one hour later there were no appointments left. My daughter was seen that evening by which time the local chemist was shut for her prescription.
- On another occasion I took my friend along whose niece (1-year-old) had fallen and split her eye, which was bleeding. This was also before 9am. She asked at reception if the nurse could take a quick look to see if a visit to casualty was required. Again… red tape and inflexibility dictated a phone call. Which she got and an appointment was made for 11am. After the Dr. took a look we were sent to casualty where the toddlers eye was 'glued'. Apart from these days is the nurse not able to do such 'glueings' in her room at the G.P. practice. Thus elevating delays in casualty? Marks out of ten for the triage method 3/10.
- I did not realise I was using the nurse triage at the time. I contacted reception with a problem following radiotherapy and I presume it was the nurse who phoned back and arranged an appointment with the doctor later that afternoon.
- Advertise the service so patients know about it before they ring the surgery.
- Needs to be publicised more/better. Came over as an apology for the unavailability of an early doctors appointment.
- Hospital said I should see doctor when I need to but I always have to speak to nurse.
- In the end you still need to see the doctor.
- As inadequate as hospital A & E triage, if not worse!
- Do not think it is necessary to have a nurse triage service. When I ring to see a doctor it is because I need to see one. I am not in the habit of ringing unnecessarily.
- I understand that it might 'weed out' those who make demands on doctors time for trivial reasons, but it's the last thing you want when you feel that your need is urgent.
- I think it is a waste of time, a nurse is NOT a qualified doctor. It is a complete waste of time and money.

Appendix 9

Case Study 3 – Comments made by patients

Patient comments (Case Study 3)

Do you think the practice could do anything to make the nurse advice line better?

- Ambiguous symptoms especially in respect of children should be referred to GP. i.e. rash/temperature/swollen glands/painful joints when presenting together.
- If they have publicised this I am sorry but I haven't heard. Perhaps I don't use the surgery enough.
- Provision of a 'well man' examination (blood pressure, urine sampling, etc.) at intervals would be a great improvement.
- It would help if you could speak to the nurse straightaway but she also has her work to do – so it's a catch 22.
- Make them ring no more than half an hour. I waited nearly 2 hours when I was told it would be within the hour.
- Some nurses need a more less abrupt attitude which I experienced the time before last.
- See the doctor.
- See the doctor.
- I would have liked to know we had this service before I required it.

Are there any other comments you would like to make about the nurse advice line?

- In no way should this service deny access to the GPs.
- I am very happy with the service and treatment I get, they are great and very helpful in every way. Thank you.
- As above – when ambiguous symptoms described 2nd opinion from GP would seem prudent, especially in respect of children and older person (65yrs+) who are especially unlikely to advocate or challenge on their own behalf.
- Discreet and very helpful. Action taken promptly.
- My one concern is nurse advice is not a doctor.
- 'Well man' clinic with prostate screening is the biggest single improvement to public health that could be made.
- I am quite satisfied.
- I was very impressed, obviously if you can help people over the phone it saves everybody's time. I would have been happy to get something from a chemist myself if advised to try something recommended.
- Like above if you could speak to the nurse straightaway it would be much better. The receptionist particular one is very un-cooperative and very unhelpful at times. At times I have had to go into deep reasons why I want to see a doctor which I feel I should not have to as its private. She always wants the full issues as to why you want to see a doctor.
- No, if necessary calm the caller down. I was being asked lots of questions about who I was but was worried about my sister and just wanted the questions to end to get advice.
- Found them very helpful.
- I feel that we in this area are extremely fortunate to have such a good GP practice with a courteous and professional practice nurse.

- The last time I rang I was very happy with the service. But the time before that I felt that I was basically 'fobbed' off until the next day and as a result ended in being in hospital for 5 days, which could have been avoided if the nurse had not made me feel that I was basically wasting her time and an inconvenience.
- The nurse advice line is useful as if you do need an appointment, they try to give you an appointment for that day if it's urgent and if you have any queries they are a nurse, on hand to give you advice.
- Anything which links the patient to the GP can only be a good thing, enabling his/her time to be used best and to the benefit of patients. As patient confidence grows with the Nurse Advice Line staff the benefits all round should be gained. Having used the line, I have confidence.
- Very happy with all the help we receive from everyone at Case Study 3.
- I feel that it is reassuring to know that you can have this immediate (or fairly immediate) contact with the nurse, sometimes that's all that is required. On the occasion I used it I did in fact need to see my GP that day (arranged by the nurse) but in some instances the nurse advice line might prevent unnecessary GP visits.
- I think it is a wonderful service and should continue. It is very reassuring to actually speak to a nurse about your particular problem, this can allay any fears you may have and stop you worrying so much until there is an appointment available to see a doctor/nurse if this is necessary.
- I didn't know about the nurse advice line, it is a very good thing to be able to talk to a nurse when you can't get an appointment with a doctor. This was what happened to me recently, much better for a nurse to decide whether you should see a doctor rather than the receptionist.
- I have used the Shrop Doc service and found that the time lapse between speaking to a receptionist and then a doctor was far too long and on one occasion the call was not answered at all. Therefore personally I am very much in favour of the nurse advice line as they responded much quicker.
- The nurse was helpful but would prefer doctor because medication would be needed.
- We are very pleased with the service you all provide us with, thank you.
- Although this was helpful I would rather see a doctor, waiting 4 days for an appointment emergency is not acceptable.
- As I said before, perhaps the receptionist who is the person you first speak to could be more helpful.
- The advice line is good – providing the nurses are trained to recognise a serious problem and are available when needed.
- I have only had to use it once and I was given an appointment immediately.
- I might not have been so satisfied if I had not warranted an immediate appointment and had to wait a few days before seeing a doctor.