Supplementary File 2: COREQ Checklist

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| **Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist1** | |
| 1. Interviewer/ facilitator | The interviews were conducted by Mairead Murphy (MM), Andrew Turner (AT) and Anne Scott (AS). These three researchers plus Jeremy Horwood (JH) formed the qualitative research team. |
| 1. Credentials | All four researchers on the qualitative team have a PhD and substantial experience in qualitative research. |
| 1. Occupation | All members of the qualitative research team are researchers at the University of Bristol. Jeremy Horwood is an associate professor of qualitative research. Mairead Murphy is a research fellow. Andrew Turner is a senior research associate and Anne Scott is a research associate. |
| 1. Gender | MM and AS are female and JH and AT are male. |
| 1. Experience and Training | All researchers have undergone training in research governance and qualitative research at the University of Bristol. The research team have between 7 and 20 years’ experience in qualitative research, including leading qualitative studies. MM and JH were co-chief investigators of the study, which was peer reviewed and independently funded by the National Institute for Health Research. |
| 1. Relationship established | Prior to study commencement, the interviewers and the participants had no previous contact, apart from one or two GPs/practice managers who were known to AT/MM from previous research studies. Rapport was built before the interview started through the researcher explaining the study, answering any questions from participants and taking informed consent. Some participants were interviewed multiple times, which further enhanced rapport. |
| 1. Participant knowledge of the interviewer | When participants were recruited, they were provided with an information leaflet about the study. This provided the name of one of the interviewers (MM) as she was study co-chief investigator. Each researcher explained their background, and the reason for doing the study prior to the start of the interview. |
| 1. Interviewer characteristics | The three interviewers were white, British, university-educated, with non-clinical backgrounds. Qualitative research is alway influenced by the perspective of the researcher, but these characteristics should not have added particular bias. To add rigour to the analysis process, three interviewers discussed data in joint meetings at the end of each interview round with JH and agreed the themes coming out of that round. |
| 1. Methodological orientation and Theory | Thematic analysis was used for the data analysis. |
| 1. Sample | The sample consisted of GPs, practice managers and nurses from GP practices in Bristol, North Somerset and South Gloucestershire CCG who were working through the COVID-19 pandemic. We purposively sampled a range of practices across different locations, levels of deprivation, size and ethnicity mixes, to ensure maximum variation in relation to these variables. Within the practices, we recruited GPs, nurses and practice managers to get a range of different views. |
| 1. Method of approach | Participants were alerted to the study via an advertisement sent from the Clincial Commissioning Group. Participants then emailed the RAPCI study mailbox and received an email back from one of the three interviewers. To improve the diversity of the sample, some practices were specifically targeted, and participants in these practices were directly approached by the chief investiogator. |
| 1. Sample Size | 41 participants from 21 GP practices. |
| 1. Non-participation | We approached 25 practices and recruited 21. Sixteen of the practices approached sent an expression of interest in response to our study research information. We approached the remaining nine directly to make the sample more diverse. Recruiting participants from the other four practices would have improved our mix of practices in terms of deprivation, locality and current implementation of e-consultations.  In round 1, staff from 14 of the 21 recruited practices participated, as the remaining 7 had not yet been recruited. In the remaining rounds we interviewed at least one participant from 20 of the 21 practices in each round, although some skipped a round (see Table 1 in the main paper). One participant dropped out in round 4 due to time constraints (health center 4). |
| 1. Setting of Data Collection | Interviews were conducted by telephone |
| 1. Presence of non-participants | No |
| 1. Description of the sample | See Table 1 in the main paper. |
| 1. Interview guide | A brief interview guide was used, which was modified and refined in later interview rounds in response to preliminary data analysis. See Supplementary file 1. This was pilot tested with six University of Bristol academic GPs. |
| 1. Repeat interviews | We carried out repeat interviews. (See Table 1 in the main paper). |
| 1. Audio-/visual recording | We used audio recording to collect the data. |
| 1. Field notes | We carried out rapid coding of each interview into a framework, prior to transcription/rapid analysis, and interpretive notes were added to this framework as applicable. The interviews were all done by telephone, so the logging of participant expression, or other non-verbal cues was not applicable. |
| 1. Duration | The interviews lasted an average of 30 minutes. |
| 1. Data Saturation | The interviews were ongoing, and new themes emerged in each round as the situation was constantly changing. The notion of data saturation is therefore less applicable, as, had we continued interviewing, we would have identified more themes relevant to the later stage of the pandemic. Theoretical sufficiency is therefore a more applicable concept than data saturation in the case of this study, |
| 1. Transcripts returned | Transcripts were not returned to participants for comment or correction. |
| 1. Number of data coders | 3 |
| 1. Description of the coding tree | Analysis was structured around two broad themes: (1) When was face-to-fact contact necessary (2) How was face-to-face contact made possible. Within this, sub-themes were developed inductively to capture the different aspects of how these were achieved. These sub-themes are described by subheadings in the main paper. |
| 1. Derivation of themes | Themes were derived from the data. Interviews were audio-recorded, transcribed, anonymised, imported to QSR Nvivo 12 and thematically analysed. MM/AT/AS/JH established an initial coding framework and each researcher coded their own interviews within this framework. MM/AT/AS double-coded six interviews (two each) to ensure a coding consensus and maximise rigour. |
| 1. Software | QSR NVivo 12 was used to manage the thematic data |
| 1. Participant checking | Transcripts were not returned to participants for checking. Rapid reports on the findings were published and sent to practices. |
| 1. Quotations presented | Yes, participant quotations are presented to illustrate the themes. Each quotation is attributed to a participant identifier. |
| 1. Data and findings consistent | Yes. Data is presented against each theme in the form of quotations to support the findings. |
| 1. Clarity of major themes | Yes. These are presented in the main text. |
| 1. Clarity of minor themes | Yes. These are presented in the main text. |

1. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care : journal of the International Society for Quality in Health Care / ISQua* 2007;19(6):349-57. doi: 10.1093/intqhc/mzm042