PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Digital NHS Wales: A Coding Reliability Analysis based on the Voices of 22,978 Patients & Clinicians on the Benefits, Challenges & Sustainability of Video Consulting.
AUTHORS	Johns, Gemma; Whistance, Bethan; Khalil, Sara; Whistance, Megan; Thomas, Bronwen; Ogonovsky, Mike; Ahuja, Alka

VERSION 1 – REVIEW

REVIEWER	Feijt, Milou University of Technology Eindhoven
REVIEW RETURNED	17-Oct-2021

GENERAL COMMENTS	Dear authors, Thank you for the invitation to review this manuscript. The study is timely and very well-written. The large amount of qualitative data offers a unique opportunity to provide new insights in the experiences of VC in mental health care. I have reviewed a similar (but quantitatively focused) paper on this topic authored by mostly the same researchers, and my comments somewhat resemble those: 1. In general, I again feel both the introduction and the discussion are quite one-sidedly positive about the use of VC in mental healthcare. I miss some nuances about the concerns that many practitioners and patients have, which have been reported in many other publications on this topic. 2. As I am not familiar with NHS Wales, it was not clear to me what the sample characteristics are in terms of job functions and types of provided care. Also demographic characteristics are not provided in the paper itself. I assume they are provided in the Appendices that are mentioned in Design, Setting, Participants, but these were not provided with the manuscript so I could not check. Please provide the appendices or describe the sample characteristics with more details in the manuscript. 3. In the Methods you acknowledge the potential bias towards more 'positive' and 'negative' responses and explain that TEC Cymru followed an approach to limit this "TEC Cymru follow a phased approach to their evaluation and research, which involves a discovery phase, two evaluation phases and a research phase, thus providing ample opportunity across their digital interventions to explore a wider range of methodologies and study types." For me, this was a very vague description. I understand this is done due to space limitations - as you describe that further information

	is available on our website - but as this is a very important point to my opinion and I would suggest clarifying this more in the paper itself. 4. In the Measures section you describe that "The qualitative feedback was retrieved from questions on use, value, benefits and challenges of using VC." However, looking at the surveys at the end of the document, I see only a few text boxes, and none specifically asking for use, value, benefits, and challenges. Actually, the only textbox that seems relevant to me is the Comments box after the first question: "Please rate the quality of your video consultation?" To me, this is quite a different question than on use, value, benfits, and challenges. Is this indeed the question that is used to gather the free-text data? I would suggest being more explicit about the question(s) that was/were used to gather the data. 5. Statistical Methods: I feel this section should provide more details on the followed procedure for the thematic analysis. Which type of thematic analysis did you exactly use (including references)? And what was the interrater reliability? 6. In the Results section, one of the subthemes is: "Ease & Unique Opportunities". Personally, I felt the unique opportunity described in this subtheme belongs more to Theme 3: The Benefits of Video Consulting, as this theme exactly described (other) such unique benefits of VC. I would suggest renaming this subtheme and moving it to Theme 3. 7. As briefly mentioned in my first comment, I feel the Discussion could be more balanced, for example by reflecting on how the current - remarkably positive - results relate to other studies that were much less praising of VC. Also, I miss any notion of what the influence of the COVID-19 pandemic could be on these experiences. For example, in our studies we found that practitioners were positive about VC in the sense that they were glad that there was at least some way of providing care possible, but they would never prefer it in a 'normal' world without distancing measures. I hope my comments are clear and received in good order. I look forward to receiving and reviewing your revised manuscript. Kind regards

REVIEWER	Gallo, Gaetano University of Catanzaro
REVIEW RETURNED	12-Jan-2022

GENERAL COMMENTS	This is an interesting original article regarding videoconsultation. I have the following comments: - During the COVID-19 pandemic the need to implement telemedicine systems was evident around the world. This article further highlights this need - On the basis of what was the study designed? What is the background regarding its realization?

	- The authors established a "6-month period (September 2020 and March 2021)." However, some lines after "From the 22,978 patient and clinician responses captured during September 2020 and February 2021" - The present study discusses the most interesting points regarding the use of VC. However, no statistical analysis has been applied and the items contain extremely generic and often not objectivable evaluations The clinical implications of the study must underlined - I would improve the discussion on two key points: 1) the possibility of avoiding a trip and economic savings; 2) the need to mend the use of VC on some pathologies and not on everything. In this context, I recommend reading and considering the following articles: - Video consultation during follow up care: effect on quality of care and patient- and provider attitude in patients with colorectal cancer. Surg Endosc. 2021 Mar;35(3):1278-1287. doi: 10.1007/s00464-020-07499-3 - Measuring patient satisfaction with video consultation: a systematic review of assessment tools and their measurement properties. Int J Technol Assess Health Care. 2020 Jun 23:1-7. doi: 10.1017/S0266462320000367 - E-consensus on telemedicine in proctology: A RAND/UCLA-modified study. Surgery. 2021 Aug;170(2):405-411. doi: 10.1016/j.surg.2021.01.049. Epub 2021 Mar 22. PMID: 33766426. - Virtually Perfect? Telemedicine for Covid-19. N Engl J Med. 2020 Apr 30;382(18):1679-1681. doi: 10.1056/NEJMp2003539

REVIEWER	Assing Hvidt, Elisabeth Syddansk Universitet Det Sundhedsvidenskabelige Fakultet, Department of Public Health
REVIEW RETURNED	20-Jan-2022

GENERAL COMMENTS	Digital NHS Wales: A Qualitative Thematic Analysis based on the Voices of 22,978 Patients & Clinicians on the Benefits, Challenges & Sustainability of Video Consulting. Thank you for giving me the opportunity to review this highly topical paper reflecting an impressive, large-scale research study that adds to international research on perceived benefits and challenges connected to video consulting across health care settings. There are some philosophical and methodological issues that need to be addressed. Specifically, I think it is necessary that the authors reflect more on, and explicitly state, which paradigm this study represents. As it is, there is no engagement with the philosophical assumptions that underlie the study, that have had clear implications for the methodological procedures. In the title, and throughout the paper, the study design is described as “qualitative”. Of course, different conceptualizations of qualitative research exist. However, I would like to problematize the qualitative nature of this study, including the data collection method and analytical strategy as “qualitative”. As a minimum, the authors need to made clear that in this research context TA is used within a post-positivist/quantitative paradigm (as opposed to qualitative, interpretative paradigm) in which a whole other set of quality standards exist than

within a qualitative paradigm. You might want to consult Braun and Clark's article: Virginia Braun & Victoria Clarke (2021) One size fits all? What counts as quality practice in (reflexive) thematic analysis?, Qualitative Research in Psychology, 18:3, 328-352, DOI: 10.1080/14780887.2020.1769238.
Also, you use positivist/quantitative terminology such as "outcome measures", "statistical methods", "validation check" which signals a paradigmatic confusion.
I am aware of the fact that TA is said to offer great flexibility in terms of use and that data-sets can range from in-depth interviews to short comments to open-ended survey-questions. Because of this wide range of use it is necessary to reflect on the approach used in order to avoid confusion.

Analysis:
Related hereto: what is the reference you use when you refer to TA? And what were your analytical procedures? You describe that data was extracted, coded manually and entered into an excel spread sheet where themes "emerged" using TA. There is a lacking clarity as to how the codes and subsequent themes were developed (themes do not "emerge") and which assumptions of the researchers that influenced this development of themes. Was the analysis purely inductive or inspired by existing research, theory? What were the professional background of the three members/coders? And which methods did you use to ensure quality and rigour? I do not understand what "a 20% validation check" signifies?

Introduction:
The introduction and background literature should highlight to the reader what are the key issues relating to VC in health care before and during the pandemic. As it stands this is very weak and provides a one-sided and much too positive review of the successes of VC across health care settings.

Setting: Could you please add, somewhere in the paper (perhaps in the limitations section) your thoughts about what the implications were of including, and analyzing together, data deriving from a very broad health care setting? Are contextual differences not being overlooked?

Methods:
For patient public involvement probably worth saying why no PPI was conducted, even if it was beyond scope of the study/funding.

Findings:
The themes (that are perhaps more like "topics", if you adhere to Braun and Clarkes' TA framework, see the above-mentioned TA reference (Braun & Clarke)) seem to be presented in an arbitrary order. Is there a kind of logic behind the order of presentation? Did you follow the order of items in the survey? And how are they delimited from one another? For example:
Theme 3: The benefits of video consulting: I wonder if this thematization is not so broad that it covers the other preceding themes? Is it not a benefit of video consulting that linking up to others becomes an opportunity? Or that VC helps the patients communicate effectively? In other words: how do you delimit this theme from the others?
Theme 4.1.: Technical quality: how is this theme delimited from: "Ease of use"?

The theme: "Ease of lived experience" – the term "lived experience" alludes to a phenomenological lifeworld-understanding, thus a theoretical interpretation of the data. Could you maybe elaborate a bit on this in the text? Or: In order for the themes to look alike, and represent the same level of abstraction, I suggest that you rename this theme and make it more theoretically "neutral"/empirical (in line with the other themes).

1.3: Ease & unique opportunities: since this theme refers to only one opportunity, and not several, i.e., of linking up others to the video call, you might want to specify this in the theme, simply by adding: "Ease & unique opportunity of linking up to others".

Theme 5.2: Patient wants and needs: you refer to patients stating that they would prefer face-to-face as opposed to VC, but do not go into more detail. Could you explain these patient

	preferences? Why would they prefer this? Is it the case that the convenience aspect of VC outweighs these stated preferences of f-t-f consultations? In all situations or only in some, non-acute cases? Discussion You write: …"22,978 clinician and patient submissions provided rich and meaningful data." Meaningful in what way? Could you elaborate on the perceived meaningfulness of the data? I would problematize, with all due respect, the richness of this kind of data (re)presentation. I am also not sure whether you could characterize your analysis as "in-depth". The qualitative, interpretative level of the analysis is weak. Each quote lacks contextualization as is naturally the case when you "pool" short open-ended survey comments. This is not to say that the study does not have strengths - but on a quantitative level. It elaborates the findings from the cross-sectional study on a population level, but hardly on an individual, in-depth level. The authors need to reflect on this, as also mentioned above in connection with research paradigm and philosophical positioning, in the introduction, discussion and limitations sections. Covid-19 In the findings there is hardly any mention of the Covid-19 situation. The reader is left in the dark in terms of understanding how Covid-19 has had an impact on how patients and professionals have perceived use of video consultation. It would be great if you could pull this out some more and it would be good to understand which elements of experience are more influenced by Covid-19 than others. Digital divide Nowhere in the article is there a mention of the digital divide or digital poverty. One would think that one of your themes: "Video Consulting is Not for Everyone" touches on this aspect, but it does not. It seems to me, that you try to cover this subject implicitly by referring to increased technological support for future VC users? This seems a bit superficial, considering the evidence about "Covid-19 is magnifying the digital divide". See for example. BMJ. https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fblogs.bmj.com%2Fbmj%2F2020%2F09%2F01%2Fcovid-19-is-magnifying-the-digital-divide%2F&data=04%7C01%7Cehvidt%40health.sdu.dk%7Cd46b09cddce941bf3da908d9aa84fb3a%7C9a97c27db83e4694b35354bdbf18ab5b%7C0%7C0%7C637728310410429682%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=jWkF34DsMtKHkEq3mjpwJjqPgy1VSGgQaHQpzzcYwls%3D&reserved=0 The reader lacks a consideration of this if not in the findings, then at least in the discussion. Overall, the current article lacks a more reflective and critical eye in respect to paradigmatic approach and also in terms of study object (video consulting). Introducing VC in health care is not without challenges and unintended consequences. The authors need to consider these challenges more - both in the introduction, discussion, and conclusion.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:
Dear authors,
Thank you for the invitation to review this manuscript. The study is timely and very well-written. The large amount of qualitative data offers a unique opportunity to provide new insights in the experiences of VC in mental health care.

Response: Thank you, our narrative data is extensive as it covers professions and specialities across all NHS services in Wales. While mental health services are covered within the data, this manuscript does not focus on one area specifically.

I have reviewed a similar (but quantitatively focused) paper on this topic authored by mostly the same researchers, and my comments somewhat resemble those:

1. In general, I again feel both the introduction and the discussion are quite one-sidedly positive about the use of VC in mental healthcare. I miss some nuances about the concerns that many practitioners and patients have, which have been reported in many other publications on this topic.

Response: Thank you for highlighting that both the introduction and discussion took a far more positive perspective than they should have when considering experience of VC. We have now edited this to reflect a more balanced approach and explore the nuanced differences that can occur when using VC. I would like to note that this manuscript is not a paper exploring standalone mental healthcare, but a number of NHS services across Wales.

2. As I am not familiar with NHS Wales, it was not clear to me what the sample characteristics are in terms of job functions and types of provided care. Also demographic characteristics are not provided in the paper itself. I assume they are provided in the Appendices that are mentioned in Design, Setting, Participants, but these were not provided with the manuscript so I could not check. Please provide the appendices or describe the sample characteristics with more details in the manuscript.

Response: Thank you for flagging these issues surrounding characteristics and demographics information, we have now included this information within our Appendices.

3. In the Methods you acknowledge the potential bias towards more 'positive' and 'negative' responses and explain that TEC Cymru followed an approach to limit this "TEC Cymru follow a phased approach to their evaluation and research, which involves a discovery phase, two evaluation phases and a research phase, thus providing ample opportunity across their digital interventions to explore a wider range of methodologies and study types." For me, this was a very vague description. I understand this is done due to space limitations - as you describe that further information is available on our website - but as this is a very important point to my opinion and I would suggest clarifying this more in the paper itself.

Response: Thank you for highlighting this, we have now added our evaluation framework as a supplement file within our uploads. We follow this phased approach using service evaluation and research combining many methodologies. While we appreciate the importance you have put on this, we have decided against detailing this in-depth due to the small relevance to the study itself. We are happy to take out all information relating to this if it is misleading.

4. In the Measures section you describe that "The qualitative feedback was retrieved from questions on use, value, benefits and challenges of using VC." However, looking at the surveys at the end of the document, I see only a few text boxes, and none specifically asking for use, value, benefits, and challenges. Actually, the only textbox that seems relevant to me is the Comments box after the first question: "Please rate the quality of your video consultation?" To me, this is quite a different question than on use, value, benfits, and challenges. Is this indeed the question that is used to gather the free-text data? I would suggest being more explicit about the question(s) that was/were used to gather the data.

Response: For the purpose of this study, we were only interested in the free text narrative box responses. The quantitative data can be found in the supplements attached to the study.

5. Statistical Methods: I feel this section should provide more details on the followed procedure for the thematic analysis. Which type of thematic analysis did you exactly use (including references)? And what was the interrater reliability?

Response: Thank you for your comment, we have since clarified reflexive thematic analysis was the procedure followed, using the steps outlined by Braun and Clark (2006). To tackle interrater reliability,

all coding was submitted to a 20% validation check completed by the clinical lead and lead author, in which they each reviewed 20% of the coded work to ensure that the raters were reliable.
6. In the Results section, one of the subthemes is: "Ease & Unique Opportunities". Personally, I felt the unique opportunity described in this subtheme belongs more to Theme 3: The Benefits of Video Consulting, as this theme exactly described (other) such unique benefits of VC. I would suggest renaming this subtheme and moving it to Theme 3.
Response: Thank you for your highlighting this issue, we have since re-evaluated this sub-topic and altered the wording so that it is clear that opportunities for unique collaboration is something that is an easy thing to do using VC.
7. As briefly mentioned in my first comment, I feel the Discussion could be more balanced, for example by reflecting on how the current - remarkably positive - results relate to other studies that were much less praising of VC.
Response: Thank you for highlighting this important point, we have since developed the discussion to give a more balanced reflection on the use of VC, including some of the challenges patients and clinicians face when using it.

8. Also, I miss any notion of what the influence of the COVID-19 pandemic could be on these experiences. For example, in our studies we found that practitioners were positive about VC in the sense that they were glad that there was at least some way of providing care possible, but they would never prefer it in a 'normal' world without distancing measures.
Response: We have now added how the COVID-19 influenced the uptake and use of VC at the start of the pandemic and how it has been evaluated continuously since.

I hope my comments are clear and received in good order. I look forward to receiving and reviewing your revised manuscript.

Reviewer: 2
I have the following comments:
1. During the COVID-19 pandemic the need to implement telemedicine systems was evident around the world. This article further highlights this need
Response: Thank you for highlighting this, we have now added how the COVID-19 influenced the need to implement VC at the start of the pandemic and how it has been evaluated continuously since.
2. On the basis of what was the study designed? What is the background regarding its realization?
Response: This manuscript is a section of a wider evaluation that has been running since the implementation of VC within Wales. It was important to us to hear more of these experiences and add to the VC background, and how these experiences could help to add to further changes of VC in the future.
3. The authors established a "6-month period (September 2020 and March 2021)."
However, some lines after "From the 22,978 patient and clinician responses captured during September 2020 and February 2021"
Response: This had now been changed to March 2021 to reflect the comment.
4. The present study discusses the most interesting points regarding the use of VC. However, no statistical analysis has been applied and the items contain extremely generic and often not objectivable evaluations
The clinical implications of the study must underlined
Response: We have now clarified within the manuscript that for the purpose of this data, we were only using the free-text narrative boxes and therefore not using the quantitative elements. We hope that this now reads better and leads to less confusion.
For clinical implications, we have now added within the discussion section that work surrounding clinical implications is underway within our wider research including mental health and sexual health studies. Due to word limit restraints, we have been unable to expand on this within the manuscript and is separate to discussing the experiences of patients and clinicians.

5. I would improve the discussion on two key points: 1) the possibility of avoiding a trip and economic savings; 2) the need to mend the use of VC on some pathologies and not on everything.
In this context, I recommend reading and considering the following articles:
Response: Thank you for your comment, we have since included the possibility of avoiding a trip under the sub-topic of 'time saved', with narrative surrounding 'travel time' that was saved when undertaking a VC appointment rather than face-to-face. We have also amended how the use of VC might not be suitable for all patients and clinical situations under the sub-topic 'Video Consulting is not for everyone and everything.'
- Video consultation during follow up care: effect on quality of care and patient- and provider attitude in patients with colorectal cancer. Surg Endosc. 2021 Mar;35(3):1278-1287. doi: 10.1007/s00464-020-07499-3

- Measuring patient satisfaction with video consultation: a systematic review of assessment tools and their measurement properties. Int J Technol Assess Health Care. 2020 Jun 23:1-7. doi: 10.1017/S0266462320000367

- E-consensus on telemedicine in proctology: A RAND/UCLA-modified study. Surgery. 2021 Aug;170(2):405-411. doi: 10.1016/j.surg.2021.01.049. Epub 2021 Mar 22. PMID: 33766426.

- Virtually Perfect? Telemedicine for Covid-19. N Engl J Med. 2020 Apr 30;382(18):1679-1681. doi: 10.1056/NEJMp2003539

Reviewer: 3
Comments to the Author:
Digital NHS Wales: A Qualitative Thematic Analysis based on the Voices of 22,978 Patients & Clinicians on the Benefits, Challenges & Sustainability of Video Consulting.
Thank you for giving me the opportunity to review this highly topical paper reflecting an impressive, large-scale research study that adds to international research on perceived benefits and challenges connected to video consulting across health care settings.
Thank you!
There are some philosophical and methodological issues that need to be addressed.
1. Specifically, I think it is necessary that the authors reflect more on, and explicitly state, which paradigm this study represents. As it is, there is no engagement with the philosophical assumptions that underlie the study, that have had clear implications for the methodological procedures.
Response: We apologise again for referring to the analysis as a qualitative analysis and have since amended the methodology to reflect the basic narrative analysis used.

2. In the title, and throughout the paper, the study design is described as "qualitative". Of course, different conceptualizations of qualitative research exist. However, I would like to problematize the qualitative nature of this study, including the data collection method and analytical strategy as "qualitative". As a minimum, the authors need to made clear that in this research context TA is used within a post-positivist/quantitative paradigm (as opposed to qualitative, interpretative paradigm) in which a whole other set of quality standards exist than within a qualitative paradigm. You might want to consult Braun and Clark's article: Virginia Braun & Victoria Clarke (2021) One size fits all? What counts as quality practice in (reflexive) thematic analysis?, Qualitative Research in Psychology, 18:3, 328-352, DOI: 10.1080/14780887.2020.1769238.
Response: Thank you for highlighting this. We have now changed how we termed our analysis and refer to it as a reflexive thematic analysis using Braun and Clarke (2006) as we understand we have misused the term qualitative and are now using patient and clinician feedback narrative, as it is more of a narrative.

3. Also, you use positivist/quantitative terminology such as “outcome measures”, “statistical methods”, “validation check” which signals a paradigmatic confusion. I am aware of the fact that TA is said to offer great flexibility in terms of use and that data-sets can range from in-depth interviews to short comments to open-ended survey-questions. Because of this wide range of use it is necessary to reflect on the approach used in order to avoid confusion.
Response: We have since clarified within the manuscript that the data we are using within this study are free-text narrative boxes and hope this has reduced confusion.

Analysis:
4. Related hereto: what is the reference you use when you refer to TA? And what were your analytical procedures? You describe that data was extracted, coded manually and entered into an excel spread sheet where themes “emerged” using TA. There is a lacking clarity as to how the codes and subsequent themes were developed (themes do not “emerge”) and which assumptions of the researchers that influenced this development of themes. Was the analysis purely inductive or inspired by existing research, theory? What were the professional background of the three members/coders? And which methods did you use to ensure quality and rigour? I do not understand what “a 20% validation check” signifies?
Response: Thank you for your comment, we have since clarified reflexive thematic analysis was the procedure followed, using the steps outlined by Braun and Clark (2006). We have removed the term ‘emerged’ and replaced it with ‘materialised,’ as the more coding that was completed, more correlating topics materialised, and corresponding quotes were put into their topics. The three coders are experienced researchers, and all coding was submitted to a 20% validation check completed by the clinical lead and lead author, in which they each reviewed 20% of the coded work to ensure that the raters were reliable.

5. Introduction:
The introduction and background literature should highlight to the reader what are the key issues relating to VC in health care before and during the pandemic. As it stands this is very weak and provides a one-sided and much too positive review of the successes of VC across health care settings.
Response: We have now revised the introduction and have included challenges that were reported from both clinicians and patients when using VC to ensure experiences are explored on a whole.

6. Setting: Could you please add, somewhere in the paper (perhaps in the limitations section) your thoughts about what the implications were of including, and analyzing together, data deriving from a very broad health care setting? Are contextual differences not being overlooked?
Response: A paragraph within the limitations has now been added surrounding the reasons why the data set is being presented as a whole and regrouped. We believe that no contextual differences are being overlooked due to previous work having already broken down the data.

Methods:
7. For patient public involvement probably worth saying why no PPI was conducted, even if it was beyond scope of the study/funding.
Response: Thank you for highlighting this. We have now added within the manuscript the reasons for no PPI during the study.

Findings:
8. The themes (that are perhaps more like “topics”, if you adhere to Braun and Clarkes’ TA framework, see the above-mentioned TA reference (Braun & Clarke)) seem to be presented in an arbitrary order. Is there a kind of logic behind the order of presentation? Did you follow the order of items in the survey? And how are they delimited from one another? For example: Theme 3: The benefits of video consulting: I wonder if this thematization is not so broad that it covers the other

preceding themes? Is it not a benefit of video consulting that linking up to others becomes an opportunity? Or that VC helps the patients communicate effectively? In other words: how do you delimit this theme from the others?
Response: On reflection, and since changing the methodology we have now removed the use of the term 'theme' and replaced with topics and sub-topics. We have used Braun and Clarke (2006) and analysed in order of the questions but reported in number of responses first. Our benefit topic is standalone to ease and opportunities as within the analysis, these were distinctively different.

9. Theme 4.1.: Technical quality: how is this theme delimited from: "Ease of use"?
Response: Thank you for your comment surrounding ease of use and technical quality. Within informatics, ease of use and technical quality are considered separately, however we are happy to change the title if needed to avoid confusion.

10. The theme: "Ease of lived experience" – the term "lived experience" alludes to a phenomenological lifeworld-understanding, thus a theoretical interpretation of the data. Could you maybe elaborate a bit on this in the text? Or: In order for the themes to look alike, and represent the same level of abstraction, I suggest that you rename this theme and make it more theoretically "neutral"/empirical (in line with the other themes).
Response: Thank you for your comment, our apologies, we have removed 'lived' from the sub-topic to avoid confusion.

11. 1.3: Ease & unique opportunities: since this theme refers to only one opportunity, and not several, i.e., of linking up others to the video call, you might want to specify this in the theme, simply by adding: "Ease & unique opportunity of linking up to others".
Response: Thank you for your comment, we have since re-evaluated this sub-topic and altered the wording so that it is clear that opportunities for unique collaboration is something that is an easy thing to do using VC.

12. Theme 5.2: Patient wants and needs: you refer to patients stating that they would prefer face-to-face as opposed to VC, but do not go into more detail. Could you explain these patient preferences? Why would they prefer this? Is it the case that the convenience aspect of VC outweighs these stated preferences of f-t-f consultations? In all situations or only in some, non-acute cases?
Response: We have now added further detail surrounding preference. When reflecting on preference, we can see why VC would be a preference due to the many reported benefits, and limited challenges. We have also discussed in more detail within the manuscript that VC may not be suitable for every patient or appointment type, and therefore it is important to consider these nuances.

Discussion
13. You write: …"22,978 clinician and patient submissions provided rich and meaningful data." Meaningful in what way? Could you elaborate on the perceived meaningfulness of the data?
Response: Thank you for highlighting this, we have since removed 'meaningful' from the report, replacing it with more accurate descriptions of 'vast and overall.' It was originally included as this is the first time this type of work has been done in Wales.

14. I would problematize, with all due respect, the richness of this kind of data (re)presentation. I am also not sure whether you could characterize your analysis as "in-depth". The qualitative, interpretative level of the analysis is weak. Each quote lacks contextualization as is naturally the case when you "pool" short open-ended survey comments.
Response: We have now amended the methods to suit the approach we took and have removed the language around richness and the analysis being in-depth. Due to the large sample size of 22,978 responses, it was not possible to report on an individual level, though the comments individually analysed, there proved to be similarities in the comments and so we were able to appropriate the

comments on a larger scale. These similarities ran from one patient to another, regardless of demographic status.

15. This is not to say that the study does not have strengths - but on a quantitative level. It elaborates the findings from the cross-sectional study on a population level, but hardly on an individual, in-depth level. The authors need to reflect on this, as also mentioned above in connection with research paradigm and philosophical positioning, in the introduction, discussion and limitations sections.
Response: Similarly, to comment 14 above, due to the large sample size of 22,978 responses, it was not possible to report on an individual level, though the comments individually analysed, there proved to be similarities in the comments and so we were able to appropriate the comments on a larger scale. In terms of paradigms, we have altered the methodology to reflect that of a more reflexive approach.

Covid-19
16. In the findings there is hardly any mention of the Covid-19 situation. The reader is left in the dark in terms of understanding how Covid-19 has had an impact on how patients and professionals have perceived use of video consultation. It would be great if you could pull this out some more and it would be good to understand which elements of experience are more influenced by Covid-19 than others.
Response: Thank you for highlighting this, we have now added how the COVID-19 influenced the need to implement VC at the start of the pandemic and how it has been evaluated continuously since. We have also included a quote in 'Convenience, Safety and Home Comforts,' that relates to a vulnerable patient being able to access care during the pandemic.

Digital divide
17. Nowhere in the article is there a mention of the digital divide or digital poverty. One would think that one of your themes: "Video Consulting is Not for Everyone" touches on this aspect, but it does not. It seems to me, that you try to cover this subject implicitly by referring to increased technological support for future VC users? This seems a bit superficial, considering the evidence about "Covid-19 is magnifying the digital divide". See for example.
BMJ. https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fblogs.bmj.com%2Fbmj%2F2020%2F09%2F01%2Fcovid-19-is-magnifying-the-digital-divide%2F&data=04%7C01%7Cehvidt%40health.sdu.dk%7Cd46b09cddce941bf3da908d9aa84fb3a%7C9a97c27db83e4694b35354bdbf18ab5b%7C0%7C0%7C637728310410429682%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=jWkF34DsMtKHkEq3mjpwJjqPgy1VSGgQaHQpzzcYwls%3D&reserved=0The reader lacks a consideration of this if not in the findings, then at least in the discussion.
Response: Thank you for this comment, we understand the importance of including discussion surrounding the digital divide. This has been addressed in the discussion.

18. Overall, the current article lacks a more reflective and critical eye in respect to paradigmatic approach and also in terms of study object (video consulting). Introducing VC in health care is not without challenges and unintended consequences. The authors need to consider these challenges more - both in the introduction, discussion, and conclusion.
Response: Thank you for this comment, we have since made the introduction, discussion and conclusion more balanced by including some challenges associated with VC from the data.

VERSION 2 – REVIEW

REVIEWER	Feijt, Milou University of Technology Eindhoven
REVIEW RETURNED	02-Mar-2022

GENERAL COMMENTS	Dear authors, Thank you for this revised manuscript. In general, I feel most of my comments were addressed satisfactorily and the manuscript provides a clearer description of your study design and results and a more balanced view on VC. I have one major comment left, which concerns the section describing the thematic analysis. In response to my earlier request to specify which kind of thematic analysis you used and which procedure you followed, the manuscript describes you have performed a reflexive thematic analysis following Braun and Clarke (2006). However, in the procedure you describe, it seems like you took more of a coding reliability approach such as Boyatzis (1998) or Guest et al. (2012), characterized by the creation of a codebook and a coder reliability check, which are explicitly not part of the reflexive TA outlined by Braun and Clarke, as they elaborate upon in their later work (see for example Braun & Clarke, 2019). In addition, your themes seem to be more conceptualized as domain summaries instead of meaning-based patterns, also a common difference between coding reliability TA and reflexive TA Please reconsider which type of thematic analysis you applied and adjust your text and references accordingly. Also, as a minor detail, as far as I know, it is uncommon to use references in the abstract, but this could be different for BMJ Open. Good luck with the rest of the process. Some references to consider: - Boyatzis, R. E. 1998. Transforming Qualitative Information: Thematic Analysis and Code Development. Thousand Oaks, CA: Sage. - Guest, G., MacQueen, K. M., & Namey, E. E. (2012). Introduction to applied thematic analysis. Applied thematic analysis, 3(20), 1-21. - Braun, V. & Clarke, V. (2019) Reflecting on reflexive thematic analysis, Qualitative Research in Sport, Exercise and Health, 11:4, 589-597, DOI: 10.1080/2159676X.2019.1628806

REVIEWER	Gallo, Gaetano University of Catanzaro
REVIEW RETURNED	23-Feb-2022

GENERAL COMMENTS	The authors improved the manuscript. There remain many limitations such as the absence of an adequate statistical analysis. Furthermore, I have suggested the following quotes which are pertinent to the topic under consideration and have not been added and discussed.

	- Video consultation during follow up care: effect on quality of care and patient- and provider attitude in patients with colorectal cancer. Surg Endosc. 2021 Mar; 35 (3): 1278-1287. doi: 10.1007 / s00464- 020-07499-3 - Measuring patient satisfaction with video consultation: a systematic review of assessment tools and their measurement properties. Int J Technol Assess Health Care. 2020 Jun 23: 1-7. doi: 10.1017 / S0266462320000367 - E-consensus on telemedicine in proctology: A RAND / UCLA-modified study. Surgery. 2021 Aug; 170 (2): 405-411. doi: 10.1016 / j.surg.2021.01.049. Epub 2021 Mar 22. PMID: 33766426. - Virtually Perfect? Telemedicine for Covid-19. N Engl J Med. 2020 Apr 30; 382 (18): 1679-1681. doi: 10.1056 / NEJMp2003539

VERSION 2 – AUTHOR RESPONSE

Reviewer: 2
Dr. Gaetano Gallo, University of Catanzaro
Comments to the Author:
The authors improved the manuscript. There remain many limitations such as the absence of an adequate statistical analysis.
Furthermore, I have suggested the following quotes which are pertinent to the topic under consideration and have not been added and discussed.
Thank you. We have removed the title 'statistical methods' as no statistical work was carried out on the data due to its narrative nature and have amended to analysis to reduce confusion. We have also added and discussed the suggested literature where appropriate.

- Video consultation during follow up care: effect on quality of care and patient- and provider attitude in patients with colorectal cancer. Surg Endosc. 2021 Mar; 35 (3): 1278-1287. doi: 10.1007 / s00464-020-07499-3
- Measuring patient satisfaction with video consultation: a systematic review of assessment tools and their measurement properties. Int J Technol Assess Health Care. 2020 Jun 23: 1-7. doi: 10.1017 / S0266462320000367
- E-consensus on telemedicine in proctology: A RAND / UCLA-modified study. Surgery. 2021 Aug; 170 (2): 405-411. doi: 10.1016 / j.surg.2021.01.049. Epub 2021 Mar 22. PMID: 33766426.
- Virtually Perfect? Telemedicine for Covid-19. N Engl J Med. 2020 Apr 30; 382 (18): 1679-1681. doi: 10.1056 / NEJMp2003539

Reviewer: 1
Dr. Milou Feijt, University of Technology Eindhoven
Comments to the Author:
Dear authors,

Thank you for this revised manuscript. In general, I feel most of my comments were addressed satisfactorily and the manuscript provides a clearer description of your study design and results and a more balanced view on VC.

I have one major comment left, which concerns the section describing the thematic analysis. In response to my earlier request to specify which kind of thematic analysis you used and which procedure you followed, the manuscript describes you have performed a reflexive thematic analysis following Braun and Clarke (2006). However, in the procedure you describe, it seems like you took more of a coding reliability approach such as Boyatzis (1998) or Guest et al. (2012), characterized by the creation of a codebook and a coder reliability check, which are explicitly not part of the reflexive TA outlined by Braun and Clarke, as they elaborate upon in their later work (see for example Braun & Clarke, 2019). In addition, your themes seem to be more conceptualized as domain summaries instead of meaning-based patterns, also a common difference between coding reliability TA and reflexive TA

Thank you for the further comments surrounding the type of thematic analysis used within our manuscript. We have adjusted the text and references to ensure it reflects the more accurately represented coding reliability approach.
Please reconsider which type of thematic analysis you applied and adjust your text and references accordingly.
Also, as a minor detail, as far as I know, it is uncommon to use references in the abstract, but this could be different for BMJ Open.

Thank you for highlighting this error, this has now been removed.

Good luck with the rest of the process.

Some references to consider:
- Boyatzis, R. E. 1998. Transforming Qualitative Information: Thematic Analysis and Code Development. Thousand Oaks, CA: Sage.
- Guest, G., MacQueen, K. M., & Namey, E. E. (2012). Introduction to applied thematic analysis. Applied thematic analysis, 3(20), 1-21.
- Braun, V. & Clarke, V. (2019) Reflecting on reflexive thematic analysis, Qualitative Research in Sport, Exercise and Health, 11:4, 589-597, DOI: 10.1080/2159676X.2019.1628806

VERSION 3 – REVIEW

REVIEWER	Feijt, Milou University of Technology Eindhoven
REVIEW RETURNED	24-Mar-2022

GENERAL COMMENTS	Dear authors, Thank you for taking my comments into consideration and adjusting the manuscript as such. In my opinion, the manuscript satisfies the requirements for publication now. Only one minor detail, I would recommend to add a reference to the coding reliability approach that you used, as even within this approach there are slight differences between authors and also to facilitate the reader for further reading. Good luck with the rest of the process.