University of BRISTOL

Qualitative Research - reflections from the field

Fiona MacKichan & Leila Rooshenas

The Sunday Telegraph

A&E is 'grinding to a halt'

Ambulance bosses warn of crisis putting lives at risk in letters seen by Telegraph

LAURA HAS A TASTE FOR WIMBLEDON GLORY

Royal College of Physicians

Setting higher standards

Hospitals on the edge? The time for action

A report by the Royal College of Physicians

September 2012

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BRITAIN'S FIRST AND ONLY CONCISE QUALITY NEWSPAPER

30p

The essential daily briefing

Poppy mania: designer tells i why he doesn't like crowds

SPECIAL REPORT

NHS hits breaking point

- A&E has worst week on record as hospitals cancel operations and turn away patients
- Cuts to elderly care blamed for putting impossible strain on health service
- 39,000 people left to wait on trolleys for up to 12 hours despite mild weather

HOMELESS VETERANS

Channing Tatum

PLUS DAILY CROSSWORD | DAILY PUZZLE PAGE

Ultimate 5:2 diet for her – and HIM

Daily Mail

Most inspiring Fast Diet success stories ever

A&E CRISIS WORST FOR TEN YEARS

- Casualty units turning away sick
- Patients treated in car park tents
- Chaos blamed on Labour's GP contract

The Sun

I was too fat for sex

CAMPING from just £1

SHOCK SUN INVESTIGATION

CRITICAL

- NHS in crisis as budgets cut
- A&E swamped, long waits for GP
- More of us on prescription pills
- Docs warn of care 'timebomb'

DAILY Mirror

250MPH jet stream storm to batter Britain

Filling foods that'll make you slimmer

HOSPITALS GO INTO MELTDOWN

OUR NHS IS DYING

'Nurses are crying, doctors are quitting and we don't have beds for patients...'

EXCLUSIVE

TERRIFYING REPORT FROM A TOP DOCTOR ON THE FRONT LINE

nuffieldtrust

WHAT'S BEHIND THE A&E 'CRISIS'?

What features of primary care are associated with use of unscheduled secondary care?

Phase 1: Systematic Review

Huntley et al BMJ 2014

1. Continuity of care – being able to see the same practitioner, but no evidence for policy change
2. Access – no overall pattern (UK/Europe cf US)
3. Organisational features / quality of care – inconclusive (complexity)

Phase 2: Quant analysis

1. Practice location (urban)
2. Continuity preference (being able to speak with /see preferred GP)
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4. Access (not able to make a GP appointment')

Phase 3: ethnographic case studies

- Six GP practices in three CCG areas
- Observation over a week
- Informal and formal interviews with staff
- Documentary evidence
- Interviews with patients and carers (recent USC use)

Case studies – accessing the field

- How to sample practices?
  - Routine data
  - Insight from PCRNs / local contacts
- Ethics
  - Practice concern about criticism/judgement
  - Consent in non-participant observation
  - Observation of concerning practice (SOP)
- Recruiting practices
  - Factoring in lead time
- Recruiting staff and patients
  - Flexible approach - local systems

Doing ethnography - reflections

- Writing field notes
  - Start with spatial exploration & site access notes
  - Field notes are selective; note your assumptions
  - Start global, go specific (inductive & thematic)
- Getting someone else to observe ('investigator triangulation')
- The value of informal 'interviews'
- The value of multiple cases
  - Avoiding essentialism (taking one account as the complete narrative)

Location	Central shopping area of large city. Less than half mile on foot from acute hospital ED and children's hospital. Co-located with a walk-in centre and a large chemist.		
Population 2013 (practice opened 2008. 2009/10 list of 935)	**List size***	6,109 (CCG avg. = 8, 992 England avg. = 7,034)	
	IMD score**	40.3 - 2nd most deprived decile (CCG avg. = 25.2, England avg. = 21.5)	
	Age distribution**	Under 18 = 7.8% (CCG avg. = 19.9%, England avg. = 20.8%) Over 65 = 1% (CCG avg. = 12.7%, England avg. = 16.7%) 73% of patients aged between 20-34 years (CCG avg. = 28%)	
	Comments	Described by staff, and observed, as caring for a large proportion of students, people whose first language is not English, homeless and alcohol/drug dependent patients.	
Staffing	**GPs***	5 salaried GPs, FTE 2.91. => 0.476 FTE GPs per un-weighted 1000 registered patients (CCG avg. approx 0.54).	
	Other staff*	6.64 FTE nurses, 14.4 FTE admin staff (I think this is includes walk-in staff). Practice telephone triage and the walk-in are both nurse-led.	
Opening hours	Advertised as 08:00 – 20:00 Mon-Fri, 09:00 – 13:00 Sat. Walk-in Mon-Fri 08:00-16:00 sit-and-wait thereafter this list closes but can pre-book (in person) appointments running from 18:00-19:30. Sat 08:00-18:00 sit-and-wait, Sun 11:00-15:30 sit-and-wait.		
GP patient survey 2013/14 (20% response rate)	**% who would recommend practice**		75 (CCG =79)
	% find it easy to get through by phone		85 (CCG = 71)
	% find receptionists helpful		93 (CCG = 87)
	% able to get appointment to see or speak to someone the last time they tried		78 (CCG = 86)
	% of those who got an appointment who saw/spoke to GP/nurse on same or next working day		<33 (CCG = 46)
	% with a preferred GP who usually get to see or speak to that GP		74 (of 34%) (CCG = 59 of 53%)
	% who know how to contact an OOH GP service		35 (CCG = 55)
Unscheduled care (NHS comparators 2009/10 – 20012/13)	**ED**	Bottom quintile 2009/10 (standardised rate 164.4), top quintile 2010/11 (303.6) and 2011/12 (305.5), middle quintile 2012/13 (257).	
	ACS	Bottom quintile 2009/10 (standardised rate 2.09), top quintile 2010/11 (18.75) and 2011/12 (18.17), middle quintile 2012/13 (9.38).	
	EHA	Bottom quintile all four years: std. rate 127.2, 169.2, 159.6, 127.2	
Data collection	**Observation**	Included first thing in morning, up until closing time and a weekend session. 16+ hours over 7 visits 28th Oct – 4th Nov 2013, plus 3 short follow-up visits 15th + 18th Nov 2013 + 20th Feb 2014. Observers: Emer Brangan, Rachel Anthwal (29th Oct), Fiona MacKichan (set up meetings).	
	Staff interviews	Receptionist/admin, HCA/admin, lead GP. Informal – reception lead, other receptionists/admins, practice manager & assistant manager.	
	Patient interviews	4 female & 2 male interviewees including one man whose daughter was the patient. Patient ages 0, 26, 30, 42, 48, 58. Five of the six had multiple ED attendances and/or admissions. Three did not have English	

On level 1 people tend to approach the reception desk position facing the sliding doors [see diagrams] first if this is staffed. There is also a touch-screen for patients to check in on each floor. The one on level 1 is attached to a pillar between the main doors and the reception desk and seemed to get some use. On level 2 the screen is off to one side and rarely used, with the reception desk much more obvious.

Level 1 noticeboard

There are an assortment of leaflets and notices around the waiting areas, particularly on level 1 - on boards, stuck to the reception desk, and behind reception (entertainingly described by RA as "the usual shabby, random notices informing people of changes or access requirements to services"). They include several notices on where to seek treatment (see photo), but these are mostly along a wall which people are unlikely to spend much time looking at.

Type of request	When presented	Solo F	Solo M	C
Check in for appointment	Weekday in hours	17	34	
	Weekday OOH	2	5	
	Weekend			
New appointment ASAP	Weekday in hours	3	2	
	Weekday OOH			
	Weekend			
New appointment routine	Weekday in hours	5	5	
	Weekday OOH			
	Weekend		1	
Follow-up appointment	Weekday in hours	6	7	
	Weekday OOH			
	Weekend			
Walk-in sit-and-wait	Weekday in hours	21	12	
	Weekday OOH			
	Weekend	1	3	
lk-in pointment	Weekday in hours	5	7	
	Weekday OOH	2		2
	Weekend			
gistration	Weekday in hours	2	8	6
	Weekday OOH			
	Weekend			
dication quest	Weekday in hours	1	5	1
	Weekday OOH	1	1	
	Weekend			
lect scription	Weekday in hours	4	8	
	Weekday OOH	1	1	
	Weekend			
quest fit e/letter	Weekday in hours			1
	Weekday OOH			
	Weekend			
lect fit e/letter	Weekday in hours	1		
	Weekday OOH			
	Weekend			
sults/ ords/	Weekday in hours	2	4	1
	Weekday OOH			

Monday 4th November 16:35. The last walk-in appointment for today is given out at 16:31. The next man to arrive does not have English as a first language and talks about a "point" in his thigh. Lead receptionist Mary tells him that they have no appointments left and suggests that he call 111. He does this on his mobile phone from the waiting room but he doesn't seem to manage to speak to anyone. Mary suggests that he can come back tomorrow morning and he will be able to sit and wait, or he can go to A&E if it gets too bad in the interim.

Two others occurred when the walk-in was accepting patients but there was a suspicion of a broken bone:

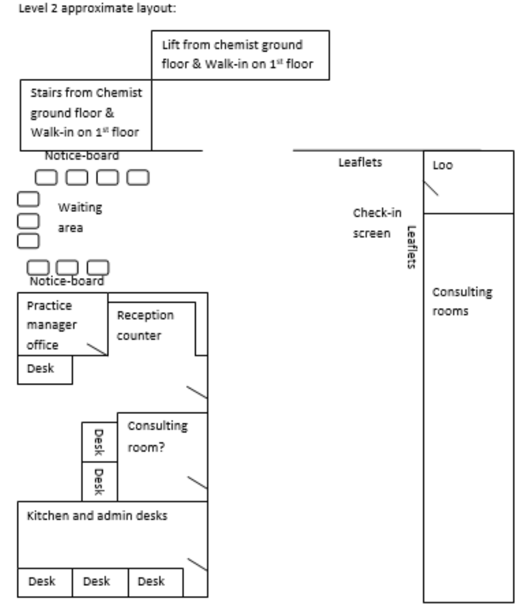
Tuesday October 29th 19:23 A woman limps to the desk and asks to see a nurse. English is not her first language. She is registered, and it seems she might have seen someone before. "Getting worse and worse. It's black". She is asked for her date of birth, and then the receptionist asks "Do you think it's broken? We can't tell you. Have to go to A&E". Patient says "Hospital?" and then says that she would prefer to see the nurse anyway. She says "Sorry, it's my first time anything like this happens". She is called in to see the nurse at 19:34. When she comes out she is joined by a man who I think she called to come and help her. They leave, saying thanks, at 19:42. I think they are going to A&E but not sure.

Saturday November 2nd 12:35ish A young couple approach the desk – the woman is hopping. The receptionist asks her "Do you think it is broken?" and explains that they do not have an x-ray. The man reckons they should go to A&E. She can't put any weight on it. He says something about carrying her and they leave.

Two interactions were comments from patients about whether better off going to A&E:

Wednesday October 30th 11:25 A woman arrives for the walk-in and one of a group of four men who are waiting for GP appointments which are running very late calls out to her "You'll be here until ele

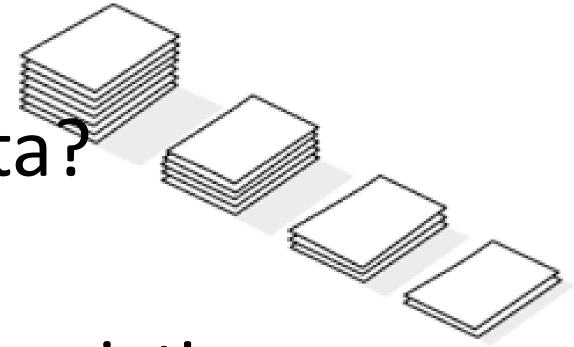
Level 2 approximate layout:



Lead GP Elizabeth was quite challenging to interact with at times from a researcher perspective – she seemed slightly hostile to what she perceived as the research agenda of reducing secondary care - and it

Analysis and interpretation

- With observation, method and findings are inseparable
- How to approach interview data?
- How to integrate findings?
  - Case summaries (key themes, description, interpretation)
  - Integrating cases (cross-cutting themes)
- Interpretation (other research phases, literature)



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What has it added to the study?

Explanation and extension, the possibility of actionable recommendations.

- Access
  - System complexity (within practices and wider system), reactive, incremental change
  - Complexity 'touch points' influence patient help seeking
  - System (in)flexibility
  - Communication (reliance on the telephone)
  - Tacit knowledge of reception staff (first line of triage)
  - Use of the word 'emergency'

Qualitative Research to enhance RCT design and delivery:

The Bluebelle study

ConDuCT-II Hub

Outline

- **Setting the scene**
- **Bluebelle overview**
- **Findings/implications**
- **Challenges and solutions**

Qualitative research in RCTs

Pre-trial/ feasibility

- Develop intervention
- Develop outcome measures
- Design effective recruitment strategies

Main trial

- Explore delivery and acceptability of intervention
- illuminate trial findings
- identify/address recruitment difficulties

Post-trial

- Explore how trial results are received and implemented in practice

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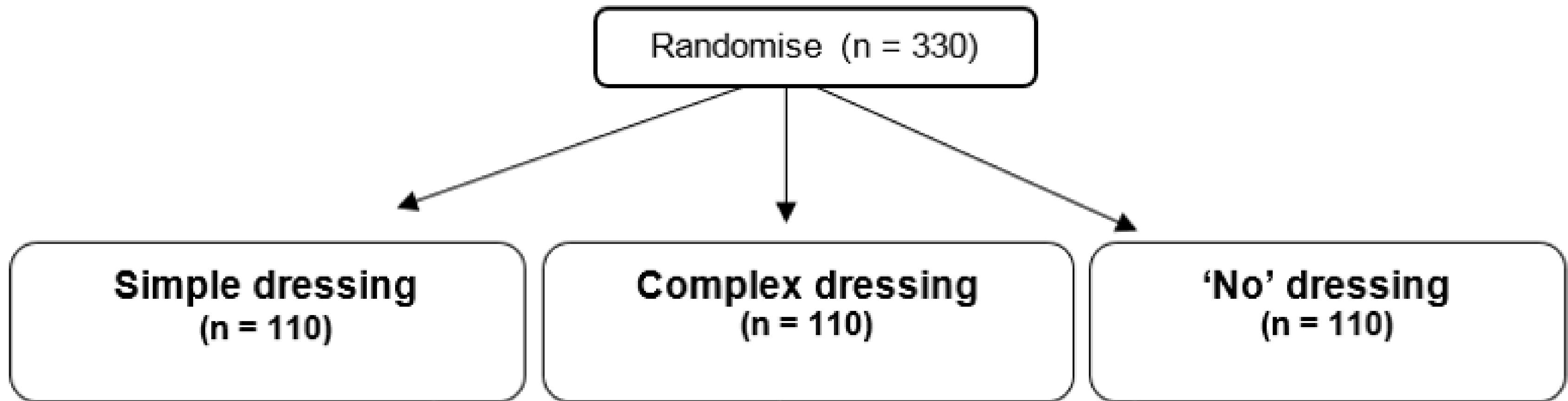
The Bluebelle Feasibility Study

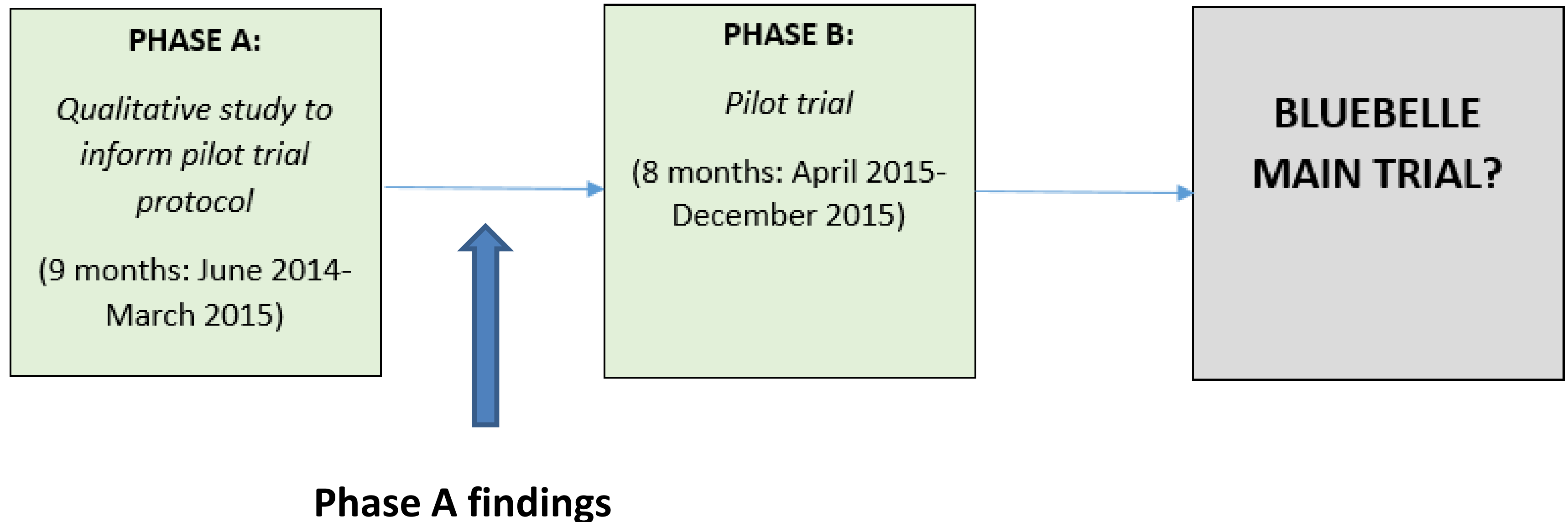
Feasibility Study of Complex, Simple and Absent Wound Dressings in Elective Surgery:



Design of the intended pilot trial

Primary outcome measure: presence of surgical site infection 30 days post operation

Feasibility Study Structure



➢ Qualitative study aims:

- To understand current wound dressing practice
- To explore patient/clinician attitudes towards proposed trial

Methods/Data Collection

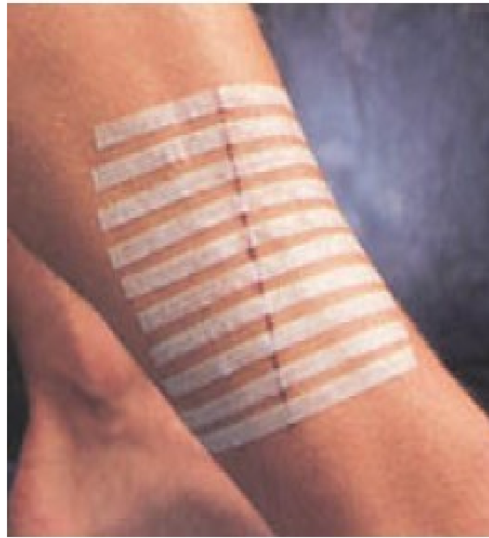
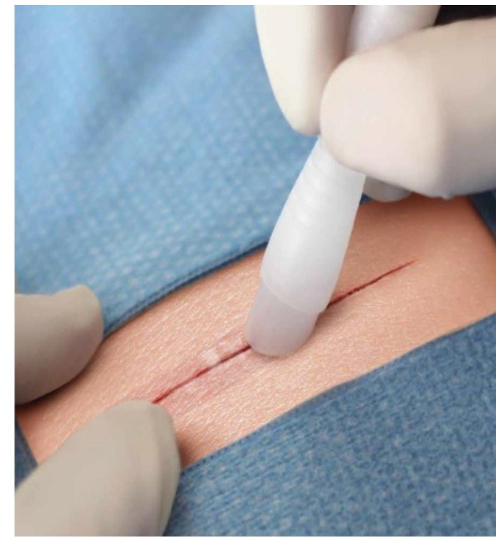
- **92 Semi-structured interviews over 8 months:**
  - Clinicians
  - Patients
- **Interviews conducted in:**
  - Range of surgical specialties (lower GI surgery, upper GI surgery, obstetrics)
  - Range of NHS hospital sites in Bristol/Birmingham.

Findings: implications for pilot RCT

1. **Defining the intervention(s)**
2. **Informing trial design**
3. **Trial outcome measures**

1. Defining the Intervention(s)

- What do we mean by the term ‘dressing’?

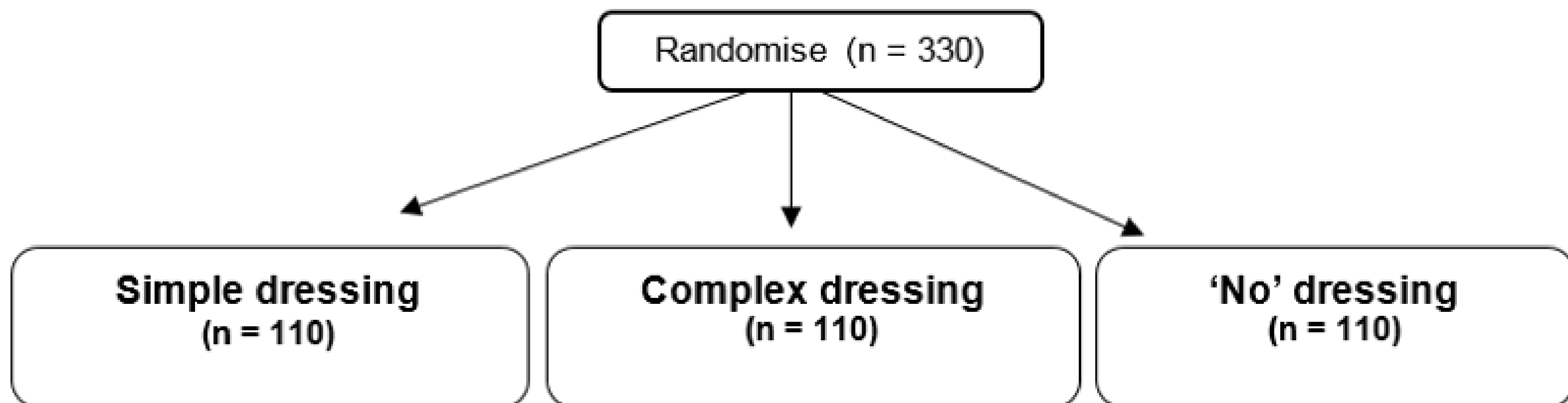
- **Necessary dimensions of definition** were clarified through qualitative study:
  - *Need to specify adherence properties; extent of wound coverage…*

2. Informing Trial Design

- Difficult to engage with 'complex dressings'…

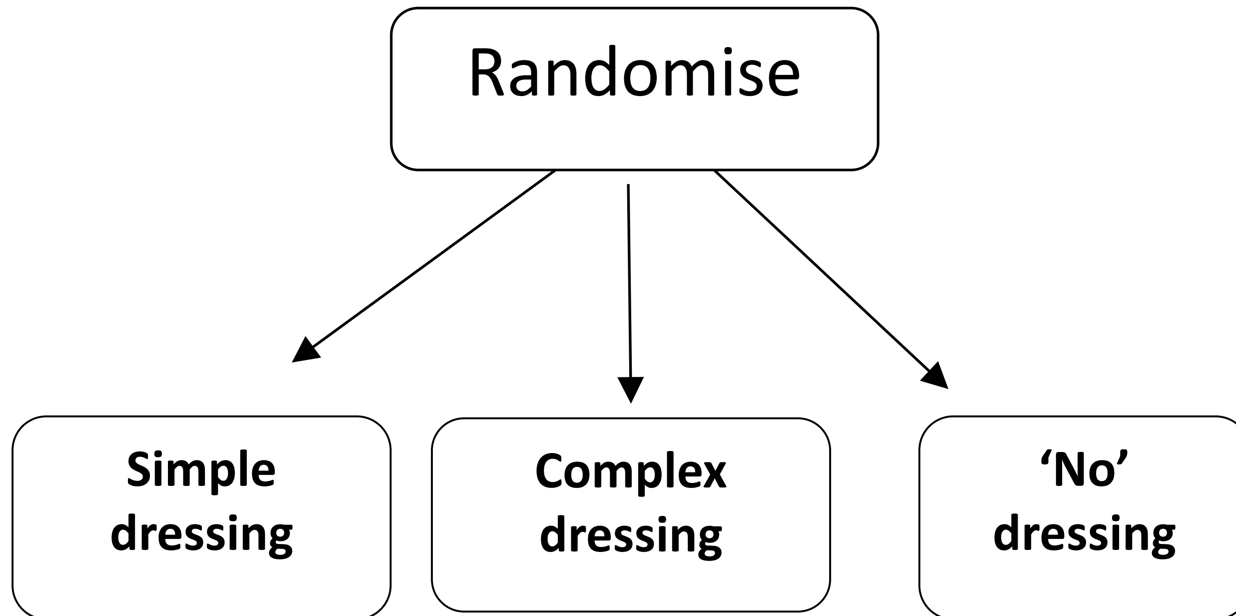
I've never heard of the term [complex] dressings.

I think in our line of work, because we don't use very many different types of dressings, probably 'dressings' or no dressings is most useful. We don't tend to use these complex dressings that you have mentioned.



Trial Design: confirming findings

- **Prospective Survey:**
- ‘Simple dressings’ used most frequently (70%)
- Followed by…glue! (approx. 30%)



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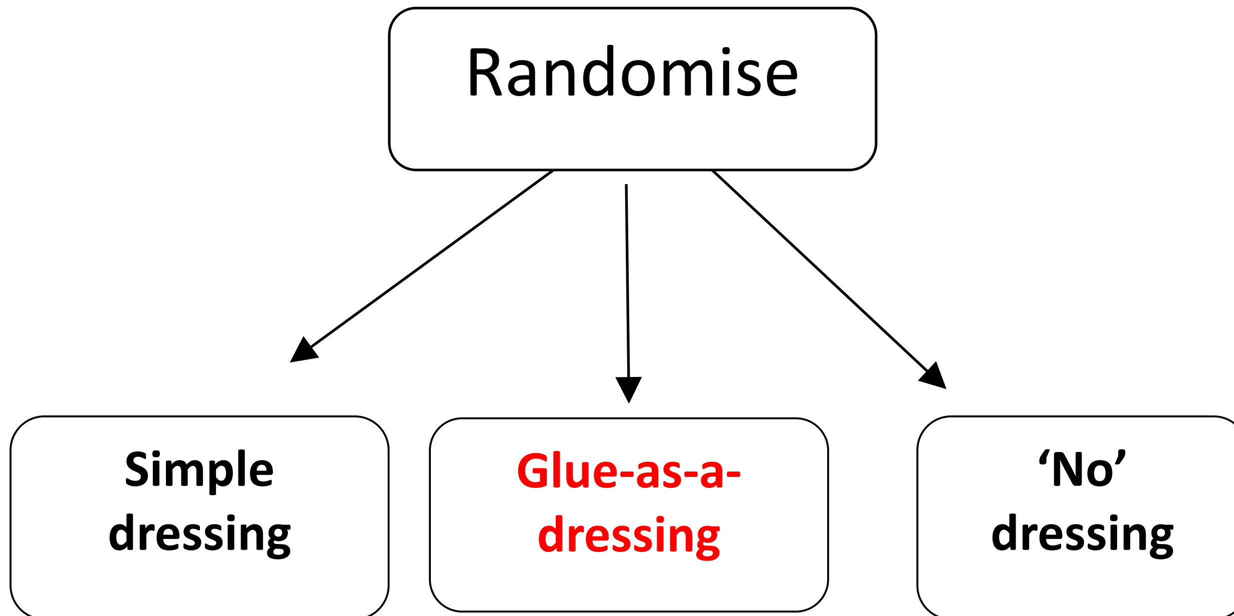
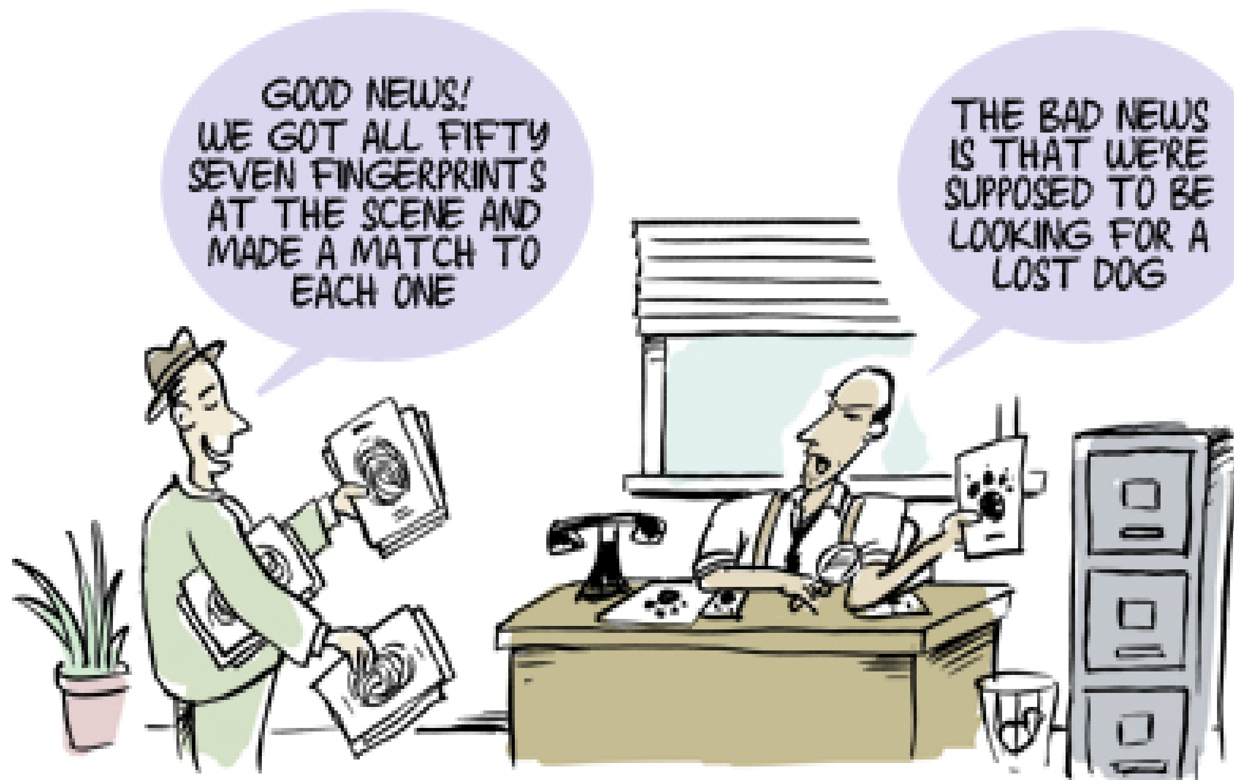


3. Trial Outcomes

- **Developing assessment tools for:**
- Practicalities of wound healing (staff and patients)
- Patient experience of wound healing



Challenges and Solutions

- How easy is it to back-track on fixed plans/ideas?
- Enough time to makes changes, once analysis complete?

A few ideas that may help:

- *Regularly present 'emerging findings' at study meetings*
- *Produce short descriptive summaries of key issues*
- *Qualitative researchers integrated as core members of TMG*

Thank you…

Questions?

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