Qualitative Research - reflections from the field

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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)
3. Non-UK trained GPs
4. Access (not able to make a GP appointment’)

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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)
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 throat. 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 entered when the walk-in was accepting patients but there was a suspicion of a broken bone.

Tuesday October 26th 10:23. 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,” she says. It’s her first time anything like this happens. She is called in to see the nurse at 15:54. When she comes out she is joined by a man who I think called. She leaves, saying thanks, at 19:42. I think they are going to A&E but sure.

Saturday November 2nd 12:33. A young couple approach the desk — the woman is shopping. The receptionist asks her “Do you think it’s broken?” and explains that they do not have an X-ray, the man explains 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 offending go to A&E:

Wednesday October 16th 11:21. 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 4.30.”

Level 2 appointment:

- Lift from floor 2, ground floor, in the lift and up to level 2
- Lifts from level 3, floor 2
- Lifts from level 4, floor 1

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 the reception desk.

A female and a male interviewee included one whose daughter was the patient. Patient ages 0, 3, 12, 49, 58. Over half the patients had multiple attendances.

On level 2 there is a notice of the reception desk position, to the sliding doors (see diagram) first if this is in staffed. There is also a touch-screen for patients to check in on each floor. There is a desk for the receptionist, with a desk for the reception team and seems to get used. On level 2 the screen is off to one side and rarely used, with a reception desk much more obvious.

There are an assortment of leaflets and notices around the waiting areas, particularly on level 1 - boxes, stuck to the reception desk, and behind the reception desk. They include several notices on where to seek treatment (see photos), but these are mostly along a wall which people are unlikely to spend much time looking at.

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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

PHASE A:
Qualitative study to inform pilot trial protocol
(9 months: June 2014-March 2015)

Phase A findings

- Qualitative study aims:
  - To understand current wound dressing practice
  - To explore patient/clinician attitudes towards proposed trial

PHASE B:
Pilot trial
(8 months: April 2015-December 2015)

BLUEBELLE MAIN 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.

Randomise (n = 330)

Simple dressing (n = 110)  Complex dressing (n = 110)  ‘No’ dressing (n = 110)
Trial Design: confirming findings

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

Diagram:
- Randomise
  - Simple dressing
  - Complex dressing
  - ‘No’ dressing
Trial Design: confirming findings

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