Author's response to reviews

Title: Drivers for change in primary care of diabetes following a protected learning time educational event: interview study of practitioners

Authors:

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Version: 2 Date: 24 November 2007

Author's response to reviews: see over
Response to reviewers comments

Dear Editor

MS:  1343951263164073
Qualitative study of the effect of a protected learning time educational event for diabetes: interview study of practitioners Aloysius Niroshan Siriwardena, Jo B Middlemass, Kate Scott and Carol Wilkinson

Thank you for inviting a revision to this paper on the basis of the comments from the reviewers. We are grateful to the other reviewers for the considered comments, criticisms and suggestions to improve the paper. We are also grateful to reviewers for the positive comments about the study. We have addressed the reviewers’ comments (in bold) in detail below.

Please let us know if there are any further comments or revisions.

Regards

Niro

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Reviewer's report

Title: Qualitative study of the effect of a protected learning time educational event for diabetes: interview study of practitioners
Version: 1 Date: 1 November 2007
Reviewer: Charles Campion-Smith

Reviewer's report:
General
This is an interesting qualitative review of the process of change in clinical care of people with diabetes. Its focus is rather broader than the title suggests as much of the qualitative material relates to drivers for change in primary care
diabetes care other than the protected time educational event and I wonder if a title change might be appropriate, or else a changed emphasis in the Results section, as four out of ten of the interview questions specifically related to TARGET.

We agree that a change in title might be appropriate and have changed this as follows:

“Drivers for change in primary care management of diabetes following a protected learning time educational event: interview study of practitioners”

The data presented does not allow any clear conclusions to be drawn about the effectiveness of this particular educational intervention either in facilitating changed clinical behaviour or in altering practices attitudes to interprofessional working and learning. This is acknowledged in the Conclusion.

We agree with the reviewer and have already acknowledged this in the Conclusion as he states.

I found the idea of stratifying Practices according to their change behaviour interesting, though using the prescription of a single – albeit evidence-based - prescribing strategy a little arbitrary, and feel more exploration of this would be worthwhile. Is the practice ethos different and do they demonstrate greater commitment to audit and interprofessional working and learning? Another study perhaps.

Thank you. We agree that this might provide the basis for another study.

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)
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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
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Discretionary Revisions (which the author can choose to ignore)

Methods:
I suspect QSR N6 would be meaningless to many non specialist readers.

We have qualified this statement.

“Qualitative data from the transcripts were analysed using specific software (QSR N6)…”
I would find a little more descriptive analysis of the analytical method and identification of themes helpful. I presume these themes are the headings of the direct quotes used, but clarification of this would be useful.

The method was clarified as follows:

“A sample of the transcripts was independently examined by all members of the project team and categories derived by induction. Categories were decided and grouped into themes through discussion. Themes were identified in the context of the stratum and the professional discipline of the interviewee through examination of transcripts and agreed by all members of the team.”

The words multidisciplinary, multiprofessional, interdisciplinary and interprofessional are all used but it is unclear if they are interchangeable. Many nowadays would suggest the use of ‘interprofessional’ – defined by CAIPE as ‘when [members or students of] two or more professions learn with, from and about one another to improve collaboration and the quality of care’ as most useful unless there is a clear distinction to be made. (Freeth D, Hammick M, Reeves S, Koppel I, Barr H (2005) Effective interprofessional education; development, delivery and evaluation. Blackwell Publishing & CAIPE; Oxford)

We agree and have defined what we mean in the background.

“In the case of interprofessional learning, “when [members or students of] two or more professions learn with, from and about one another to improve collaboration and the quality of care [9]”

Reviewer’s report
Title: Qualitative study of the effect of a protected learning time educational event for diabetes: interview study of practitioners
Version: 1 Date: 31 October 2007
Reviewer: DAVID CUNNINGHAM
Reviewer's report:
General

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Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)
I found this paper to be interesting and as such is worthy of publication. There are some points I would want to raise with the authors that need addressed, before publication.

1. the aim of the study is to investigate the perceptions of practitioners, but the results in the abstract section focus on prescribing issues, rather than the perceptions of practitioners towards PLT and diabetic care.
In fact the aim was to investigate perceptions relating to process of diabetes care following an educational intervention. We have clarified the aim in the abstract as follows:

“We undertook a qualitative study to investigate the perceptions of practitioners involved in a specific educational intervention in diabetes as part of a protected learning time scheme for primary health care teams, relating to processes of diabetes care in general practice.”

2. in the background section of the paper, the authors describe TARGET as being "innovative". Can their TARGET scheme be described as innovative, when they refer to TARGET Doncaster starting in 1998, some three years earlier. is their scheme innovative only to their local area?

We agree with this point; the innovation was not the protected learning time (PLT) scheme but the fact that it was coordinated across a whole county. The word “innovative” has been qualified as follows:

…Lincolnshire TARGET (Time for Audit, Review, Guidelines, Education and Training), set up as an multidisciplinary protected learning time (PLT) scheme, and innovative in that it involved all general practices with their associated primary care teams in a large rural county of the East Midlands, United Kingdom.

3. page 5 describes the study as having aims (plural) but I felt the study had only one aim: to explore the perceptions of participants in the TARGET scheme.

We agree. This has been changed to the singular and modified following point 1 above.

The aim of this parallel qualitative study was to investigate the perceptions of practitioners on the effect of the educational event relating to their processes of diabetes care.

4. the Methods section was confusing. much of the methods section deals with the description of TARGET rather than the description of the study itself- the exploration of participants’ perceptions towards TARGET and how it improved diabetic care. the authors need to label this more accurately, or divide the methods section into one that describes TARGET and then the method of the study itself.

This is a helpful suggestion. We have divided the methods section into headed subsections to address this point.
5. Page 6 describes the selection of interviewees as being random. This is a term more akin to quantitative research than qualitative, and I wonder if this should be purposive selection. The use of “interviewees” needs further description. Is this individual participants or selected general medical practices?

In fact, it was the practices that were chosen at random from strata according to the extent of change *(or lack of change)* in prescribing. This was because practices who might have been more likely to change or to attend TARGET would have been more likely to volunteer for interview.

“Interviewees were chosen purposively from selected practices. Nurses and general practitioners providing diabetes care in practices were specifically chosen because they were more likely to have in-depth knowledge of changes in processes of care whether related to the intervention or not.”

6. Page 6. Could the authors describe what they mean by "little/some/great". and how did they decide how prescribing figures were used to allocate practices to the four groups?

The categorisation was described in the parallel quantitative study published in 2007 in Family Practice and is referenced here rather than repeated in detail in this paper.

7. How were individual practices invited to participate? And how were individual participants in practices recruited? How were they interviewed? One-to-one in depth interview, or focus groups? If so how were these run and moderated? More detail is needed here so that readers can understand the process. Perhaps the method section of TARGET could be reduced to compensate.

Under Interviews and analysis in the results section the following changes were made:

One-to-one in depth interviews took place at the practice premises in 2003, within 18 months of the educational session. They were 45 to 90 minutes in duration and conducted individually by two researchers. They were tape recorded and transcribed in full. Qualitative data from the transcripts were analysed using specific software (QSR N6) and themes identified in the context of the stratum and the professional discipline of the interviewee through examination of transcripts by all members of the team.

8. Were just GPs and practice nurses invited to take part in the research? Why were these two groups chosen? What about practice managers, administrators,
district nurses etc? Would they not have a role to play in the changes described? I think this is a narrow view of the agents of change in a practice, the authors need to tell why they were chosen to the exception of others.

We partly agree with this. However, the clinical education on diabetes care was not open to district nurses or non-clinical staff. This has been explained as follows:

Nurses and general practitioners providing diabetes care in practices were specifically chosen because they were more likely to have in-depth knowledge of changes in processes of care whether related to the intervention or not.”

9. Why did the authors chose to wait 18 months after the TARGET event? Can they reflect that participants may have forgotten what happened at the event that made them alter their practice's prescribing?

In fact we did not wait 18 months; interviews were conducted within 18 months and ranged from 12-18 months after the TARGET event for practical reasons of undertaking the quantitative analysis which would determine the sampling method. We agree with the problem of recall bias or decay.

10. when transcriptions were returned, were they checked against the audio-recording?

11. the authors need to give more details of the analysis used- who did the analysis? One or more people? How were conflicts and differences in the analyses resolved if any?

The method was clarified as follows:

“A sample of the transcripts was independently examined by all members of the project team and categories derived by induction. Categories were decided and grouped into themes through discussion. Themes were identified in the context of the stratum and the professional discipline of the interviewee through examination of transcripts and agreed by all members of the team.”

12. page 7 results section. The results describe the results of the TARGET meeting, rather than the results of the interviews. The authors need to describe this more effectively. Perhaps there should be two results sections. Bullet points could be used to make this more effective- the results could be bulleted, or placed into a table, so that readers can quickly find a summary of the results.
Results are now summarised in a table as suggested: Box 1.

13. In general the results section showed under-analysis. Some pages showed a list of quotes from research participants. These lists were often quite fragmented and need more connections made. The authors should spend more time on analysing the results rather than just listing quotes. In my opinion this was the biggest weakness of this paper. The use of different heading styles would emphasise the results into more obvious themes. Page 10 is a good example of how a series of sub-themes with a range of quotes of raw data beneath them shows under-analysis and portrays sub-themes as being themes.

Themes and subthemes have been extensively reanalysed, reorganised and revised for clarity.

14 Discussion. I found no problems with this section

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
the paper's sections should be laid out on separate new pages for each section i.e. abstract, introduction, methods etc.

References
The authors should have publications in italics so that readers can identify the journal/publication quickly. I could not find the website for reference 7 and there is no access date given for this. I know from previous experience that this website has not been available for several years. Reference 11. Should give more detail of the journal involved. At present it is listed as "qual 1992" what is meant by this?

References have been revised in line with guidance to authors. Reference 7 has now been removed and Reference 11 has been updated.