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support patients at high risk of T2D. Opportunities to adapt, try, negotiate, and ultimately reinvent SP to suit patients' own needs allowed practitioners to engage with complexity and provide the personalised (usually more intensive) support that patients at high risk of T2D required.

Conclusions Practitioners' capacity to be creative in accommodating patients' needs ('I do what it takes'), resign to delivering insufficient SP services ('I do what I can') or uncritically adhere to existing conventions ('I do as I'm told') represented different types of SP practices, enacted within dynamic and highly contested contexts.

7 THE LISTEN METHOD – SYNTHESISING COLLABORATIVE AND DIGITAL METHODS FOR BIG QUALITATIVE DATA ANALYSIS

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Background Big qualitative data analysis is an emerging discipline in qualitative health research and has been used with online posts, open-ended survey responses, and patient health records. Traditional methods of qualitative data analysis can be time-consuming and biased by small sample sizes. The combined strengths of collaborative and participatory methods from rapid research approaches and the efficiency of digital software analyses can mitigate these issues.

Aim We developed the LISTEN method (Collaborative and Digital Analysis of Big Qualitative Data in Time Sensitive Contexts), combining interdisciplinary expertise in collaborative, participatory, and digital methods for big qualitative data analysis.

Methods The LISTEN project iteratively combines findings from a systematic review of peer-reviewed literature and world-wide-web data as well as consultation with stakeholders, collaborative team discussions and text network analysis using digital software. Text and thematic analysis software was used to conduct sentiment analysis and text network analysis of data from academic literature on digital software usage, types of qualitative data, qualitative analysis methods, analysis steps, and citations of notable publications in the field of big qualitative analysis methods.

Results 520 peer-reviewed studies and 37,129 internet posts were systematically reviewed. Web and social media posts referencing large qualitative data sets presented negative sentiments and many posts expressed ambiguity surrounding the categorization of digital and computational methods within the qualitative data analysis discipline. Over 50 types of digital software, and several collaborative qualitative data analysis methods and steps were identified. A LISTEN method manual has been developed to train and support the implementation of the method at three different sites, as well as the development of an interactive living systematic review.

Conclusions The newly developed LISTEN method will provide research teams with the flexibility to triangulate different types of data and combine the strengths of rapid research designs and digital methods.

8 THE ESSENCE OF HEALTH COMPLAINTS MECHANISMS IN THE IMPROVEMENT OF QUALITY PRIMARY HEALTHCARE DELIVERY IN MALAWI

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Background Complaints mechanisms are key components of healthcare accountability in health systems across the world. They can help identify structural problems and poor service by individual health workers and can support equitable access and ensure that patient safety is a priority. As part of a larger study on accountability and anti-corruption, the aim of this study was to explore and understand the role of the different channels for complaints that are available to Malawian healthcare users. It aimed to explore how they function, and what undermines their use.

Methods We conducted a qualitative study in Blantyre district using participant observations, in-depth interviews and focus group discussions. We spent 8 weeks at health facilities and the Blantyre district health office (Directorate of Health and Social Services) and then explored the challenges of accessing and using patient complaints mechanisms.

Results Healthcare users continuously encounter numerous challenges within the Malawian health system. We identified 32 mechanisms for complaints handling and redressal which are also meant to act as tools for checks and balances. At the same time, interviews with health providers, stakeholders and document analysis demonstrated that the complaints and redressal system has multiple weaknesses. These include geographical barriers, lack of trust and visibility of these mechanisms, and limited capacity in institutions to manage the complaints and redress process, as well as lack of political will to adopt changes within the health system.

Conclusion The weaknesses of the health complaints and redress system in Malawi pose obstacles to delivering quality primary healthcare to the most disadvantaged communities. Urgent interventions to redesign these mechanisms, ensuring that they are not constrained by power differentials and lack of trust is needed.

9 SCHOOL FOOD PROVISION PARTNERSHIPS FOR CHILD HEALTH: INSIGHTS FROM THE ACTEARLY FIGS STUDY

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This paper focuses on the central role of partnerships in public programmes seeking to address child health inequalities, which have increased with the UK's cost-of-living crisis, leaving millions of UK children vulnerable to food insecurity. In Tower Hamlets, a diverse London borough where over half of children experience poverty, child-centred initiatives like universal provision of free school meals are crucial. Although offered to all primary school children in the borough, not all families take up this offer. More research is needed to

understand why and the potential impact this might have on widening pre-existing health inequalities.

Our Food Improvement Goals in Schools (FIGS) study is a focused ethnography exploring school-based food provision in ten primary schools in Tower Hamlets. It evaluates a new council initiative 'Fantastic Food in Schools' designed to improve and increase uptake of free school meals and promote whole school approaches to healthy food. FIGS sits within the UKPRP funded ActEarly programme, aiming to tackle child health inequalities through upstream interventions.

Beyond empirical findings, in this paper we reflect on the essential collaborative groundwork that enriches this project through the lens of knowledge encounters. Knowledge encounters represent inclusive interactions reflecting different sources and forms of knowledges in a partnership. We highlight how relational dynamics in our case are based on flexibility and commitment to make use of a shared pool of 'insider-on-the-ground experience' with 'outsider-conceptual-evidence-based' knowledges which permeate and enrich how we navigate various spaces. We argue these encounters are instrumental for research aimed at informing policy and practice, whilst ensuring that qualitative insights resonate with the communities we aim to serve. This work is timely in light of the Mayor of London's recent extension of the universal free school meal offer to all primary school children across the city.

10 TRANSFORMING INTEGRATED CARE THROUGH CO-PRODUCTION: A SYSTEMATIC REVIEW USING META-ETHNOGRAPHY AND PATIENT AND PUBLIC INVOLVEMENT

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Background There is a requirement for health and care systems and services to work on an equitable basis with people who use and provide integrated care. In response, co-production has become popular in the design and transformation of services. An array of approaches have been implemented to achieve this. This presentation explores how an exceptional combination of methods were used to systematically review global publications of co-production within integrated care.

Methods This systematic review used meta-ethnography with input from a patient and public involvement (PPI) advisory group comprising six members representing service users, family carers and the workforce. Meta-ethnography can generate theories by interpreting patterns between studies set in different contexts. Nine academic and four grey literature databases were searched for publications between 2012–2022. Data were extracted, analysed, translated and interpreted using the seven phases of meta-ethnography, with involvement of the advisory group throughout.

Results A total of 2,097 studies were identified. 10 met the inclusion criteria. Studies demonstrated a variety of integrated care provisions for diverse populations. The methods applied organically drew out new interpretations, namely an additional step on the 'ladder of co-production' is proposed; a cyclic co-delivery framework for application within integrated care.

Conclusions The use of meta-ethnography with input from an advisory group was successful in ensuring perceptions from lived experience and operational viewpoints were integral to the systematic review decisions and findings. Co-production was most effective through person-centred design, innovative planning, and collaboration. Key impacts on service transformation were structural changes, accessibility, and acceptability of service delivery. The cyclic co-delivery framework has the potential to enable better-sustained person-centred integrated care services.

11 'OPEN', 'CLOSED', AND IN-BETWEEN: A WORKED EXAMPLE OF AND REFLECTIONS ON DATA-SHARING PRACTICES IN QUALITATIVE INTERVIEW RESEARCH

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Background Modern open science initiatives have implications for qualitative researchers, particularly in relation to 'open' data.

Aim We describe the process of data-sharing for a qualitative interview study, to make transparent our thinking and decision-making around open data for our particular project.

Methods The initial project aimed to explore perspectives of young adults on what precipitates and maintains feelings of loneliness among this age group. Participants did not necessarily need to discuss personal experiences of loneliness. 27 virtual interviews were conducted with young adults between 18 and 25 years.

Results 26 participants consented to make their anonymised transcripts available via the Irish Qualitative Data Archive; 24 transcripts were archived. One excluded transcript contained very rich descriptions of niche social activities and rare life events that could identify the participant. However, redacting these details meant that there was scant information left, and what was left was divorced from the rich context in which it was provided. For a further transcript, the participant had a relatively rare combination of demographic characteristics. These, combined with the detailed discussion of participants' own characteristics and activities in the interview, meant that risk of identification of the participant was too great, even if access was restricted to educational and research use. Interestingly, one participant (whose transcript was archived) used no identifying information that definitively merited redaction or replacement, suggesting that even when participants consent to data archiving, this might shape the way in which they engage with the interview.

Conclusions Data-sharing is more complex than 'open' or 'closed'. Purposeful consideration of the why and how of data-sharing can support researchers to make optimal use of participant data while being mindful of the ways in which data sharing can shape the context of qualitative data collection.

12 FACILITATING INCLUSIVITY: A COLLABORATIVE APPROACH TO RESEARCH IN CARE HOMES

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