Author's response to reviews

Title: Implementing a framework for goal setting in community based stroke rehabilitation: A process evaluation.

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Author's response to reviews: see over
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Dear Editor,

Thank you for your consideration of the above noted paper for publication in BMC Health Services Research. As requested, we have addressed the reviewer’s comments in a revised manuscript. A point-by-point response to each reviewer’s concerns is detailed attached.

You will note that a different illustration of the G-AP framework is being submitted with the revised manuscript. We believe the new illustration (which was developed using different software and in collaboration with an expert in the design field) better reflects the G-AP process and will be more helpful to clinicians in practice.

I would like to take this opportunity to thank the editorial board and reviewers for their careful consideration of this paper. All reviewers’ comments were extremely helpful and revisions made in response to them have resulted in a much improved paper.

Yours Sincerely

Lesley Scobbie
**Point by point response to reviewer’s comments**

1. **Reviewers Report (Diane Playford) with actions/ responses noted.**

   **D. Discretionary revision:** The setting of and structure of the Reach team is clearly described in the results but I think this should be described in detail under a heading setting in the methods.
   **Action:** The section describing the structure of the ReACH team had been moved to the methods section (pg. 9).

   **E. Minor essential revision:** The sentence ‘The G-AP framework was implemented for a 6 month period (Jan-June 2008) with all new stroke patients seen by the ReACH team who would normally be involved in goal setting’ needs slight clarification. Is it the Reach team who would normally be involved in goal setting or the patients? How was this done before? And how much of change would the G-AP framework be?
   **Action:** The aforementioned sentence has been restructured for clarification. A section describing ‘G-AP informed’ goal setting practice remains in the background section (pg.6-7) and a section describing ‘usual’ goal setting practice in the ReACH team prior to G-AP implementation added to the methods section (pg. 9-10).

   **E. Minor essential revision:** The rest of the methods are clearly described although a table describing the age gender and disability of the patients recruited would be helpful, and I would tend to put this in the methods rather than the results in order to help the flow of the paper (this may be less of a problem in print version).
   **Response:** Table 1 describes the age, gender and disability levels of recruited patients. We feel this should remain in the results section and hope this will be clear to readers in the print version of the paper.

   **F. Major Compulsory Revision:** The data appear sound. No comment is made about data saturation or the interpretation of ideas suggested by a single patient or HP?
   **Response/ Action:** Thank you for this point. We are not absolutely certain that we reached data saturation on all of the main themes, particularly in relation to implementation of coping planning which few health professionals commented on. Ideally, we would have extended the study and continued interviewing but resources did not allow for this. We have noted this as a limitation within the discussion section (pg. 32).

   **Re: the interpretation of ideas suggested by a single patient or HP**
   **Response:** In the methods section, we explain our approach to data analysis. The responses of individual patients and HPs were coded into three main themes, and subsequently into sub-themes. In doing this we took care to include all views expressed to be sure that any individual participant would recognise their views reflected in the analysis. In presenting the results we chose extracts that reflect the main points of the analysis and note any dissenting views. We are confident that our analysis reflects the views of all participants.

   **G. Minor essential revision:** Page 17 typo patent for patient.
   **Action:** Typo corrected.
H. Minor essential revision: The discussion and conclusions are well balanced and adequately supported by the data. The limitations of the work are clearly stated although it might be helpful to reflect on the age of the patients who seem relatively young for a stroke population.

Action: The relatively young age of patients included in our sample has been noted as a limitation in the discussion section of the paper (pg. 32).

2. Reviewer’s report (Kathryn McPherson) with actions/ response noted.

a) The abstract mentions that all aspects of the approach were implemented according to the protocol except for perhaps the most novel in non-psychological practice (i.e. the coping plans and measuring confidence) but it is not clear why and appears at odds with the conclusion that the G-AP was successfully applied? It would be helpful to clarify this and revise the conclusion accordingly.

Action: The conclusions section of the abstract (pg. 3) and the paper (pg. 33) have been revised to accurately reflect the finding that coping planning and measuring confidence to complete action plans were not consistently implemented according to protocol.

c) On pg. 8 the phrase ‘ten monthly updates’ might be clearer if it were ‘monthly updates over 10 months’ or similar.

Action: This sentence has been revised for clarification.

d) The choice of DMcL as the interviewer could have had some impact on what participants (particularly staff) said given their role in the project – a justification of this role would be helpful and its potential limitations noted.

Action: DMcL conducted the interviews as he had secured protected time to complete this specific aspect of the project. This has been noted on pg. 9 in the methods section. The potential this created for introducing staff response bias has been noted as a limitation (pg. 31) and discussed.

e) Whilst I understand the need to limit numbers for the qualitative investigation, I would anticipate that for fidelity and uptake, it would have been useful to review all case notes and justification of a selection should be added.

Action: A justification for only including eight case notes in the case note review has been provided and noted as a limitation and the limitation of this study (pg. 31).

f) If only a subset of case notes were reviewed, it would be reassuring to know the professional participants were not aware who was involved to prevent this knowledge effecting their use of G-AP. Clarification of this would be helpful and, if not the case, the potential limitation noted

Action: A sentence has been added in the methods section under the heading of study design (pg. 8) to confirm that health professionals did not know which patients would participate in the interview and case note review during the implementation period.

g) What steps are taken to assure confidentiality and anonymity for the professionals?

Action: A sentence has been added under the heading of data analysis to explain that transcripts of health professionals were anonymised by an administrator not involved in the study prior to the analysis stage has been added (pg. 12).

h) It is not clear whether the 23 patients noted on page 12 are the total number of patients in the service during the study period or just those where the tool was implemented. Could this be clarified?

Action: This has been clarified in the first paragraph of the results section (pg. 13).
i) I’m not quite sure I understand why the study researchers were excluded - could the rationale be stated (for example – it might have been interesting to see whether use of the tool varied when the champion was involved in the patient’s care???

Response: This is a valid point. We have noted that DMcL’s patients were not invited to participate in the study in an attempt to minimise patients’ response bias (pg. 9). The point about whether use of G-AP varied when a ‘champion’ was involved is an interesting one; however, within the context of this study, DMcL was no greater a champion of the intervention than other team members.

j) I think it would be clearer to start the results section by clearly stating how many took part e.g. 8 patients took part........ followed by the other details.

Action: The start of the results section has been revised as recommended (pg. 13).

k) You say on pg. 13 at one point that each step had a distinct purpose and yet then say the first two were more a continual rather than distinct phase – it would be good to synch those two comments more clearly

Action: These comments have been synced for clarification under the heading of goal negotiation and goal setting in the results section (pg. 14).

l) You interpret a patient’s response on the top of pg. 4 without telling the reader the actual response – I like to see the data!

Response: I think the reviewer may have been referring to an interpretation of a patient’s response at the top of page 14 in the PDF document rather than 4. We agree, presenting data in the form of quotes is important and we have endeavoured to do this where practical and useful through the paper. However, having gone back to the original data, we feel that what we have written is an accurate representation of the data, and that to alter it would upset the flow of the paper without adding any value. Therefore, on this occasion, we believe it is better to leave the text as it is.

n) The discussion is appropriate and does indeed consider the lack of integration of coping plans. However - I still think the conclusion is therefore a bit over-bold(i.e. it has not really been successfully implemented) and I think discussion around this could be enhanced and the conclusion revised to be more cautious.

Action – The first paragraph of the discussion has been revised to acknowledge that G-AP was not fully implemented according to protocol (pg. 26-27). This is addressed further in the discussion section under the heading of ‘Optimising implementation of G-AP stages’ (pg. 28).

3. Reviewer’s report (William Levack) with actions/ responses noted.

4. One minor issue (a minor essential revision) is that it is somewhat unclear what proportion of stroke admissions are represented in the study data. I would be interested in know how many people with stroke in the six month period of the evaluation COULD HAVE received the G-AP framework, and if some were not, why they were not. That would help me estimate how representative the eight cases were.

Action – Further details of the proportion of stroke admissions represented in the study have been given in the first paragraph of the results section (pg. 13) and reasons noted why a small proportion patients did not received the G-AP framework.

In fact, a discretionary revision would be to describe the demographic characteristics of stroke patients admitted to the service in general, and the demographic characteristics of the study participants, as this would also help understand how representative their data might be.

Response: We have not addressed this discretionary revision as this information was not collected and is no longer held in team based records.
5. Are the discussion and conclusions well balanced and adequately supported by the data? Again, in general, yes. The findings and discussion did raise some further questions for me that the authors (at their discretion) may wish to address.

Firstly, I was very interested in the notion of evaluating the participants’ confidence to achieve set goals as this is an emerging issue of importance for goal setting in rehabilitation (relating to self-efficacy). I also wondered if, in addition to confidence, whether it would be a good idea in the future to also evaluate participant COMMITMENT to achieving set goals. This is an issue highlighted by Locke and Latham as another important moderator of the effects of goals on human behaviour, and one that is seldom if ever addressed in a health care context. Patient commitment to achieve negotiated goals is often just assumed to be high, but like self-efficacy it may possible range from patient to patient from high to low levels of commitment.

Response - This is an interesting comment worthy of consideration. Firstly, we have noted that using the G-AP framework, confidence is explicitly measured in relation to specific action plans rather than goals and a justification for this given (pg. 7). It is an interesting and valid point that in the future, it would be good to consider patient’s commitment levels in relation to set goals, as that is an important moderator included with Latham and Locke’s theory (which has informed the development of the G-AP framework). We have chosen not to comment perceived commitment in this paper as it was not our initial focus and was not raised as a theme within the patient or health professional data.

I also wondered about the idea of allowing goals where no coping plans were required because no barriers to the action plans were identified. I wanted to know how examples of these situations could occur because my suspicious (perhaps incorrectly?) was that if the health professionals were so certain that a goal could be achieved (i.e. there were no barriers), perhaps it did not really count as a rehabilitation goal at all? If the target end-point is just going to happen, wouldn’t this then just be a ‘task’ to complete, not a goal? Alternatively, perhaps the issue here is that health professionals need more help with identifying possible barriers to goal completion and possible solutions to those barriers. (This was a part in the G-AP process that the health professionals struggled with after all.) I wondered whether for instance patient motivation or level of striving were regularly identified as potential barriers, and whether these were discussed with patient, with strategies put in place to help patients stay motivated and focused on achievement of their goals.

Response – These are interesting points to consider. Unfortunately, our available data did not allow for a more detailed analysis of coping planning or to describe scenarios where no coping plans were required and health professional’s understanding of why that was. This will be a focus of our ongoing work in this programme of research. The concept of coping planning and measuring confidence to complete plans has been further developed in the results (pg. 17 & 18) and discussion section (pg. 28-29).

6. Are limitations of the work clearly stated? Yes, this is covered in a section towards the end of the discussion. Again, I wonder whether the representativeness of the study population was another limitation worth mentioning.

Action – The over 65 age group were not well represented in our patient sample, this has been noted as a limitation (pg. 33).

7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished? Yes and no. Some aspects of the findings are more novel than others. The information on how health professionals responded to requirement to develop coping plans and evaluate patient confidence to achieve selected goals explores new concepts. Also relatively novel is the comparison of health professional views and patient views of whether non-attainment of goals is demotivating or
It was also interesting to read about the case involving a person who found all the paperwork for the G-AP method too complicated. Less new is the notion of a goal process that involves a cycle going from assessment to goal planning to plan implementation to re-evaluation of outcomes; problems with cognitive or communicative impairments on patient participation in goal planning and the use of family members as proxy goal negotiators in these contexts; and the notion of progress toward goals facilitating patient motivation – like ‘stepping stones’ guiding progress. These concepts have previously been discussed as far back as the 1990’s, so it might be worth acknowledging this earlier work that has provided the foundation to studies and new goal processes like the ones outlined in this paper.

Action – This has been a very useful point to consider. The paper has been revised to highlight the ‘novel’ versus ‘standard’ aspects of the framework (pg. 28) and references added to support this distinction.

As a bit of an aside, the reports on the concerns that the health professionals had regarding patients not achieving goals reminded me a little of the paper by Wiles et al. (2004) which looked at how physiotherapists have difficulty with management of disappointment when patients do not fully achieve their objectives/goals in stroke rehabilitation, and how this impacts on the relationships and communication between physiotherapists and their patients at the time of discharge from rehabilitation services. I wondered if the authors might be interested in looking at the potential connection between Wiles et al’s (2004) paper and their own. 

Action – Thank you for this very useful observation and comment. The Wiles et al (2004) paper has been reviewed as suggested and has informed development of our discussion of goal non-attainment and cited as such (pg.27).

9. Is the writing acceptable?
Some minor typographic or syntax errors were noted:

Action – All errors have been corrected and suggested amendment made.