Dear Editor,

Thank you for the set of referees' comments. Their comments are uniformly constructive and wherever possible we have changed the manuscript in line with their suggestions. We could have taken a number of weeks debating the finer points of our response but in the interests of timeliness we have elected to leave one or two of what we consider to be the more minor points unchanged.

We have addressed the Reviewer's comments as follows:

The paper would read better if "protocol" and "proposal" were replaced by "study".
We agree with the referee and have changed this throughout.

p. 6, line 12 - "other factors" - would be helpful to have examples.
We have not done this.

line 19 - "illness cognitions" - would be useful to explain briefly here, although it is fully explained later in the article.
As the referee indicates this is explained later in the text and we have made no change.

p.7 - the phrase "subjective norms" is introduced without immediate explanation. Although it is explained later in the paragraph, it might help those not familiar with the terminology to include a brief explanation on first mention.
As with the above comment, we have left this unchanged.

It would be useful to refer to Table 1 at this point.
We agree with the referee and have done this.

The last few lines of p.7 are slightly repetitive of material presented earlier on this page.
We disagree and have left this unchanged.

p.8 Operant conditioning: In addition to the example of remuneration as a positive consequence, it might be worthwhile to give an example of the absence of a negative consequence.
We haven't done this

line 16. "An incentive is a positive consequence of a behaviour". I would suggest that "perceived" should be inserted before "positive". If consequences are positive in actuality but not perceived as
that in advance, they do not function as incentives.
We agree with the referee and have changed this along the lines of her suggestion.

I would also suggest that the construct "perceived consequences of behaviour" (line 24) would be more appropriately placed under the motivational theory of social cognitive theory (equivalent to outcome expectancy) than under operant theory. In Table 1, the construct is labeled "anticipated consequences of the behaviour" - this supports the interpretation that this is a psychological construct that precedes behaviour and serves to motivate, rather than one that succeeds the behaviour and serves to reinforce. Reinforcers may increase the frequency of the behaviour without this function having been anticipated in advance.
This is an interesting comment but one which will ultimately be informed by the data from the study. We have, at this point, chosen to leave it unchanged.

My other substantial point concerns the inclusion of "implementation intention theory" as providing constructs that are not already incorporated within the other theories. There are two components to this 'theory'. The first is "cues to action". This construct is part of operant theory in that behaviour is influenced both by what happens after, but also by what happens before ("antecedents" or "cues to action"). The other component attributed to this theory is "action planning". Part of action planning is to plan the occurrence of antecedents and consequences of behaviour that will maximise the likelihood of it occurring (operant theory). Another function of action planning is to increase self-efficacy: knowing one has an action plan increases a sense of self-efficacy which increases the likelihood of the behaviour occurring, independently of the effects of implementing the plan itself. If the study data show that self-efficacy mediates the association between action planning and behaviour, it may be that the authors could consider this construct as part of social cognitive theory.
This is an interesting comment but one which will ultimately be informed by the data from the study. We have, at this point, chosen to leave it unchanged.

It would be helpful to provide a rationale for selecting anxiety as the emotional construct to measure. On p.10, examples of emotional reactions are given as fear and 'heartsink' reactions (which would seem closer to depression than anxiety).
We have changed the text to refer to "the emotional reaction to "heartsink" patients" thus not labeling the emotional response.

p.12, penultimate sentence - I wasn't sure what "tracer activities" referred to, and whether they were the same as "behavioural outcomes". I am assuming that all of these are attributable to individual professionals: it would be good to make this clear.
We have clarified that these are tracer clinical activities and added text to clarify that these are attributable to individual professionals.

A final paragraph summarising the questions that these data will inform would strengthen the paper. As this is a protocol, rather than a paper, we have chosen not to do this.

We have addressed all of the formatting changes requested in your email.

We hope the paper is now acceptable for publication.