Author’s response to reviews

Title: The Discharge Communication Study: research protocol for a mixed methods study to investigate and triangulate discharge communication experiences of patients, GPs, and hospital professionals, alongside a corresponding discharge letter sample

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Author’s response to reviews:

Thank you for your constructive comments which have helped us to improve the quality of our protocol manuscript. We have responded to all comments and responses are below. Responses and changes are found in coloured font on the attached revised (marked copy) document.

Technical Comments:

Editor Comments:

In addition to the reviewers’ comments below, please address the following editorial concerns:

1. Trial registration number

We did not notice trial registration details, which are usually required for your study protocol. If your study is registered in an international trial registry, please include the name of the registry, the registration number, and the date of registration at the end of your abstract. If your trial does not require trial registration, please indicate that this is not applicable.

As this is not a clinical trial, trial registration is not applicable; this is a qualitative study.

2. Sample size justification

We require that all study protocols include detailed information regarding sample size justification. Usually this information is included in the form of a power calculation, but we
understand that this is not always suitable for studies in the field of health services research. Please include a power calculation, or suitable alternative form of sample size justification for your study.

As this is a predominantly qualitative study, a formal power calculation was not suitable or applicable. We aimed to have sufficient qualitative data to reach data saturation. We have expanded the sample size justification for this study on page 8 lines 166-70 which now reads as follows:

“The study aims to build 30 case “quartets”. Marshall et al. report the average number of interviews for a qualitative study is 24 and that 15-30 interviews are generally recommended for data saturation to be achieved. Therefore, 30 quartets was considered to be an adequate sample size to produce findings that reflect the views of the groups included as participants.”

3. Spirit checklist

We usually require authors to upload a completed SPIRIT checklist for study protocols. Please upload this as supplementary file to your manuscript. If SPIRIT is not appropriate for your study type, please indicate this is the case in your point-by-point response.

The spirit checklist is not appropriate for this study as it is not a clinical trial, interventional study or quantitative study. However, as stated on page 12 line 280, the COREQ checklist by Tong et al. (47) for qualitative reporting will be used to structure analyses and reporting of findings.

BMC Health Services Research operates a policy of open peer review, which means that you will be able to see the names of the reviewers who provided the reports via the online peer review system. We encourage you to also view the reports there, via the action links on the left-hand side of the page, to see the names of the reviewers.

Reviewer reports:

Marianne Weiss (Reviewer 1): This is a very well written, detailed protocol that addresses critical aspects of discharge communication to providers and patients. The completed study will make important recommendations for practice improvement. I only have a couple of recommendations for improvement. and researchers in countries other than UK. But the alternative word, discharge summary, also not used in the same way in every country. I don't really have a suggestion. It becomes clear as one reads the paper that this is a written summary provided to providers and sometimes patients. It would be helpful to clarify the content of the letters in the final report of the study. Is the letter a reminder for follow-up, a summary of the hospitalization, or patient instructions for self-care at home. With the expansion of electronic
communication, it is not clear how these letters are transmitted and if they remain in the form of a 'letter' when transmitted electronically.

We agree that forms of written discharge communication vary across healthcare settings. We have expanded the definition of discharge letters in the introduction. Contents of letters may vary greatly and this is one of the remaining issues in this area; for this reason we have kept the definition of the term broad and inclusive as we looked at all types of discharge not limited to specialty or type of hospital admission. The following text has been added on page 3 line 44-

“Written discharge communication may be sent electronically or in hard copy; they may contain information relating but not limited to a summary of the patient’s hospital visit, treatment and required followed up. Such communication is generally described as being a “discharge letter” in the UK, and this is the term that we have used throughout the current paper. The content and structure of such discharge letters vary depending on the speciality, type of hospital care (e.g. outpatient or inpatient), and the individual preferences and style of the physician who authored the content.”

I do not see in the GP interview guide questions t The use of the term ‘discharge letter’ may be confusing to providers hat would address research question 3.

The GP interview guide asked GPs for their experiences of written discharge communication as we sought a broad range of perspectives relating to all forms of written communication (inclusive of discharge letters) as defined in the opening paragraph (page 3, lines 41-50). We have not found it to be confusing to participants. However, for further clarity we have altered references to discharge communication (where applicable) throughout the paper and changed these to “discharge letters”, in line with the comment above.

Lines 76 and 83 - The term service-user is introduced but not explained.
This has been changed to “patient” for increased clarity.

Line 97. you refer to programme theory. Those familiar with realist review will know what this is but the general audience will need this defined or described.

We agree and so the following definition of programme theory has now been added to page 5 lines 102-105:
“As outlined in the work of Pawson, a “programme theory” comprises a series of “context, mechanism, outcome” configurations and explains how an intervention or programme may be theorised to “work”; this details within what contexts, for whom, why and to what extent.”

Line 150 purpose should be purposive
This has been amended.

Line 152 - add patients after 10,000
This has been amended.

Line 173 - address the potential bias in having GPS select letter - will they screen out poor letters

Line 199 on page 9 has been modified to reflect that, “GPs were encouraged to choose letters for the study which they assessed to be “successful” or “unsuccessful” examples of discharge letters.” As such, GPs were asked to select a range of different quality letters and so less likely to screen out poor letters. In addition, we have added the following to the limitations section on page 17 lines 412-5, “‘There is inherent subjectivity in GPs’ selection of the discharge letter sample. We specifically wanted to understand from the perspective of GPs, what constitutes successful communication and what is seen as being unsuccessful.”

line 176 - patients who lack capacity.... capacity for what? Later in the paper it suggests lack of capacity to consent - the term decisionally incapacitated could be used.
This has been modified and now reads “who lack capacity to give informed consent”.

Line 187 and 190 - you use the term 'more or less' successful examples of discharge letters - then you state that they are coded as successful or unsuccessful. The term 'more or less has different connotations than the binary coding.
This has now been amended and reads “successful” and “unsuccessful” on all occasions as this was the coding system.

Line 192 - what kinds of comments on reasons for selection are you referring to - was a list of reasons developed a priori
The following text has been added to line 204-5 on page 9 to clarify,
“Comments, as with the categorisations, were entirely open; there were no guidelines or lists of reasons.”

Line 344 - the abbreviation PPI is used so seldom in the paper that it should be written out

This has been addressed in all cases where it applies.

Wolf Langewitz (Reviewer 2): this is an extremely carefully designed and well founded research project that merits any support necessary. The authors are to be congratulated to their willingness to perform research within the complexity of a multi-perspective design. I am looking forward to the results!

There is a perhaps slightly cynical reason to focus on the quality of discharge communication, rooted in education and memory research: the recency and the primacy effect. In this regard hospitals should engage in the final - the most recent from a patient’s perspective - exchange between hospital staff and patients/relatives: the discharge and its documentation. If this is well organised and perceived as correctly and understandably summarising the hospital stay, patients might well build a positive memory even though (the cynical part of this argument) during their hospital stay many things were less than perfect.

Thank you for your comments and positive feedback. We agree that discharge communication is an important area. Our main rationale for selecting this area was due to reviewing the evidence base and speaking to GPs, both of which indicated that quality of discharge letters are currently unsatisfactory. We agree that good quality discharge communication may well have the potential to ameliorate patients’ experiences of hospital visits.

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Editorial Policies
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Where a mandatory section is not relevant to your study design or article type, for example, if your manuscript does not contain any individual persons data, please write "Not applicable" in these sections.

For the 'Availability of data and materials' section, please provide information about where the data supporting your findings can be found. We encourage authors to deposit their datasets in publicly available repositories (where available and appropriate), or to be presented within the manuscript and/or additional supporting files. Please note that identifying/confidential patient data should not be shared. Authors who do not wish to share their data must state that data will not be shared, and provide reasons for this in the manuscript text. For further guidance on how to format this section, please refer to BioMed Central's editorial policies page - http://www.biomedcentral.com/submissions/editorial-policies#availability+of+data+and+materials.

Declarations

- Ethics approval and consent to participate
- Consent to publish
- Availability of data and materials
- Competing interests
- Funding
- Authors' Contributions
- Acknowledgements
- Authors' Information

This section has been revised based on the formatting guidelines. The ordering and content of headings are now as follows, page 18-19:

“DECLARATIONS

Ethics approval and consent to participate: Ethics approval was granted by the UK Health Research Authority (HRA) in July 2017 (IRAS ID: 219871, REC reference: 17/WM/0170, sponsor: University of Warwick). Participants were provided with participant information sheets and consent for participation has been received for all study participants.

Consent to publish: Not applicable to protocol manuscript.
Availability of data and materials: The datasets generated during the current study are not publicly available due to the sensitive and identifiable nature of the qualitative data; despite names and other identifiers being removed, the in depth nature of the interviews themselves may mean that participants can be identified. Quotes will be used in results publications and further quotations are available from the corresponding author on reasonable request.

Competing interests: The authors declare that they have no competing interests.

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Authors’ contributions: KW drafted the initial manuscript. JD, SS and ES supervised conceptualisation and design of the study. All authors edited and read the final manuscript.

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