Author’s response to reviews

Title: A case of misalignment: The perspectives of local and national decision-makers on the implementation of psychological treatment by telephone in the Improving Access to Psychological Therapy service

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Author’s response to reviews:

Dear Dr Brettschneider,

RE: BHSR-D-19-01909 ‘A case of misalignment: The perspectives of local and national decision makers on the implementation of psychological treatment by telephone in the Improving Access to Psychological Therapy service’

Thank you for your email dated the 17th October 2019 and for the helpful set of reviewer comments. We have now revised the manuscript in line with these comments, and we feel this has strengthened the manuscript. Please find below our responses to individual comments. Revisions are evident within the manuscript through the use of tracked changes.
Reviewer 1

Congratulations on a well-articulated, theoretically grounded and relevant study! It was a pleasure to learn more about the health care context in the UK and about your methodology.

RESPONSE: Thank you

For the conditions/findings reviewed in lines 94 to 99, are these also for mild-moderate illnesses?

RESPONSE: Yes; the findings outlined in lines 94 – 99 encompass varying severities of anxiety and depression, including mild-moderate illness and we have now clarified this in the manuscript (lines 94-95).

I would encourage a critical description of the findings related to the delivery of treatment by telephone. Were these experimental studies?

RESPONSE: We have now included reference to the research designs of the referenced studies (lines 106 – 109). We agree this is an important issue which links to a number of points in our results and discussion.

Could you spend some additional time clarifying where you want to explore the gap?

RESPONSE: We have added some more specific stakeholder detail to explain what appeared to be the ‘missing step’ (lines 170 – 174). By expanding on the more specific roles of decision makers, we believe the introduction now demonstrates the rationale for the study more logically – thank you.
I wonder about your objective or goal (lines 142/143): "The current study is the first to apply NPT principles to the exploration of decision maker's perspectives of the use of telephone as a mode of treatment in a psychological stepped care programme." I think your focus is really on the implementation gap, not hearing their thoughts on the use of the telephone for treatment. You go on to say later, in the methods (lines 147-149) "The study was designed to seek the views of decision makers who could provide insights into policy and organisational issues concerning implementation of telephone treatments." This latter point in the methods appears much more aligned with your study as it is set out.

RESPONSE: Thank you, we have changed this wording to read: ‘The current study is the first to apply NPT principles to the exploration of decision makers’ perspectives of the policy and organisational issues regarding the implementation of telephone as a mode of treatment in a psychological stepped care programme.’

The use of the present tense in the Results Section makes it a bit challenging to know if the first statement is a statement or a finding given that it is in present tense. Perhaps this is a linguistic difference between Canadians and British (😊), however I wanted to note it in case upon further reflection any confusion is noticed.

RESPONSE: Thank you; we have altered the wording for clarification: ‘Typically, increasing engagement with telephone treatment for depression and anxiety in primary care relies on decision makers such as policy leads and service managers understanding its purpose and potential value, and effectively communicating that down to clinical services.’

Just of note there does appear to be considerable overlap between the four categories of the model throughout the results. I am not sure what to do, other than to acknowledge this overlap.

RESPONSE: We agree, but feel it is important to allow this overlap for demonstration of how the four NPT domains interlink; we hope this is a satisfactory explanation.
On page 20, lines 424-449 the notion of the "misalignment" is introduced as it pertains to what data should be collected (patient experience or clinical outcome measures or other selected KPIs). This point is crucial as it framed your entire manuscript (as evidenced in the title). Could this be explored a bit more?

RESPONSE: We agree, the notion of misaligned drivers for the use of telephone does frame our findings, and as such is now discussed in detail in the discussion section which we think covers this idea comprehensively (lines 502 – 517).

Stating on line 457- the start of the discussion that it is about patient engagement not being maintained seems to disrupt the flow of the study. Only a portion of the responses and questions directly related/ reflected this reason. Instead, more time was devoted to the implementation challenges at an organisational level. As well, it is unclear how this data could inform the design of a quality improvement project. Additional details are needed to build this point.

RESPONSE: More detail has been added at the start of the discussion to better frame the purposes of the study: ‘Despite acknowledgement of the clinical, practical and service benefits of telephone treatments, patient engagement is often not maintained (21), raising the question as to why this is so. Exploring the implementation of telephone delivered treatments in IAPT services from multiple angles including insights from high level local and national decision makers, PWP s at the clinical interface and patients receiving treatment, is crucial in drawing a global picture to identify key issues to address’.

Reviewer 2

The paper focuses on an interesting topic, using a relevant theoretical approach and appropriate methods. The paper is well written and the quality of the reporting is good throughout the manuscript.

RESPONSE: Thank you
The authors state in the discussion (page 22, lines 457-458) that patient and professionals perspectives will be reported elsewhere. Given the important ethical implications associated with such decision, I think this needs to be clearly and appropriately justified - i.e. why are decision-makers perspectives reported separately? What are the implications in terms of enabling a proper understanding in terms of the 'normalisation' of telephone treatments, knowing that patient and professionals perspectives are available but chosen not to be reported here?

RESPONSE: We have clarified in our manuscript that findings from patients and professionals are from separate studies: ‘Data from this study will be combined with findings from associated studies of patient and PWP perspectives of telephone delivered treatment’. The findings from this study will be drawn together with other studies in a synthesis later on in our research programme, which will explore any differences and similarities in perspectives between the different groups. In the current manuscript, presenting the decision makers data alone provides the opportunity to explore findings from this study in greater depth and detail, to provide a comprehensive representation of the data.

The way this section is currently worded suggests that moving from stage 1 to stage 2 of the data analysis process was based on analytic criteria (i.e. 'inductive' thematic analysis was performed first, and then themes were mapped against the theoretical framework and their 'fit' assessed, resulting in no themes falling outside the framework) - however, the actual analytical significance of such a perfectly good 'fit' between stages 1 and 2 was perhaps less central than the current wording suggests (and certainly to be expected) in light of the theoretically-informed approach to semi-structured interviewing adopted (page 9, lines 178-179).

RESPONSE: We have revised the wording in the manuscript in line with your suggestion: ‘All themes were mapped to the framework and demographic information collected for participants was used to contextualise the data.’ We have included this detail for thorough description of the process.
The authors rightly acknowledge in the introduction the importance of considering "context and multiple levels of influence", some of which is addressed with their sampling strategy focusing on key local and national decision-makers. However, on a different level, the paper does not provide much contextual information to enable readers to understand the issues identified and data presented in this paper - for example, although data collection takes place (if I understand correctly) around 10 years post-implementation of the programme under study, we do not know how participants perceived the overall success (or not) in terms of engagement and buy-in both nationally and locally.

RESPONSE: As the focus of the study was to gain insights into perspectives on the implementation of telephone-delivered treatment, it was not explicitly asked of decision makers to offer their global view on the success of IAPT. However, we believe the overall data gives a feel for general perspectives, as views towards implementation are likely to be greatly influenced by their overall views of the IAPT program and its success.

Given the lack of any local-level specific prescriptions about implementation strategies, it is also difficult to understand the findings as whole (and the significance of the various local perspectives being brought together) without some contextual knowledge about local-level implementation approaches/strategies. This contextual information is key to understand if and how this contrasts with national informant views.

RESPONSE: To provide greater context, more detail has been added into the results section (lines 222-228) in particular with regard to current telephone provision within different services. We have also added further information to individual quote references, to provide detail on the level of telephone provision within the informants’ particular service. We believe this additional detail helps to frame our findings more clearly and hopefully addresses reviewer 2’s concerns.

I think it would also help if the authors could summarise (I would suggest adding a table at the beginning of the findings section) some of the key demographic data they took into consideration (as reported on page 10, line 196).
RESPONSE: Thank you – we have added a table containing this information (page 10). We are somewhat limited to the amount of detail we can include for national informants to comply with ethical restrictions and ensure protection of anonymity, but have provided as much detail as we feel we can.

The references placed alongside data examples in the findings section would benefit from some form of identification relating to the service they originated from, so that readers can get a sense of the diversity of local implementations represented in the chosen examples (particularly given that a number of participants were from the same service).

RESPONSE: We have added further detail to quote references to provide information regarding telephone provision within services. We are unable to refer to services by name for individual informants’ anonymity. We hope the added detail provides sufficient context.

I think the discussion does not clearly address whether and how the findings from this study address the gap identified in the introduction (page 6, lines 110-114) - particularly in terms of how barriers/facilitators from decision-makers perspectives differ, contradict or complement clinical-level barriers/facilitators identified in previous studies.

RESPONSE: We have added some detail into the discussion to cover this issue more thoroughly (lines 494 – 497 and 507 – 509), and refer to the ‘comparisons with other studies’ section for detail on how our findings link to the wider literature. We believe this study has addressed the gap identified in the introduction by highlighting how higher level decision makers views on implementation of telephone delivered interventions are currently not in sync with local decision makers, which appears to stem from additional pressures on local services to take into consideration additional variables such as meeting performance targets, financial limitations and tackling obstacles at the front line i.e. PWP resistance. We believe this now comes through more clearly in our manuscript.
Responses for Reviewer 3

The present study presents a valuable contribution to understanding challenges involved with implementing telephone-psychotherapy from a system-perspective and potential reasons for variations in offering telephone-psychotherapy as an evidence-based treatment option.

RESPONSE: Thank you

The description of the study procedure reveals the broad inclusion criteria of interview partners, but not how the representativeness of the sample or the information power was ensured. Even though the authors state that there was no relationship between the interviewees and the researchers, it is not entirely clear according to which criteria the authors invited the 36 potential participants

RESPONSE: Thank you; we have given additional clarification in our methods section. The individual unique positions and roles of participants meant that a snowball sampling approach was most appropriate. None of the researchers directly involved in the data collection had existing relationships with any participants or the services with which they were affiliated. We highlight in the methods in respect of our sample that ‘we sought to identify those involved locally and nationally in policy, practice and/or research in relation to IAPT service delivery and workforce development’ which was our key criteria for inclusion. In terms of power, we worked towards the principle of ‘information power’(1) due to the specific expertise of each individual, as opposed to aiming to achieve saturation. As each of the participants held a different role, in particular the national informants, it was expected that a variety of different issues and perspectives would arise due to participant uniqueness. To ensure agreement across the research team, recruitment was discussed between the team at regular meetings to reach consensus with regard to sufficient data collection.

How did the authors ensure that the interview partners talked about their experiences from the perspective of their current role? It appears as though numerous opinions represented by the quotations are informed by personal experience as (former) clinicians, even the narratives provided by national informants. Given that only 5 participants were classified as national informants, it would be important to know what their exact function was or at least - in case detailed role information compromises anonymity - how these individuals differed from the clinical managers in their role, function, and closeness to telephone-psychotherapy.
RESPONSE: Interview questions were specifically related to participants’ current roles based on their critical understanding of contemporary IAPT services and telephone delivery. Previous clinical experience no doubt plays a role in that understanding, and therefore, we did not seek to exclude this influence from interviews; just as prior experience may have influenced interview responses, our data shows it also plays an important role in the perspectives local and national informants about their role and the IAPT programme. As this plays an important role in opinions and therefore decisions made by informants, we did not believe it necessary therefore to exclude such experience. In terms of national informant’s roles, to avoid compromising anonymity, a broad description has been included: ‘Role responsibilities included clinical practice, clinical leadership, service management, education, national policy decisions, academic and research activity.’

I agree that personal opinion is an important factor related to this study, but the important question is from who the personal opinion is presented. For readership not entirely familiar with how NHS is organised, the precise role or "power" of decision-makers is not clear.

RESPONSE: Thank you; greater detail regarding decision makers roles and responsibilities has been included in the methods section: ‘Local informant role responsibilities included clinical practice, clinical leadership, service management and decision making around front-line practice, PWP working arrangements and service provision of telephone treatment. National informant responsibilities encompassed education and curriculum, national policy decisions, academic and research activity’.

Did the authors gather information about how telephone-treatment is currently implemented and realised in the clinical practices of their respective centres?

RESPONSE: We have now included this information in a table (Table 2).

I hope these revisions meet with your approval and I would like to thank the reviewers for their helpful contributions to the article. Should you have any further queries, please do not hesitate to contact me.
Yours sincerely,

Kelly Rushton