Author's response to reviews

Title: Implementation of a self-management support approach (WISE) across a health system. A process evaluation explaining what did and didn't work for organisations, clinicians and patients

Authors:

Anne Kennedy (a.kennedy@soton.ac.uk)
Anne Rogers (a.e.rogers@soton.ac.uk)
Carolyn Chew-Graham (c.a.chew-graham@keele.ac.uk)
Thomas Blakeman (t.m.blakeman@manchester.ac.uk)
Robert Bowen (robert.a.bowen@manchester.ac.uk)
Caroline Gardner (caroline.j.gardner@manchester.ac.uk)
Victoria Lee (victoria.lee@manchester.ac.uk)
Rebecca Morris (Rebecca.morris@manchester.ac.uk)
Joanne Protheroe (j.protheroe@keele.ac.uk)

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Author's response to reviews:

Dear Editors

Re: MS: 2879684901125250 - Implementation of a self-management support approach (WISE) across a health system. A process evaluation explaining what did and didn't work for organisations, clinicians and patients.

Thank you for giving us the chance to respond to the reviewers concerns and resubmit the paper. We have now addressed each of the comments and amended the manuscript accordingly. The revised manuscript includes tracked changes.

We hope you will find the paper suitable for publication

Editorial comments

In particular, the reviews by Drs. Green and Palinkas have identified some critical concerns. Both have raised the issue that the qualitative methods need to be more clearly articulated. Attention to issues in the outer context alluded to in the introduction should be followed up later in the manuscript, or if not addressed should be noted as a limitation of the study. It is still not clear that WISE can be considered an EBP even though it is composed of evidence-based components and this is a clear limitation that should be noted.

Response

We have specified below how we have more clearly articulated the qualitative methods used; followed up the issues in the outer context in the discussion and now state that WISE is an intervention with evidence-based components.

Referee 1
It is important that negative results are published and the processes of implementation are understood in terms of how systems/approaches to care become embedded in clinical practice. Knowing and understand what doesn’t work in a particular context is just as important as knowing and understanding what does work. This is particularly important in the context of supporting patients to self-manage where large scale roll out of programs often report disappointing results and this is further reinforced by ambivalence towards self-management by health professionals

Response

We thank the reviewer for the positive endorsement of the revised paper

Referee 2

Major Compulsory Revisions

1. The rationale for conducting this study remains unclear. On p. 4, the authors state “there is a need to understand how a systemic patient-centred approach to SMS reconfigures existing relationships, communication and practices and how (and if) the principles of a whole systems approach can translate, embed and integrate into routine practice.” Why there is such a need to understand this isn’t clearly established.

Response

We have now added to the previous sentence to make the rationale clearer:

“However, an implementation gap has been identified between these national policy aspirations and current means of delivery as patients are not being directed to local resources or engaged in behaviour change. The components of the WISE approach (Whole System Informing Self-management Engagement) to SMS had been firmly established but not implemented in a primary care context.”

2. In addition, on p.5, the authors state the reason for the process evaluation was to explain “why this evidence-based approach was not implementable in routine primary care.” The need to understand how the approach to SMS reconfigures existing relationships, communication and practices appears to be absent. Moreover, the paper lists four aims of the process evaluation on p. 6. However, there appears to be no results presented that describe the fourth aim: changes in personal management arrangements, impact on existing caring relationships and use of additional services and resources.

Response
The WISE approach entailed establishing a structured and evidence based approach and the process evaluation was undertaken to find out if this could reconfigure relationships, communication and practice. The structured approach is set out in table 1 and the table and text on p.5 has been amended to show this more clearly.

Results for the 4th aim of the process evaluation were not included because the trial led to no changes or impact on relationships or use of additional services. We have added a sentence at the start of the results section to highlight this:

“This analysis explains why there were no effective changes in personal management arrangements, existing care “as usual” relationships or use of additional services and resources.”

3. The rationale for conducting this study also seems somewhat narrow. The authors fail to make a convincing case for wanting to know why the reader should care about barriers and facilitators to using WISE as an implementation strategy or intervention. What is needed is a link about the specific instance of WISE to a broader theory of implementation.

Response

WISE was linked to NPT from its inception. It formed the bases of the process evaluation to identify implementation barriers and facilitators. We used NPT constructs to develop a survey questionnaire to gain a view about how WISE was being operationalised across settings and actions. The wall charts represented part of a framework approach drawing on NPT (refs 40-42) which we applied to emergent data. The semi-structured interview schedule contained questions which were orientated loosely around NPT constructs. The adequacy of the mapping and interpretations of the data was established through discussion of emergent data with all co-authors and refined in a data analysis workshop with an external expert (Carl May, the developer of NPT)

We have added a sentence to the start of the methods section:

“NPT formed the bases of the process evaluation methodology and analysis; the survey questionnaire and the interview schedules were orientated around NPT constructs to gain a view on how WISE was being operationalised and actioned across settings.”

And added to the analysis section:

“…exemplar quotes. In line with how others have used NPT to provide a conceptual framework [40-42] coding reliability was established through a series of team meetings. This emergent data was collated to create a wall-chart to map NPT constructs. The adequacy of the mapping and data interpretation were established through discussion with all co-authors and refined in a data analysis workshop with an external expert (Carl May). The chart was finessed to produce the final version of table 2.”
4. The authors stated they provided more information on qualitative methods, but more information is required in order to properly evaluate the methodology employed. For instance, how long were the interviews? How was the reliability of coding the data assessed? More detail is needed to explain the “wall chart based on NPT constructs.”

Response
We have added details about the length of the interviews and amended the analysis section on p.7 to address the points raised (see above).

5. The authors indicate that “had we the foreknowledge to predict the scale of the political change which occurred during the lifespan of this long research project, we could have built this into the process evaluation. I found this response to be weak and unconvincing. The introduction of the manuscript includes a statement that “we also considered the outer systems which influence implementation [21] and have added to the original model (see figure 1)” Presumably, the political environment is a critical element of the outer setting. Further they note in the discussion section that “the PCT was disbanded as part of wider NHS changes so there was a considerable amount of organisational change, loss of staff and shifting priorities.” It would seem that disbanding the PCT was a significant outer context change. At the very least, the lack of focus on this change should be identified as a limitation to the study, and an elaboration of how it might have contributed to the reluctance of patients and providers to adopt the SMS should be included in the manuscript.

Response
We have added a sentence to the discussion p.17 to address this point:
“This represented a significant ‘outer context’ change [21], which could not have been anticipated and had most impact at the organisational level (where the research team had developed good relationships) but little at the professional or patient levels.”

6. In the end, it is unclear whether the results answer either of two questions: 1) whether SMS cannot be implemented because both practitioners and providers have little confidence in it, or 2) whether WISE is a poor strategy for implementing WISE. As there is no data or results from other studies to compare WISE with other implementation strategies, the paper does not really answer the second question. As to the first question, I’m not certain that the results offer any new insight.

Response
We feel the paper clearly answers the first question – that SMS cannot be implemented because it is not a priority for patients or practitioners. From this it follows that the WISE approach was a poor strategy – we feel that in the
discussion we have compared some of the components of WISE with other studies in order to highlight what elements might be worth pursuing and which are more likely to fail in implementation.

7. One of the most obvious reasons why SMS failed to be implemented that is not discussed in this paper is that the RCT found no significant outcomes. Whether it was due to a self-fulfilling prophesy on the part of both patients and providers or that it failed to improve patient outcomes or patient-provider relationships, practices are unlikely to be implemented unless either have some form of personal experience in their effectiveness. Clearly, that was lacking in this instance.

Response
We don’t quite understand the point being made here – the process evaluation set out to explain why the RCT found no significant outcomes

Minor essential revisions
p. 4. WISE may have evidence-based components, but it is not an evidence-based intervention as the authors claim.
Response – amended to address this on p.5
“The WISE approach [18], is an intervention with evidence-based components”

p. The authors claim that the training was successful. However, the quotes provided suggest otherwise.
Response
We feel this distinction is a result of the difference between the quantitative survey data collected immediately post-training and the reflection evident in the qualitative interviews. We have highlighted this in the discussion:
“The training aimed from the outset to instil a learning organisational ethos and to actively engage a range of staff. This was successful as notes from the trainer indicated that in the first WISE sessions an enjoyable collegial atmosphere was evident which seemingly underpinned the positive scores in the post-training satisfaction survey (table 3). However, the clear engagement and satisfaction with training did not translate into the practices of everyday working”
We have added a quote from a trainer (page 12):
“The trainers reported (in detailed notes and in interviews) on the positive reception to the training and alluded to the problems in putting it into practice.
“they all seem to enjoy the training but it’s what they do with it is, perhaps, we’re not quite clear.” (trainer)”

Referee 4
- Major Compulsory Revisions
The authors have responded to the previous review and the manuscript is much
improved. Two significant problems remain that, if addressed, would strengthen the paper significantly.

1) The authors argue that the intervention was in fact evidence-based, though I continue to disagree with this contention. The intervention was composed of a series of components that were evidenced-based, but their combination was, in fact, new, as was the setting for implementation. Moreover, the authors indicate that one of the components (online directory) was cumbersome to use and too time-consuming to use within consultations. Most EBPs would not be characterized in this way, calling into question whether the specific components in fact had an evidence-base rather than a theoretical base alone. For these reasons, I believe it is misleading to call this an evidence-based intervention. The manuscript would be improved by dropping this designation and discussion that revolves around it, and including as a limitation that it is not possible to determine whether the lack of results were a function of the intervention, problems with implementation, or both.

Response
WISE is an intervention with evidenced-based components (amended on p.5 see above). We have amended the third paragraph of the discussion to make our views clear:

“Why did WISE fail in implementation? The RCT itself was well-implemented, with good reach in terms of practices and patients recruited. How WISE was interpreted and made meaningful in a particular primary care context contributed to a failure to embed the intervention in everyday practice. This came from professional and, to an extent, patient views that self-management support was something that ultimately was not the core business of primary care and these expectations shaped the fate of the intervention post-training.”

2) The section describing analytic methods remains weak in terms of theoretical approach and details about the analytic process. Much greater detail is needed.

Response
More detail has been added to the analysis section and references added to strengthen the theoretical approach

- Minor Essential Revisions
1) Although the authors removed some language describing context specific to the NHS, other such language remains (e.g., “The imminent changes around commissioning exacerbated these uncertainties.”; “The commissioning manager…” It would be helpful if these terms could be explained for those not
familiar with specifics of the NHS.
Response
An explanation has been added p8:
“Commissioning Directorate (the point in the NHS system where planning, agreeing and monitoring of services occurs)”