PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Protocol for an exploration of knowledge sharing for improved discharge from a mental health ward
AUTHORS	Rowley, Emma; Wright, Nicola; Waring, Justin; Gregoriou, Kyri; Chopra, Arun

VERSION 1 - REVIEW

REVIEWER	Claire Henderson King's College London Institute of Psychiatry
REVIEW RETURNED	12-Jun-2014

GENERAL COMMENTS	The authors make a good case for the discharge process as a good topic for improvement science. A few points for improvement: Abstract instead of stating the study has 'ethical approval' state which REC has given approval. Introduction This refers to 'interesting findings' but the paper does not describe these nor does it explain how the proposed research relates, if at all, to these findings. For example, one study was found about communication in the USA but the results are not discussed. Too much of a distinction is made between psychiatric and other inpatient units in terms of the % who lack capacity to make treatment decisions. I have come across one estimate of 40% on medical wards. Further, since this capacity is regained following acute episodes in the majority of mental health service users it would be worth interviewing them after discharge about the process instead of just involving them in the planning of the study. I was not clear whether the trust where the study is to be conducted already has an electronic health record. If it does not it would be unusual making the study not easily generalisable. The authors state one is to be introduced but it is not clear when in relation to this the research is taking place. If the research takes place beforehand then it will be much less useful. Eligibility criteria- surely all employees will be able to give consent if they wish to participate?

REVIEWER	Sandra Nutley University of St Andrews, UK
REVIEW RETURNED	01-Aug-2014

GENERAL COMMENTS	The study will be tackling an important issue and sharing the study protocol is a good way of alerting others to the study prior to the publication of the findings. In reviewing the protocol, I have focused on the Managing Editor's request that reviewers should 'help ensure protocols are scientifically credible… [and] the design should be ethically and procedurally sound'. My comments below relate to these criteria but I have also commented on the clarity of the protocol. Where line numbers are mentioned to, these refer to the line numbers found in the BMJ Open pdf version of the protocol. Study design 1. Is the study best described as a 'qualitative exploration'? I note that baseline and repeat quantitative measures will be used to assess the success of the intervention. 2. The introduction presents a rich picture of the problems and processes of mediating professional boundaries in order to share knowledge. There is recognition that knowledge is often dynamic, 'sticky', and difficult to share via explicit codification strategies. For these reasons, it seems somewhat out of keeping to hypothesise that a 'central information repository resource' (p 9) might be the answer to the knowledge sharing problems. The basis for this assertion should be more clearly explained in the introduction to the protocol. 3. At present there is inconsistency in the description of who will be involved in the study. Much of the time the protocol defines the study participants as healthcare practitioners (acute and community based), but in places it refers to involving health and social care practitioners (e.g. p 15, line 24). 4. The proposed analysis of the repeated baseline measures is under-specified in the protocol and further details should be provided. 5. The paragraph on p 21 about service user involvement in the planning and management of the study comes out of the blue and should ideally be mentioned earlier in the protocol. 6. In the competing interests statement (p 22), there is no mention about the potential for bias if AC and KG are involved in data analysis or how this will be handled. Of course, many qualitative researchers would argue that objectivity is neither a feasible nor relevant criteria for judging the quality of qualitative research. Clarity of protocol The following suggestions are aimed at improving the clarity of the proposal P3, line 16, state year rather than use the phrase 'last year' P3, line 45, state locality rather than use the phrase 'locally' P4, lines 3-8, the way this is currently written makes it sound as if 133 of the 139 citations were dated prior to 2000 and this is why they were excluded from full text review. Is this the case? P4, line 14, there are some missing words in the sentence. Maybe add 'was adopted' after 'identified literature' P4, lines 43 and 46, are 'problems' and 'factors' being used as interchangeable terms? If so, it would be better to stick with just 'problems'. P4, line 55, need to provide a source for the estimated cost of £400 per day P5, line 34, it was hard to follow the flow of the argument in this paragraph – particularly how the rest of the paragraph related to the first sentence. P 6, line 8, is it possible to provide a reference to the audit referred to in this paragraph? In addition, talking about the 'study site' in general terms seems premature at this stage because the site has not yet been introduced. Is the study site the NHS Trust or Ward A?

	P 11, lines 24-28, there is a need to revisit the wording of these lines because a series of causal assumptions are stated as facts P 12, line 43, not sure what 'care team' refers to in this context P 12, line 54, 'able to having' needs rewording.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1

Instead of stating the study has 'ethical approval' state which REC has given approval. > Clarified – now states "The study has received ethical approval from Nottingham University Business School ethics committee, and has all appropriate NHS research governance clearances". We were advised (by the NHS organization in which the research is taking place) that NHS ethics was not required; however, we still needed School approval (a condition of our funding) and NHS R&D approval.

Introduction - This refers to 'interesting findings' but the paper does not describe these nor does it explain how the proposed research relates, if at all, to these findings. For example, one study was found about communication in the USA but the results are not discussed > Paragraph has been added, giving details of results and how they are linked to this study.

Too much of a distinction is made between psychiatric and other inpatient units in terms of the % who lack capacity to make treatment decisions. I have come across one estimate of 40% on medical wards. Further, since this capacity is regained following acute episodes in the majority of mental health service users it would be worth interviewing them after discharge about the process instead of just involving them in the planning of the study > Our focus isn't on the capacity to consent but about the ability to adequately knowledge share upon admission to the ward (when the majority of patients will be in a state of crisis). We have clarified the text, and have removed the Owen reference.

I was not clear whether the trust where the study is to be conducted already has an electronic health record. If it does not it would be unusual making the study not easily generalisable. The authors state one is to be introduced but it is not clear when in relation to this the research is taking place. If the research takes place beforehand then it will be much less useful > Clarified the text; the Trust does have electronic patient records but there are problems with access, meaning time delays in information being entered into the system.

Eligibility criteria- surely all employees will be able to give consent if they wish to participate? > Deleted for clarity.

Reviewer 2

Is the study best described as a 'qualitative exploration'? I note that baseline and repeat quantitative measures will be used to assess the success of the intervention. > Have deleted 'qualitative' from the title.

The introduction presents a rich picture of the problems and processes of mediating professional boundaries in order to share knowledge. There is recognition that knowledge is often dynamic, 'sticky', and difficult to share via explicit codification strategies. For these reasons, it seems somewhat out of keeping to hypothesise that a 'central information repository resource' (p 9) might be the answer to the knowledge sharing problems. The basis for this assertion should be more clearly explained in the introduction to the protocol. > Have rephrased, so that now refers to 'research question' rather than hypothesis, which sits better with the preceding claims about knowledge.

At present there is inconsistency in the description of who will be involved in the study. Much of the time the protocol defines the study participants as healthcare practitioners (acute and community based), but in places it refers to involving health and social care practitioners (e.g. p 15, line 24). > Have amended – now refers to 'healthcare practitioners' throughout

The proposed analysis of the repeated baseline measures is under-specified in the protocol and further details should be provided. > Further details are given: The quantitative data from the baseline and repeat measures (Length of Stay; Readmission Rates) will be analysed simply; given the complexity of the admission/discharge process, it will not be possible to statistically show the 'effect'

of the proforma due to so many confounding influences. However, by running simple statistical tests (such as median length of stay, and average readmission rates) over two time periods (before / during the use of the proforma), we may be able to see some difference, which would then suggest the need for more detailed, subsequent investigation if the research were to be repeated on a larger scale.
The paragraph on p 21 about service user involvement in the planning and management of the study comes out of the blue and should ideally be mentioned earlier in the protocol. > This paragraph has been moved to the start of the methodology section
In the competing interests statement (p 22), there is no mention about the potential for bias if AC and KG are involved in data analysis or how this will be handled. Of course, many qualitative researchers would argue that objectivity is neither a feasible nor relevant criteria for judging the quality of qualitative research. > Clarified; now states: AC is the main consultant psychiatrist on the ward where the study will be conducted, and is the problem owner, having identified the issue requiring improvement and bringing it to other members of the research team. KG is a senior nurse on the ward. To maintain objectivity and minimise threats of bias, neither AC nor KG will be involved in data collection or preliminary analysis. They will only have access to anonymised data that is used by the research team in producing the analytical narrative. At all times, the team will be mindful of any potential loss of objectivity, and as such, data analysis will be led by ER and NW.
P3, line 16, state year rather than use the phrase 'last year' > Changed to: since 2011
P3, line 45, state locality rather than use the phrase 'locally' > So not to identify the Trust, we have not given the locality – as there is only one mental health provider in the city. Instead, we have referred to the location as the 'East Midlands (UK)'
P4, lines 3-8, the way this is currently written makes it sound as if 133 of the 139 citations were dated prior to 2000 and this is why they were excluded from full text review. Is this the case? > We have reworded this section. It now states: Despite the different methods employed, these studies have highlighted some useful findings. Regardless of the service and organizational variations across the different countries these papers originated from, the problems and difficulties encountered in sharing information between professionals working in inpatient and community settings was consistent. For example, Durbin et al. describe the quality of information sharing and reporting between primary care and mental health services that takes place at referral and post discharge as, at bast, variable. However, the use of interventions, such as liaison services and specific workers to assist service users with the transition from hospital to community, were found to produce improvements and therefore demonstrate that this process is amenable to intervention. The issue of 'delayed discharge' at an organizational level was explored by the two UK based studies. Although they both highlight that there are differences in the reporting and definition of 'delayed discharges' across the UK, delayed discharges remain a concern with potential financial ramifications. Lewis and Glasby suggest that organisations are desperate to tackle delayed discharges by any means possible. This includes supporting policy directives, such as reimbursement, when in other circumstances they would not do so.
P4, line 14, there are some missing words in the sentence. Maybe add 'was adopted' after 'identified literature' > Amended
P4, lines 43 and 46, are 'problems' and 'factors' being used as interchangeable terms? If so, it would be better to stick with just 'problems'. > Amended
P4, line 55, need to provide a source for the estimated cost of £400 per day > Amended
P5, line 34, it was hard to follow the flow of the argument in this paragraph – particularly how the rest of the paragraph related to the first sentence. > Amended
P 6, line 8, is it possible to provide a reference to the audit referred to in this paragraph? In addition, talking about the 'study site' in general terms seems premature at this stage because the site has not yet been introduced. Is the study site the NHS Trust or Ward A? > Have added (unpublished) to text – as audit is not available publicly, nor to name the Trust would identify the study site, which we do not wish to do
P 11, lines 24-28, there is a need to revisit the wording of these lines because a series of causal assumptions are stated as facts > Amended

P 12, line 43, not sure what ‘care team’ refers to in this context > Changed to ‘healthcare practitioners’
P 12, line 54, ‘able to having’ needs rewording. > Amended