PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Helping patients prepare their dependent children for parental death: mixed-methods evaluation of a co-developed training programme for palliative and allied healthcare professionals in the UK.
AUTHORS	Cockle-Hearne, Jane; Groothuizen, Johanna; Ream, Emma

VERSION 1 – REVIEW

REVIEWER	Herbst, Franziska A. Hannover Medical School, Institute for General Practice and Palliative Care
REVIEW RETURNED	15-Dec-2023

GENERAL COMMENTS	Thank you for giving me the opportunity to review the manuscript "Helping patients to prepare their dependent children for parental death: mixed-methods evaluation of a co-developed training programme for healthcare professionals" (Manuscript ID bmjopen-2023-081775) for BMJ Open. The authors describe results from the evaluation of a training programme for health professionals to help dying parents support their minor children, using Kirkpatrick's four-level model of evaluation. A particular strength of this study is the skilfully executed mixed-methods design (see e.g. information on the integration of interview data and free-text responses from questionnaires in coding frame in Nvivo or Table 5 on convergent themes). Overall, it was a pleasure to review this high quality, clearly written manuscript. Results are concisely presented and well embedded in the discussion. I only have few minor concerns and suggest accepting the manuscript for publication when these minor concerns have been addressed. The paper adheres to the journals' standards; the authors have used the Cre-DEPTH checklist. Detailed minor comments: General comment: Please check the entire manuscript for punctuation, double blank spaces, etc. There were a few oversights throughout the manuscript. Methods: p. 10, line 40: Please could you add one or two sentences in your manuscript to explain why you have chosen Framework Analysis to analyse your interview data? Results:

	p. 10, lines 26-40: In this paragraph the numbers and percentages in brackets are confusing as I would read e.g. the first bracket (n=31,89%...) as follows: “n is equal to 31.89%”. I see that you have used a comma (not a dot) to separate numbers and percentages, but I would suggest to use the following format throughout to ensure better readability (n=31; 89% : n=25; 89%); i.e. use a semicolon and a space instead of the comma without space.

REVIEWER	Kristiansen, Ida Lykke University of Copenhagen, Department of Economics
REVIEW RETURNED	01-Mar-2024

GENERAL COMMENTS	Referee report for ”Helping patients to prepare their dependent children for parental death: mixedmethods evaluation of a co-developed training programme for healthcare professionals.” The paper aims to evaluate the training programme "No conversation too tough" on healthcare professionals' practice style and their feeling of usefulness for their patients. The program targeted healthcare professionals working with end-of-life patients that have dependent children. The authors examined the perception of learning provided by their training and the effect on their confidence in using the material learned. While I think the intention of the program seems to be very important, I am missing some key information that I could not find in the manuscript. To fully understand the estimates reported in the paper, I would need more information, especially on potential selection into the samples. Additionally, I worry about the lack of a control group, the sample sizes, and the absence of any patient outcomes. You write in Table 1: “Potential delegates were contacted via personal and email approaches through the supporting UK cancer charity and the co-design team’s networks.” How was the potential delegate chosen? Did you send out an invitation to all potential delegates in the UK, or was the selection somehow targeted? How many did you contact in total, and of those, who ended up participating? Were the delegates who participated different from those who did not? If so, in what ways? Did all delegates who were interested enroll in the program, or did you select from those who showed interest? Who decided on participating, the individuals themselves, or their workplaces? Similarly, how were the individuals who were interviewed and those who participated in the log-data selected? Were invitations extended to everyone, or was there a selection process? If everyone was invited, how did those who participated differ from those who did not? If there was a selection process, how were individuals chosen? You write on page 16 “Post-training, most participants had not had an opportunity to apply their learning, but they spoke of intentions to do so.” How large a share was this? Additionally,

	when is this measured? Was it measured from the solely from the log data or also from interviews? In addition to a larger sample, incorporating a control group would enhance the study's robustness. There's a concern that, in the absence of treatment, participants might have become more confident over time, and having more objective data, not organized by the authors, targeted at measure the participants awareness of engaging with parents in conversations around death and dying would be valuable.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1 comments		
1.	General comments: Please check the entire manuscript for punctuation, double blank spaces, etc. There were a few oversights throughout the manuscript.	Corrected.
2.	Please could you add one or two sentences in your manuscript to explain why you have chosen Framework Analysis to analyse your interview data?	In the Methods section, under Data Analysis/Qualitative, as requested, we have added two sentences to explain our choice to use Framework Analysis. Page 10.
3.	p. 10, lines 26-40: In this paragraph the numbers and percentages in brackets are confusing as I would read e.g. the first bracket (n=31,89%...) as follows: “n is equal to 31.89%”. I see that you have used a comma (not a dot) to separate numbers and percentages, but I would suggest to use the following format throughout to ensure better readability (n=31; 89% : n=25; 89%); i.e. use a semicolon and a space instead of the comma without space.	Thank you for pointing this out. We have amended all the data in this section as advised. Pages 10 and 11.
Reviewer 2 comments		
Note: Each point below is a summary of the points raised.		
1	How were the delegates chosen?	We have addressed this under the section Participant Recruitment on pages 7 and 8.

2.	How were the samples for taking part in the interviews and practice logs selected?	This has been explained under Participant Recruitment on Page 8.
3.	Intention to use learning – how measured (logs, interviews), size?	This was from the interviews. Due to the closeness of the post interviews to the training, there had been little opportunity for participants to have conversations with patients. We have amended the first sentence of the section *Intentions to use learning* on page 17.
4.	Lack of a control group.	Our article reports an evaluation of the first iteration of the training programme. As such the research aimed to assess feasibility and to identify areas where the training programme requires development. In this case, we considered that a single-arm, pre-post design would be appropriate. Key impact data will be collected when the second iteration of the training is rolled out nationally, at which time a much larger, powered sample will be obtained. To include a control group in relation to training for healthcare professionals would be impractical in that it would be impossible within given time and cost constraints to control for the variation in organisational, role, practice and caseload variables. We have acknowledged the limitation of the study due to lack of control group in the Strengths and Limitations section.
5.	Absence of patient outcomes.	We agree that patient outcomes (Kirkpatrick level 4) are very important to measure in assessing the effectiveness of the training. In this study we were looking at how the training succeeds in improving healthcare professional skills, confidence, and knowledge to have conversations with patients who have dependent children. Effectiveness in terms of translating knowledge into practice will be the focus of a follow-up, long-term study. Patient outcomes in respect of the developed and tested training programme are a distal outcome, which will require a long-term research design to examine the specific effect on families and child development. This stepped approach to training evaluation is consonant with the Kirkpatrick model, and we have acknowledged in the Discussion that patient outcomes have not been assessed.