## PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (see an example) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below. Some articles will have been accepted based in part or entirely on reviews undertaken for other BMJ Group journals. These will be reproduced where possible.

## ARTICLE DETAILS

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| **TITLE (PROVISIONAL)** | THE WORK OF COMMISSIONING: A MULTI-SITE CASE STUDY OF HEALTHCARE COMMISSIONING IN ENGLAND'S NHS |
| **AUTHORS** | Smith, Judith; Shaw, Sara; Porter, Alison; Rosen, Rebecca; Mays, Nicholas |

## VERSION 1 - REVIEW

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| **REVIEWER** | O'Cathain, Alicia<br>The Univetsity of Sheffield, School of Health and Related Research (ScHARR) |
| **REVIEW RETURNED** | 14-Jun-2013 |

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| **GENERAL COMMENTS** | I think this is a useful, well executed and well written study. It is extremely challenging to condense these large amounts of data into a coherent short paper and I congratulate the authors on succeeding in this. I am highly supportive of this paper and know it will have an avid and influential readership. I have written some comments on the pdf, drawing attention to missing information from my perspective and where there is a need for further clarity on specific issues (see attached pdf). As well as attending to these comments, I would recommend:<br>1. Revisiting the abstract and making it sharper so that readers can more quickly get the main messages you wish to communicate. This is what I have taken away: That commissioning for LTCs is a long drawn out process involving working with lots of partners and seems largely divorced from the contracting process. Commissioners taking an incremental approach appeared to be more successful in terms of delivering the planned changes in service delivery than those attempting to transform interconnected systems. The amount of effort appeared to be disproportionate to the service changes achieved. A more transactional approach may be more efficient and CCGs may be more able to do this because they are not as reliant on service providers for clinical expertise as PCTs. You may disagree with my reading but I would like to see yours more clearly articulated. (I find it very difficult to get the abstract right prior to journal submission and find it easier to write a sharper abstract when I've received the reviews.)<br>2. You want to link processes and impact. I like this but you give little information about impact throughout the paper. I think you need to be more explicit about what you mean by impact. First, does the planned change occur. Second, do you get expected outcomes e.g. less use of emergency admissions. The methods and evidence for change in outcomes is missing. You need to add these in or take the outcomes out of the paper.<br>3. You use what I call certainty language: 'it is like this'. You need to attend more to what you could see in the time period you were there in the PCTs. Use 'appeared' and 'seemed' a bit more. Add a limitations section and describe and reflect on your access to some |

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| | areas of commissioning. You say transactional commissioning occurred behind closed doors so was there more relational commissioning because that's all you were allowed to see? I don't think it is due to this but there will be some of this going on and you need to address it. Also, can you generalise from your three PCTs? I think you can, but would like to see you reflect on this.<br>4. Your implications/conclusions are a bit woolly. Again, mine usually are too at this stage, but I would like to push you to be more explicit about them.<br>5. Is the poorly performing PCT OK about you naming them?<br>6. My team published some research on surveys of commissioning processes for long term conditions (Sampson et al, JHSRP 2012) which showed the extent of what we called partnership commissioning – initiatives that were instigated by groups rather than PCTs - and the fact that it had appeared to increase between 2009 and 2010. This also showed the considerable extent of relational commissioning for LTCs in PCTs close to the time of your research and offers a useful context to show that your case studies are not unusual in any way. We also published a report on the outcomes of commissioning for long term conditions showing little effect on outcomes within two years of the service change occurring which again supports your findings. I think this work complements and supports your findings. |

- The reviewer also provided a marked-up pdf which is available on request from the publisher.

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| **REVIEWER** | Checkland, Kath<br>University of Manchester, Institute of Population Health; Centre for Biostatistics |
| **REVIEW RETURNED** | 14-Jun-2013 |

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| **GENERAL COMMENTS** | Overall I think this is a good paper that should be published. However, I would recommend that it would benefit from some minor revisions focused upon the comparisons made between 'relational' and 'transactional' commissioning work. The paper demonstrates clearly that commissioning work is highly relational in nature. They then go on to imply that this contrasts with the more 'transactional' work associated with contracting, which was generally pursued by different teams of managers. However, they collected little (if any) data directly about the contracting aspects of the work. Previous studies of contracting (eg those by Allen et al cited in the paper) have demonstrated that, in fact, although 'contracting' might be thought to be largely transactional in nature, in practice much NHS contracting is also relational in character. This may not seem to be a big point, but as it reads at present the authors have used the relational/transactional distinction rather loosely and in a way which is not borne out by the literature they cite. It is probably more correct to say that this study shows that commissioning work is highly relational, and that previous studies have shown that contracting also remains largely relational, in spite of a perception from these study participants that it should be more transactional in nature.<br>In addition, there is little if any mention in the paper of any engagement between commissioners and local GPs via the 'practice-based commissioning' initiative which was in place at this time. It may be that the local PBC groups had little to do with the work being done, or it may be that they were involved in particular activities. Given that the reorganisation of the English NHS since this |

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| | study was undertaken was designed to involve GPs much more fully in the commissioning process, it would be useful if the authors could highlight more clearly both where GPs were engaged and where their input might have added value. |

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| **REVIEWER** | Sheaff, Rod<br>Plymouth University, School of Applied PsychoSocial Studies |
| **REVIEW RETURNED** | 02-Jul-2013 |

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| **GENERAL COMMENTS** | I recommended disambiguating the notion of 'effective commissioning' (effective at what and for whom?); see comments above.<br><br>Page 12, lines 43-48 report the large amount of work involved in evolving a service redesign, and questions whether the amount of work is 'worth the likely impact'. However, someone has to design the care pathways for a service, even if the methods reported seem unduly laborious. |

**VERSION 1 – AUTHOR RESPONSE**

| **Comment** | **Response** |
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| Two reviewers suggested revisiting the abstract and making it sharper | We agree. We have rewritten the abstract to make the key messages from our study clearer to readers. |
| AOC: You use what I call certainty language: 'it is like this'. You need to attend more to what you could see in the time period you were there in the PCTs. Use 'appeared' and 'seemed' a bit more. Add a limitations section and describe and reflect on your access to some areas of commissioning. You say transactional commissioning occurred behind closed doors so was there more relational commissioning because that's all you were allowed to see? I don't think it is due to this but there will be some of this going on and you need to address it. Also, can you generalise from your three PCTs? I think you can, but would like to see you reflect on this. | We agree and have softened the language that we use throughout the paper.<br><br>We have included a section in the conclusion that reflects on the limitations of the study in terms of access to the more transactional aspects of commissioning. |
| AOC: Your implications/conclusions are a bit woolly. Again, mine usually are too at this stage, but I would like to push you to be more explicit about them. | This is a really helpful comment which, along with the specific comments on the pdf file, has guided us to hone the key messages from our study. We have reworked the conclusions section to reflect this. |
| AOC: Is the poorly performing PCT OK about you naming them? | This reviewer is referring to a particular service in Wirral. We have rephrased a couple of points that relate specifically to this service. It is worth noting that Wirral (the PCT in which the service was based, and the successor clinical commissioning group) is aware of the findings and formally approved our final study report (published via the National Institute for Health Research in March 2013). |
| AOC: You want to link processes and impact. I like this but you give little information about impact | We agree and have removed any mention of impact altogether. We have done this because our paper is |

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| throughout the paper. I think you need to be more explicit about what you mean by impact. First, does the planned change occur? Second, do you get expected outcomes e.g. less use of emergency admissions? The methods and evidence for change in outcomes is missing. You need to add these in or take the outcomes out of the paper.<br><br>RS: Outcome. This paper concerns non-clinical outcomes mainly. It discusses 'effective' commissioning, a term which is ambiguous (see p.7, lines 29-32) between:<br>(1) commissioning which enhances the clinical effectiveness of services<br>(2) commissioning which produces changes in the way services are provided (which might include (1) but might equally serve other purposes such as cost containment).<br>(3) maintaining the smooth running of services (reportedly, a main concern of the commissioners).<br>This paper focuses on (2)… I recommended disambiguating the notion of 'effective commissioning' (effective at what and for whom?); see comments above. | specifically about the work of commissioning – as the title and aims clearly indicate – rather than impact *per se*.<br><br>As Rod Sheaff suggests, part of the work of commissioning involves reflecting on what might be effective, and for whom. We have therefore made it clearer within the paper about what our sites thought was important in terms of effective commissioning i.e. commissioning that produces changes in the way services are provided (which might include enhanced clinical effectiveness), but might equally serve other purposes such as cost containment. |
| AOC: My team published some research on surveys of commissioning processes for long term conditions (Sampson et al, JHSRP 2012) which showed the extent of what we called partnership commissioning – initiatives that were instigated by groups rather than PCTs - and the fact that it had appeared to increase between 2009 and 2010. This also showed the considerable extent of relational commissioning for LTCs in PCTs close to the time of your research and offers a useful context to show that your case studies are not unusual in any way. We also published a report on the outcomes of commissioning for long term conditions showing little effect on outcomes within two years of the service change occurring which again supports your findings. I think this work complements and supports your findings. | We thank the reviewer for drawing our attention to this specific work. It is very helpful context which supports our findings. We now refer to the concept of 'partnership commissioning' in the paper, and cite the relevant paper by Sampson et al.<br><br>Having removed references to impact from the paper (see above), we have not referred to the report on outcomes of commissioning. However, we are hoping to write up elements of our study findings relating to outcomes and will certainly return to this work when we do. |
| KC: I would recommend that [the paper] would benefit from some minor revisions focused upon the comparisons made between 'relational' and 'transactional' commissioning work. The paper demonstrates clearly that commissioning work is highly relational in nature. They then go on to imply that this contrasts with the more 'transactional' work associated with contracting, which was generally pursued by different teams of managers…It is probably more correct to say that this study shows that commissioning work is highly relational, and that previous studies have shown that contracting also remains largely relational, in spite of a perception from these study participants that it should be more transactional in nature. | We agree and have made changes that draw this out further in our findings, and make further clarification in the discussion.<br><br>In the discussion section we also reflect on the limited opportunities afforded to the study team to observe directly the more transactional contracting aspects of commissioning work. |
| KC: there is little if any mention in the paper of any engagement between commissioners and local GPs via the 'practice-based commissioning' initiative | This is an important point and we have now included a specific reference to GPs and practice-based commissioning within our findings. As the |

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| which was in place at this time. It may be that the local PBC groups had little to do with the work being done, or it may be that they were involved in particular activities. Given that the reorganisation of the English NHS since this study was undertaken was designed to involve GPs much more fully in the commissioning process, it would be useful if the authors could highlight more clearly both where GPs were engaged and where their input might have added value. | paper is primarily about the work of commissioning (in terms of processes, activities etc. as well as roles) we have not gone into further detail here. We are keen to keep the paper well-focused, readable and accessible. However, we are currently drafting a further analysis paper which will focus on this aspect of the study and in which we will give GPs' role – before and after the recent reorganisation – the more detailed attention that it deserves. |
| RS: Page 12, lines 43-48 report the large amount of work involved in evolving a service redesign, and questions whether the amount of work is 'worth the likely impact'. However, someone has to design the care pathways for a service, even if the methods reported seem unduly laborious. | This is an important point. We have reworded this slightly and, elsewhere, sought to emphasise a need for balance to ensure that such work is (necessarily) undertaken whilst also keeping likely impact in mind. |
| RS: Study sites are identified, but this appears to be intentional. | Yes, this is intentional. At the outset we agreed with each of the sites (and the relevant NHS Research Ethics Committee) that we would reveal the identity of organisations/sites. |
| AOC: varied comments on pdf | We thank this reviewer for taking the time to give such detailed and helpful comments, all of which we agree with. We have made changes to each of the points, as suggested. |