

## PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (<http://bmjopen.bmj.com/site/about/resources/checklist.pdf>) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

### ARTICLE DETAILS

<b>TITLE (PROVISIONAL)</b>	Research Protocol: A qualitative study of diverse providers' behaviour in response to commissioners, patients and innovators in England.
<b>AUTHORS</b>	Sheaff, Rod; Halliday, Joyce; Exworthy, Mark; Allen, Pauline; Mannion, Russell; Asthana, Sheena; Gibson, Alex; Clark, Jonathan

### VERSION 1 - REVIEW

<b>REVIEWER</b>	Naomi Chambers University of Manchester, UK
<b>REVIEW RETURNED</b>	21-Dec-2015

<b>GENERAL COMMENTS</b>	<p>I think this will be a really valuable study and is very timely. I really like the notion of developing a behavioural profile of each provider type.</p> <p>More up to date references on competition policy in the NHS in England since Liberating the NHS would be helpful as a scene setter - see for example</p> <p><a href="https://www.england.nhs.uk/about/gov/choiceandcompetition/">https://www.england.nhs.uk/about/gov/choiceandcompetition/</a></p> <p>Also there is no mention of : new models of care and the FY4V, prime contracting and accountable care organisations/systems; these are all heavily influencing providers and commissioners currently</p> <p>A few other minor comments:</p> <ol style="list-style-type: none"><li>1. RQ2 - is it in reality 2 RQs? ie having operational freedom isn't the same as making use of it....</li><li>2. 'seldom heard' is now favoured as a term in preference to 'hard to reach'</li><li>3. The detail of what constitutes the 12 cases is somewhat hard to follow - a visual representation would be helpful</li></ol>
-------------------------	---

<b>REVIEWER</b>	Alison Porter Swansea University, UK
<b>REVIEW RETURNED</b>	12-Jan-2016

<b>GENERAL COMMENTS</b>	I think that this paper still requires some revisions in order to present a clear outline of a coherent research study. At the moment, there are aspects of it which I find confusing and/or unconvincing.
-------------------------	--

	<p>1. Abstract – the research question or aim of the research is not clearly presented in the abstract.</p> <p>2. p2 Abstract lines 18-19 – is it really mixed methods? Seems to be entirely qualitative (though a number of different methods of data collection). This sentence deals with the case studies by mentioning 'a purposive sample' without saying anything more about data collection and analysis.</p> <p>3. p2 Abstract line 39 – 'apprising provider development and competition policy' – this sentence is unclear. Apprising whom?</p> <p>4. p2 line 51 'Addresses the policy relevant question of diverse provision of NHS funded services' – this is not a question.</p> <p>5. p2 line 58 'This protocol does not include as much quantitative analysis as might be ideal' – why not? Is the data not available? Sounds a bit odd as a sentence in isolation.</p> <p>6. p3 lines 12 onwards 'Such variations in ownership and management raise questions about how these providers differ in implementing health policy and NHS commissioners' aims'. This sentence seems to imply that providers have a lot of independent discretion in this area. Later in the paper, reference is made to providers working with commissioners – but there seems to be some ambiguity in how the provider/commissioner relationship is conceptualised in the study. It would be useful to have more clarity from the start about the stance taken on this relationship by the research study – acknowledging that there are some fundamental issues of power and authority at stake, and setting out whether the level and nature of interaction between providers and commissioners is one aspect of interest which will feed into the schemas (as the research questions seem to suggest).</p> <p>7. p3 Lines 36-40 – are these two separate questions? They read like an either/or, but don't make sense in that way.</p> <p>8. p3 line 52 – introduces the concept of 'behaviour' but does not explain or expand on it. Since 'behaviour' is in the title of the paper, and recurs throughout, it would be really useful to have the term defined in this context, and the use of 'behaviour' as a central concept justified.</p> <p>9. p4 lines 23-37 – this paragraph seems to assume that issues such as appropriateness of providers for particular market niches and innovation will be related to organisational model – but they may not be. Would be worth discussing this.</p> <p>10. p4 lines 41-49 – 'The strongest reason for expecting a diverse provider landscape to benefit the NHS is that diverse providers may deliver and develop services in different ways, creating a necessary variety from which NHS commissioners can select.' As the cautious phrasing suggests, this is a theory not a fact – and I think it would be worth presenting as such. Is this what you are testing out through the research?</p> <p>11. p4 line 51 – choice for patients is presented as a topic of interest - presumably this means choice of provider? How does this square with the earlier sentence (quoted above) which talks about choice as being made by commissioners, not patients?</p> <p>12. p6 the description of the case studies could be made clearer. Will there be four case studies per service category? Will there be 12 different providers? There could be 12 different CCGs involved – how will the study team account for differences associated with CCG rather than provider? What is the time period over which fieldwork will be conducted? Is the study team interested in currently provided services or those under development or review?</p> <p>13. p7 lines 15 – 31 talk about 'freedoms' – how are these defined in this context?</p> <p>14. Section on Tracer studies of patient experience – there seems to</p>
--	--

	<p>be some confusion here between PPI (ie involvement in the development and management of research ) and qualitative research looking at the experience of patients. PPI ought to relate to all aspects of the study, not just to work on patient experience. The reference on line 43 to including PPI 'as a policy outcome' is particularly unclear. The second para on using PPI to support the development of research instruments is clear. However, the focus in this section on patient choice needs justifying. Firstly, why is patient choice chosen as the one important thing to look at from the patient point of view – what about care quality, or continuity of care ( a really important issue in relation to provider diversity which isn't really mentioned in this proposal)? Secondly, having diversity of provision does not necessarily create choice for patients, if it simply means that providers are competing for business from the CCG.</p> <p>15. p8 lines 30-43 – does this paragraph relate to the whole project or just to the work on patient experience? If it's about project as a whole, it needs to come earlier.</p> <p>16. p9 line 5 'Comparing these populations will show the loci of variation in provider behaviour' – I don't understand this sentence.</p> <p>17. p9 Lines 5-8 'We hypothesise that....' This sentence needs to be presented much earlier in the paper as a justification for the study design, and explained more fully.</p> <p>18.p9 line16 'the assumed mechanism' – assumed by whom? The study team? Or the department of health – in which case needs referencing.</p> <p>19. p9 line 42 – seems very relaxed about the risk of involuntary participation, but in fact the team will have to take care about this as they will be observing meetings with potentially a lot of different people involved. There are research governance implications too.</p> <p>20. p10 lines 4-7 – states that the study will contribute evidence on which types of provider are best for which role – this sounds a bit confident, bearing in mind the small number of case studies and the complex set of variables they will include.</p> <p>21. p10 lines 12-13 – states that the study will help to inform clinicians about making a referral – how?</p>
--	---

## VERSION 1 – AUTHOR RESPONSE

### Substantive Points: Reviewer 1

We have up-dated our references on competition policy in the NHS in England since Liberating the NHS and acknowledged the influence of the changing policy environment on providers and commissioners.

We have also looked at the research questions again and redrafted these to remove duplication and ambiguity.

Both referees asked for more detail on the case studies. Additional textual information has been added and a table inserted to show how organisational model and service types are distributed.

### Minor Points:

Terminology has been updated with respect to seldom heard groups.

### Substantive Points: Referee 2

The abstract has been revised to ensure the research questions (and aim) are clear from the outset. Similar attention has been given throughout to ensuring the aim of the study and what we seek to test are clear, together with our time frame and case study approach. Material has been re-arranged to ensure a logical progression.

We have also corrected the description of the study design. The original application included a quantitative work package, which was not funded. The protocol has been reworded, deleting reference to this element.

We have inserted a brief textual comment (and reference) to the media-of-power conceptualisation of commissioning, and how much scope for variation commissioners' exercise of power in fact leaves. We have inserted additional commentary to explain that we mean 'behaviour' at whole-organisation level. Similarly, we have noted that 'freedoms' are defined by reference to policy documents. Explanation and references have been added

Two main commissioning structures co-exist in the NHS: providers competing for contracts to provide whole services ('competition for markets') and providers competing to attract individual referrals and the payments that follow ('competition in markets'). We have added clauses to give (and contrast) these contexts, then re-sequenced the Research Questions more logically, given that change.

We have amended the text to separate PPI from the research into patient experience. PPI is now discussed separately under 'Ethics, Benefits and Dissemination'. The focus on patient choice is a focus of current health policy (hence, stipulated by the project funder). We now acknowledge the importance of (also) continuity and quality of care as study limitations. Patients will be asked about their experience of care.

Provisions for covering the risk of involuntary participation (and related issue of research governance) are now added to the ethics section and will guide our actions in the field.

Where undue assumptions appear to have been made we have added the necessary caveats (e.g. around the degree of importance attaching to organisational model).

Minor Points:

Sentences have been redrafted to ensure clarity of meaning.

## VERSION 2 – REVIEW

<b>REVIEWER</b>	Professor Naomi Chambers University of Manchester UK
<b>REVIEW RETURNED</b>	11-Mar-2016

<b>GENERAL COMMENTS</b>	Minor edits only  The reviewer also provided a marked copy with additional comments. Please contact the publisher for full details.
-------------------------	---

<b>REVIEWER</b>	Alison Porter Swansea University UK
<b>REVIEW RETURNED</b>	10-Mar-2016

<b>GENERAL COMMENTS</b>	<p>The one point in your paper which I still find a little confusing is the objective relating to patient choice, and the methods associated with this. I am assuming you are talking about choice of provider, rather than other types of choice such as what date to have surgery. If so, I would think of that as being more an aspect of the local healthcare system or market, rather than of a particular providers, as you have presented it.</p> <p>Also, p3 line 24 'hence differ implementing health policy' - the wording is confusing.</p>
-------------------------	--

## VERSION 2 – AUTHOR RESPONSE

Reviewer: 1

We have changed the title of the protocol replacing innovations with innovators to ensure comparability of subject

We have divided the research question into two parts in order to reflect the distinction between responsiveness and patterns of innovation

We have rephrased the sentence on commissioner power (noted by both reviewers) in order to increase readability (p3) and changed the sentence on case study selection to capture high spending on non-NHS (rather than private) providers.

Reference to the Care & Support Bill has been updated to The Care Act.

Reference to Chief Executives has been left as submitted because this relates to provider organisations. With commissioners we will work primarily with the lead commissioner or contract manager as identified by each provider organisation. The sentence has been changed to improve clarity.

Our interviews with commissioners include questions around PPI and this is now made explicit.

Typographical errors have been addressed (including the grammatical error which R1 pointed out in the 'Research Questions' part of the abstract).

The comment that took the form of advice (e.g. the need to take account of Sustainability and Transformation Plans as they emerge) is welcomed but given that it is advice we have left the text unaltered at that point.

Reviewer: 2

Where the research questions are detailed (p5) we have changed the wording in order to clarify the concept of patient choice

We hope that a publishable paper has now resulted, but if anything else remains to be done please do not hesitate to ask.