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

TITLE (PROVISIONAL)	EVIDENCE-BASED COMMISSIONING IN THE ENGLISH NHS. Who uses which sources of evidence? A SURVEY 2010/2011
AUTHORS	Taylor-Phillips, Sian; Clarke, Aileen; Swan, Jacky; Gkeredakis, Emmanouil; Mills, Penny; Nicolini, Davide; Powell, John; Roginski, Claudia; Scarborough, Harry; Grove, Amy

VERSION 1 - REVIEW

REVIEWER	Martin Bardsley Head of Research Nuffield Trust
REVIEW RETURNED	25-Feb-2013

THE STUDY	The paper addresses an interesting and important area - the way we use information as part of real life decision-making about health care investments. It is to their credit that the authors have used some systematic methods in a difficult area. However, I think the presentation and writing needs to be improved to clarify the purpose of the analysis, highlighting why they focussed on certain questions. I think the abstract is particularly unclear and needs to be rewritten– the article summary gives a much better overview
RESULTS & CONCLUSIONS	The paper assumes a knowledge of NHS structures that may be difficult for international readers – some greater explanation of terms is needed in places. Table 1 could be an appendix, Table 3 could be captured in a sentences to say why its is important ie not a concern about non responds bias. Tables 4 & 5 could be laid out better and diagnostic stats only used where relevant. I think the paper could do with some editing to clarify the messages. The discussion dwells more on the methodology and less on the implications – I would prefer it the other way round and wanted the paper to flesh out what the findings will mean in practice in a changing NHS - and reflect what others have said in this area. What are there implications for an NHS which is subject to repeated organisational change - and recent changes in organisation of PH support? So for example the findings in Fig 1- are interesting but not really discussed in relation to the other results.

REVIEWER	Siobhan McClelland Visiting Professor Health Policy and Economics University of Glamorgan UK
REVIEW RETURNED	26-Feb-2013

THE STUDY	No patients involved. Limited supplemental documents and these are appropriate as supplemental

REVIEWER	Dr Alison Porter Senior Research Officer College of Medicine Swansea University Swansea SA2 8PP UK No competing interests
REVIEW RETURNED	04-Mar-2013

THE STUDY	I have done my best to use the 'tick box' scoring above, though it is hard to relate some of them to this particular paper. I couldn't fit into those tick boxes one I have with this paper, which is that it conceptualises decision making in commissioning as if it is a solo process, carried out by individuals, whereas in practice it is very much a collective process, into which both empirical and practical evidence need to feed (empirical evidence is necessary to tell you what service model to use; practical evidence to tell you how many potential users you will get per year in your patch). The authors clearly know this: on p7 they mention the possibility of a 'healthy mix of different types of input to commissioning decisions', and their questionnaire (which is not reproduced but is described in an appendix) acknowledges that decision-making in commissioning involves many parties and takes place over a long period of time. If many parties are feeding into commissioning decisions, the evidence used or valued by one individual matters less since between them the evidence each brings to the process may add up to make a useful whole. However, it is not clear from this paper if this is the case since: 1) The authors do not tell us if there is any overlap between the decisions described by the respondents – so, if there were 30 respondents from a single PCT, were they describing 30 different decisions, or were we getting, for example, 6 viewpoints on each of 5 decisions? If the latter, then there is potentially some very interesting further analysis which could be done, comparing viewpoints. 2) There is some confusion about what exactly respondents were reporting – was it what evidence 'was considered important in the decision' (l42, p4), which presumably describes their perception of the influences on the collective process of decision making? Or was it about the evidence which respondents themselves used, which is the wording reported in lines 17 and 18 on p8? I suspect it is actually the former, and so responses will be shaped by what people are aware of, what they recall, what they value/prioritise, as well as what is actually used. The gender/grade/background and so on may be

	influencing any of these. It would be useful to see the exact wording of the relevant questions from the questionnaire. I think this difficulty could be addressed by some changes to the introductory section (justifying the focus on individuals' perspective and clarifying what exactly was being asked) and some changes to the discussion. I think the discussion could perhaps draw out some of the more striking findings – in particular, I was intrigued by the fact that people qualified in public health are less likely to use public health evidence than others – why might this be? I also think that the discussion misses a trick by not picking up on some other very interesting aspects of the findings, as presented in the Figure, which suggests, among other things, that 50% of decisions are not based on clinical evidence, and 50% are not based on consideration of cost-effectiveness (I wonder if these are the same 50%!). Perhaps, though, the authors are keeping this for another paper with a different focus.

VERSION 1 – AUTHOR RESPONSE

Reviewer: Martin Bardsley Head of Research Nuffield Trust

The paper addresses an interesting and important area - the way we use information as part of real life decision-making about health care investments. It is to their credit that the authors have used some systematic methods in a difficult area.

Thank you

However, I think the presentation and writing needs to be improved to clarify the purpose of the analysis, highlighting why they focused on certain questions.

I have reviewed the whole document and amended sections to improve clarity, including subheadings. I have added a purpose and justification in paragraph three of the introduction.

I think the abstract is particularly unclear and needs to be rewritten– the article summary gives a much better overview

I have rewritten the abstract to give a better overview and bring it inline with the article summary.

The paper assumes a knowledge of NHS structures that may be difficult for international readers – some greater explanation of terms is needed in places.

I have amended the first two paragraphs of the introduction to give a better explanation of commissioning, PCTs and CCGS.

Table 1 could be an appendix,

We agree and have moved to the appendix 2.

Table 3 could be captured in a sentences to say why its is important ie not a concern about non responds bias.

Table 3 has been removed and replaced with a sentence describing the data. See Results section paragraph 1.

Tables 4 & 5 could be laid out better and diagnostic stats only used where relevant.

In tables 4 and 5, we have cut out 3 columns (B, SE(B), and wald statistic) we have also improved the lay out

I have moved the p value to the end, so the columns are now just be DoF, odds ratio, 95%CI of odds ratio, and p value.

These are now tables 1 and 2

I think the paper could do with some editing to clarify the messages.

I have reviewed the whole document and amended sections to improve clarity, including subheadings in methods and results sections. I have added a purpose and justification in paragraph three of the introduction

The discussion dwells more on the methodology and less on the implications – I would prefer it the other way round and wanted the paper to flesh out what the findings will mean in practice in a changing NHS - and reflect what others have said in this area.

I have shortened the methodology section so the key research methods and justifications are listed. I have stated the importance of the work for CCGs in the introduction and amended the discussion to reflect how the work impacts upon the NHS both now as PCTs and what needs to be addressed as they move to CGGs.

What are there implications for an NHS which is subject to repeated organisational change - and recent changes in organisation of PH support? So for example the findings in Fig 1- are interesting but not really discussed in relation to the other results.

In the discussion I have added a paragraph to include
- Changing PH support
- PH going into local authorities in the UK
- not clear how commissioning will be evidence based

Reviewer: Siobhan McClelland Visiting Professor Health Policy and Economics University of Glamorgan UK

No patients involved.

Agreed

Limited supplemental documents and these are appropriate as supplemental

Thank you

Reviewer: Dr Alison Porter Senior Research Officer College of Medicine Swansea University

Swansea SA2 8PP UK

I have done my best to use the 'tick box' scoring above, though it is hard to relate some of them to this particular paper.

No comment required

I couldn't fit into those tick boxes one I have with this paper, which is that it conceptualises decision making in commissioning as if it is a solo process, carried out by individuals, whereas in practice it is very much a collective process, into which both empirical and practical evidence need to feed (empirical evidence is necessary to tell you what service model to use; practical evidence to tell you how many potential users you will get per year in your patch).

No amendment needed – thank you for your comments

The authors clearly know this: on p7 they mention the possibility of a 'healthy mix of different types of input to commissioning decisions', and their questionnaire (which is not reproduced but is described in an appendix) acknowledges that decision-making in commissioning involves many parties and takes place over a long period of time. If many parties are feeding into commissioning decisions, the evidence used or valued by one individual matters less since between them the evidence each brings to the process may add up to make a useful whole.

The questionnaire is now included in appendix 1.
We agree with the comment

However, it is not clear from this paper if this is the case since:

1) The authors do not tell us if there is any overlap between the decisions described by the respondents – so, if there were 30 respondents from a single PCT, were they describing 30 different decisions, or were we getting, for example, 6 viewpoints on each of 5 decisions? If the latter, then there is potentially some very interesting further analysis which could be done, comparing viewpoints.

Unfortunately we do not know. We asked about a recent decision that was complete that they were involved in – not the details of the case/project. This has been added as a limitation of the study

2) There is some confusion about what exactly respondents were reporting – was it what evidence 'was considered important in the decision' (l42, p4), which presumably describes their perception of the influences on the collective process of decision making? Or was it about the evidence which respondents themselves used, which is the wording reported in lines 17 and 18 on p8?

The survey used is reported in appendix 1. It was the participants about the decision as it was made – so it was collective. This is made clearer in methods paragraph 1.

I suspect it is actually the former, and so responses will be shaped by what people are aware of, what they recall, what they value/prioritise, as well as what is actually used.

Yes we agree

The gender/grade/background and so on may be influencing any of these.

Yes we agree

It would be useful to see the exact wording of the relevant questions from the questionnaire.

This is included in appendix 1 b. See appendix 1 b– taken from Swan J, Clarke A, Nicolini D, et al. Evidence in Management Decisions (EMD) – Advancing Knowledge Utilization in Healthcare Management. Final Report. 2012. NIHR Health Services and Delivery Programme

I think this difficulty could be addressed by some changes to the introductory section (justifying the focus on individuals' perspective and clarifying what exactly was being asked) and some changes to the discussion.

The study focused on individuals because of the multidisciplinary nature of commissioning and our interest in their individual disciplinary backgrounds and what effect that might have. Also not clear what an alternative data collection method would look like

I think the discussion could perhaps draw out some of the more striking findings – in particular, I was intrigued by the fact that people qualified in public health are less likely to use public health evidence than others – why might this be?

This is incorrect – public health were more likely to use evidence. This is discussed more in the discussion section under implications for the NHS

I also think that the discussion misses a trick by not picking up on some other very interesting aspects of the findings, as presented in the Figure, which suggests, among other things, that 50% of decisions are not based on clinical evidence, and 50% are not based on consideration of cost-effectiveness (I wonder if these are the same 50%!). Perhaps, though, the authors are keeping this for another paper with a different focus.

We agree and have added to the abstract results, core text results paragrapgh 4 and in the discussion paragraph 5.

VERSION 2 – REVIEW

REVIEWER	Dr Alison Porter Senior Research Officer College of Medicine Swansea University Swansea SA2 8PP No competing interests
REVIEW RETURNED	12-Apr-2013

THE STUDY	Authors should check a couple of typos, including a reference to 'cost-effeteness'
GENERAL COMMENTS	I think you have addressed the concerns I had about the previous version