Reviewer’s report

Title: 'Holding the line': A qualitative study of the role of evidence in early phase decision making in the reconfiguration of stroke services in London.

Version: 0 Date: 15 Dec 2016

Reviewer: Angus Ramsay

Reviewer's report:

First, many thanks for giving me the opportunity to review this paper, which presents a retrospective qualitative analysis of the approaches taken in leading the reconfiguration of acute stroke services in London, implemented in 2010. I enjoyed reading it a great deal.

By analysing how power and hierarchy (also EBM) were used so that system leaders in London could 'hold the line' on the proposed reconfiguration, I think this paper offers valuable insights on how change of this kind is/can be led. Further, the authors raise important questions about how managerial power and the language of evidence-based medicine can be used to promote a change even when the evidence for it may not be entirely conclusive. Below, I outline a number of questions and minor revisions, which I hope are useful.

BACKGROUND

It might be useful to present the context a little more with an international audience in mind, e.g. in terms of the functions of SHAs, etc. (this applies throughout, but can perhaps be addressed most helpfully in this section).


METHOD

The authors justify the use of a single case study clearly, and describe clearly how their different data sources were drawn together.

As discussed further down, I found myself wondering whether, in addition to how information was produced and distributed, the authors could reflect more on how the information was responded to.
A few points related to the method as described:

1. Is it possible to share a summary of the topic guide used to elicit interviewees' views?

2. What sorts of deviant cases were identified and explored? How did these contribute to the analysis?

3. Is it possible to provide more detail on the inductive themes (all of which sound highly relevant) and how they were brought together under the two overarching themes of discursive power and NPM-style power?

RESULTS

This section draws together interview and documentary evidence very smoothly, providing useful examples of the ways in which senior SHA management kept control of the reconfiguration process, e.g. through top-down decision-making and by making the reconfiguration 'everybody's business'.

It seems clear that - as suggested by the authors - the decision to go for 8 HASUs was a senior management decision. Re references to 'clinical research evidence' (e.g. p12): I think a potentially relevant point is that there was relatively little evidence at the time to demonstrate appropriate HASU size (in terms of necessary volume/activity levels).

Is it possible to provide some evidence suggesting an objective of challenging "the dominance of the capital's most powerful institutions" (p15, line 29)? If this issue is important to the paper, I think a bit more detail would be useful.

Something that strikes me as potentially important, here, is how clinicians were kept 'onside', given the rejection of the Clinical Expert Panel's recommendation of 10-12 HASUs, and the introduction of 'ex post' selection criteria (colocation with Trauma or Neuroscience centres).

DISCUSSION

I think the above speaks to a wider point, and a potential gap in the interpretation of this important analysis: the reader gets the perspective of those who exercised power, but we get less about how that power was experienced, and how mastery of the language on EBM played out. That is, how were the actions of senior SHA management perceived by clinicians, hospital management, commissioners, and other stakeholders? Did interviewees say more about how these other stakeholders' reactions were managed? Essentially, I agree with the authors on the
need to explore and discuss the messy and contested nature of reconfigurations - but I wonder whether more could be presented to illustrate this issue.

While the authors identify a gap in the form of public and patient participants, I wonder whether other important stakeholder groups involved in the negotiation of these changes should also be noted, including for example hospital management, healthcare commissioners, and local politicians.

I also wonder whether the points relating to the potential limitation of retrospective analysis should be discussed here, rather than in the methods.

CONCLUSIONS

Implications - given that SHAs no longer exist, possibly worth considering identifying organisations/bodies that have system leadership role. That is, who might use these lessons today - both in the English NHS and elsewhere?

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