PROTOCOL TITLE:

Exploring the local operation and impact of Healthwatch in England five years on: using actor-network theory to optimise patient and public voice in NHS commissioning and service provision.

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Title of study	Exploring the local operation and impact of Healthwatch in England five years on: using actor-network theory to optimise patient and public voice in NHS commissioning and service provision.
Protocol Short Title/Acronym	The local operation and impact of Healthwatch in England
Sponsor name	Mr Keith Brennan
Chief Investigator	Professor Glenn Robert
REC number	IRAS ID: 252993 (application pending)
Medical condition or disease under investigation	Health services research
Purpose of clinical trial	To investigate how Healthwatch creates and sustains relationships locally with key NHS and other stakeholders as a key element of Patient and Public Involvement and Engagement.
Primary objective	The aim of the study is to explore and enhance the operation and impact of local Healthwatch in ensuring effective patient and public voice in the commissioning and provision of NHS services.
Trial Design	Multi-method design in four related phases: phase 1 national online survey of 152 Healthwatch; phase 2 ethnographic fieldwork at 4 local Healthwatch; phase 3 Delphi process; phase 4 multi-stakeholder meetings in the format of Joint Interpretative Forums.
Endpoints	Exploratory study
Sample Size	48 Healthwatch, NHS staff, other non-NHS staff and patient interviewees (12 per site).
Summary of eligibility criteria	People working at or with local Healthwatch; current or former NHS patients or carers, or members of the public, who have been involved in local Healthwatch.
Version and date of final protocol	v.1. 20.09.2018
Version and date of protocol amendments	XXXX

Full title of project

Exploring the local operation and impact of Healthwatch in England five years on: using actor-network theory to optimise patient and public voice in NHS commissioning and service provision.

Summary of Research

Enabling citizens' voices to be heard is a vital part not only of planning for provision of healthcare services in a patient-centred, publicly-funded NHS but also of ensuring that the NHS is accountable to the public, communities and patients that it serves. Healthwatch was set up in 2013 with the ostensible aim of being the 'consumer champion' in health and social care in England, centrally concerned with the quality of and access to healthcare. There are 152 local Healthwatch, which are funded through local authority budgets and which have statutory powers to advise local authorities and NHS commissioners about their communities' needs and concerns relating to the provision of health and social care.

To date there is no robust, theoretically-informed, contextually-specific evidence about the processes through which local Healthwatch influence is created and maintained and how this enables more effective services. This is a significant research gap given Healthwatch's role as a key NHS partner in monitoring the quality - and supporting the development - of health and social care locally by providing NHS England and local authorities with information and advice based on the views of citizens and patients.

Employing a mixed method design, this study will produce the first generalizable evidence base of how local Healthwatch acts through mutually-influencing relations with a broad range of organisations and other stakeholders. At the heart of the study is an Actor-Network Theory (ANT)-informed ethnographic approach which will allow us to map holistically everyday practices and the broader context in which they take place. We will do this by studying the everyday interactions between local Healthwatch bodies and a range of actors including local authorities, Health and Wellbeing Boards, residents, Trusts, Clinical Commissioning Groups (CCG), other Patient & Public Involvement (PPI) and third-sector organisations, as well as the objects (documents, reports, data and funding) that shape these interactions, to provide a detailed understanding of how these relationships are created and maintained.

The aim of the study is to explore and enhance the operation and impact of local Healthwatch in ensuring meaningful patient and public voice in the commissioning and provision of NHS services. In doing so, we aim to address the following **overarching research questions:**

- What are the strategies, practices and structures that enable Healthwatch to enhance patient and public voice in the NHS?
- How is patient and public involvement made impactful for citizens themselves as well as commissioners, providers and other NHS actors as they are brought together through the daily work of Healthwatch?

Answering these questions will also inform the broader issue of what 'effective PPI' entails from the different perspectives of patients, commissioners, providers and other NHS actors.

To achieve our aims, the study will be organised in four phases. In phase 1 we will design and carry out a nationwide survey of the 152 local Healthwatch in England. Using the phase 1 findings to construct a

sampling frame, we will then (phase 2) conduct an ANT-informed ethnographic study in four local Healthwatch. The data from this phase will be analysed in cooperation with a panel of fifteen local Healthwatch staff and volunteers (Healthwatch Involvement Panel – 'HIP' – see Box 1 below) recruited from other local Healthwatch organisations. This will ensure the generalisability of our ethnographic findings beyond the four case study sites. Based on our findings from phase 2, we will conduct a Delphi study with a representative sample of key stakeholders to build consensus as to 'good practice' in the operation of local Healthwatch (phase 3). In phase 4 we will hold Joint Interpretative Forums (JIF) at each case study site with multiple stakeholders (local authorities, Health & Wellbeing Boards, CCGs, CLAHRCs) engaging them in shared reflection on our findings and analysis. We will complete our interpretation of all four phases and then formulate and disseminate actionable recommendations for policy and practice.

BOX 1 Healthwatch Involvement Panel (HIP)

<ins>What is the Healthwatch Involvement Panel (HIP)?</ins>

It is a panel of fifteen local Healthwatch staff and volunteers (eight staff members and seven volunteers) recruited from fifteen local Healthwatch organisations which are not case-study sites.

<ins>What will the HIP do?</ins>

Invited HIP members will receive one-day training in relevant qualitative methods from King's College London. HIP members will then attend 5 bimonthly, half-day meetings during the ethnographic fieldwork phase (Phase 2). At each HIP meeting, ethnographic data from case-study sites will be presented by research staff conducting the fieldwork. HIP members will be asked to:

- reflect on the data presented and provide interpretation and explanation based on their own experience and knowledge of working at a local Healthwatch;
- look for points of similarity and difference with their own organisational practices to help build a broader picture of local Healthwatch activity across England;
- guide the research team with detailed suggestions on how to develop the ethnographic work in accordance with short and medium-term fieldwork objectives.

<ins>Why are we involving the HIP in our ethnographic data analysis?</ins>

- to provide the basis for ensuring the ongoing generalisability of our finding by ensuring that local Healthwatch members and volunteers have the chance to jointly reflect on the data presented and provide ongoing interpretation and explanation based on their own experience;
- to ensure that our study outputs are meaningful to local Healthwatch staff and volunteers thus improving likelihood of beneficial change in the way in which Healthwatch currently operates;
- to ensure the PPI in this phase through engagement with Healthwatch volunteers.

The study will generate important new understandings and recommendations for key stakeholders helping to enhance patient and public voice at a time when the NHS is facing challenges and undergoing change. The combination of research methods and our innovative, sustained engagement with PPI and relevant stakeholders will ensure that our findings are nationally relevant, contextually sensitive and generalizable. The ongoing involvement of the HIP in phase 2 and the use of a Delphi study with a wider range of stakeholders in phase 3 - together with the JIFs in our case study sites in phase 4 - will increase the likelihood of beneficial change in the way in which Healthwatch currently operates.

Our study will produce practical recommendations and actionable guidance based on formulations of best practice drafted in collaboration with the HIP and our Advisory Board. These outputs will provide evidence-based and contextually sensitive rationales both for how Healthwatch might enhance patient and public voice in healthcare commissioning and provision, and also how CCGs, providers and patients can more effectively participate in these processes.

Background and Rationale

Every time the NHS undergoes significant reform, its structures and processes for involving patients and the public also change. Since 2000, there have been three major reorganisations of the official systems for patient and public involvement (PPI) (1). Community Health Councils (CHCs) were replaced by PPI Forums in 2002, which were themselves abolished and replaced by Local Involvement Networks (LINks) in 2008. LINks operated for four years and were superseded by Healthwatch, which was established as part of the Coalition Government's 2012 reform of health and social care. Each iteration of official PPI has had different duties, powers, funding, composition and mechanisms for accountability.

Originally conceived as a 'consumer champion', Healthwatch is ostensibly a key NHS partner in monitoring the quality - and supporting the design - of health and social care locally by providing NHS England, CCGs, provider organisations and local authorities with information and advice based on the views of citizens and patients (2, 3). Healthwatch activities include signposting health services, gathering intelligence on people's views and experiences of care and monitoring the standard of health provision locally. Local Healthwatch are awarded contracts by the local authority, the money for which comes from the Department of Health via the Department for Communities and Local Government. Healthwatch bodies are differentiated from LINks by their statutory membership of new strategic local Health and Wellbeing Boards, which were themselves a key plank of the 2012 reforms for integrating health and social care (4, 5). As one commentator has stated, 'local Healthwatch are unique - they are the only organisation that has a helicopter view of an entire local Health and Wellbeing system. In the world of localism and integrated health and care this is key.'(6)

Five years on, there are 152 local Healthwatch bodies across England, supported by a national organisation, Healthwatch England. Though there have been several studies of Healthwatch's predecessors (7-11), our study will be the first comprehensive examination of how local Healthwatch bodies variously build influence and whether and how they are meaningful as a key pillar of citizen and patient involvement in the NHS.

In the period before Healthwatch became operational, a NIHR-funded study looked at how CCGs conduct PPI in relation to long-term conditions; it recommended that 'further research is urgently required to examine how [PPI] is being developed within the reformed … NHS' (12). However, since then there has been little research on the work of Healthwatch. Based on research conducted between September 2014 and February 2015, a King's Fund report examined the initial operation of local Healthwatch, noting the variability of Healthwatch work, identifying activities which make Healthwatch effective and proposing recommendations for change (13).

More recent work by Martin & Carter looking at a local Healthwatch in the East Midlands has pointed to several challenges caused by a lack of clarity of Healthwatch's role in the landscape of health and social care planning and provision (1, 14). One such challenge is the jurisdictional misalignment between local Healthwatch, local authorities, Health and Wellbeing Boards and the NHS organisations with which they must work (4, 14, 15). Other tensions include competition with third sector and PPI organisations and processes, and constrained local authority budgets from which local Healthwatch contracts are awarded for two or three years at a time (1, 14). Reflecting on the design of 'Local Healthwatch Quality Statements' launched in 2016 in order to encourage local Healthwatch organisations to collect information about and assess the quality of their work, Gansu similarly highlighted the importance of local context and the quality of relationships between service managers, local authority leaders, CCG members and Healthwatch (6).

While these studies point to the challenges and tensions faced by local Healthwatch, they provide little contextually-specific evidence about the practices and relationships through which Healthwatch influence is created and maintained and how this enables or hampers more effective services for patients. Building on the available literature and addressing its limitations, our study aims to map the current practices and relationships of local Healthwatch in England and to provide an in-depth understanding of the ways in which local Healthwatch succeeds or fails to exert influence on key stakeholders.

To achieve this aim, our theoretical framework will be Actor Network Theory (16, 17). Originating in Science and Technology Studies, ANT focuses on the role of 'mutually-influencing relations' (18) between various human and institutional actors as well as the socio-material contexts – e.g. objects, documents, buildings, meetings, technologies, data, policies, strategies, contracts, ideas - in which they operate (see Box 2 below).

BOX 2 What is Actor-Network Theory (ANT)?

- ANT is a theory developed by Bruno Latour, Michel Callon and John Law as part of Science and Technology Studies during the 1980s.
- although it carries 'theory' in its name, it is better understood as a range of methods for doing social science research
- ANT sets out to describe the connections that link together *humans* and *non-humans* (e.g. objects, documents, buildings, meetings, technologies, data, policies, strategies, contracts, ideas). Both humans and non-humans are understood as 'actors' that can have influence on phenomena of interest.
- in particular, ANT describes how these connections come to be formed, what holds them together and what they produce in particular contexts. This system of mutual influence between and among humans and non-humans is called an 'actor-network'.
- to study an actor-network, ANT researchers employ some key qualitative research methods as part of their data collection:
  - participant observation i.e. spending time in the places where the interactions between actors (both human and non-human) happen and decisions about them are taken, and recording them as fieldnotes;
  - interviews with relevant human actors, to discuss their opinions, frustrations, emotions, hopes and beliefs as well as the reasons underlying their practices;
  - collection and analysis of relevant documents, particularly if they play a part in interactions.

In the context of healthcare service and delivery, ANT has typically been advanced as a framework for investigating health care organisations and technologies (19-21) and has been applied successfully in other NIHR-funded studies (22-25). Three members of the proposed project team - GR, AD and GZ - are currently involved in a NIHR-funded project which uses ANT to investigate and optimise the use of patient experience data in acute NHS trusts (Donetto HS&DR 14/156/08) (25). This work explores the mutually-influencing relationship between different forms of patient experience data, technologies and the people and institutions which use or fail to use them to improve the quality of care for patients (26).[1]

Our study of Healthwatch similarly pays attention to these 'mutually-influencing relations' between various human and nonhuman actors in shaping how Healthwatch creates influence in promoting patient and public voice. Using ANT overcomes the limitations of the studies of Healthwatch that have been completed to date in two main ways. Firstly, existing studies have focused on a limited range of human and institutional actors [e.g. (1)] and give inadequate consideration to the ways in which relationships between local stakeholders are shaped and mediated on a daily basis by artefacts such as data, policies, documents, funding arrangements, technologies (i.e. nonhumans). This has provided a partial view of the way local Healthwatch creates influence. (See **Box 3** for examples of human and nonhuman actors).

BOX 3 Examples of 'human' and 'non-human' actors considered in the study

Humans	**Non-humans**
● Healthwatch staff and volunteers ● Patients ● Carers ● Local citizens ● Charities staff and volunteers ● CCG members ● Local authority officers ● Local GPs ● Trust staff (e.g. Patient experience managers, engagement managers, nurses, clinicians, etc)	● Documents (e.g. 'Enter and View' reports, strategy documents, STP plans, Healthwatch Quality Statements) ● Technologies (e.g. computers, software, patient experience data, surveys, internet, email, telephones) ● Funding and funding applications ● Policies ● Buildings ● Contracts ● Ideas

For example, we would look at the work that is undertaken to transform a concern about hospital services collected by a local Healthwatch volunteer into a report containing data that a hospital can act upon. The type of data (e.g. qualitative or quantitative), the quality of the personal relationships between the patient experience team and the local Healthwatch staff, the social media technologies that are used to expose the issue, the NHS and local authority meetings at which the concern is discussed may all play an important role in determining the influence exerted by local Healthwatch.

Secondly, existing studies rely primarily on interviews and surveys which can only provide post-hoc reflections of events (1, 13, 14).[2] These methods do not capture the processual nature of relations, thus obscuring the emergent and unexpected ways in which local Healthwatch enhance patient and public voice, and limiting the validity and utility of recommendations for good practice. By prospectively examining the nature and quality of interaction between local Healthwatch and key stakeholders as well as the nonhuman elements that enable such interaction, our study will provide a timely, contextually-sensitive and robust examination of these key but hitherto neglected organisations.

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[1] GR has also previously proposed ANT as potentially offering insights into the process of decommissioning health service (Williams HS&DR 12/5001/25) (24), and the assimilation of technological innovations in healthcare organizations (27). ANT has informed studies of Lean in healthcare organisations (28), the 'invisible work' of nurses in the delivery of care (29, 30) and the effectiveness of quality improvement interventions (31).

[2] Similarly, the data collection method for the new 'Local Healthwatch Quality Statements' is largely survey-based (32).

Evidence explaining why this research is needed now

There is a legal duty for the NHS to consider public involvement in commissioning and providing health care, and at all stages in major healthcare planning decisions (33). This is a cornerstone of a patient-centred NHS and does positively impact design and provision of care (34). There is increasing evidence of a positive association between public involvement and more ‘innovative, effective and efficient ways of designing, delivering and joining up services’ (3). It is argued that NHS managers and staff are better equipped to understand the needs of the community they serve and to make better decisions about how to use limited resources when they listen to what matters to citizens (3).

While it is recognised that Healthwatch is well-placed to provide this, it is also clear that it is not fulfilling its full potential (1, 13, 14). Commissioners and providers, as well as national NHS bodies, need Healthwatch to be more influential in ensuring the impact of patient and public voice on their decision-making processes (35). Healthwatch England have also expressed a need for this work and contributed to its design through the involvement of Jacob Lant, Head of Policy and Partnerships, in our preliminary PPI activities, and will assist in its execution and dissemination of findings via our Advisory Group.

The research is timely. The lack of evidence of how Healthwatch works is particularly problematic given the changes underway in the organisation of English health and social care. As the NHS responds to the *Five Year Forward View* (36) and develops Sustainability & Transformation Plans (STPs), policy and decision-makers need to have a contemporary and in-depth understanding of the strengths and weaknesses of Healthwatch and how local Healthwatch activities and relationships might be optimised to maximise their contribution to shape and advise on the changes to come. A 2017 King’s Fund report on the progress of the STPs noted that local NHS leaders have not hitherto adequately and meaningfully engaged patients, citizens and local authorities in their development; doing so is described as an ‘urgent priority’ (37).

Understanding and optimising the work of local Healthwatch in relation to these processes will not only ensure that more informed decisions about resources are made by NHS management; it is also argued that more participatory decision-making increases the likelihood of building sustainable support for changes to services among local communities (24).

There is no robust, theoretically-informed evidence about the processes through which local Healthwatch influence is created and maintained. The combination of research methods and our innovative, on-going engagement with relevant stakeholders through the HIP, Delphi and the Advisory Group will ensure that our findings are nationally relevant, contextually sensitive and generalizable. In particular, the national online survey in phase 1 of the study will provide an up-to-date and integrated assessment of the current state of Healthwatch practices and impact across England. The ethnographic data produced in phase 2 will provide the basis for the first-ever evidence-based analysis of the daily work of local Healthwatch, allowing connections to be made between activities, relationships and intended outcomes. Drawing on these different sets of data, our research findings will offer the most securely evidenced set of ‘good practice’ for local Healthwatch to date.

Aims and objectives

The aim of the study is to explore and enhance the operation and impact of local Healthwatch in ensuring effective patient and public voice in the commissioning and provision of NHS services. We will achieve this aim by pursuing four objectives:

1. To establish current priorities, activities (e.g. advocacy, signposting, surveys, inspections) and organisational arrangements (e.g. staffing, funding, nature of contract, jurisdictions) of the 152 local Healthwatch in England;

2. To explore the particular processes and interactions that link local Healthwatch to a range of individual and institutional actors (such as commissioners, GPs, CCGs, Trusts, patients, local authority staff, care homes, third-sector organisations, and Healthwatch England) and to the wider contexts through which they operate (such as funding, contracts, reports) in order to assess their impact on local healthcare commissioning and provision;
3. To build consensus about what might constitute 'good practice' in terms of the operation of local Healthwatch;
4. To distil and then disseminate generalizable principles around what facilitates and/or limits the influence of local Healthwatch as a key element of patient and public voice in the NHS.

Doing so will help us answer our two key research questions:

- What are the strategies, practices and socio-material structures that enable Healthwatch to enhance patient and public voice in the NHS?
- How is patient and public involvement made impactful for citizens themselves as well as commissioners, providers and other NHS actors as they are brought together through the daily work of Healthwatch?

Research Plan / Methods

Overall design and theoretical/conceptual framework:

Our study will produce the first robust account of the organisational strategies and practices that shape how local Healthwatch influence commissioning and provision of health and social care. As discussed above, there is little evidence about how local Healthwatch work in practice, how its relationships are established and maintained and how these help or hinder the ability of local Healthwatch to represent the views and interests of their local communities. To achieve its aims, the study will use a mixed method design across four phases. The core data will be produced through an ethnographic study of the relationships through which the work of Healthwatch is performed.

Phase 1: nationwide online survey

We will design and carry out an online nationwide survey of the 152 local Healthwatch bodies in England. The survey will provide an up-to-date account of the institutional contexts of Healthwatch operations. Elements of the survey (those looking at jurisdictional contexts – see Box 4 below) will be used to construct the sampling strategy for recruitment of case-study sites participating in the ethnographic phase (Phase 2).

Sampling:

All 152 local Healthwatch bodies in England.

Setting/context: all 152 local Healthwatch bodies in England.

Data collection: the survey will ask questions across key variables, some of which are indicated by the existing literature and others which were raised during the project team's initial PPI work. The set of variables to be explored will be finalised in discussion with our advisory group prior to the survey being undertaken. In Box 4 we list the main areas the survey will cover in order to map the organisational, bureaucratic and financial arrangements of local Healthwatch.

BOX 4 Key variables considered in Phase 1 national online survey with examples

Variable	Rationale for inclusion	Examples
1. Local Healthwatch priority areas[3]	Importance of priorities highlighted during a pre-study PPI Focus Group	o Mental Health o Social care o Primary care o Children and young people's experiences of health and social care o The experiences of seldom heard groups, including BAME communities
2. Range of activities	Highlighted in Gilburt et al (2015)	o providing information and advice about services o gathering people's views and experiences of services o monitor the standard of provision in local health and social care services (e.g. 'enter and view' privileges) o bringing together and analysing the views of local people and making reports and recommendations o influencing health and social care providers and commissioners o operating as a member of the Health and Wellbeing Board o sharing information and escalating concerns to the Care Quality Commission o sharing information and intelligence with Healthwatch England
3.Organisational structure	Highlighted in Martin and Carter (forthcoming)	o staffing (number of employed staff and volunteers) o length and type of contract from the local authority o amount of funding and funding arrangements o whether the organisation which runs Healthwatch services is a standalone enterprise or runs other Healthwatch elsewhere as well.
4.Jurisdictional context	Highlighted in Carter and Martin (2016)	o urban/suburban/rural location o size of population covered o number of health and social care providers in the area o number of organisations where local Healthwatch has formal representation (e.g.

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[3] 2017 priorities as listed on Healthwatch England website (http://www.healthwatch.co.uk/news/healthwatch-network-reveals-public's-health-and-care-priorities-2017), accessed 09/09/17.

		Boards or Committees where local Healthwatch sit at Trusts, CCGs etc). o involvement with STPs

Data analysis: The survey data and analysis will comprise descriptive statistics consisting of single variables and include frequency and percentage response distributions, measures of central tendency, and dispersion measures such as the range and standard deviation. All open comment responses will be analysed using open coding and constant comparison.

Phase 2: ethnographic study

We will carry out an ANT-informed ethnographic study (38-40) to map the everyday interactions of four local Healthwatch bodies with a range of other institutional actors (e.g. local authorities, CCGs), and the nonhuman entities (e.g. data, documents, strategies, funding structures) that mediate and shape relations. Data in this phase will comprise fieldnotes of non-participant observation, interviews and primary documents; these will be analysed by the study team in collaboration with the HIP comprising members from fifteen local Healthwatch which are not case-study sites.

Sampling**:**

We will build our sampling strategy for the selection of 4 case study sites from the results and analysis of the Phase 1 survey, focusing particularly on the findings associated with variable 4, 'Jurisdictional contexts'. This choice is justified by our theoretical approach which gives prominence to the analysis of mutually-influencing relations between and among humans and nonhumans in identifying how impact is created in the daily work of local Healthwatch as it interacts with a range of other organisations. As Carter & Martin have discussed, 'local authority areas may not be coterminous with CCG or provider organisations' catchment; consequently some local Healthwatch must deal with multiple commissioners and providers that have different administrative and geographical boundaries' (14). The choice of focussing on variable 4 also addresses the expressed need to better understand how these relationships work in the context of the changing geographies of health promoted by STPs and moves towards integrating health and social care.

Focusing on this variable will allow us to select local Healthwatch based on the complexity of the jurisdictional context in which they operate and with whom they interact. This includes, for example, the number of health and social care providers, the number and type of organisations where local Healthwatch has formal representation (i.e. the number of Boards or Committees local Healthwatch participate in at Trusts, CCGs, local authorities), and the type of local authority (unitary or county)[4]. The exact nature and number of connections used to sample case study sites will be established on the basis of the results and analysis of the Phase 1 survey. We will select four local Healthwatch to be our organizational case studies which - taken together - provide a sufficiently wide range of examples of jurisdictional complexity to inform our overall findings and produce good practice for Healthwatch and other key stakeholders.

Healthwatch involvement Panel (HIP): We will invite 15 Healthwatch to participate in the HIP. The inclusion criteria are that they will have responded to the Phase 1 survey and indicated a willingness to participate. The exclusion criteria are that they have been selected as one of the four case study sites. In the event that we receive more positive responses than needed (n=15), we will aim to ensure

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[4] An earlier study of Health & Wellbeing Boards found differences in operation between those in unitary local authorities and those in county council areas (4).

maximum variation of HIP members based on the same criteria used for the sampling strategy for recruitment of case study sites.

Interviews: During Phase 2, we will invite Healthwatch staff, volunteers, and relevant stakeholders from the four case studies to take part in individual semi-structured interviews (12 per site; 48 in total). We will aim to interview a sample of staff, managers, volunteers, local CCG members, local authorities, local Health and Wellbeing Board members and relevant provider representatives e.g. Trust patient experience managers, patients and patient organizations who are involved in the daily work of local Healthwatch.

Setting/context:

Following successful recruitment of the case-study sites and before the start of the fieldwork, we will conduct a preliminary visit to each of the four Healthwatch in order to formally introduce the aims, objectives and methods of the project. We will carry out ethnographic data collection at the four selected local Healthwatch across England. We will base our observational practice in Healthwatch offices as well as accompanying the staff and volunteers to relevant daily activities and meetings (for example, visits to NHS Trusts, Health and Wellbeing boards, GP surgeries, community meetings and local authority presentations).

Data collection: we will map the everyday interactions between the four local Healthwatch and a range of actors including local authorities, citizens, Trusts, CCGs, and charities. An ANT approach will allow us to attend to the socio-material environments (documents, reports, data and funding) that shape the interactions between individual and institutional actors (1). We will collect 3 forms of data:

- ethnographic fieldnotes (nine 3-days visits at each site; total 108 days) e.g. attending meetings; accompanying staff and volunteers on data gathering, outreach and inspection activities; attending training and observing the daily work in offices.
- individual semi-structured interviews (12 per site; 48 in total; 60-90 minutes each) with employed staff of all levels, volunteers, CCG members, Health and Wellbeing Board members, local authorities and relevant provider representatives e.g. Trust patient experience managers, patients and patient organizations.
- documentary evidence such as internal documents, reports, Health and Wellbeing Board minutes, local Healthwatch and Healthwatch England strategy documents.

At each local Healthwatch, we will identify key interactions between human and non-human actors and observe the practices in which these interactions are embedded. As part of our ethnographic work, we will record our observations of office work, meetings, the production and circulation of reports, the collection of data, everyday interactions between Healthwatch members and external actors such as the CCG, local GPs, Health and Wellbeing Board, patient experience and engagement managers at Providers. The role of social care commissioning and provision in our study of local Healthwatch will be considered as it arises in the observed work of the 4 local Healthwatch selected as case-study sites (and among the additional 15 Healthwatch that form the HIP). For instance, how and why might a local Healthwatch's focus on issues of social care commissioning and provision help it build influence in ways that are different to those of health care commissioning and provision? What examples are there of Healthwatch engaging in social care commissioning and provision and what are the implications of this for their operation and effectiveness?

We will pay equal attention to interactions between human and nonhuman actors (for example, strategy documents, funding applications, data, 'Enter and View' reports) as they take place and produce effects. Observational data will be recorded as written fieldnotes. Occasional still photographs will be taken of meetings and daily activities. In each of our four case study sites we will also carry out individual semi-structured interviews with a range of local Healthwatch staff and volunteers, CCG members, Trust staff, Health and Wellbeing Board members, local authority officers. This will enable us to explore themes that emerge through the other two forms of data collection (non-participant observation and documentary evidence), as well as elicit opinions from research participants, test hypotheses, and obtain targeted information.

The discussions of emerging findings at 5 half-day meetings with the Healthwatch Involvement Panel (HIP) during phase 2 will be minuted to serve as a record of proceedings and enable data analysis.

Data analysis:

Data from documents, interviews, observations and still photographs will be triangulated to develop detailed descriptions of the daily work, relationships and strategies of the four local Healthwatch case study sites. These data sources will provide both contextual information and specific insights into how local Healthwatch creates influence in their daily interactions with key actors. ANT is primarily concerned with giving equal analytical prominence to the relations between and among nonhumans as well as humans; that is, the way in which people and objects shape each other through ongoing mutual relations. In interrogating our ethnographic data, we will prioritise and foreground the detailed, contextualised description of interactions and relations between various actors (both human and non-human) that constitute the work of local Healthwatch. We will generate topical word codes, which will have an indexing function as the ethnographic work progresses through Phase 2, and thus help us to order our analytical framework. The codes will consist of key words, concepts and ideas, some of which may be 'in vivo' i.e. provided by research participants themselves. We will place codes at the top of fieldnote entries and at appropriate points in the text as they are written at the time of fieldwork; these will be refined as fieldnotes are read and re-read during data analysis. Likewise, codes will be attached to interview transcripts and documentary material. Case-study site researchers will conduct case-by-case analysis; cross-site analysis will be conducted at study team meetings and in collaboration with the Healthwatch Involvement Panel (HIP).

Data analysis will be an iterative process alongside data collection and will include 5 half-day meetings with the HIP. In advance of the first data analysis meeting, HIP members will attend a one-day training session on ethnographic data collection and analysis run by AD and GZ and facilitated by the HIP Chair SB. At each HIP meeting, data from case-study sites will be presented using a PowerPoint presentation by the research staff conducting the ethnographic fieldwork. HIP members will be asked:

- to reflect on the data presented and provide interpretation and explanation based on their own experience and knowledge of working at a local Healthwatch;
- to look for points of similarity and difference with their own organisational practices to help build a broader picture of local Healthwatch activity across England;
- to guide the research team with detailed suggestions on how to develop the ethnographic work in accordance with short and medium-term fieldwork objectives.

The core purpose of the HIP is to provide the basis for ensuring the ongoing generalisability of our findings.

Phase 3: Delphi study

Building directly on the emerging findings from phase 2, a three-round, online Delphi study (41-45) will be used to elucidate consensus on current 'good practice' relating to the operation of local Healthwatch in England as identified by the ethnographic research.

Sampling: three key stakeholder groups, each comprising 10 people, will be purposively selected for their experience and expertise relating to the contemporary operation of Healthwatch in England. The three groups will comprise: senior Healthwatch staff (drawn from local Healthwatch and Healthwatch

England); CCG members and local authority representatives; and provider representatives (e.g. Trust patient experience managers and patient organizations). Our Advisory Group will provide recommendations as to potential participants.

Setting/context: online via Survey Monkey.

Data collection: Participants will be asked to consider, define and rate factors and processes that shape the operation and impact of Healthwatch by means of three iterative rounds. These factors and processes will be identified during the ethnographic research phase in collaboration with the HIP. Delphi participants will be asked to complete each round within one week and to provide examples of 'good practice'. Open-comment fields will allow participants to provide explanations and justification for their suggestions and to raise any questions or issues relating to the aims of the study.

In round one, participants will be asked to nominate up to five factors or processes that, in their view, shape the successful operation of local Healthwatch. The online questionnaire will provide examples of possibly significant factors and processes from the findings of phase 2. Open-comment fields will allow participants to provide explanations and justification for their suggestions and to raise any questions or issues relating to the aims of the Delphi study. The anonymised, cumulative responses will then be fed back to the whole Delphi panel to inform round two.

In round two each of the suggested factors and processes from round one will be categorised and defined by the project team (based on participant responses) and then participants will be asked to rank their importance in shaping the successful operation of local Healthwatch on a scale of 1 (low) to 5 (high). Open comment fields will allow participants to explain why they rated particular factors or processes as particularly high or low. The anonymised, cumulative responses will then be fed back to the whole Delphi panel to inform round three.

In round three participants will be asked - taking into consideration the summarised comments from all the other Delphi participants as presented in the questionnaire - to nominate (5 points for top priority, 4 for second priority etc.) their suggested top five factors and processes from the ranked list that are most important in shaping the successful operation of local Healthwatch. For these five each participant will be asked to suggest any further examples of 'good practice'. The final outcomes from rounds one to three will be fed back to all participants and further comments invited.

Data analysis: Analysis will be iterative and thematic across the three rounds and consensus will be statistically operationalised by testing for heterogeneity and inter-quartile range dispersion. If consensus is not achieved by the end of the Delphi process, this will be brought into wider conversations with the JIFs (phase 4), i.e. a lack of consensus would indicate clear areas/issues which would need to be the subject of further discussions in phase 4 of the study, and would possibly be the subject of more locally contingent implications arising from the study overall.

Phase 4: Joint Interpretive Forums (JIF)

Joint Interpretative Forums (46) will engage multiple stakeholders in joint reflection and interpretation of findings from phases 1, 2 and 3. In particular, we will ask participants to examine the generalised, consensual statements emerging from phase 3 (Delphi) with the aim of converting them into practical recommendations for Healthwatch and its interlocutors. A cross-site JIF with key stakeholders from the four case study sites and national policy makers and representatives from patient organisations will take place in London to enable cross-sites exchanges and dissemination. This will be followed by JIFs conducted at each of the four case study sites participating in phase 2.

Sampling: Participants in JIFs at each case-study site locality will comprise local Healthwatch staff and volunteers, CCG members, local authority officials, Health and Wellbeing Board members, GP surgeries, Trust staff involved in patient experience and engagement, citizens and patients, relevant members of local CLAHRC, with the addition of policymakers for the cross-site JIF. These will have been purposively identified on the basis of their involvement in networks associated with local Healthwatch and their willingness and availability to participate. We will aim to involve 8 participants at each case-study JIF (of which 2 participants are patients or public) and 14 participants at the cross-site JIF (of which up to 8 will be key stakeholders from case study sites).

Setting/context: The initial cross-site JIF will be held in London and will involve representatives from all case study sites as well as policy makers and representatives from patient organisations. One JIF will then be held at each of the four case-study sites selected for the ethnographic work in phase 2. Each JIF will last no more than two hours.

Data collection: At each JIF, members of the research team will present the background to the study and the findings from Phases 1, 2 and 3. The participants at this JIF will be asked to interpret verbally the findings with the aim of converting them into principles of good practice for local Healthwatch. Discussion will be facilitated by one member of the study team. The proceedings of each JIF will be audio-recorded and transcribed.

Data analysis: JIF transcripts will be analysed thematically with the specific purpose of developing practical and generalizable recommendations for policy and practice to optimise patient and public voice in NHS commissioning and service provision.

Dissemination and projected outputs

Our research study will produce practical recommendations and actionable guidance based on formulations of good practice. These outputs will not only provide evidence based but contextually sensitive rationales for how Healthwatch might enhance patient and public voice in healthcare commissioning and provision, but also how CCGs, providers and patients can more effectively participate in these processes. The ongoing involvement of the HIP in Phase 2 and the use of a Delphi study with a wider range of stakeholders in Phase 3 - together with the Joint Interpretive Forums in our case study sites in Phase 4 - will increase the likelihood of our findings and recommendations being generalizable and relevant to the way in which local Healthwatch currently operate across England.

Sally Brearley as a core team member and PPI representative will be co-authoring all outputs and dissemination activities. Patients and members of the public will be invited to the dissemination events to be held at the 4 local Healthwatch sites to encourage engagement with the research. We will also disseminate specifically to the Research Expert Group at St George's/Kingston University, which comprises interested members of the public and was involved at an early stage of designing our research proposal.

A range of other dissemination approaches will be used to target different audiences. We will produce a final research report for the NIHR Journals Library detailing all the work undertaken and including an abstract and executive summary focussed on findings and suitable for use separately from the report as a briefing for NHS managers. We will also prepare a set of 10 PowerPoint slides presenting the main research findings and designed for use by the research team and others in disseminating the findings to the NHS, Healthwatch and local authorities, along with an accompanying podcast series of four episodes (15 minutes) to maximise reach. The content of the podcasts will be decided towards the end of the study. Possible topics will include the range of work that local Healthwatch do, how they build relationships and how health services users and citizens can become more involved in their activities. The slides, report and podcast will be made available on the HS&DR programme website.

We will prepare at least 2 high impact academic papers (one focusing on how patient and public voice can be better embedded in the planning and provision of health and social care; the other aimed at academics interested in the everyday processes of health citizenship). We will submit abstracts for presentation at 2 national and 1 international academic conferences related to patient and public participation in healthcare. These may include, for example, the BSA Medical Sociology and HSRUK conferences.

We will also prepare short articles for the Health Services Journal and the Healthwatch England Bulletin and share our findings with organizations with a strong interest in this area of research (such as the King's Fund and the Health Foundation). Further specific routes for dissemination relevant to Healthwatch were identified at our second PPI Focus Group (as part of formulating this proposal) and include:

- National Healthwatch Conference
- Local Healthwatch assemblies
- NHS Confederation conference
- Local Government Association Annual Conference

The cross-site JIF with key stakeholders from the 4 study sites will be held in London at the end of the study and will represent an opportunity for cross-site exchanges and dissemination. It will be open to local authority health commissioners, CCGs, Providers, patient groups, interested third-sector organisations and citizens. Dissemination events will be held at the end of the study at each case-study site to engage a range of local stakeholders and members of the public.

We will establish Twitter and Facebook accounts for the project through which we will engage members of the public and solicit responses for specific aspects of our study.

A key output of the research will be robust evidence about the organisational strategies and practices that shape how local Healthwatch influence commissioning and provision of health and social care. There is little evidence about how local Healthwatch works, how its relationships are established and maintained and how these help or hinder the ability of local Healthwatch to represent the views and interests of their local communities. Our findings will provide a map of current practices of local Healthwatch in England and an in-depth understanding of the ways in which local Healthwatch succeeds or fails to exert influence on key stakeholders in a sample of organisations. From these, 'good practice' will be extracted and shared with NHS commissioners, providers, local Healthwatch and Healthwatch England, local authorities, NHS England and policymakers.

The study incorporates two main pathways to impact which combined will ensure that the outputs are tailored and reach the diverse audiences for which they are intended. The HIP will meet five times in Phase 2 and include local Healthwatch managers, staff and volunteers, providing a forum for sustainable engagement and long-term reflection on everyday strategies and challenges of local Healthwatch work. This ongoing commitment will help us refine our research focus and dissemination strategies to ensure that our study outputs are meaningful to local Healthwatch staff and volunteers.

The study will be overseen and steered by an Advisory Group which will meet twice a year and will consist of a broad body of key stakeholders. Members who have already agreed to participate include two PPI researchers at different NIHR CLAHRCs (East of England and South West England), representatives from NHS England, the Department of Health and Healthwatch England. The involvement of the latter will guarantee that our outputs are shared with the wider Healthwatch network and will have an impact on national Healthwatch strategies. Other invited members of the Advisory Group include two Health and Wellbeing Board members, local authority and NHS commissioners, patient experience and engagement managers at NHS Trusts, Healthwatch Regional Networks, patients (e.g. patient participation group members) and charities. This combination of members will enable us to target our outputs to create maximum impact.

Plan of investigation and timetable

Before the start of the study: we will recruit one researcher at 50% FTE and - following consultation with HRA - prepare and submit ethical approval our application form through the IRAS system for consideration by REC.

Months -2 to 1: design the national online survey of 152 local Healthwatch and pilot questions with the Advisory Group; gain HRA and ethics approval [**Milestones 1 & 2 (month 1): ethics approval granted; survey designed**]

Months 2-4: online survey of all local Healthwatch in England (n=152); **[Milestone 3 (month 4): minimum 60% response rate]**

Months 5-8: analyse survey data and construct the sampling strategy; recruitment of four case study sites and 15 HIP participants; training of HIP members. **[Milestone 4 (month 8): successful recruitment of four case study sites; successful recruitment and training 15 HIP participants]**

Months 9-19: ethnographic data collection visits (nine three-day visits, total 27 days per site) to gather documentary evidence, carry out observations and conduct interviews; iterative data analysis in collaboration with HIP (five half-day meetings during fieldwork). [**Milestone 5 (month 19): fieldwork at four case-study sites successfully completed and final meeting with HIP completed]**

Months 20-23: carry out a three-round online Delphi study based on the findings from the survey and ethnographic case studies - with a representative sample of key stakeholders. **[Milestone 6 (month 23): successful completion of three rounds of Delphi]**

Months 24-25: Completing research findings interpretation and developing actionable recommendation for policy and practice; a cross-site Joint Interpretative Forums (JIF) and JIFs at each case study site with multiple stakeholders. **[Milestone 7 (month 25): complete JIFs]**

Months 26-30: complete analysis of data from JIFs and integrate with findings from the other phases; complete report writing; record podcast for dissemination; prepare further outputs; wider dissemination. **[Milestone 8 (month 30): disseminations activities underway and submission of final report to NIHR]**

Project management

The study will be led by Professor Glenn Robert, who will have overall responsibility for meeting research milestones as agreed with NIHR, and supported by the core project group. This group will comprise co-applicants Professor Graham Martin, Dr Giulia Zoccatelli, Dr Amit Desai and Sally Brearley and a research fellow appointed prior to study commencement and will be chaired by Professor Robert. It will meet monthly either in person or via Skype or teleconferencing.

Our HIP panel will meet bimonthly (5 times) during Phase 2. It will comprise representatives from 15 local Healthwatch which have not been selected as one of our four case study sites. Selection of members of the HIP will be based on their involvement in the Phase 1 survey and their willingness to participate. The exclusion criteria is that they have been selected as one of the four case study sites. The core purpose of the HIP is to provide the basis for ensuring the ongoing generalisability of our findings. At each meeting HIP members will be asked:

- to reflect on the data presented and provide interpretation and explanation based on their own experience and knowledge of working at a local Healthwatch;
- to look for points of similarity and difference with their own organisational practices to help build a broader picture of local Healthwatch activity across England;
- to guide the research team with detailed suggestions on how to develop the ethnographic work in accordance with short and medium-term fieldwork objectives.

The project will be overseen by an Advisory Group of 11 people who will meet in person twice a year for a total of 5 meetings over the 30-month study period. The Group comprises the following members:

- Michael Dent, Professor of Health Care Organisation, University of Leicester (Chair)
- Jonathan Boote, Visiting Research Fellow, Centre for Research in Primary and Community Care, University of Hertfordshire
- Rebecca Charlwood, Councillor and Chair, Leeds Health and Wellbeing Board, Leeds City Council
- Rachael Finn, Professor of Organisation Studies, University of Sheffield
- Pete Flavell, Manager, Healthwatch Sutton
- Andy Gibson, Associate Professor in Patient and Public Involvement, University of the West of England
- Tim Gilling, Director, Centre for Public Scrutiny
- Jacob Lant, Head of Policy and Partnerships, Healthwatch England
- Helen Lloyd, PenCLAHRC, Lecturer, University of Plymouth
- Monica Stannard, PPI advisor
- Shani Shamah, PPI advisor

Approval by ethics committees

We believe this proposal may meet the conditions for a ‘no confirmation of capacity or capability required’ HRA decision (see question 4.13 on http://www.hra.nhs.uk/documents/2016/06/hra-approval-qas-2.pdf). We will begin discussions with HRA as soon as we are informed our proposal has been successful and before the study commences. We will begin the ethical approval process 2 months prior to the formal start of the project with the aim of securing approval by end month 1 of the funded study; this is an adequate time frame based on our previous recent experiences. We will gain feedback on our information sheets and other documentation from our Advisory Group before our ethics application is submitted.

Issues of anonymity, confidentiality and informed consent will be addressed in the recruitment of all participants; Glenn Robert, Graham Martin, Giulia Zoccatelli and Amit Desai have experience of leading and conducting research projects which have required similar ethics approval. Participant information sheets and consent processes will be produced. We do not foresee any major ethical issues or anticipate any adverse events from this study given our experience with using ethnographic research methods in acute hospital settings in a previous NIHR study (Donetto HS&DR 14/156/08). However, non-participant observations may be perceived as intrusive. All participants would be made aware prior to giving consent of the ways in which researchers would carry out their observations.

The interviews will be digitally audio-recorded on encrypted devices after obtaining participants’ consent. Encrypted audio files will be stored on university computers or encrypted portable devices. Transcripts will be anonymised at the point of transcription. Any printed material containing personal information will be stored in a locked cabinet on King’s College London premises.

Patient and Public Involvement

Patient and public involvement (PPI) is an integral element of this research project. In the planning phase, it has shaped the formulation of research questions, study design and plans for dissemination. During the study, patients and the public (including volunteers at local Healthwatch) are involved in various ways across the four phases in an ongoing, embedded fashion:

- in pre-study phase focus groups, we involved 17 patients and members of the public to refine research questions and study design;
- in Phase 2, we will recruit seven local Healthwatch volunteers to the Healthwatch Involvement Panel (HIP) to analyse data from the case-study site ethnography;
- in Phase 4, we will invite two patients and members of the public who have used the services of each of the four local Healthwatch case study sites to contribute to the site-specific Joint Interpretative Forum;
- we will recruit two patients or members of the public to join our Advisory Group. These may be patients who are involved in GP patient participation groups or members of care charities;
- we will establish Twitter and Facebook accounts for the project through which we will engage members of the public and solicit responses for specific aspects of our study.

These patients and members of the public will be offered full support to contribute effectively to the study. This will include travel costs to meetings; accommodation and subsistence where appropriate for Healthwatch Involvement Panel members as well as training in qualitative methods for them during Phase 2. We will also provide payments to participants in accordance with INVOLVE guidelines.

Ultimately, the involvement of patients and members of the public in this study aims to ensure that they have a say in how Healthwatch - itself an organisation which seeks representation for citizens in local healthcare – might work better to serve their interests. Below we detail the four principal ways in which patients and the public are involved in our research.

<u>PPI Focus Groups</u> (Pre-study phase, completed April 2017)

People involved

- Focus Group A: Research Expert Group at the Centre for Public Engagement, Kingston University and St George's.
  - ten members of a standing 'Research Expert Group' including former and current NHS patients, carers, former and current local Healthwatch volunteers
- Focus Group B: Local Healthwatch and Healthwatch England, held at King's College London
  - nine people comprising staff and volunteers from several London local Healthwatch and Jacob Lant, Head of Policy and Partnerships at Healthwatch England.

Aims

- to refine research questions, study design, objectives and pathways to impact and dissemination
- to identify the need for the research

Methods

- Focus group

Outcomes

The Focus Groups:

- emphasised the need for this research
- rejected our initial proposal to focus exclusively on local Healthwatch's dementia-related work which the Group said would not be representative of the work of all local Healthwatch in England. The Group suggested that we adopt a broader focus by means of the Phase 1 survey to account for the variability of each local Healthwatch's annually agreed priorities
- identified variables to include in Phase 1 survey
- approved and refined methods of recruitment strategy for the Healthwatch Involvement Panel (HIP) (see below)
- suggested Delphi phase (Phase 3) to build consensus around ethnographic data analysis

Healthwatch Involvement Panel (HIP) (Phase 2)

People involved

- seven volunteers and eight staff from fifteen local Healthwatch which are not case-study sites
- the HIP will be chaired by Sally Brearley who is an experienced Patient and Public representative and facilitator. SB is Lay Member for PPI on the Governing Body of NHS Sutton Clinical Commissioning Group.

Aims

- to involve Healthwatch volunteers as well as staff given that volunteers play a large role in local Healthwatch activities – there are over 6000 volunteers nationwide.
- to ensure that volunteers as well as staff reflect on the data presented and provide interpretation and explanation based on their own experience and knowledge of volunteering at a local Healthwatch;
- to look for points of similarity and difference with their own organisational practices to help build a broader picture of local Healthwatch activity across England
- to guide the research team with detailed suggestions on how to develop the ethnographic work in accordance with short and medium-term fieldwork objectives.

Methods

- All HIP members (including volunteers) will receive one-day training in relevant qualitative methods from King’s College London, plus tailored ongoing support from the research team to promote meaningful participation;
- HIP members will attend 5 bimonthly, half-day meetings in Phase 2. At each HIP meeting, ethnographic data from case-study sites will be presented by research staff conducting the fieldwork. HIP members will be asked to conduct within case and across case comparisons in line with the aims articulated above.

Projected outcomes

- provide an inclusive forum for sustainable engagement and long-term reflection on everyday strategies and challenges of local Healthwatch work.

This ongoing commitment will help us refine our research focus and dissemination strategies to ensure that our study outputs are meaningful not only to Healthwatch staff but also members of the public who volunteer with Healthwatch.

Joint Interpretative Forums (JIFs) (Phase 4)

People involved

- Of the eight total JIF participants at each site, two will be patients or members of the public who have used the services of the case-study local Healthwatch.

Aims

- To engage patients and the public as key stakeholders in joint reflection and interpretation of the findings from Phases 1,2 and 3
- To examine the generalised consensual statements which emerge from Phase 3 (Delphi study) with the aim of converting them into practical recommendations for Healthwatch and its interlocutors and which conform to the needs of local patients and members of the public

Method

- One two-hour meeting in the locality of each case-study site
- Presentation of the data emerging from the study followed by discussion and creation of principles of good practice

Projected outcome

- That patient and public voice is taken into account in the interpretation of study results and the formulation of principles of good practice
- That the JIF builds the basis for collaboration to ensure that patient and public voice is involved in the creation of resulting action at the local level.

<u>Advisory Group</u> (all phases)

People involved

- Two patients and members of the public of a total of twelve. These may be recruited from Healthwatch volunteers or people who have used Healthwatch services.

Aims

- to ensure that patient and public views are considered throughout the research process along with those of policy makers and practitioners
- to ensure that patient and public perspectives contribute to the dissemination of research findings and recommendations

Method

- Five two-hour meetings over the 30 month study period
- During the first meeting the Advisory Group will be asked to approve the survey questions produced early in Phase 1
- Later meetings will discuss project progress

Projected outcomes

- through patient and public involvement in the Advisory Group, the study outputs will be tailored to and reach the audiences for which they are intended.

Expertise and justification of support required

The study team has relevant expertise in various aspects of the social scientific study of organisations, including sociological and anthropological approaches to healthcare and experience of applying Actor Network Theory to contemporary healthcare delivery issues.

Glenn Robert's (GR) research focuses on quality improvement and studying innovations in the organisation and delivery of health care services. He has been a PI or CI on 13 NIHR-funded studies including currently being a CI on an HS&DR study using ANT to explore the journeys of patient experience data in NHS acute Trusts. GR will provide overall co-ordination of the project, line management of AD, GZ and the 'to be appointed' Research Fellow, input to qualitative data analysis and lead the writing of the final report and dissemination.

Graham Martin (GM) has published extensively on various aspects of PPI policy and practice, including Healthwatch, predecessor organisations, and the interface between PPI and health system reconfiguration (1, 9, 14, 47, 48). He will provide input at all stages of the study and will contribute to data analysis, final report and other outputs.

Amit Desai (AD) is an anthropologist with expertise in patient experience, NHS organisations and mixed-methods research. He will be responsible for day-to-day project management. He will lead on the survey design and data analysis in Phase 1 and will collect and analyse ethnographic data at two case-study sites.

Giulia Zoccatelli (GZ) is an anthropologist with expertise in health citizenship and ANT. GZ will lead on securing ethics (and any necessary local R&D) approval, and co-ordinate work on phases 1 and 3 and advise on Phase 2.

Both AD and GZ will contribute to writing the final report and other dissemination activities.

Sally Brearley (SB) is an experienced Patient and Public representative and facilitator and is a Lay Member for PPI on the Governing Body of NHS Sutton Clinical Commissioning Group. She will coordinate the PPI strategy throughout the study and chair the HIP.

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