Programme Development Grants are designed to allow strong collaborative teams to undertake development work to position themselves for successful applications for full NIHR Programme Grants; hence, it is anticipated that a final report will be an annex to any subsequent Stage 2 Programme Grant application.

Nevertheless, final reports are required for all work funded through the NIHR Programme Development Grants scheme, irrespective of whether or not they lead to an application for a full programme grant. The reasons are to:

- ensure accountability of the scheme
- demonstrate what has been achieved
- assess the impact of the work supported by the grants
- understand grant holders' plans beyond the award
- encourage quality assurance of research outputs
- aid in appropriate dissemination of research results

Please keep these aims in mind while completing your final report.

The report needs to offer:
   a) a clear summary of the development work for practitioners and users of research
   b) a record of challenges faced and modifications made as a consequence
   c) plans for research that will follow the development work
   d) a summary of any outputs, such as publications, from the research

A final statement of expenditure should be submitted at the same time as a final report. Please note that the final payment will only be released once the completed final report along with a final statement of expenditure has been received by the CCF

For further guidance or information on completion of your final report, please contact the Programme Grants for Applied Research Team at NIHR CCF, using the details below:

Programme Manager's Name
NIHR CCF help line:

NIHR Programme Development Grants

Final Report Form

1. Development Grant details

Reference Number:	**RP-DG-1209-10020**
Title:	**Enhancing the quality and purpose of care planning in mental health services.**
Lead Applicant's Name:	**Professor Karina Lovell**
Contracting NHS Organisation:	**Manchester Mental Health and Social Care Trust**
Contract Start Date:	**01/10/2010**
Development work Start Date:	**01/10/2010**
Current Contract End Date:	**30/09/2011**
Original Duration:	**12 months**
Current Duration:	**12 months**
Total funding awarded (prior to any inflation uplifts):	**£95,431**

2. Grant holder's details

Title:	Professor
Surname:	Lovell Forename: Karina
Department:	School of Nursing, Midwifery and Social Work
Role in Research:	Principal Applicant

Institution:	University of Manchester
Street:	Oxford Road
Town/City:	Mancheste County: Manchester
Post Code:	M13 9PL
Telephone:	▓▓▓▓▓▓ Extension:
Email Address:	▓▓▓▓▓▓▓▓▓▓▓▓▓▓

3. Summary (in Plain English)

Please provide a summary of the development work, including background, findings and conclusions. It is essential that you make the content of your summary and the implications of your work evident to the lay public. It should avoid technical terms and should be written in an accessible style and emphasise in particular the potential for patient benefit. **(Maximum 2,500 characters)**

Involving and allowing service users choice in their own care and hence recovery is at the centre of policy initiatives aimed at improving quality of care. This principle is enshrined and prioritised in healthcare. Despite this and the literature produced by user and carer groups which advocate that involving users and carers in care planning is fundamental to improving the quality of care, there is substantial evidence that many users and carers are marginalised and removed from the care planning process.

The aim of the programme grant is to improve user and carer involvement in care planning in mental health services. To prepare for a full application we conducted the following preparatory work:
- i) to develop strong service user and carer collaboration in two mental health trusts and increase their capacity to engage in the Programme Grant,
- ii) to undertake a review of the literature to better inform the Programme Grant,
- iii) to enable the project team to form a consensual strong working group in order to deliver on the Programme Grant and
- iv) to prepare, develop and confirm the design of individual work streams for the Programme Grant

We developed and delivered a successful research methods course for users and carers which equipped them with an understanding of research in order to improve their ability to engage with and understand research and researchers. Our user and carer consultation group has given us the time to develop close working relationships and to work in true partnership. Together we have reviewed outcome measures, defined the attributes of a suitable measure and agreed that we will develop and validate a suitable measure in our programme grant application.

The review of the literature achieved its objective, and has identified the key barriers and facilitators of sustained user and carer involvement in care planning processes. Its findings provide a solid foundation on which to base the programme grant. The team building workshops allowed us the time to work as a collaborative and effective group and to develop the programme application and to fully discuss the design in detail as well as the integration of all work streams.

In conclusion the preparatory work has allowed us to develop a full application for a programme grant with significant user and care involvement.

4. Research team

Describe any changes in the research team over the course of the development work. **(Maximum 1,500 characters)**

During the programme development grant a number of changes occurred. Professor Gask is retiring in 3 years and hence will not be available for the duration of the programme grant. She has requested that that she change her status from co applicant to collaborator. In consultation with Dr Gask we have engaged Dr Richard Drake (RD, psychiatrist) to be a co-applicant. RD has a clinical appointment with Manchester Mental Health and Social Care Trust and is actively involved in care planning. In addition he has a strong research track record in mental health.

Given the amount of qualitative work incorporated into the programme grant we have also engaged Dr Caroline Sanders (CS) as co-investigator. CS has a strong track record in medical sociology & qualitative methods and is experienced in devising peer-led training for care planning (in the context of end of life care).

Throughout the programme development grant we have worked with service users & carers and we have engaged 3 further co applicants from this group. Lauren Walker (LW) & Andrew Grundy (AG) have lived experience of mental health problems and Lindsay Cree (LC) a carer for her son who uses mental health services. Importantly LC is accredited to provide carer-led teaching to medical students.

Although Dr Quirk made a full contribution to the programme development grant he is unable to participate in the programme grant.

5. Keywords

Provide up to 8 keywords that relate to the work undertaken.

Care planning; mental health, User involvement, carer involvement, realist review, education, collaboration

6. Additional background information

Provide any background information that is essential to assessing the outcome of your Development Grant that is not in the original application. **(Maximum 3,000 characters)**

The new "No health without mental health" strategy (HM Government 2011) emphasises the importance of addressing poor outcomes in terms of employment and engagement of personal communities. This mental health outcomes strategy looks to communities, as well as the state, to promote independence and choice reflecting the recent vision for adult social care". It is thus suggested that user centred care planning remains central to current and future policy direction in mental health.

The programme development grant has also benefitted from synergies with related work ongoing at the University of Manchester on care planning, including the Department of Health Policy Research Programme CAPITOL project on care planning in long-term conditions (Bower, Rogers), and the NIHR funded WISE trial on primary care based education for self management support and care planning (Rogers, Sanders, Bower). These projects have common core philosophies around shared decision making and patient involvement, which has enabled sharing of conceptual frameworks, empirical data and research designs which has made a substantive contribution to the current programme development grant and the resulting programme grant application titled Enhancing quality of user involvement in the planning of care (EQUIP).

Taking each component of your Development Grant research plan in the order in your application form, describe the work that you have undertaken and whether or not it successfully addressed the questions or problems that it was aimed to address. Also mention any challenges faced and modifications made as a consequence. **(Maximum 25,000 characters)**

The programme development grant work plan had four stages:
   i)   to develop strong service user and carer collaboration in two mental health trusts and increase their capacity to engage in the Programme Grant,
   ii)   to undertake a review of the literature to better inform the Programme Grant,
   iii) to enable the project team to form a consensual strong working group in order to deliver on the Programme Grant and
   iv)   to prepare, develop and confirm the design of individual work streams for the Programme Grant including the identification of key outcome measures and/or the need to develop new ones.

Stage 1: Engage with and develop strong service user collaboration, increasing the capacity and confidence in order to fully engage in the programme grant.

Aim
This stage of the programme development grant aimed to build the capacity of service users and carers by providing a tailored training course on research methods. The aim of the training was to ensure that users and carers informed the research process and fully engaged in the development of the programme grant.

Recruitment & selection
Advertisements were widely distributed via two NHS trusts (Manchester Mental Health and Social Care Trust & Nottingham NHS Trust) and local user & carer groups. A single page application form was devised to capture recent lived experience in mental health services and preferably of care planning. From 25 applications, 13 candidates were short listed and invited to interview (9 Manchester, 4 Nottingham). Candidates who were not shortlisted did not have lived experience of care planning in secondary care. Although we only intended to offer 8 places we were so impressed by the calibre of applicants at interview that we decided to offer them all a place on the course, resulting in 5 additional places being created.

Training development and content
A 6 day course delivered 1 day a month for 6 months was developed and delivered at the University of Manchester. Each day was divided into four 50 minutes session, two in the morning, and two in the afternoon. The course was pitched at Masters Level and delivered using a blended learning approach including lectures, large & small group formats and online resources. Masters level training was felt to be necessary to engage participants fully in the research process. A key challenge was locating educational materials which both met the requirements of this level yet remained accessible to lay readers. Ben Goldacre's Bad Science was adopted as the core text and provided free of charge to all participants via development grant funding

Sessions were delivered by applicants from the programme team, who taught research theory and methods within their specialist area. Homework exercises were internally developed for use between sessions and drew on key mental health and health services literature relevant to each research topic.

All students were enrolled on a non-credit bearing course, enabling full student access to University of Manchester facilities, IT systems and library resources (databases, e-journals and books). Students were enrolled on Blackboard 9.0, the university on-line learning facility, allowed participants access to electronic as well as hard copies of all handouts, academic articles and audio recordings of teaching sessions. Learning materials were circulated in advance, and enlarged for those with visual impairment. All sessions were digitally recorded and audio files were available on Blackboard.

Training content:
Day 1: Orientation to the grant & the University of Manchester, IT and study skills refresher;
Day 2: Understanding the research process & developing research questions;
Day 3: Literature searching & critical appraisal;
Day 4: Qualitative methods;
Day 5: Quantitative methods & health economics;
Day 6: Ethical conduct, training evaluation and grant development discussion.

Attrition

Of the 9 completing the course 5 had 100%, two 83.3%, and two 66% attendance. Two service users and two carers withdrew for personal reasons (including one service user who was offered employment). All of those who withdrew stated that they would attend the course again given the opportunity.

Evaluation

The qualitative evaluation is based on feedback from both trainers and trainees. The course and content was very well received by attendees. All participants reported a high level of satisfaction with the course in particular, learning about research and its governance including understanding of research design, qualitative and quantitative methods and cost effectiveness. The 'Bad Science' text was highly regarded by participants who felt that it provided the necessary depth of knowledge to understand core research concepts (e.g. effect sizes & confidence intervals). Research interest was also raised with a number of participants also reading Ben Goldacre's weekly 'Bad Science' column in the Guardian.

'I would just like to say thank you for giving me het opportunity to take part in the research program; it made me feel so good about myself as it really boosted my confidence. It made me realise just how much of a difference I can make with the right tools and training. I would also like to thank all the tutors who took time to help; I learned a lot especially from Ann Rogers. I also enjoyed doing team work and being part of a team. I learned so much by being able to take part in the research program. It has been a dream come true attending university: it just proves that no matter what disabilities someone may have – physical or mental – with help dreams can come true. I hope I can be part of future research programs and I look forward to finding out what the future holds for me.' (Service user)

Positive messages emerging from the feedback included the experience of being on a course which promoted learning, validated previous experiences, improved confidence and provided opportunities. Value was also afforded to the added extras (e.g. Food, support, recordings, printing), regularity of the breaks provided, engaging staff and the genuine involvement of service users/carers. One of the key messages that came through from the group was the view of being treated as an equal amongst health professionals (a new experience for many of the group).

For future courses a number of suggestions were made to improve the course including: overcoming IT delivery problems, providing more resources in advance, and increasing inclusion in the university.

Requests were also made for opportunities to discuss health/wellbeing in a contained manner so as to prevent tangents during training, and to discuss issues about the training endpoint and further opportunities for the group.

Key messages from the trainers

Most participants had days when their mental health influenced their learning, and this required some additional input. However the course was developed from a normalisation stance which aimed to make the application and process like any other university course. The maintenance of this principle was important to both participants and trainers.

Training was resource intensive, and required 2-3 trainers per session to facilitate small group learning. All trainers commented on the enthusiasm of the participants, and their course commitment, demonstrated through the completion of all homework activities and learning beyond the mandatory content, i.e. by visiting the library to find out more.

Trainers identified a number of value added components including the resolution of remuneration to enable cash payments, provision of lunches & refreshments, and the development of learning materials in a variety of formats.

One of the key messages that emerged from the trainers was that the training itself had enabled them to feel more confident working with users and carers. None of the trainers had taught research methods to user and carers before and we learnt some valuable lessons (perhaps most importantly the lack of user friendly material available). In addition valuable feedback was provided from users and carers about teaching styles and materials used.

Post course legacy

During the course participants began engaging in PPI activities to provide feedback on several grant applications. They expressed a desire to continue to undertake this role and engage in developing service user/carer-led research projects. A number of participants have been co-opted into the programme grant application, steering group, and/or potential researcher roles (identified as PhDs within the programme grant application).

In order to ensure the legacy of the group and to undertake future training sessions, applications for additional funding have been made to Manchester Academic Health Sciences Centre (MAHSC) and Manchester Mental Health Trust Flexibility & Sustainability Funding. An additional day has been organised in November 2011 to update the trainees on the outcome of these. The course has already been cited by the MHRN as an exemplar of good practice. Regardless of the outcome of the

programme grant application we are committed to continuing this group and involving them in further research opportunities.

Outcome
The training achieved its objective, to equip service users and carers with an understanding of research in order to improve their ability to engage with and understand research and researchers. Considerable learning has been achieved by service users, carers and trainers about how to devise educational course of this kind and improve future courses. Trainees have contributed to the programme grant design and some will be part of the research team.

Stage 2: A substantial (realist) review of the literature

A substantial review has been completed, the findings of which underpins the proposed Programme Grant The word limit preclude us from detailing the full report here. An extended abstract is presented below.

Background and aim
Recent policy initiatives (1-3), emphasise the importance of involving service users in the planning of their own care. The drive to include service users within this process is considered a necessary and potentially effective means of improving the responsiveness of services, and making them better tailored to people's needs and social circumstances. Despite this there is a wealth of evidence to suggest that, in mental health services, users are dissatisfied with their level of involvement in care planning (4). A previous review (5) identified a range of benefits to user involvement in care planning including: improved service development, information provision, service user feedback mechanisms, esteem of service users, and the attitudes and morale of staff. Included studies were limited to small-scale, uncontrolled studies however and failed to elucidate impact on service utilisation, quality of care, or health improvement. Recent studies in mental health have evaluated the impact of enhanced user involvement interventions on service level outcomes, but, by nature of their design, are limited in terms of their ability to reveal barriers to wider implementation. In order to improve outcomes across mental health populations, it is necessary to understand the various intra and inter-individual mechanisms and organisational systems by which user involvement in care planning can be optimised over time.
The primary aim of this review was to identify the key barriers and facilitators of sustained user & carer involvement in care planning. To this end, we set out to examine how user involvement is typically operationalised in a mental healthcare context and where, how and why user involvement may meet with resistance. A secondary aim of the review was to identify where further research synthesis may be warranted if the subtleties of these key challenges and catalysts to user involvement are to be better understood.

Methods
Realist review as a method of evidence synthesis aims to delineate the core mechanisms through which complex programmes are deemed to work. The essential steps in a realist review comprise clarifying the scope of the review, articulating the underlying theoretical framework, and searching for and appraising evidence. The scope of the review was international and examined user involvement across both organisational and service settings. Following substantial reading and consultation, a theoretical framework conceptualised user involvement in care planning as a core component of three broader philosophies: patient-centred care, shared decision making and patient empowerment. The success of each philosophy was further hypothesised to depend on three intervening variables: i) the capacities & competencies of users, ii) their relations with health professionals and iii) the organisational context in which their care occurs. Cross-matching these three frames of reference with the three care philosophies identified the key pathways and mechanisms through which user involvement may be expected to succeed or fail. Subsequent synthesis of the primary evidence provided a means of identifying the specific routes and procedural points through which user-involved care planning has been facilitated or barred.
A comprehensive search strategy was applied to electronic databases and grey literature sources. Results were screened for eligibility and data indexed against our framework. Each primary data source was evaluated in terms of its reporting quality, the appropriateness of its methods, and its internal and external validity.

Results
Searching yielded a total of 4800 articles, 1730 of which were retained after initial abstract screening. We excluded papers that failed to present useable data on the potential barriers & facilitators of user involved care planning in mental health. 137 papers were used to interrogate the central assumptions of our conceptual model. Of these 116 were empirical academic studies, 15 grey literature studies and 6 national consultations.

The synthesis revealed effective user involvement in care planning to be a multi-stage intervention, dependent on a number of broad conditions:

- the motivation of the user
- the perceived adequacy of information provision and choice
- the quality of the care planning relationship
- the effective engagement of users in the care planning process

Each condition incorporates multiple, complex processes and potential confounding influences, with consistency of practice and communication being identified as key mediating factors.

Users' ability to sufficiently influence their care was found to extend beyond the level of the individual, to relational and organisational hierarchical constraints on care. At the relational level, barriers included a lack of congruence between user and staff priorities for care, and staff anxiety surrounding implications for user well-being and safety. There was a general underestimation of users' willingness and ability to be involved, and a suggested failure among professionals to communicate care planning processes in lay terms. Staff in turn reported a lack of resources & support, and there was evidence of deficits in the skills, knowledge, and confidence required to effectively engage users in the process. Both users and professionals noted that factors related to staff working conditions, particularly in acute inpatient settings, such as stress, burnout, and lack of time, challenged user involvement in care planning.

Most notably, synthesis suggests that failures in partnership working will most likely occur wherever the frames of reference adopted by service providers and consumers diverge. Whilst staff tend to focus their attention on enhancing the outcomes of care planning, users are much more concerned with the process. Users report perceiving care-planning as too hierarchical and exclusive and it may be that health professionals are misattributing a lack of user motivation, with disaffection with the process. The situation may only improve when health professionals engage users in prospective decision making processes.

Future research is necessary to more fully examine the relationships between intra and inter-individual competencies and organisational capacities, including the propensity for intervention at the inter-individual level to moderate effects elsewhere.

Outcome

The review achieved its objective, and has identified the key barriers and facilitators of sustained user and carer involvement in care planning processes. Its findings provide a solid foundation on which to base the programme grant. In particular there appears to be a need to reduce the perceived power differential between users and professionals, potentially through promoting user self-efficacy whilst concomitantly reducing professional self-importance. Findings indicate that services should broadly, adopt strength-based recovery oriented approaches to care and provide sufficient training and adequate working conditions for staff. Efficient administrative systems are essential to facilitating user involvement including the timely allocation of care coordinators and stakeholder invitations to review meetings. Such features will directly inform the development of interventions in the programme grant.

Stage 3: Enable the team to form a strong and consensual working group.

Our aim was to enable the project team to meet regularly during the project to finalise key aspects of the Programme Grant. We said that we would organise 3 structured away days for the team to form a strong and consensual working group. We achieved this and held 3 full day meetings, the first was focussed on team building (facilitated by an external trainer) and developed and refined our shared objectives for the programme development grant. The second & third day workshops consisted of presentations on the user/carer training and the realist review. A half day workshop was convened between our user/carer group and programme team to explain the nature of the programme grant and present the initial results of the realist review. Discussions focussed on developing the content and coherence of the future work streams. A fifth workshop was held with both groups to present the review of potential outcome measures (see stage 4).

Outcome

We achieved our objective and provided us the opportunity to achieve a well functioning team essential to developing and delivering a programme grant.

Stage 4: Preparation, development and confirmation required for the development of a cluster randomised trial.

This stage consisted of two key components. The aims of these two components were to:
- Identify the potential outcome measures which evaluate the level of user/carer involvement & satisfaction with care planning.
- To develop and finalise the work streams of the full programme grant.

Identifying potential outcome measures which evaluate the level of user and carer involvement and satisfaction with care planning

As part of our search strategy for our realist review (stage 2) we searched for potential outcome measures for a planned randomised controlled trial. Nine measures were identified. A workshop with our user/carer consultation group (n=10) and co-applicants (n=6) was held in July 2011. The key details of each of the 9 measures found in our review were tabulated and actual copies of measures (where available) were presented to the group.

Three small groups were formed to discuss each measure in turn and to either reject or accept its potential value to the trial. Results of this exercise were tabulated and used to prompt further discussion. Consensus was achieved on each measure. Two measures were viewed as potentially useful but despite the team writing to the authors we were unable to obtain copies. These measures therefore had to be rejected. Only 2 measures were developed for UK use and none were deemed suitable by the group. It was thus agreed that a new measure would be developed and validated in the programme grant.

To inform this development, the group divided into their small working groups to list the key concepts/attributes important in developing a user/carer measure. From these discussions a shared list of attributes was generated.

The final exercise consisted of determining the key domains which should be measured as secondary outcomes. To assist the group we provided each member with a copy of Crawford M et al 2011, 'selecting outcome measures in mental health: the views of service users. (J Ment Health. 20:336-346). This article details how expert panels of people with experience of mental health problems discussed and rated a range of commonly used questionnaires/measures used in mental health research studies. The group was asked to use this document as a platform for discussion rather than using the domains detailed in the article. The key domains identified were Quality of life, Alliance/engagement, Hope, Satisfaction, Mental health symptoms, Satisfaction, Recovery and Medication side effects.

To develop and finalise the work streams of the full programme grant.

We have developed and finalised all 4 work streams and have developed a coherent programme grant. The entire team (included additional applicants) and the user and carer consultation group have significantly contributed to the final application. One key example was the decision to develop and validate an outcome measure (as detailed above). A second example was to decide on the most appropriate design to evaluate the extent of user and care involvement in care planning. Following lengthy discussion our design depends in part on the outcome measure that will be developed for assessing quality in care planning. Where the outcome depends on data gathered directly from the patient, a cluster cohort design may be appropriate as this allows adjustment for baseline characteristics at an individual level thereby increasing power. It does nevertheless bring with it the possibility of selection bias and may be weakened by retention in the study, a key factor in this clinical group. The alternative is to use a cross-sectional design but this would tend to require a larger sample size due to the lack of baseline adjustment and reduced sensitivity of the measure. This would be more feasible where data can be gathered from clinical records using an audit tool. Given that we propose to use both patient responses and clinical records, the trial may combine features of both designs according to the outcome measure selected. In this event, we may nest a design cohort within two cross-sectional surveys taking place prior to and after the intervention.

Outcome
We achieved our aims and have been able to develop all aspects of the programme grant application.

Overall Conclusion
We successfully completed our aims of the programme development grant within a 12 month period and most importantly have submitted a fully developed programme (EQUIP). Our training programme for users and carers exceeded both applicants and training participant's expectations with regard to both the process and outcomes. Our user and carer consultation group and training has given us the time to develop close working relationships and to work in true partnership. Together we have reviewed the literature on suitable outcome measures, defined the attributes of a suitable measure and agreed that we will develop and validate a suitable measure in our programme grant application. In addition we

have identified those domains that will be used as secondary outcomes in the programme application.

Perhaps our biggest challenge has been the review which was much larger than originally anticipated. The size and complexity of this review necessitated more resource (supported by the University of Manchester) than we budgeted for. However, the output (which will be published) provides one of the most sophisticated critiques of barriers & facilitators to user and carer-involved care planning in the literature. The team building workshops allowed us the time to work as a collaborative and effective group and to develop the programme application into what we feel is a significantly better application than had we not been afforded this opportunity.

References
1. Department of Health, The NHS Plan: A plan for investment, a plan for reform. 2000, London: DH.
2. Royal College of Physicians, Advance care planning. Concise guidance to good practice, ed. L. Turner-Stokes and B. Higgins. 2009, London: Royal College of Physicians.
3. Care Services Improvement Partnership and National Institute for Mental Health in England, Our Choices in Mental Health: A Framework for Improving Choice for People Who Use Mental Health Services and Their Carers. 2005: DH, London.
4. Healthcare Commission, The pathway to recover: a review of NHS acute inpatient mental health services. 2008, London: Healthcare commission.
5. Department of Health, Effective care co-ordination in mental health services: modernising the care programme approach - A policy booklet, London, Editor. 1999, DH.

8. Future plans for this programme of work

Do you still intend to submit a Stage 2 application for a Programme Grant?   Yes

If Yes, briefly tell us when you plan to do this, and also how the development work has been useful in consolidating or modifying your original programme plans as described in the Development Grant application. **(Maximum 2,500 characters)**

The development work has been invaluable to us as a team; most significantly we have achieved what we believe to be truly meaningful user and carer involvement in the application. The user and carer consultation group (derived from all the participants on the programme group) has expressed its desire to continue its involvement in the application. 3 members are co applicants, 2 have expressed a desire to study further for a PhD. Both candidates have first degrees but had lost confidence in their academic abilities due to their mental health problems. Their fees have been costed into the full application. Three further members have agreed to be members of our steering group if successful in our application and 2 have stated a desire to be researchers.

The workshop with users/carers and applicants has led to an open discussion and consensus on the attributes from a service user and carer point of view and the decision to develop and validate an outcome measure. Secondary outcomes (domains) have been identified by users and carers and this gives us a basis to decide on measure that fit these domains.

The realist review has provided us with evidence based and conceptually rigorous underpinning to the application. The integration of all our development work has allowed us to discuss the design in considerable detail as well as the integration of all work streams. The process helped to identify developments to the economic components of the programme grant, including the addition of stated preference surveys, to ensure the quantitative assessment of the value and cost effectiveness of user led training is fully integrated into the research.

If No, please explain why, and explore if and how you might take research on the topic forward in another way in light of your development work. **(Maximum 2,500 characters)**

O

Describe your plans for disseminating the findings of your development work. **(Maximum 2,500 characters)**

Our training course has been cited by the MHRN as an exemplar of good practice. We are seeking funding from a range of sources to run further courses.
An abridged version of the research training programme will be run at Nottinghamshire Healthcare NHS Trust's Recovery Education Centre in the form of a two-day workshop in March 2012. This workshop will be run by the four service users and Professor Callaghan.

We are presenting our work with users and carers to both Trusts and we are encouraging the group to publish their experience of the course. The realist review is now complete and we are currently in the process of preparing this for publication.

Please list any reports of the research funded via the Programme Development Grant award which have already been published or submitted for publication. Please also list any other outputs such as conference presentations, media interviews *etc*. achieved during the award.

Author (s)	Title	Reference/Further Details

Please note that all publications must acknowledge the funding from the NIHR Programme Development Grants scheme and must also contain a disclaimer indicating that the views and opinions expressed within it do not necessarily reflect those of DH/NIHR. Please also note that all publications and other outputs (whether in oral, written or other form) should be submitted to the NIHR CCF at the same time as submission for publication, or at least 28 days before the date intended for publication/presentation, whichever is earlier.

Grant-holders are also reminded of NIHR's support for the principle of Open Access to research as set out in its statement supporting UKPubMed Central:

http://www.nihr.ac.uk/files/pdfs/OpenAccessPolicyStatement.pdf.

10. Any other comments

Please tell us about any other aspect of the award that would help us to assess its success.
(Maximum 2,500 characters)

11. Feedback

Please let us have any other comments, including ways in which the system for reporting might be improved.