Study Protocol

1. TITLE PAGE

Full Title	**Cross-national comparative study of recovery-focused mental health care planning and coordination in acute inpatient mental health settings (COCAPP-A)**
Short Title/Acronym	**COCAPP-A: Recovery-focused care planning**
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2. GLOSSARY

Care Planning: In England the care programme approach (CPA) is the system through which the needs of an individual using mental health services are assessed, planned, provided and reviewed. The written care plan lies at the heart of this process, and should be collaboratively developed by professionals working in partnership with individual service users and their significant carers. It should include details on goals or intended outcomes, on services to be provided, on plans to be followed in the event of a crisis and on the maintenance of safety.

Care and Treatment Planning: In Wales, with the passing of new law the Mental Health (Wales) Measure (2010), the care and treatment plan (CTP) is the document which supersedes the CPA for all people using secondary mental health services. CTPs must address at least one of eight areas (accommodation; education and training; finance and money; medical and other forms of treatment, including psychological interventions; parenting or caring relationships; personal care and physical well-being; social, cultural or spiritual; work and occupation).

Care Coordination: this is the responsibility of a named mental health professional, whose work (under both the CPA and the CTP systems) includes coordinating the assessment and planning processes for named individuals using mental health services. The coordinator, who is most often a mental health nurse, social worker or occupational therapist, takes responsibility for planning care with the person’s close involvement and ensures that this care is reviewed regularly.

Recovery: the contemporary idea of personal (rather than necessarily clinical) recovery in mental health originated in the service user movement, and is now claimed as the philosophical underpinning for many mental health policies and services including care planning. Anthony's (1993:15) definition is often used, which is: “a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness.” [*longer version below]

*Recovery is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.

Personalisation: Defined by Larsen et al (2013) as a way to “describe the enhancement of individual choice and control for eligible adults using social-care services through personcentred planning and self-directed support", personalisation underpins the idea that health and social care services should be tailored to the particular needs of individuals, and should enable people to live as independently as possible exercising choice and control. The use of personal budgets to purchase social care support can be a feature of personalisation.

3. SIGNATURE PAGE

Chief Investigator Agreement

The clinical study as detailed within this research protocol **(Version 3, dated 01.09.2014)**, or any subsequent amendments will be conducted in accordance with the Research Governance Framework for Health & Social Care (2005), the World Medical Association Declaration of Helsinki (1996) and the current applicable regulatory requirements and any subsequent amendments of the appropriate regulations.

Chief Investigator Name: Professor Alan Simpson

Chief Investigator Site: City University London

Signature and Date: 01.09.2015

4. SUMMARY/SYNOPSIS

Short Title	COCAPP-A: Recovery-focused care planning in mental health inpatient settings
Methodology	Cross-national comparative study of care planning in mental health inpatient settings, employing a concurrent transformative mixed methods design with embedded case studies.
Research Sites	Abertawe Bro Morgannwg University Health Board Avon and Wiltshire Mental Health Partnership NHS Trust Cardiff and Vale University Health Board East London NHS Foundation Trust (ELFT) Lincolnshire Partnership NHS Foundation Trust Sussex Partnership NHS Foundation Trust
Objectives/Aims	The aim of this study is to identify factors that facilitate or hinder recovery-focused personalised care planning and coordination in acute mental health inpatient settings. The following questions will be explored: a) What impact do national and local policies and procedures have on care planning and coordination? b) What are the key drivers impacting on care planning and coordination? c) What are the views of staff, service users and carers on care planning, therapeutic relationships, recovery-orientation and empowerment in acute care settings? d) How is care planning and coordination currently organised and delivered in local services? e) How and in what ways is care planning and coordination undertaken in collaboration with service users and, where appropriate, carers? f) To what extent is care planning and coordination focused on recovery? g) To what extent is care planning and coordination personalised?

	h) What specific features of care planning and coordination are associated with the legal status of service users? i) Is care planning and coordination affected by the different stages of stay on a ward (i.e. at admission, during stay, pre-discharge)? j) What suggestions are there for improving care planning and coordination in line with recovery and personalisation principles?
Number of Participants/Patients	Service users (n=414) Inpatient staff (n=336) Informal carers (n=174)
Main Inclusion Criteria	Service User/Patient inclusion criteria: Participants will be service users admitted to in-patient units meeting these criteria: • 18 years or older • With a history of severe mental illness • Able to provide informed consent • Sufficient command of English Staff inclusion criteria: • Any qualified or unqualified staff working on inpatient wards involved in care planning or review Ward inclusion criteria: • The ward provides an acute mental health care admissions facility to the local adult population; and • Has an established ward manager/team leader in post; • Is not subject to any plans for closure or merger during the study period; • Is not currently experiencing excessive pressures or responding to elevated levels of untoward incidents (so that we do not add to participant burden); and • There is MDT support to participate in the study.
Statistical Methodology and Analysis (if applicable)	Descriptive statistics will be calculated and presented in order to provide an overview of clinically significant findings prior to statistical interpretation. To ascertain any differences between the six sites on the four outcome measures for service users,

	(VOICE, RSA, STAR and ES) a one-way Multivariate Analysis of Covariance (one-way MANCOVA) will be conducted. If statistically significant differences are found subsequent One-way Analysis of Covariance (One-way ANCOVA) will be employed post hoc to ascertain which measures differ between which locations. Correlations will be carried out to identify if there is a relationship between the outcome measures. Selective correlations will be conducted using Multiple Linear Regression. Similarly a one-way MANCOVA will be conducted to analyse staff questionnaires (RSA and STAR) with appropriate post hoc analyses. A one way ANCOVA will be used to analyse the carer questionnaire (RSA) and if significant differences are found Tukey's post hoc test will be conducted. Analysis of qualitative data will be undertaken using Framework method with the aid of QSR NVivo10. The Framework method will be employed to bring together charted summaries of qualitative data alongside summary statistics of measures of satisfaction with inpatient care and care planning; recovery-orientation of services, quality of therapeutic relationships and empowerment of service users. Armed with our set of six within-case analyses we will then conduct a cross-case analysis to draw out key findings from across all sites.
Proposed Start Date	1st July 2014
Proposed End Date	31st October 2015
Study Duration	16 months

5. BACKGROUND AND RATIONALE

Improving the treatment and care of people with mental illness is amongst key priorities for health and social care in both England and Wales (HM Government 2012, Welsh Government 2012). However, despite the shift to community-based models of care, considerable resources are still spent on acute inpatient beds - £585million in 2009-10 (Naylor & Bell 2010).

In 2011/12 in England, 101,424 people who accessed mental health services spent some time in hospital (over 7 million days in total), with around 42% admitted under a section of the Mental Health Act (The Information Centre 2013). Every year around 45,000 men and women are detained in hospital for assessment and treatment under the Mental Health Act (1983) and at any one time there are about 16,000 detained patients and a further 4,000 subject to Community Treatment Orders (CTOs) (CQC 2013). In 2011-12, a further 10,773 people were admitted to mental health wards in Wales with 1,428 admitted under the Mental Health Act and 377 subject to CTOs (Welsh Government 2013). Such vast numbers require considerable planning and coordination to ensure effective care is delivered consistently.

The context and delivery of mental health care is diverging between the countries of England and Wales whilst retaining points of common interest, hence providing a rich geographical comparison for research. Across England the key vehicle for the provision of recovery-focused, personalised, collaborative mental health care is the care programme approach (CPA). The CPA is a form of case management introduced in England in 1991, then revised and refocused (DH 2008). In Wales the CPA was introduced in 2003 (WAG 2003) but has now been superseded by The Mental Health (Care Co-ordination and Care and Treatment Planning) (CTP) Regulations (Mental Health Measure), a new statutory framework (WAG 2011). Data for England shows that 403,615 people were on the CPA in 2011/12 (The Information Centre 2013). Centrally-held CPA numbers supplied by the Corporate Analysis Team at the Welsh Government indicate 22,776 people in receipt of services as of December 2011, just six months prior to the introduction of CTP under the Mental Health Measure.

In both countries, the CPA/CTP obliges providers to: comprehensively assess health/social care needs and risks; develop a written care plan (which may incorporate risk assessments, crisis and contingency plans, advanced directives, relapse prevention plans, etc.) in collaboration with the service user and carer(s); allocate a care coordinator; and regularly review care. In Wales, as evidence of further divergence, statutory advocacy has been extended to all inpatients. CPA/CTP processes are now also expected to reflect a philosophy of recovery and to promote personalised care (DH 2008, Welsh Government 2012).

The concept of recovery in mental health was initially developed by service users and refers to “a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness,” while developing new purpose or meaning (Anthony 1993: 527). The importance of addressing service users’ personal recovery, alongside more conventional ideas of clinical recovery (Slade 2009) is now supported in guidance for all key professions (BPS 2000, COT 2006, CNO/DH 2007, RCPsych 2008). To this has been added the more recent idea of personalisation. Underpinned by recovery concepts, this aims to see people and their families taking much more control over their own support and treatment options, alongside new levels of partnership and collaboration between service users (or citizens) and professionals (Duffy 2010: 3). Recovery and personalisation in combination mean practitioners tailoring support and services to fit the specific needs of the individual and enabling social integration through greater involvement of local communities (Shepherd et al 2014).

The CPA/CTP is central to modern mental health care yet there are few studies that explicitly explore the practices of care planning and coordination and even fewer focusing on inpatient care planning. In our successful proposal to undertake a study of care planning and coordination in community mental health care settings (HS&DR project 11/2004/12) (currently underway), we summarised the available literature to demonstrate that: 1) there is limited evidence concerning the implementation of the CPA/CTP, care planning and coordination; 2) the evidence that does exist suggests that the quality of care planning and coordination is variable and most commonly is NOT collaborative or personalised; 3) little, if any, evidence exists of a recovery focus; and 4) the CPA as currently implemented fails to ensure care planning and coordination is safe, and is seldom valued by service users or carers.

Whilst use of enhanced levels of care, such as that offered by the CPA/CTP, may play a strong role in preventing suicide within two weeks of discharge (Bickley et al 2013), a previous SDO-funded study of continuity of care for people with severe mental illness concluded that there was a pressing need for a “detailed study of user and carer experience of the care of severe mental illness” and that “More involvement of users in care planning and delivery is a promising but as yet unevaluated means of improving care in a cost-effective way” (Freeman et al 2002, p7-8).

National quality statements include the requirement that service users in adult mental health services can jointly develop a care plan with mental health professionals, are given a copy with an agreed date to review it, and are routinely involved in shared decision-making (NICE 2011). National policies (DH 2011, Welsh Government 2012) outline expectations that people will recover from mental ill health and be involved in decisions about their treatment. This holds true for both informal and detained patients, with reasonable adjustments made where necessary to ensure that people are supported to live as full and socially participative lives as possible (CQC 2013). In light of this, the Care Quality Commission (CQC) recommend that ‘Care planning should have clear statements about how a person is to be helped to recover, and follow guidance set out in the national Care Programme Approach. Care plans should focus on individual needs and aspirations, involving patients at all stages so as to reflect their views and individual circumstances’ (CQC 2013, p6).

Yet in care plans checked by the CQC, 37% showed no evidence of patients' views being included; patients were not informed of their legal right to an Independent Mental Health Advocate in 21% of records reviewed; and almost half (45%) showed no evidence of consent to treatment discussions before medication was administered. The CQC were also concerned that cultures may persist where control and containment are prioritised over the treatment and support of individuals and that in 20% of visits the CQC expressed concerns about the de facto detention of patients who were voluntary rather than compulsory patients. However, in other settings excellent practice delivers care and treatment in line with policy expectations.

Earlier national reviews across both nations found that service users remain largely mystified by the care planning and review process itself, with significant proportions not understanding their care plans, not receiving written copies of their plan and often not feeling involved in the writing of care plans and setting of goals (CQC 2011, WAO 2011). Clearly, there are significant problems with inpatient care planning with the CQC noting "significant gap between the realities observed in practice and the ambitions of the national mental health policy" (CQC 2013: 5). Further evidence is clearly needed to develop care planning interventions that embed dignity, recovery and participation for all people using inpatient mental health care.

The Healthcare Commission (2008) measured performance on 554 wards across 69 NHS Trusts providing mental health acute inpatient services. They found that almost two-fifths of trusts (39%) scored weak on involving service users and carers; 50% of care plans sampled did not record the service user's views; and nearly a third of care records (30%) did not record whether or not the service user had a carer. A third of all care records sampled (33%) showed that community care coordinators provided input into the service user's care review meetings only "some or none of the time". The Commission called for more to be done to "ensure that acute inpatient services are more personalised as a basis for promoting recovery" and to address the apparent "schism between inpatient and community teams". The House of Commons Health Committee (HC584 2013) recently reported widespread concerns about delays in care planning and an imbalance between a focus on risk rather than recovery.

Furthermore, the authors of a study of inpatient stays in England reported that large numbers of patients are admitted for a week or less which has implications for inpatient and community services, and suggested that the CPA is 'cumbersome', 'rigid' and 'impractical' in relation to short admissions (Malone et al 2004).

Whilst the evidence base for community care planning and coordination is sparse, research studies exploring care planning and coordination in acute inpatient mental health settings are almost non-existent. This may reflect the reported historical neglect of inpatient care by policy makers and researchers (Bowers et al 2005) or some of the ethical and practical challenges faced in conducting research in settings where significant proportion of patients are detained under legislation and/or may lack the capacity to consent. These challenges are addressed directly in this proposal.

A recent service user-led study restricted to London only and not focused on inpatient care, employed questionnaires and focus groups to explore how effective service users found the CPA in promoting recovery (Gould 2012). The good practice checklist produced by the study participants will be used to inform the interview schedules and care plan reviews in this study.

A rare study of care planning in acute care was conducted in north Wales shortly after the CPA had been introduced by Jones & Bowles (2005), who employed focus groups with staff to identify 'best practice from admission to discharge in acute inpatient care from a whole system perspective'. Eleven suggestions for best practice were organised under two themes: 'Planning and Purpose' and 'Connectedness and Continuity' and these will inform our proposed study.

Other studies of inpatient psychiatric care have considered overall patient experiences (Goodwin et al 1999) or particular aspects such as conflict and containment (Bowers et al 2007), but few have included or specifically focused on care planning. Quirk's (2006) ethnographic study involving participant observation and interviews on three acute wards attempted to provide "an insider's account of life on an acute psychiatric ward" through immersion into ward life and observation and reported a deeper, more nuanced view of patient and staff experiences but care planning was not mentioned. One service user-led study in Northern Ireland employed ten focus groups with inpatients across eight hospital sites to identify ways that inpatient care might facilitate patients' recovery. Suggestions included greater involvement in care planning and improved planning and communication around admissions and discharge arrangements (Walsh & Boyle 2009), which are core features of existing policy.

Recent initiatives designed to increase service user involvement in care planning through the use of Joint Crisis Plans (JCPs) found no significant improvements on a range of measures and evidence to suggest the JCPs were not fully implemented in all study sites, and were combined with routine clinical review meetings which did not actively incorporate patients' preferences (Thornicroft et al 2013). Similarly, a trial of Community Treatment Orders (CTOs) found that compulsory supervision of service users post-discharge failed to reduce rates of readmission (Burns et al 2013). New research that examines in detail how plans for care and treatment are developed and agreed and the recovery orientation of these from the perspectives of all involved may shed some light on the process.

The evidence above points to the relative lack of genuine service user involvement in CPA processes and is significant in the context of what we know about therapeutic relationships and recovery. The therapeutic relationship is a reliable predictor of patient outcomes in mainstream psychiatric care (McCabe & Priebe 2004). Strong, collaborative, working alliances between case managers and people with long-term mental health difficulties have been shown to reduce symptoms, improve levels of functioning and social skills, promote quality of life, enhance medication compliance and raise levels of satisfaction with care received (De Leeuw et al 2011). Yamashita et al (2005) describe negotiating care within a trusting relationship as key in case management and this relationship may influence users' perceptions of stigma (Kondrat & Early 2010).

To summarise: the recent CQC report identifies serious concerns in relation to care planning, patient involvement and consent to treatment for patients detained under the Mental Health Act and the de facto detention of patients who were voluntary rather than compulsory patients. Earlier reports by the Healthcare Commission had previously identified serious concerns about care planning and called for measures to ensure that acute inpatient services are more personalised as a basis for promoting recovery.

Whilst the research evidence for community mental health care contrasts with the aspiration that care planning and the CPA should be collaborative, personalised and recovery-oriented, there is an almost total absence of research that explores the realities and challenges of planning and providing care and treatment in inpatient settings which includes people detained under the Mental Health Act.

6. STUDY OBJECTIVES

Aims

The aim of this study is to identify factors that facilitate or hinder recovery-focused personalised care planning and coordination in acute inpatient mental health settings.

This study will complement and build on our study of care planning and coordination in community settings (HS&DR Project 11/2004/12) to provide a whole systems response to the challenges faced in providing collaborative, recovery-focused care planning. We also aim to respond to the CQC (2013) questions of how to embed dignity, recovery and participation in inpatient practice when people are subject to compulsory care and treatment.

As an exploratory study guided by the MRC (2008) Complex Interventions Framework the study will generate empirical data, new theoretical knowledge and greater understanding of the complex relationships between collaborative care planning, recovery and personalisation. It will help identify the key components required and provide an informed rationale for a future evidence-based intervention and evaluation aimed at improving care planning and patient outcomes within and across care settings and likely to be acceptable to service users, families/carers, practitioners and service managers. It will also provide lessons for similar, equally problematic, care planning processes in a range of other health/social care settings (Challis et al 2007).

Objectives

To this end we will investigate care planning and coordination for inpatients in acute mental health settings at and throughout three transition stages recognised as key points where care planning can fail (CCAWI 2010):

Stage1: On admission (from community mental health services and via other routes, e.g. police or accident and emergency)

Stage 2: During inpatient care and treatment

Stage 3: In preparation for and at discharge

This novel study will also recognise the different needs of people admitted and detained under the Mental Health Act 1983 and those admitted informally, given the reported challenges of working in partnership with service users detained against their will for assessment and/or treatment.

7. RESEARCH QUESTION

Main research question: What facilitates or hinders recovery-focused personalised care planning and coordination in acute inpatient mental health settings?

In order to answer the main research question the following questions will be explored:

a) What impact do national and local policies and procedures have on care planning and coordination?

b) What are the key drivers impacting on care planning and coordination?

c) What are the views of staff, service users and carers on care planning, therapeutic relationships, recovery-orientation and empowerment in acute care settings?

d) How is care planning and coordination currently organised and delivered in local services?

e) How and in what ways is care planning and coordination undertaken in collaboration with service users and, where appropriate, carers?

f) To what extent is care planning and coordination focused on recovery?

g) To what extent is care planning and coordination personalised?

h) What specific features of care planning and coordination are associated with the legal status of service users?

i) Is care planning and coordination affected by the different stages of stay on a ward (i.e. at admission, during stay, pre-discharge)?

j) What suggestions are there for improving care planning and coordination in line with recovery and personalisation principles?

8. METHODOLOGY

Methodology

This is a cross-national comparative study of care planning in mental health inpatient settings, employing a concurrent transformative mixed methods design with embedded case studies.

Inclusion criteria

Ward inclusion criteria:

- The ward provides an acute mental health care admissions facility to the local adult population; and
- Has an established ward manager/team leader in post;
- Is not subject to any plans for closure or merger during the study period;
- Is not currently experiencing excessive pressures or responding to elevated levels of untoward incidents (so that we do not add to participant burden); and
- There is MDT support to participate in the study.

Service User/Patient inclusion criteria:

- Admitted to in-patient units;
- 18 years or older;
- With a history of severe mental illness;
- Able to provide informed consent;
- Sufficient command of English/Welsh.

These criteria are deliberately broad in order to include patients with organic brain disorders, substance abuse and who may be not fluent in English, which is very often the case in NHS routine care. Patients will be stratified by legal status (informal vs. sectioned).

Staff inclusion criteria:

- Any qualified or unqualified staff working on inpatient wards involved in care planning or review.

Study Design/Plan

Design

We propose to undertake a cross-national comparative study of recovery-focused mental health care planning and coordination in inpatient settings. This two-phase exploratory mixed methods study will produce theory and empirical evidence to add to that developed in our current study of community mental health services to inform a future whole systems intervention study.

Cross-national comparative research involves ‘comparisons of political and economic systems …and social structures’ (Kohn, 1989: 93) where ‘one or more units in two or more societies, cultures or countries are compared in respect of the same concepts and concerning the systematic analysis of phenomena, usually with the intention of explaining them and generalising from them’ (Hantrais & Mangen 1996: 1-2). In this study, we will conduct a detailed comparative analysis of ostensibly similar approaches to recovery-focused care planning and coordination within different government, legislative, policy and provider contexts.

Theoretical/conceptual framework

The study is guided by a theoretical framework emphasising the connections between different ‘levels’ of organisation (macro/meso/micro) (Byrne 1998) and will employ mixed methods (including those currently used in our community study to enable synthesis of findings) across two phases.

Phase 1: a) Extend our current review of international peer-reviewed literature, and English and Welsh policies to include recovery-oriented care planning in inpatient settings (macro-level).

Phase 2: We will conduct in-depth case study investigations (Stake 1995) across six contrasting case study sites in England (n=4) and Wales (n=2) employing mixed methods (meso level) with embedded case studies (micro level) (Creswell 2009).

Figure 1 below illustrates this embedded design, and the data which will be generated at each ‘level’ throughout the totality of the project.

Table 1 below identifies data methods associated with the research questions.

Embedded case study design for COCAPP-A

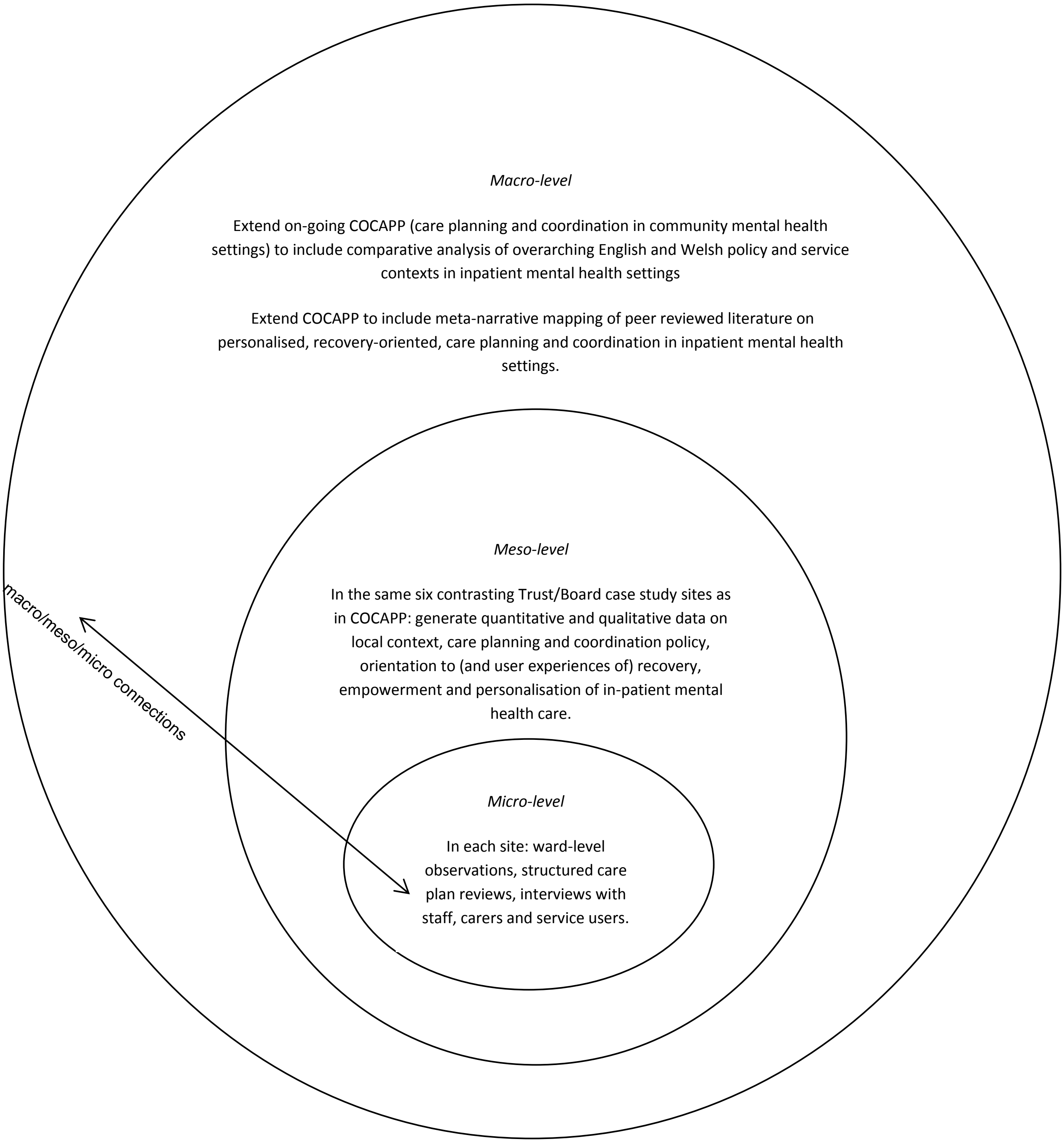

Figure 1: Diagram illustrating embedded case study design and integration with (and extension of) initial COCAPP study of care planning and coordination in community mental health settings.

Table 1: Research Questions and Data Collection.

Research questions	Data collected to answer the research question
a. What impact do national and local policies and procedures have on care planning and coordination?	• Policy narrative review • Interviews with managers and senior practitioners
b. What are the key drivers impacting on care planning and coordination?	• Policy narrative review • Local polices/documentation review • Interviews with managers and senior practitioners
c. What are the views of staff, service users and carers on care planning, therapeutic relationships, recovery-orientation and empowerment in acute care settings?	• Questionnaire survey of ward staff, service users and carers • Interviews with ward staff, service users and carers
d. How is care planning and coordination currently organised and delivered in local services?	• Interviews with managers and senior practitioners • Interviews with service users, carers and ward staff • Structured review of care plans • Observation of care planning and coordination meetings
e. How and in what ways is care planning and coordination undertaken in collaboration with service users and, where appropriate, carers? f. To what extent is care planning and coordination focused on recovery? g. To what extent is care planning and coordination personalised? h. What specific features of care planning and coordination are associated with the legal status of service users? i. Is care planning and coordination affected by the different stages of stay on a ward (i.e. at admission, during stay, pre-discharge)?	• Questionnaire survey of ward staff, service users and carers • Interviews with service users, carers and ward staff • Structured review of care plans • Observation of care planning and coordination meetings
j. What suggestions are there for improving care planning and coordination in line with recovery and personalisation principles?	• Interviews with managers and senior practitioners • Interviews with service users, carers and care coordinators

Building on the existing HS&DR study

This study will complement and build on the research team's current study of care planning and coordination in *community* mental health care settings (HS&DR project 11/2004/12) to provide a whole systems response to the challenges faced in providing personalised, collaborative, recovery-focused care planning. This will occur in three ways:

1) Findings/insights from the community study will inform questions posed in the new study;

2) Results from within-case and cross-case analysis of the community study will inform and be considered alongside findings from the new inpatient study; and

3) Findings and results from both studies will be employed to explore and propose a service-level intervention designed to improve care planning and coordination within and across service boundaries.

Study Plan

Phase 1: Literature and policy review and synthesis

We will extend our current meta-narrative mapping review (Wong et al 2013) of English and Welsh policies and the international peer-reviewed literature on personalised recovery-oriented care planning and coordination to include inpatient settings using the following strategy:

a. *Comparative analysis of policy and service frameworks*

   Through searching English and Welsh Government websites we will identify all key, current, national-level policy and guidance documents directly relating to inpatient mental health care planning and coordination across the two countries, along with those which relate directly to the promotion of recovery and the delivery of personalised care. Drawing on these we will produce a narrative synthesis identifying major themes and areas of policy convergence and divergence, and use these materials to lay out the large-scale (or 'macro-level') national policy contexts to inform our research interviews.

b. Drawing on expertise of researchers and service users from within the research team and SSC to devise a list of keywords and search terms. The current COCAPP study review will be extended to incorporate sources of evidence that fall under current exclusion criteria. For example, studies that focus on care planning, personalisation and recovery within the context of mental health in-patient settings will be reviewed, appraised and synthesised. Initial search terms include but are not limited to: "mental health", "mental illness", "care planning" , "care coordination", "coordination", "collaborative care", "patient care planning", "person centered care", "personali*", "recovery", "recovery focus(ed)", "care programme approach", CPA, CTP, "user experience" , "carer experience", "therapeutic relationship".

c. Exploratory scoping and searching the literature via health, social care and other bibliographic databases. We will locate international research papers, publications from professional and service user bodies, case studies and other grey literature. The process here is iterative, progressing from exploratory scoping to specific searching of keywords/search terms identified in step 1. We will also supplement our initial electronic searches with other methods (e.g. hand searching of key journals) and consultation with expertise provided by members of SSC and Lived Experience Advisory Group (LEAG).

d. Selection and appraisal of documents: Judgements will be made by the research team about including and excluding data from documents.

e. Data extraction: Data and information will be extracted from the included documents.

f. Analysis and synthesis processes: We will bring together our descriptive map, quality appraisals and focused reviews in the form of a narrative synthesis and conclude with an account of those features of care planning and coordination which are associated with recovery and personalisation in inpatient settings. Initial overview of synthesis to be shared with SSC and LEAG whose feedback will influence the final synthesis.

g. Comparison with existing literature: Where applicable, we will compare and contrast the review’s findings with the review undertaken for the original COCAPP study which excluded in-patient research, thus providing a "whole system" critical overview of the literature. We will also compare our conclusions from the COCAPP-A MNM review to other and different types of reviews (e.g. systematic/Cochrane) that may have been undertaken into overlapping topics, so making sure that we compare conclusions at the level of overall review, rather than the level of individual papers which is a more natural thing to do within the review.

The review will form an integral part of the final report, helping to set the overall context of research in this area whilst also playing a central role informing the analysis and interpretation of data.

Phase 2: Case Studies Methods and Sample Size

We will conduct in-depth case study investigations (Stake 1995) across six contrasting case study sites in England (n=4) and Wales (n=2) employing mixed methods with embedded case studies (Creswell 2009).

2a: Collate policy documentation and officially collected data:

> e.g. local meso-level CPA/CTP policy and procedure documents, CQC, national and local CPA/CTP audits and reviews, and routinely collected (non-personally identifiable) data (e.g. on local admission/discharge rates).

2b: Conduct a questionnaire survey of acute inpatient staff (n per Trust/Health Board=50; total=300), service users (n=50; total=300) and carers (n=25; total=150) that currently or have recently used acute adult inpatient mental health services to:

i. Measure service user views on patient-reported outcome measure of perceptions of acute mental health care, including involvement in care planning and ward round discussions;
ii. Measure service user, carer and staff perceptions of recovery oriented practices in inpatient care;
iii. Measure service user and staff views of the quality of therapeutic relationships in inpatient settings
iv. Measure service users' views of empowerment in inpatient settings

2c: Conduct semi-structured interviews and structured care plan reviews with service users:

i. A sample of service users (n per ward=6; total=36) approaching discharge (and purposively selected from acute ward patient lists to include different diagnoses, nature and length of admission, detained/informal), will be invited to be interviewed about their experiences of care planning during their admission and to *jointly review* their inpatient care and aftercare plans and their involvement in developing and implementing those plans in line with recovery and personalisation approaches.

2d: Conduct semi-structured interviews with key staff and informal carers to:

i. Investigate experiences and views of care planning processes and how to improve them in line with a personalised, recovery-oriented focus amongst a sample of multidisciplinary ward staff (n=6; total=36), and carers (n=4; total = 24). A total of 60 interviews across six NHS Trust/Health Boards.

2e: Conduct a structured review of patient care plans for a sample (n per ward=10; total=60) of consecutive discharges:

With the agreement and consent of service users approaching discharge, anonymised care plans will be systematically reviewed by researchers against a template specifically developed and tested in our community care planning study for an additional series of 10 consecutively discharged inpatients (including first admissions and re-admissions; with replacements for refusals) at each of the six acute inpatient wards taking part in the study, yielding a total sample size of 60 The review will focus on good practice in involvement of service users and carers and a focus on recovery and personalisation. Patients who opt of the study and those transferred from another acute ward for non-clinical reasons (e.g. bed management) will be excluded.

2f: Conduct non-participant observation of care planning processes on inpatient units (n per ward=3; total = 18):

i. On each acute ward, researchers will with prior agreement attend and observe at least three meetings in which patient care is routinely discussed and planned. These may include individual care planning meetings, discharge planning meetings and ward rounds. Researchers will keep contemporaneous notes of meetings and, with permission, digitally record interactions to check for accuracy when notes are transcribed and analysed. Observations will be informed by a structured guide previously developed to identify good practice in involvement of service users and carers and a focus on recovery and personalisation.

Data Collection Instruments

Views on Inpatient Care (VOICE) (Evans et al 2012)

VOICE is a 19-item patient-reported outcome measure of perceptions of acute mental health care that includes questions on involvement in care planning and ward round discussions. An innovative participatory methodology was used to involve services users throughout the development and testing of this measure. VOICE encompasses the issues that service users consider most important and has good validity and internal and test–retest reliability. It is easy to understand and complete and therefore is suitable for use by service users while in hospital and has been shown to be sensitive to service users who have been compulsorily admitted and who tend to report significantly worse perceptions of the inpatient environment. Within each case study site, service users will be asked to complete the VOICE.

Recovery Self-Assessment Scale (RSA) (O'Connell et al 2005)

The RSA is designed to measure the extent to which recovery oriented practices are evident in services. It is a 36-item self-administered questionnaire with service user, family/carer and provider versions. The scale addresses the domains of life goals, involvement, treatment options, choice and individually tailored services. The RSA has been tested for use with people with enduring and complex mental health problems and across a range of ethnic backgrounds. Within each case study site, service users, carers and staff will be asked to complete the RSA.

The Scale to Assess the Therapeutic Relationship (STAR) (McGuire-Snieckus et al 2007)

The STAR is a specifically developed, brief (12-item) scale to assess therapeutic relationships in mental health care with good psychometric properties and is suitable for use in research and routine care. The subscales measure positive collaborations, positive clinician input and non-supportive clinician input in the patient version. This measure was used in the recently completed SDO funded study of therapeutic alliance and patient satisfaction in acute inpatient settings (SDO PRO 09-1001-51). Within each case study site, service users and staff will be asked to complete the STAR to rate their subjective experience of therapeutic relationships on the ward.

The Empowerment Scale (ES) (Rogers et al, 1997)
The ES is a 28-item questionnaire with five distinct sub-scales: self-esteem, power, community activism, optimism and righteous anger. Empowerment is strongly associated with recovery and this is the most widely used scale. It has good psychometric properties. Within each case study site, service users will be asked to complete the ES to rate their subjective experience of empowerment.

Semi-structured interviews and structured care plan reviews with service users
A sample of service users approaching discharge will be invited to be interviewed about their experiences of care planning during their admission and to *jointly review* their inpatient care and aftercare plans and their involvement in developing and implementing those plans in line with recovery and personalisation approaches. Interviews will be conducted by experienced, specially trained researchers and service user researchers. A semi-structured interview schedule will be informed by relevant literature (e.g. Gould 2012, Jones & Bowles 2005) and developed through consultation with our Study Scientific Committee (SSC) and Lived Experience Advisory Group (LEAG) to guide the interview and narrative review of the care plan and care planning process.

Semi-structured interviews with managers, consultant psychiatrists, ward staff and carers
Interview schedules will be developed by the study team, informed by the policy/literature review and through consultation with our SSC and LEAG. All interviews will explore participants' experiences of care planning and will be conducted by experienced, specially trained researchers and service user researchers (who will conduct the carer interviews).

Structured review of service user care plans
Anonymised information will be obtained from the care plans for a series of 10 consecutively discharged patients (including first admissions and re-admissions; with replacements for refusals) at each of the six inpatient wards taking part in the study (total n=60). Ward staff will provide information about the study to selected service users shortly prior to discharge and information will also be included in ward posters. Service users may choose to opt out of including their anonymised care plans for review in the study and will be replaced by the next patient discharged. Where consent is provided, anonymous CPA/CTP care plans will be systematically reviewed and appraised against a structured template incorporating identified key concepts of good practice in care planning, user and carer involvement, personalisation and recovery. Exclusion criteria from the study sample will include patients who optd out of inclusion in the study and those patients transferred from another acute ward for non-clinical reasons (e.g. bed management). The template will be specifically developed and informed by CPA good practice checklists developed by service users and

staff (Gould 2012, Jones & Bowles 2005); our community care planning study; and the CPA Brief Audit Tool (CPA-BAT) designed and used to assess the quality of CPA care planning for service users who have more than one compulsory admission in a period of three years (Centre for Mental Health/Mental Health Act Commission 2005).

Non-participant observation of care planning processes on inpatient units
This will include staff-patient assessment/care planning meetings, ward rounds and discharge planning meetings. Observations will be informed by a structured guide developed to identify good practice in involving service users and carers and a focus on recovery and personalisation. The guide will be developed in consultation with the Lived Experience Advisory Group (LEAG).

9. STUDY PROCEDURES

Recruitment and Informed Consent Procedures

Wards: During initial contacts with senior managers in each participating NHS Trust/Health Board we will ask them to suggest up to three wards that meet the inclusion criteria that we may approach to seek agreement to participate. All three wards will take part in the questionnaire survey and one of the three wards will be selected for the more in-depth case study of care planning.

Ward staff: All managers and ward staff involved in care planning or care plan review will receive written and verbal information about the study and be invited to participate in the questionnaire survey. On the ward selected for the in-depth case study, purposive sampling will be employed to invite a selection of staff to participate in interviews. Usual procedures for obtaining informed consent with permission to decline or withdraw will be employed. All participants will be anonymous.

Informal/family carers: Ward staff will be asked to give carer questionnaire packs to carers (family members and friends) visiting service users on the ward. The packs will include an information sheet and a Freepost return envelope. Researchers working on the ward will also approach carers to invite them to participate by either completing the questionnaires, with assistance if required, and/or by taking part in an interview.

Service users: Ward staff will be asked to identify service users nearing discharge that in their view have the capacity to be invited to participate in the study. Staff will make an initial approach to the service user, inviting them to meet with the research assistant (RA) to find out more about the study.

The RA will provide the service user with written and verbal information about the study and invite and respond to any questions. During this process the RA will appraise the capacity of the service user to understand the information and make an informed decision whether to participate. The service user will be given at least 24 hours to consider their decision and will be encouraged to discuss it with family, friends, advocates or staff if they wish. If a service user lacks the capacity to provide informed consent or declines to participate, the next service user approaching discharge from the ward will be approached to participate.

Service users will be invited to participate in the following ways:

1. Complete the pack of questionnaires, with assistance from the RA if required; **and/or**
2. Agree to their care plans being independently reviewed on discharge; **and/or**
3. Take part in an interview about their experiences of care planning and jointly review their care plan with the RA (until sample size is achieved).

Arrangements will be made for service users requiring interpreting services to enable them to take part in interviews. Particular attention will be given to ensure the inclusion of Black and Minority Ethnic (BME) service users and those detained under the Mental Health Act (1983).

Non-participant observation of care plan reviews, ward rounds etc.: Information about the intention of researchers to attend and observe care plan reviews, ward rounds etc. will be included in posters displayed in the ward. It will be made clear that:

- The aim is to review how care planning is discussed in meetings
- No names or identifying information will be recorded
- Service users may request that the RA does not attend the meeting if they wish and this will be respected

In addition, staff will advise researchers when service users participating in meetings do not have the capacity to give informed consent and these meetings will not be observed.

Capacity to participate

We see capacity to give informed consent as crucial to participation in our research. It is important to clarify that admission to hospital or detention under the Mental Health Act does not *necessarily* imply a lack of capacity. We will take advice from clinical staff on the wards on the appropriateness of approaching patients to participate in the study and will assume capacity to consent unless advised to the contrary. We will distinguish between those patients who are detained and who have capacity to consent to participate and those who are lacking such capacity. Any person who is deemed to lack such capacity will not be approached to participate. We also recognise that capacity to make informed decisions can change depending on the person’s condition and as experienced mental health practitioners we will continually review capacity decisions, such that we will suspend data collection with individuals that give rise to concerns until they are once again able to continue. All research staff on the team will receive training and supervision in obtaining informed consent from potential participants in line with NHS research ethics and governance requirements and in addition, will receive guidance on ensuring a continual process of checking capacity and consent during any data collection process. Consent will be assumed in the case of participants choosing to return completed standardised questionnaire measures.

Withdrawal from study

Participants will be free to withdraw from interviews or observation at any time without consequence to their treatment or employment status. We will ask that we can use any information we have already collected unless participants ask us not to. Questionnaires will be anonymous and cannot be withdrawn once submitted as individual participants cannot be identified.

End of Study Definition

The study will end when the final piece of data is collected (last interview conducted, last questionnaire received, last care plan reviewed or last observation conducted).

10. SAMPLE SIZE

A total of six NHS trusts in England (n=4) and Wales (n=2) will participate in the study.

Within each trust, a questionnaire survey of acute inpatient staff (n per Trust/Health Board=50; total=300), service users (n=50; total=300) and carers (n=25; total=150) that currently or have recently used acute adult inpatient mental health services will be conducted.

Within each trust/health board, one ward will participate in micro-level data collection. Semi-structured interviews with staff (n per ward=6; total=36), service users (n per ward =6; total=36; to include joint review of care plan) and carers (n per ward=4; total=24) will be conducted. Structured case reviews of care plans will be conducted for service users on each participating ward (n per ward = 10; total = 60). Non-participant observation of care planning processes on inpatient units (n per ward=3; total=18)

Justification of the sample size, and the effect size

For the questionnaire survey, an a priori sample size calculation was conducted using the software package G*Power. The sample size was based on completing a multivariate analysis (MANCOVA) for comparing the interaction of within (Covariates) and between factors (sites). Assumptions are based on six groups (sites), four outcome measures (questionnaires) and 10 potential predictors (i.e. gender, age, ethnicity, and time on CPA etc.). We calculated sample size using α level of 0.05, power of 0.80 (Cohen, 1992) and a small effect size (Pillai's Trace V = 0.10). Given the many potential influences on our outcome measures we anticipate that the magnitude of the observed relationship will be small. A small effect size was therefore chosen in order to represent the subtleties in relationships of the data. This calculation suggests that a sample size of 276 is required in order to reach power.

In our study we aim to obtain complete questionnaire survey responses from 300 service users (approx. n =50 per site) 300 inpatient staff (approx. n =50 per site) and 150 informal carers (approx. n =25 per site). By sampling 300 survey responses we are sampling in excess of the sample size suggested for the service users and inpatient staff. In contrast, we anticipate that we will not achieve this sample size for informal carers. This is because not every service user will have a carer therefore analysis for the informal carers will be underpowered (estimated power will be 0.44). The data for the informal carers will be exploratory in preparation for a future larger scale study. We anticipate that with non-response and incompletion of the questionnaires we will need to oversample in order to meet the sample sizes.

Calculations for the sample size for qualitative interviews were based on previous research with similar populations by the co-investigators and others; understanding of the practicalities and time commitments of recruiting and interviewing participants and analysing in-depth qualitative data; and the numbers required to feel confident that the findings would be transferable to other similar settings.

11. DATA ANALYSIS

Analytical framework

This study involves a range of methods including policy review, narrative synthesis, cross-sectional survey, and semi-structured interview methods. Accordingly several distinct approaches to the analysis of findings will be used.

We will frame our data analysis by drawing on social scientific ideas and on the findings of our Phase 1 evidence and policy review, an approach we have used in previous funded studies e.g. Hannigan (2013). Our concern to explore commonplace practices in inpatient mental health settings is congruent with interactionist interests in social processes and human action (Atkinson & Housley 2003). This perspective also recognises the importance of social structures, so that in any given setting person-to-person negotiations are shaped by features of organisational context (Strauss 1978). The immediate context for frontline practitioners/service users in this study is the inpatient unit, each of which we view as a complex, open system. Each participating ward also sits within a larger, meso-level, NHS Trust/Health Board site, which in turn is located within a national-level system of mental health services. This idea of ‘nested systems’ is a feature of complexity thinking (Byrne 1998), and informs our plan to generate, analyse and connect data at different (but interlocking) macro/meso/micro ‘levels’ of organisation.

Our Phase 1 policy and literature review will allow us to compare and contrast the largest-scale (or ‘macro-level’) systems for mental health care across the two countries, and consider the degree to which ideas of recovery and personalisation are represented in prevailing frameworks. We will analyse what managers and professionals say, and write, about care planning and coordination across participating sites to make the connections between the ‘macro’ and the ‘meso’, and in the first instance we will present a detailed account of our six different local organisational contexts in within-case fashion (Ayres et al 2003). The most important phase of our data analysis will be our exploration of what frontline practitioners, service users and carers say, and write, about how actual, individual (or ‘micro’)-level care is planned and coordinated. We will establish the day-to-day realities of how care is planned and experienced in inpatient settings and the degree to which processes and actions reflect orientations to recovery and personalisation.

Data management

The study will involve the collection and storage of a large volume of data. The research team have a reliable, structured and transparent system for collating, recording, storing, checking, anonymising and analysing a large volume of quantitative and qualitative data collected by site and data type, informed by experience of managing data in the COCAPP project. Members of the research team at City University will continue to manage this process with input and support from colleagues in Wales. We have an established encrypted system for transcription and transfer of qualitative data and all quantitative data will be collated and inputted on SPSS at City University London. We are using a recognised method of handling multiple sources from different sites with the aid of QSR NVivo10 software and Framework method. The team have received bespoke training in the use of Framework for this study provided by the National Centre for Social Research (NatCen). We will first conduct a series of within-case analyses, treating each of our six NHS sites as a 'case' for this purpose.

Quantitative analysis

Questionnaire returns for each site will be entered, checked and cleaned using SPSSv21. The distribution of questionnaire data (VOICE, RSA, STAR and ES) will be assessed for normality by exploring the data graphically using plots and numerically using statistical methods (Shapiro-Wilk and Kolmogorov-Smirnof tests). Descriptive statistics will be calculated and presented in order to provide an overview of clinically significant findings prior to statistical interpretation. To ascertain any differences between the six sites on the four outcome measures for service users, (VOICE, RSA, STAR and ES) a one-way Multivariate Analysis of Covariance (one-way MANCOVA) will be conducted. Covariates will reveal if there are any external influencing factors in care or if these are result of within-case (site) effects. Potential covariates will be patient demographics (i.e. age, gender, ethnicity, diagnosis, and civil/family/accommodation/employment status), diagnosis (type of severe mental illness), and service use (informal/formal, frequencies of admissions, length of stay/service use) and clinical variables (number of staff on ward number of patients). If statistically significant differences are found subsequent One-way Analysis of Covariance (One-way ANCOVA) will be employed post hoc to ascertain which measures differ between which locations. Correlations will be carried out to identify if there is a relationship between the outcome measures. The type of correlation that will be performed will be informed by hypotheses derived from the descriptive data and the qualitative data. Selective correlations will be conducted using Multiple Linear Regression. Similarly a one-way MANCOVA will be conducted to analyse staff questionnaires (RSA and STAR) with appropriate post hoc analyses. A one-way ANCOVA will be used to analyse the carer questionnaire (RSA) and if significant differences are found Tukey's post hoc test will be conducted.

Qualitative analysis

Data from interviews with managers, professionals, carers and service users and from non-participant observations of care planning processes will be transcribed in full. Transcripts, local policy documents and field notes will be anonymised with pseudonyms inserted and person and place identifiers removed. Data will be analysed using the framework method (Ritchie & Spencer 1993) on QSR NVivo10. Our framework will reflect our research questions, allowing us to directly identify instances in our data where local policies, interviewee accounts and observed everyday practice reflect (or do not reflect) commitments to (and experiences of) inpatient mental health care which is coordinated, recovery-focused and tailored to the particular needs and wishes of individuals. We will compare and contrast orientations to recovery and personalisation in local policy and in the accounts of senior managers and professionals with our analysis of actual care as this is provided and received.

Integration of Data

We are employing a concurrent transformative mixed methods design with embedded case studies (Creswell 2009: p15). Concurrent procedures require that we will collect quantitative and qualitative data at the same time during the study and then integrate that data in order to provide a comprehensive analysis of the research problem. One form of data is nested within another larger data collection procedure in order to analyse different questions or levels of units in an organization. In this study, the more detailed qualitative data from in-depth interviews, local policy reviews, care plan reviews and observations are nested within larger survey datasets in order to provide potential explanation and understanding of scores on various measures.

Transformative procedures require the researcher to employ a theoretical lens as an overarching perspective within a design that contains both quantitative and qualitative data. This lens provides a framework for topics of interest, methods for collecting data, and outcomes or changes anticipated by the study. In our study, our choice of methods, data collection and approach to analysis is informed by theories of recovery and personalisation. The Framework method will be employed to bring together charted summaries of qualitative data alongside summary statistics of measures of satisfaction with inpatient care and care planning; recovery-orientation of services, quality of therapeutic relationships and empowerment of service users.

We will bring our framework analysis and our analysis of questionnaire data together for each site, noting points of comparison and contrast between what we find in our analysis of each type of data. Where consistently strong orientations to recovery-focused, personalised care are found in local policy documents and in the accounts of senior managers and practitioners and are reflected in the experiences of users and carers and in our observations of everyday practice we will say so. Where discrepancies are found, or where questionnaire data contrast with data generated through interviews and observations, we will say so.

Armed with our set of six within-case analyses we will then conduct a cross-case analysis to draw out key findings from across all sites (see Figure 2). We will consider the relationships between stated orientations to recovery and personalisation in national and local policy, and in senior staff interviews, and what we have found by studying the accounts of users and carers and by analysing everyday inpatient care. In this way we will consider the relationships between the ‘macro, 'meso' and the 'micro', drawing lessons for NHS managers and professionals concerned with the promotion of inpatient mental health care which is aimed at the promotion of recovery and the particular needs of individuals.

12. ETHICS

The research team will obtain NHS Research Ethics Committee approval prior to recruiting any participants in the study. We will seek NIHR Clinical Research Network (NIHR CRN) and NISCHR portfolio adoption in Wales. In each case we expect to receive assistance with necessary approvals (such as ethics and research governance, including research passports) across both English and Welsh sites.

All case study participants will be given detailed written information on the study and asked to provide written consent. Consent will be assumed in the case of participants choosing to return completed standardised questionnaire measures. All participants will be assured of anonymity in the use of their data. Participants will be informed that research interviews will be audio-recorded, transcribed and all identifying material such as names or place names will be removed to protect their confidentiality. Participants will be free to withdraw at any time without consequence to their treatment or employment status. We do not anticipate any risks to individuals from participation in this research but should anyone become distressed we will terminate the research interview and make arrangements with their treatment team to offer further support.

13. SAFETY CONSIDERATIONS

The study does not pose any risk of harm to participants. Participants do not have to answer any questions that they do not wish to. All research staff will receive training and advice in working in acute inpatient mental health settings and regular

Macro, meso and micro level model of data analysis

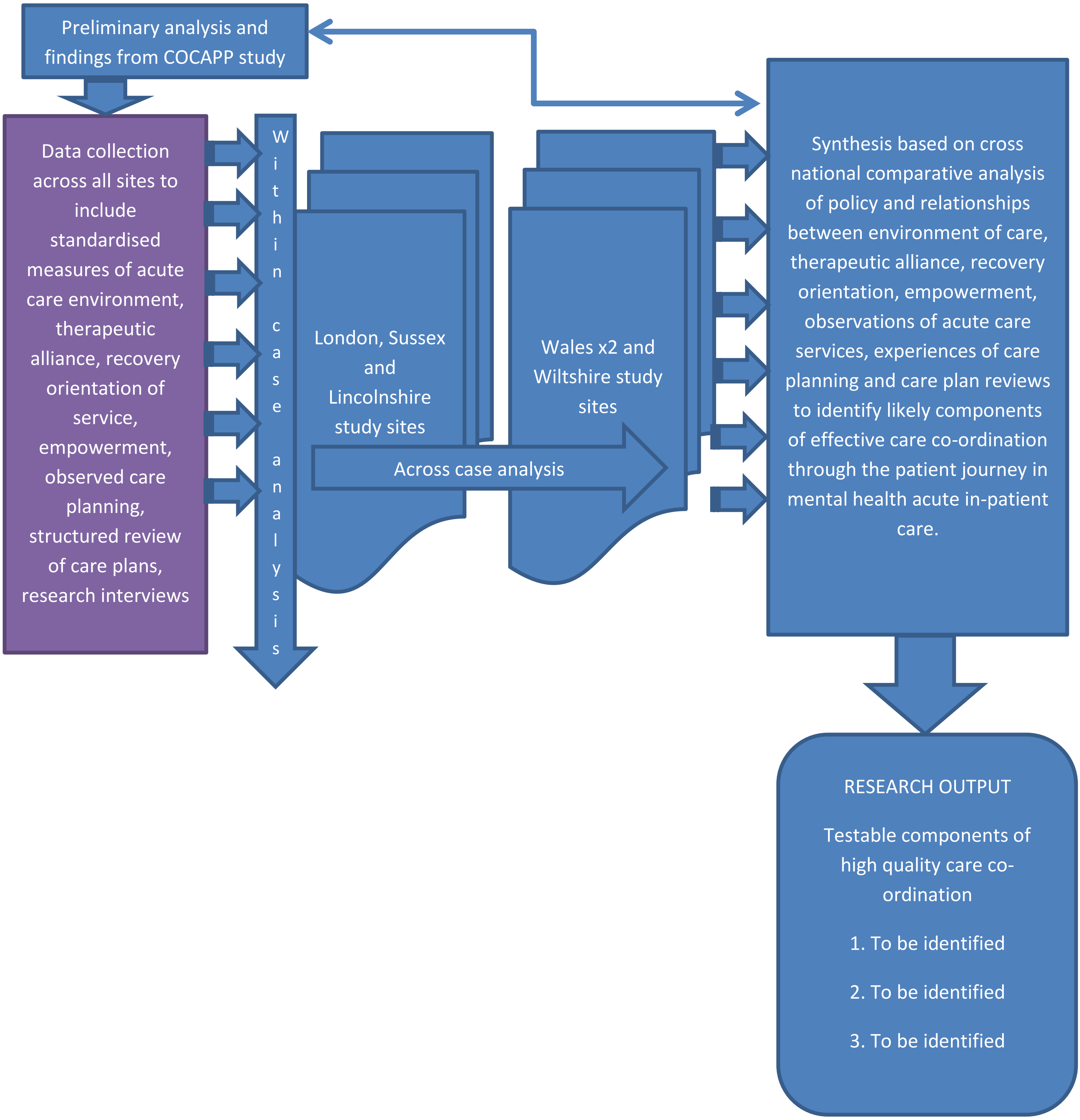

Figure 2: Diagram detailing macro, meso and micro level analysis of data.

supervision where issues can be raised and addressed. Researchers will follow City University London Health and Safety Policy and Procedures. If travelling off site they will follow the Health Services Research Staff Personal Safety Procedures.

14. DATA HANDLING AND RECORD KEEPING

Confidentiality

Participants will be referred to by a study number on interview transcripts. Interview recordings and participants' demographic data will be saved to password-protected university computers. Once saved onto the university computer system, the original recordings will be erased from digital recorders. The recordings will be transcribed and the transcriptions will also be saved to encrypted files on password-protected university computers. Paper copies of transcriptions, demographic information data sheets and ICFs will be stored separately from each other, in locked cabinets at both City University London and Swansea University. Participants will not be named in any study publication.

Record Retention and Archiving

When the study is complete, it is a requirement of the Research Governance Framework that the records are kept for a further 15 years. Data will be archived at City University London secure storage facility.

16. STUDY COMMITTEES

Study Scientific Committee (SSC)

The SSC will meet four times during the study to provide oversight of the project and advice to the study team as required. Membership will include senior academics including a statistician or health economist, representatives from each of six NHS Trusts/Health Boards participating in the study and two service user representatives from the Lived Experience Advisory Group.

Lived Experience Advisory Group (LEAG)

The LEAG will meet four times during the study to provide oversight and advice to the study from the perspective of people with lived experience of mental health services, inpatient care and care planning. LEAG will also input into the SSC. There will be seven LEAG members recruited through participating organisations, and the Chair, Ms Alison Faulkner (Chair), Independent Service User Researcher/Consultant.

17. PUBLIC AND PATIENT INVOLVEMENT

This study came about through feedback from presentations of the community-focused care planning study to service user and carer groups who strongly suggested that attention needs to be focused on inpatient care planning. Such a view has since been supported by reports outlined above.

The outline and full proposals have been developed in consultation with an NIHR-funded service user/carer research advisory group (SUGAR), established and facilitated by the lead applicant. In addition, co-investigator Alison Faulkner is a highly respected and published service user researcher who has contributed to the design of the study and will play a central part throughout.

Service user researchers (SURs): Four SURs will be trained and supported by Alison Faulkner and other members of the research team to undertake the interviews of service users and carers. They will also contribute to analysis of the qualitative data from interviews, observations and care plans. The SURs will have regular individual supervision and attend group supervision/support. At each case study site, one or two SURs will visit the site with the RA and jointly make contact and initial introductions and then organise their work together.

Alongside the SSC we have an established Lived Experience Advisory Group (LEAG) of service users and carers which will meet at least four times with the study team to discuss and advise on the development of the study and findings from a service user/carer perspective and to feed into the SSC. Additionally, the group will be sent monthly email updates regarding the progress of the study. We will consult with this group throughout the project as follows:

- We will present the findings of the literature/policy review to LEAG and invite them to help develop the conceptual framework and content of the questions for the interview stage of the study.

- During the Framework analysis of the interview data, LEAG will be invited to collaborate on refining initial dimensions or categories and subsequent themes (following a similar process recently led by the CI on his recent peer support study).

18. FINANCE AND FUNDING

This study has been commissioned by the National Institute of Health Research, Health Services and Delivery Research (HS&DR Project: 13/10/75).

19. INDEMNITY

City University London is the sponsor for the study. City University London has extensive insurance cover in place for the academic year 2014/2015, relevant details of which currently are:

1. Employers Liability

This is cover for legal liability to employees for death, injury or disease arising out of the business of the University. The limit of indemnity is £50,000,000 for any one claim.

2. Public and Products Liability

This is cover for legal liability to third parties for accidental loss of or damage to property or for death, injury, illness or disease arising out of our business and including liability arising from goods sold or supplied. The limit of indemnity is £50,000,000 for any one claim.

3. Professional Indemnity

This is cover for legal liability to third parties for breach of professional duty due to negligent act, error or omission in the course of our business. The limit of indemnity is £25,000,000 for any one claim.

Clinical trials cover is included within the above insurances in place.

20. DISSEMINATION OF RESEARCH FINDINGS

We have established a weblog for promoting the current study of community mental health care planning where core information, regular updates and findings will be posted with the agreement of HS&DR. This weblog will be extended to incorporate the new study of inpatient care planning and provides an easily accessible site for participating organisations and the public. All members of the research team are active users of Twitter and we will post regular links to the weblog.

In addition to the delivery of final reports to the HS&DR Programme we will produce different outputs for different audiences. For managers and staff we will produce accessible summaries of our findings, for online use and for distribution via Mental Health Nurse Academics (chaired by Coffey), the NHS Confederation Mental Health Network, the Mental Health Nurse Directors and Leads Forum, the Royal College of Nursing's Mental Health Nursing forum (Haddad is a committee member), the Royal College of Psychiatrists general adult division and their research unit to disseminate to their members and on their website as appropriate. As we have established good working relationships with the NIHR Clinical Research Networks in England and Wales we will also distribute our summaries through these networks.

Papers will be published in international open access journals to ensure our findings are widely available to managers, policymakers, professionals and academics. For service users, carers and practitioners we will produce shorter papers targeted at journals such as Mental Health Practice and Mental Health Today and again via our online weblog and Twitter. Alison Faulkner is a leading service user research in the Europe and will disseminate results via her service user networks.

Members of the team have strong reputations for presenting at a range of conferences internationally, nationally and locally and will ensure findings from this study are presented regularly.

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