RESEARCH ARTICLE

Harnessing Lived Experience in Mental Health Recovery: Co-producing a Self-Directed Relapse Prevention Manual

[version 1; peer review: awaiting peer review]

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Abstract

Background

There is growing recognition of the value of self-directed, co-produced resources in supporting recovery from mental health conditions. This paper reports on the co-production and development of a novel self-help manual. The Peace of Mind (PoM) manual provides practical steps to support recognition of relapse signatures, relapse prevention planning, mental health recovery, goal-setting and successful living, authored by an individual with over 30 years of lived experience.

Methods

The manual was developed through personal experiential reflection and informal peer engagement, incorporating practical relapse prevention strategies, behavioural tools, and motivational guidance. Detailed comments on the manual were gained from patients with previous inpatient experience, carers and mental health peer workers at an NHS mental health trust. Online feedback was then sought from a Patient Public Involvement (PPI) group at the Centre for Health Services Studies, University of Kent, to assess acceptability and perceived usefulness ahead of future formal evaluation.

Results

Preliminary feedback indicated high levels of engagement and appreciation for the manual's purpose, general accessibility, relatable

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tone, and emphasis on empowerment from a lived experience perspective. PPI reviews affirmed the relevance and clarity of the manual and endorsed its potential value in inpatient and community mental health settings. Patients, carers and peer workers provided critical constructive comments on content, structure, format, tone, language and usefulness which was used to refine the intervention for further usability and implementation in an NHS setting.

Conclusions

This co-produced intervention shows promise as a recovery-oriented tool for individuals with mental health conditions. Positive initial feedback highlights its face validity and potential to support self-management. Feedback gained from those with lived experience and a PPI group enabled refinement to enhance usefulness and usability. Future research will focus on review by mental health professionals before piloting in a clinical setting to formally evaluate outcomes and implementation feasibility.

Plain language summary

An introduction from Andrew Welcome, Peace of Mind manual author:

My name is Andrew Welcome. I was born in Kent, United Kingdom, in 1967. I was adopted in 1968 and in 1971, my adoptive mother died of cancer, when I was 3 ½. Despite this, I did really well at school and army cadets. My father died of a stroke in my arms, when I was 18, in 1985. Since then, I successfully got and held down jobs until 1995, when I had a nervous breakdown.

I was Sectioned and diagnosed with acute depression (feeling very down), bipolar disorder (extreme moods, high and low) and schizophrenia (seeing or hearing things that other people in the same location do not experience). Being so depressed, I attempted to hurt myself fearing I would never become fully well. I survived and recall promising myself that if ever I get out of this, I am going to write about it to help other people avoid or recover from such dire circumstances.

Since then, I have been Sectioned a further 7 times. Each time I recovered, I learnt more and more about recovery. As a result of these experiences, I wrote a book, called “Do I Need Help?”, a relapse (falling ill again) prevention guide. The title was chosen as the guide was designed to help individuals do as much for themselves as possible, whilst making them aware when they need to ask for professional help. I casually distributed and sold about 100 copies, and only three people ended up back in hospital. Comments I received back were things like “Thank you for this informative book” and “Thank you Andrew, you have changed my life”.

In 2017, I realised that I knew a lot more about actual mental health recovery than was covered in my guide. I knew what things can be

done to reduce readmission, and suicide rates, which are not taught in hospital or in the mental healthcare system. So, I started adding to my first Do I Need Help? Book, which then became my new manual, called “Peace of Mind: A Mental Health Recovery Manual”. I then reached out to research support staff at Kent and Medway Partnership NHS Foundation Trust and researchers at the University of Kent and Canterbury Christ Church University to see if we could test my manual to help more people.

What this article describes:

In this article, we describe the comments and views of seven people with lived experience of severe mental health or caring for loved ones with severe mental health issues. These members of the public were asked to read and review the Peace of Mind: A Mental Health Recovery Manual; providing detailed written comments on a copy of the manual and filling in a questionnaire with their views.

The comments received highlighted positive things about the manual, in particular, the unique use of Andrew’s lived experience to help support and reassure others. Views for changes were taken on board, including the removal of more personal thoughts that might not be relevant to everyone and some re-ordering and shortening of the manual. The comments received helped to update the manual, creating a version that would be usable by a wider group of people. The aim of this was that it could also potentially be used in the NHS. The next steps to develop this further, include work with mental health professionals to get more feedback before testing how it might help those experiencing severe mental health in a research project. New support for patients has real potential to reduce the large amounts of money new options like this, have real potential to support people experiencing mental health struggles and reduce the large amounts of money spent on those that go back into hospital.

Keywords
Mental health recovery, Self-help intervention, lived experience, Relapse prevention, co-production, Patient and Public Involvement (PPI), Recovery-oriented practice.

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Introduction

Relapse signatures, relapse prevention, mental health recovery and successful living

Mental health conditions represent a significant and growing public health concern, with one in four adults in the UK experiencing at least one diagnosable mental disorder annually, representing the largest single cause of disability[1]. These conditions contribute to reduced quality of life, impaired functioning, and increased mortality[2]. Despite increased awareness and investment, many individuals continue to experience fragmented care, lack of autonomy, and insufficient support for long-term recovery[3].

While clinical interventions and pharmacological treatments remain essential components of care, there is increasing recognition of the role that psychosocial, recovery-oriented, and patient- or lived experience-led approaches play in achieving long-term wellbeing[3]. In this context, self-directed, co-produced resources have emerged as valuable tools in supporting autonomy, empowerment, resilience and personal agency among people living with mental health conditions[4–7]. With growing evidence and enthusiasm for such interventions, such tools are particularly relevant in bridging the gap between clinical services and the lived realities of service users[8]. There is evidence that integration between a person-directed management of illness and a professionally-directed treatment of disease can converge, resulting in positive outcomes for people with mental illness[9].

Co-production, in a general context, is a way of working where service providers and users collaborate on an equal basis to design, deliver, and evaluate services or products, ensuring that the needs and perspectives of all involved are valued and respected[10]. Co-production in mental health involves service providers, people with lived experience, and their communities collaborating to design, deliver, and evaluate mental health services[11]. Traditional co-production means that people with lived experience of mental health work alongside professionals (like therapists, researchers, service designers) create or shape the interventions through shared decision making, compared to top-down approaches[12].

This paper introduces *Peace of Mind (PoM): A Practical Manual to Relapse Signatures, Relapse Prevention Planning, Mental Health Recovery and Successful Living;* a self-help manual co-produced by AW with over 30 years of lived experience of mental illness. The manual was developed as a direct response to the lack of accessible, experiential guidance for those navigating the complexities of mental health recovery. Drawing on personal experiences, informal peer interviews, and emerging understandings of relapse prevention and recovery planning, the manual provides structured, practical guidance and exercises designed to be used by individuals with a diagnosis, as well as by carers, families, and mental health professionals. Although primarily focused on those discharged from an inpatient mental health stay in line with lived experience inspiring the manual, it has wider applicability to support mental health recovery and wellbeing.

Here, we describe the development process, underlying conceptual framework, intended audience, and early patient and public involvement feedback on the manual and changes made as a result. We also reflect on the implications of co-produced, lived-experience-led resources for mental health practice, service delivery, and the evolving understanding of recovery within psychiatric care.

Methods

Development of the manual

The self-directed manual, *Peace of Mind (PoM): A Practical Manual to Relapse Signatures, Relapse Prevention Planning, Mental Health Recovery and Successful Living*, was developed by the lead author (AW), a mental health service user with over 30 years of lived experience including multiple mental health inpatient stays. The manual arose from the author's personal journey of recovery, initiated during an inpatient psychiatric admission in 1995. The motivation to document effective relapse prevention strategies originated during this period, following a moment of personal resolve to contribute something of lasting value to others navigating similar challenges.

The manual's content was compiled through a combination of autobiographical reflection, informal interviews with other service users, collating of exercises and useful methods alongside long-term experiential learning. The author systematically documented techniques, habits, and lifestyle changes that contributed to sustained recovery and wellbeing. These included strategies for recognising early warning signs of relapse ('relapse signatures'), healthy lifestyle insights, self-advocacy, supporting wider and environmental wellbeing, and development of daily habits to promote mental stability and life satisfaction. It has been made available online for use (https://www.doineed-help.net and https://www.peaceofmind.help) and has had positive responses from those that have utilised the intervention:

'I am still working on my recovery - in a much better place but I still found some helpful things in your book.'

'Suffering a schizoaffective disorder myself am always looking for prevention techniques on Relapse and I will be sharing this book with close friends.'

Co-production and lived experience integration

Although developed by a single author, with subsequent input from a mental health nurse, professor of mental health nursing and senior research fellow - the manual is informed by principles of co-production. Over the course of its development, the author engaged with peers through informal dialogue, support groups, and recovery communities. These exchanges helped to refine and validate many of the included strategies, ensuring that the content reflected not only individual experience, but also common recovery trajectories observed across a range of service users.

The co-produced nature of the manual is further reflected in its practical format, intended to be accessible to a broad audience, including individuals diagnosed with mental health

conditions, their families, carers, and mental health professionals. The manual was designed to be both sequential and modular: readers are encouraged to progress from beginning to end, but the format also allows selective engagement based on immediate needs.

Format and accessibility

The manual includes a combination of narrative guidance, relapse prevention templates, lifestyle checklists, structured guidance through goal-setting, and motivational tools. It is written in plain, compassionate language from a perspective of lived experience, aiming to reduce stigma and increase reader empowerment. Usability was a central design principle, with the goal of fostering self-efficacy in individuals navigating complex mental health conditions.

The author emphasises an incremental approach to recovery, advocating for the cumulative impact of small, manageable lifestyle changes. The manual encourages self-pacing and personal reflection, enabling readers to take control of their recovery process. It supports this with practical tools and psychological insights presented in an encouraging, action-oriented pitch.

Patient and Public Involvement (PPI) to review the manual

Patient and Public Involvement

Patients and members of the public were first involved in this research prior to formal evaluation of the manual, when structured consultation was carried out with public advisors from Kent and Medway NHS and Social Care Partnership Trust.

The research questions were shaped by lived experience priorities. Feedback from reviewers highlighted the importance of relapse prevention, empowerment, and practical accessibility, which directly informed the study aims and outcome priorities.

Patients and the public were involved in:

(a) Design and conduct: reviewing the manual through structured feedback forms and annotated copies; providing comments on tone, length, structure, and usability; and advising on revisions.

(b) Choice of outcomes: highlighting that relevance, clarity, and usability of the manual were central, which informed outcome measures focusing on accessibility, user empowerment, and relapse prevention planning.

(c) Recruitment: advising on barriers to engagement and accessibility considerations, which will shape participant information and consent procedures in future research.

They also contributed to discussions about methods and plans for dissemination. Involvement through the Opening Doors to Research PPI group at the University of Kent provided guidance on ensuring accessibility, designing future NHS-based research, and planning co-design of participant-facing materials and dissemination strategies.

We thank the PPI contributors for their valuable input, which has strengthened both the manual and study design.

Ethical considerations

The manual was authored by a person with lived experience of mental illness who drew upon their own recovery journey and informal conversations with peers over a period of 30 years. These informal exchanges were not conducted as formal interviews and did not involve identifiable personal data; rather, they were used to inform the general insights and strategies presented in the manual. As public and patient involvement work, NHS Research Ethics Committee approval was not required. However, ethical principles of co-production, respect, and inclusion were embedded throughout the manual's development process. No personal health information from third parties was used or disclosed and PPI members contributed as advisers rather than research participants. Their input was used to improve the clarity, accessibility, and perceived usefulness of the intervention. All engagement was voluntary and conducted with full transparency about the purpose of feedback and the potential future direction of the manual.

The project aligns with current standards in co-produced mental health research, promoting autonomy, dignity, and shared ownership of mental health recovery tools. Plans for future testing of the manual in clinical settings will be subject to appropriate research ethics approval.

Results

Lived experience PPI review

Seven members of the public expressed interest in reviewing the manual and received a printed copy on which they were asked to make annotations along with a set of structured and open questions to provide comments. Six of the seven returned the manual and comments, all providing annotations on the manual and five returning the structured and open questions. Feedback came from two people with lived experience of an inpatient mental health stay, 1 carer of a person with severe mental illness who was also a community support worker and 3 peer support workers with prior lived experience and who were currently supporting patients within NHS services.

Figure 1 shows PPI review responses to the structured questions. The content was felt to be comprehensive and generally helpful with a median score of 2 indicating the content needed some improvement. Two reviewers scored the content of the manual highly (scoring 4 and 5 – good and very good content), two recommended the content needed some improvement (score of 2) and one recommending much improvement (score of 1). A key positive aspect was the unique offering of the voice of lived experience as well as the interactive tools like charts, templates, and progress trackers. The strong focus on personal growth, financial planning, and relapse prevention was commended.

'I loved how it has been written by someone who has actually been in the system & who uses these techniques himself. Lots of practical help as well as interactive charts/lists to fill out'

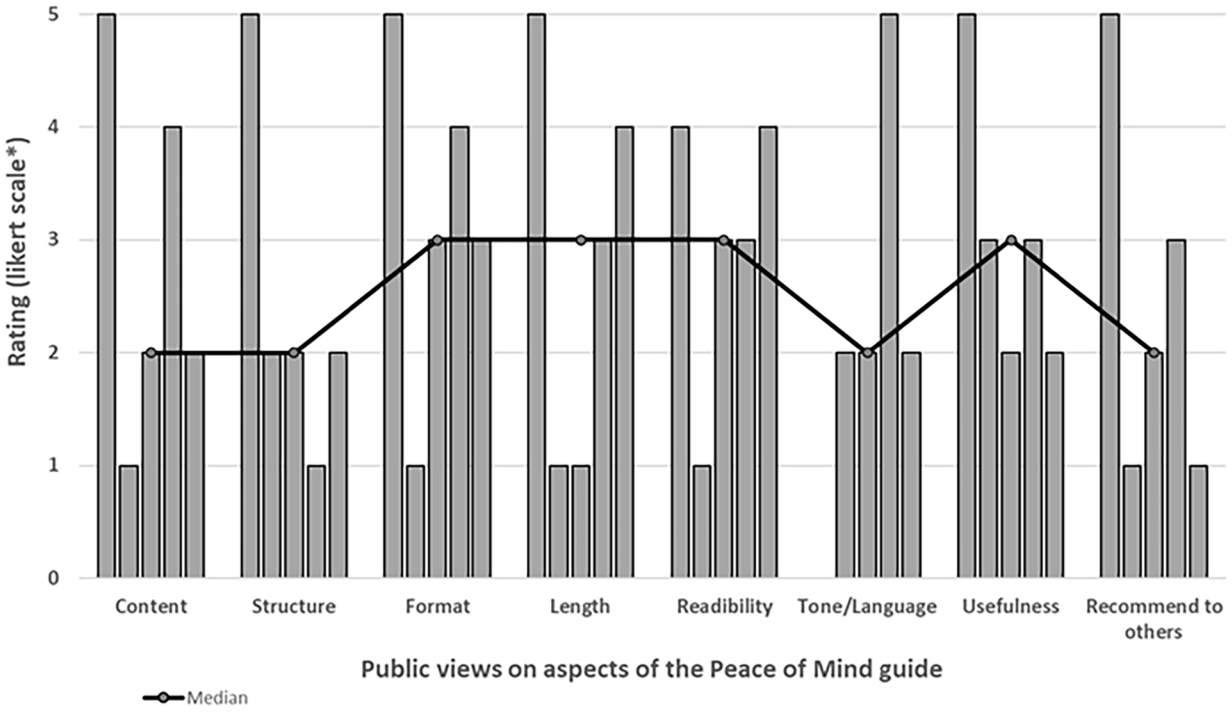

Figure 1. Responses to structured questions on aspects of the Peace of Mind manual.

'The content is comprehensive, well-structured, and clearly the result of significant effort from the author.'

To support improvements, reviewers felt the manual would benefit from being more concise, objective, and better organised. Some sections were felt to be repetitive, overly detailed, or irrelevant, for example some lifestyle topics whilst other key areas were felt to be lacking.

Most reviewers (n=3) felt the structure also required some improvement (score of 2 in Figure 1), being made more concise by removing repetitive sections and ensuring ideas were properly referenced and evidence based. Several sections where the author had included more personal opinions and religious content were felt to be too subjective and should be removed. Further organisation to improve chapter arrangement and clearer, more logical section titles was recommended alongside more focus on practical topics like relationships and parenting in the context of mental health. These changes were recommended to create a clearer flow allowing readers to move through the manual in a logical order.

'Overall, the book did not feel particularly structured. It is felt that consideration needs to be focused on the arrangement of the chapters and content to improve readability.'

Although most reviewers felt the format was satisfactory to good (4/5 scored this 3 or more indicating satisfactory to good and very good format), the further structuring and reorganisation was recommended to be important for accessibility as well as providing a way of reducing the long sections of text. Despite mixed scores, it was generally felt that the manual was too lengthy and that this could easily be addressed with removal of repetitive sections which would make it a more reasonable length. Reviewers liked that the manual could be 'dipped in and out of' and provided plenty of space around exercises to annotate and add thoughts with text broken up well with illustrations, templates and exercises. However, some sections were felt to be split awkwardly which should be addressed.

'I think A4 is a good sized for the manual, it is not too condensed & nicely paragraphed, lots of headings & subheadings to break up content'

'I did not feel the book was particularly accessible for different learning styles – there is a lot of wording and little to no imagery or variation in text, which often felt overwhelming'

Most reviewers highly praised the manual's readability (with four reviewers scoring 3 or above – satisfactory, good or very good). The manual was thought to use clear, conversational language with moments of humour, empathy, and motivation, making it accessible and uplifting. However, reviewers felt the manual may be hard to follow for those still unwell due to dense text, long sentences, and in places a directive tone. Positive changes suggested included clearer formatting, third person writing, accurate titles, more visuals, and proper citation of research. The language could be improved by reviewing the places where the manual came across as too critical, directive, or dismissive in tone to remove the risk alienating a recovery audience.

'Love has a humorous element to it at times which lightens it in areas'

'Sometimes a little too directive/prescriptive'

Respondents were asked to provide a score for the overall usefulness of the manual and whether they would recommend it to others. A median score of 3 indicated that most reviewers felt the manual was somewhat useful, with two scoring the manual as slightly useful, two as somewhat useful and one as extremely useful. There was a mixture of scores from reviewers with respect to whether they would recommend the manual to others to use in its current form. One participant felt it was extremely likely they would recommend the manual to others, one neutral response, two unlikely to recommend to others and one very unlikely to recommend.

Finally, reviewers were provided with an open text question to provide any other comments or feedback. Comments commended the valuable, practical, and motivational content delivered through material that can be personalised with the voice of lived experience as a unique aspect. There was a need to reduce subjectiveness, include more references to evidence behind the content and amend areas where language was too critical or directive which could be triggering to some. The tone was felt to be uplifting and inspiring with 'gold nuggets' of useful advice and reviewers appreciated the author's effort. Key to the interventions future success was to reduce the manuals length, reduce areas of repetition, create a clearer structure and widen the content inclusiveness across gender, race, sexuality, faith and other identities. Despite seeing potential for the manual to support people with mental health recovery, it was not felt to be suitable in its current form for use in an NHS setting.

Alongside the above detailed feedback, six of the seven reviewers completed the task of annotating changes onto the manual itself in the form of notes to varying levels. Some gave detailed comments whilst others identified more copy-editing issues and key areas where the felt changes were needed. All comments and the structured feedback were then used to make significant changes. Changes were co-produced between the author and researchers to create an improved and updated manual with good potential as an intervention for use in an NHS delivery setting ready for further PPI review and testing in future studies (Figure 2).

Wider feedback on future study design and usability – wider PPI group review

Twelve members of the Opening Doors to Research PPI Group from the University of Kent subsequently reviewed extracts from the revised manual and discussed study design and

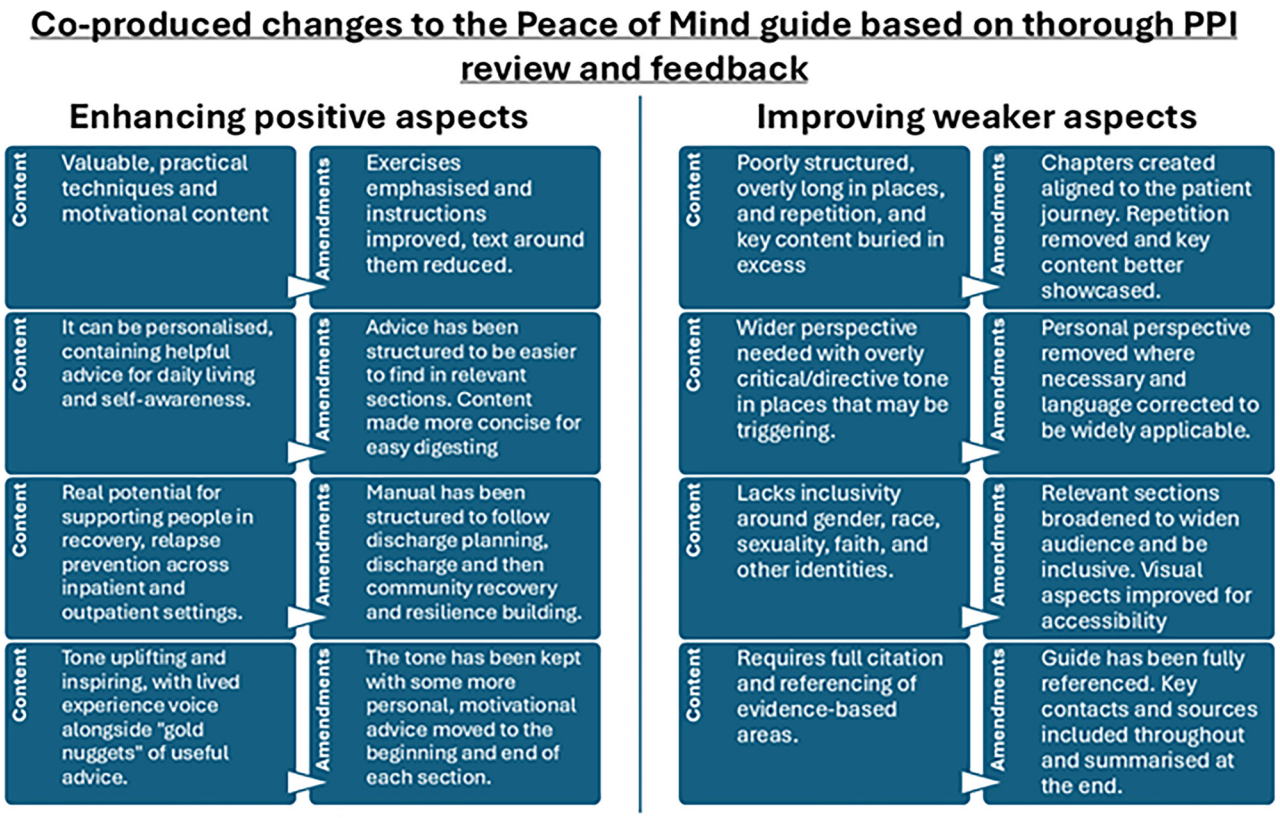

Figure 2. Examples of manual revisions following PPI feedback. This figure shows the feedback from the public reviewers and the PPI group that was incorporated. Changes included improving clarity of language, restructuring exercises to enhance usability, and refining layout and tone to increase accessibility and relatability for people with lived experience of mental health conditions.

approaches to testing the manual in an NHS setting across two occasions. The group recognised this as a much needed and well-rationalised intervention, with strong support for exploring it further through clinical trials. There was consensus on the value of a small proof-of-concept or pilot study, though views differed on its necessity. The team acknowledged feedback on accessibility, applicability across service levels (including community and inpatient settings), and the importance of who presents the manual. Local organisational links were also shared. The expert by experience co-lead appreciated the group's warm reception and valued the suggestion to develop short videos to accompany the manual, which will be included in the initial pilot phase.

Video was seen as a valuable format for the intervention, especially for engaging men and those less likely to seek help. The Department for Work and Pensions (DWP) was identified as a key stakeholder, and the delivery process supported by the manual was considered important. Presentation of the intervention will be crucial, and it has potential for use across various settings, including discharge, DWP, and community services. Consultation with the voluntary sector was also viewed positively. These insights will inform the development and piloting of the intervention.

Furthermore, several PPI members affirmed the potential benefit of offering self-directed materials as a supplement to standard inpatient care.

Overall reflections on the PPI reviews

The key features throughout the feedback were appreciation for the personal, relatable, and insightful nature of the self-help intervention derived from its lived experience origins. Readers praised the interventions content but also how it shares wisdom, real-life experience, and practical advice for mental health recovery and self-improvement. The PPI reviews also provided invaluable feedback on improvements to make the manual more widely accessible, strengthen the content and improve usability and acceptability.

Discussion

The power of shared experience in mental health recovery

Our intervention stems directly from the original lived experience and is embedded at conception with lived experience in supporting mental health recovery. Offering a co-produced, user-led mental health manual designed to support relapse prevention and recovery. Developed by someone with personal experience of mental health challenges, it stands apart from traditional, professionally driven resources through its authenticity, relatability, and practical utility. This aligns with recent calls to strengthen the evidence base on co-produced interventions in mental health, where significant gaps remain[13].

Early feedback from online users and a formal PPI group has been positive, highlighting its motivational tone, accessibility, and potential as a complement to inpatient and community care. Future work will focus on piloting the manual in clinical settings to evaluate its effectiveness, with ongoing co-production ensuring continued relevance and impact. This work provides some critical appraisal to iteratively improve the intervention for use in NHS settings.

Key themes from the feedback included:

Empathy and Personal Connection: Many readers praise the author for making the book feel personal, approachable, and human. It's clear that the book resonates because it speaks from lived experience, creating an empathetic connection with readers.

Practical Advice and Insights: The book offers tangible, helpful advice for dealing with mental health challenges, such as relapse prevention, boredom management, and coping with various mental health conditions. Readers recognize its value not just as an informative resource but also as a manual to navigating their own struggles.

Hope, Inspiration, and Recognition of Hard Work: There's a strong undercurrent of encouragement, with readers expressing how the book inspires hope, acknowledges the difficulty of recovery, and provides a sense of solidarity. The author's acknowledgment of recovery's tough journey and offering tools for that process has left a lasting impact.

Improvements for use in NHS care: Feedback provided invaluable appraisal of how the manual could be refined for use. As a result, work to make it more concise, better structured, and objective, with removal of repetitive, overly personal views and providing clearer referencing of evidence was completed. This enabled improved accessibility, better flow and use of more visuals alongside inclusive language, to improve the relevance of the content whilst maintaining the manual's motivational tone and lived experience which were particularly praised. Having completed these co-produced revisions, the manual has been enhanced for further testing in clinical studies and provided better potential for use in NHS settings.

The feedback gained highlighted the manual's strengths in authenticity, motivational tone, and the inclusion of practical tools such as templates and trackers. The lived experience voice was praised as particularly powerful, enhancing relatability and empathy. The feedback further praised the manual's authenticity, motivational tone, and practical tools, with the lived experience voice enhancing relatability. However, structured feedback (Figure 1) indicated that most aspects required improvement, with median scores between 2 and 3 out of 5. Content, structure, and tone were rated lowest, highlighting the need for clearer organisation and a more objective, evidence-based approach. While format, readability, and usefulness were viewed more positively, responses on recommending the manual were mixed, reflecting uncertainty about its readiness for wider use.

Subsequent co-produced revisions, based on this detailed feedback, focused on: improving structure, shortening the manual, clarifying language, and ensuring inclusive, accessible, and

evidence-informed content. The revised version is now more suitable for further PPI testing and potential NHS use.

Strengths and limitations

There are, however, limitations to this preliminary work. While online and PPI feedback has been encouraging, the manual has not yet undergone formal evaluation in clinical settings. The feedback from a limited number of reviewers requires wider structured research to increase evidence for usability, generalisability and outcomes such as recovery, relapse rates, self-efficacy, and quality of life. Plans are currently underway to seek funding to pilot the intervention in an inpatient setting, which will include assessment of acceptability and implementation design with healthcare professionals and assess ability to measure formal outcome measures.

The ongoing nature of the co-production process is essential, which we will continue to incorporate, however, this creates an intervention that is not static; it is being shaped and refined based on continued user feedback, clinical insights, and evolving research findings. Although this iterative process ensures that the manual remains adaptable, relevant, and responsive to the diverse needs of people living with mental health conditions, it also presents difficulties in assessing its effectiveness. By centring the manual's development on lived experience, we contribute to a growing body of work that challenges traditional power dynamics in mental health care[8,14–17]. It not only promotes self-management and self-empowerment but also advocates for a shift towards more person-centered, inclusive, and recovery-oriented mental health practices. This approach is in line with broader movements in mental health care that seek to empower service users and validate their knowledge, making them central to both the design and the delivery of mental health services[18].

Conclusions

The *PoM* manual demonstrates strong potential as a co-produced, recovery-oriented intervention grounded in lived experience. While initial feedback affirms its authenticity, motivational tone, and practical value, structured review highlighted key areas for refinement, particularly around structure, tone, and clarity. Substantial revisions have since been co-produced to address these issues and enhance accessibility, inclusivity, and usability. Further research is now needed to evaluate the manual's effectiveness in clinical settings and its role in supporting self-management and relapse prevention within mental health recovery.

It serves as a valuable example of how authentic, user-led interventions can fill gaps in traditional mental health care, offering an approach that is as much about personal empowerment as it is about recovery. Nonetheless, the positive reception from both online users and the PPI group suggests that the manual has strong face validity and could serve as a promising tool in mental health recovery. Further evaluation will be essential to understand its role within a broader recovery framework and to explore how it can be implemented effectively in various care environments.

Figure 1 shows individual public responses to structured questions after reviewing the Peace of Mind manual. Questions considered the content, structure, format, length, readability, tone and language, usefulness and whether they would recommend the manual to others. Answers were recorded on a likert scale with 1 indicating a poor view of the manual or much improvement would be needed and 5 indicating a view of very good with little improvement needed.

Consent

As this work was patient and public involvement, consent was not required. All those involved did so of their own free will and were renumerated for their time in line with NIHR Involve guidelines for public involvement.

Data availability

Extended data are available on Zenodo: Harnessing Lived Experience in Mental Health Recovery – Extended Data

Zenodo: https://doi.org/10.5281/zenodo.17186248

This project contains the following extended data:

- Supplementary Figure 1. Example manual pages (PDF)
- Questionnaire. Full feedback form from the PPI group (PDF)

We used publicly available data that was already in the public domain, provided by a third party website. Specifically, the data comprised written feedback and questionnaire responses shared by members of the public who reviewed the Peace of Mind: A Mental Health Recovery Manual. This data was collected through a public involvement process facilitated by the Author AW and was shared with our research team with appropriate consent and permissions in place. The data used in this study is not individually identifiable and is available in anonymised form.

A summary of the written comments and the questionnaire used is included in this report [or: can be accessed upon request via the corresponding author]. These materials are representative of the dataset analysed and can be used to apply the same methodology described in this article.

Reporting guidelines

As this work was patient and public involvement, no guidelines apply.

Acknowledgments

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