Peer support: increasing participation through clinician engagement

Renal patients can often benefit from the support of others who have experienced their condition. In her final article in this series on renal peer support, Eleri Wood discusses ways in which participation can be increased through exploration of a case study of the dedicated service at King’s College Hospital.

Peer support, defined as the giving and receiving of informational, emotional and appraisal support between individuals who share a common health condition (Dennis, 2003), is an increasingly common adjunct to standard renal care. In 2011, NHS Kidney Care commissioned a kidney care programme to embed peer support principles in renal units across England. Moreover, a 2012 survey showed that 78% of English renal units had or were in the process of establishing peer support services for patients (NHS Kidney Care, 2013).

However, it is common for peer support programmes to find that significantly fewer patients than anticipated come forward to receive support. One of the country’s first formal schemes for renal patients, at King’s College Hospital, reported initial low participation levels (Hughes et al, 2008), and similar experiences have been reported by others (Day, 2012; NHS Kidney Care, 2013; Taylor et al, 2015).

Renal patients who receive peer support are largely positive about their experience (Hughes et al, 2009) and can benefit in terms of enhanced engagement (Perry et al, 2005; Sattoe et al, 2013) and greater feelings of control, confidence and acceptance (Hughes et al, 2009). However, if few participate in peer support programmes, the majority will miss out on a potentially beneficial intervention.

Low levels of utilisation are also frustrating for clinicians who have invested time and resources into establishing services, while patients who volunteer to become supporters often feel disappointed, frustrated or hurt when they are not called on to give support (Arnstein et al, 2002; Brunier et al, 2002; Hughes et al, 2008). It is therefore important to ascertain the reason for low levels of participation. If lack of engagement is due to fully aware patients simply not desiring peer support, expectations will need to be reduced to more realistic levels and peer volunteers recruited and advised accordingly. However, studies looking into other long-term conditions have shown that patients’ lack of awareness of peer support or how it might be useful is the most significant factor contributing to poor uptake (Rankin et al, 2004; Ieropoli et al, 2011), and renal patients have described the encouragement of their clinician as crucial in order for them to access peer support (Taylor et al, 2015). Consequently, it is possible that the success of renal peer support programmes has been impeded by inadequate clinician engagement. If this is the case, increasing clinician engagement will be an important element of maximising patient benefit.

This article explores the issue of peer support and clinician engagement and will be presented in two parts. The first part of the article describes a case study of the peer support programme at King’s College Hospital renal unit. It quantifies all activity that occurred over the first 6 years of the programme in order to both evaluate patterns of use and ascertain what influence clinician engagement had on patient participation. The second part of this article explores whether clinician engagement and patient participation could be increased through the implementation of a package of simple interventions.

Part one
Method

A summary of the peer support service at King’s College Hospital can be seen in Box 1. Data relating to patient referrals, support sessions, and recipient and supporter characteristics, were prospectively collected from the launch of the service in November 2005 through to June 2012. The data were first anonymised and then analysed.

Participant characteristics

A total of 184 patients received peer support, of which 88% (n=162) chose to do so face-to-face and the remaining 12% (n=22) by phone. As the unit’s...
Launched in 2005, the service initially focused on low clearance patients, but very quickly broadened to be available to all patients and kidney donors. It predominantly offers single sessions of individual patient-to-patient informational, emotional and/or appraisal assistance; however, it does accept requests for more long-term support. The service complements the existing care and education provided by health professionals. It offers recipients the choice of whether to receive support face-to-face or by phone/email, and offers a choice of time/location of the contact. The service accepts referrals direct from patients and clinicians. It has around 20 trained, active supporters, and it attempts to match recipients using their support requirements and demographics.

Population in 2011 was 11 155, about 1.6% of all patients received peer support. However, demand for peer support fluctuated. The number of referrals per year-quarter ranged from 4 to 13, with a mean of 7. Peer supporters and recipients were slightly younger and more likely to be female than the unit’s population. Black patients were twice as likely to have received peer support than their white counterparts (Table 1). Recipients were predominantly at the low clearance stage of kidney disease, but all modalities were represented (Table 1).

Table 1. Characteristics of recipients, supporters and unit population (King’s College Hospital Renal Unit, 2012)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Recipients (n=184)</th>
<th>Supporters (n=31)</th>
<th>Unit population (n=11 155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>49.9</td>
<td>51.3</td>
<td>59.7</td>
</tr>
<tr>
<td>SD</td>
<td>16.6</td>
<td>13.2</td>
<td>19.9</td>
</tr>
<tr>
<td>Range</td>
<td>16–88</td>
<td>28–76</td>
<td>16–96</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>88 (48%)</td>
<td>14 (45%)</td>
<td>6135 (55%)</td>
</tr>
<tr>
<td>Female</td>
<td>96 (52%)</td>
<td>17 (35%)</td>
<td>5020 (45%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>83 (45%)</td>
<td>17 (55%)</td>
<td>6693 (60%)</td>
</tr>
<tr>
<td>Black</td>
<td>77 (42%)</td>
<td>12 (39%)</td>
<td>2900 (26%)</td>
</tr>
<tr>
<td>Asian</td>
<td>17 (9%)</td>
<td>2 (6%)</td>
<td>1004 (9%)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (4%)</td>
<td>0 (0%)</td>
<td>558 (5)</td>
</tr>
<tr>
<td>Modality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td>6 (3%)</td>
<td>0 (0%)</td>
<td>9878 (89%)</td>
</tr>
<tr>
<td>Low clearance</td>
<td>145 (79%)</td>
<td>0 (0%)</td>
<td>332 (3%)</td>
</tr>
<tr>
<td>PD</td>
<td>6 (3%)</td>
<td>3 (10%)</td>
<td>89 (1%)</td>
</tr>
<tr>
<td>HD</td>
<td>20 (11%)</td>
<td>7 (23%)</td>
<td>407 (4%)</td>
</tr>
<tr>
<td>Transplant</td>
<td>5 (3%)</td>
<td>20 (65%)</td>
<td>348 (3%)</td>
</tr>
<tr>
<td>Donor</td>
<td>2 (1%)</td>
<td>1 (3%)</td>
<td>101 (1%)</td>
</tr>
</tbody>
</table>

Some 78% sought predominantly informational support, most commonly to facilitate a treatment modality decision. In total, 22% of recipients primarily requested emotional support to facilitate adjustment to life with kidney disease.

**Referral source**
Clinicians instigated 96% of referrals and 4% were made by patients themselves. Doctors and nurses were nearly equally prolific referrers (45% and 51%, respectively). Referrals from junior staff were rare—96% of referrals by doctors were from consultants and all referring nurses were band 6 or above.

A total of 23 clinicians had referred into the service, but the mode number of referrals per clinician was one, with 58% of all referrals coming from two individuals. Approximately 325 clinical staff have been employed at the unit during the period that peer support has been operational, indicating that only 7% of clinicians have made any referrals to the service.

**Supporter utilisation**
Thirty-one supporters were trained in five cohorts, and 23 were active at the time of analysis. The maximum number of sessions delivered by one supporter was 13, but the mode was three, showing that a minority of supporters had delivered many sessions, but that the majority had done few. On average, each supporter provided support once every 9 months.

**Discussion**
Over 6.5 years, a total of 184 patients received peer support, approximating a very small proportion—less than 2% of the unit’s population. Even if only those with advanced renal impairment are considered, by removing the 90% of patients under nephrology care, just 14% of patients have used peer support. The fact that, on average, each supporter provided support only once every 9 months suggests that this modest usage is not due to inadequate capacity. It accords with reports from other renal units of the use of peer support services below both expectation and capacity (Day 2012; NHS Kidney Care, 2013; Taylor et al, 2015).

**Patient choice**
Renal patients can be affected by severe physical symptoms of the illness, a factor which has been shown to reduce participation in peer support in other long-term conditions (Bui et al, 2002; Perry et al, 2005; Ieropoli et al, 2011). Concerns about travel arrangements or the addition of further appointments to existing heavy appointment burdens are common (Bui et al, 2002; Ieropoli et al, 2011; Taylor et al, 2015). However, the service made efforts to minimise these barriers by allowing recipients to decide whether...
to receive support by phone or face-to-face, as well as the time and location of the session, even when possible arranging sessions to coincide with recipients’ clinical appointments to avoid additional visits. This may be why the majority (88%) of recipients chose to meet their supporter face-to-face, contrary to most programmes described in the literature.

Alternately, a desire for face-to-face support may be a product of the specific needs of renal patients, or could arise from the fact that the service mainly promotes one-off support sessions rather than ongoing supportive relationships that would necessitate many meetings. Given that recipients were granted such control over when, where, and how they received support, it seems unlikely that the low participation rates were due to the service not fitting in with the practicalities of patients’ lives. However, it is unknown how comprehensively potential recipients were informed about their options. It might be valuable to ensure clinicians are aware of all options and able to communicate them clearly to patients to avoid those who could benefit from the intervention unnecessarily excluding themselves. This is an example of the influence that clinicians have over patient participation and demonstrates why engagement is crucial for the success of peer support services.

Clinician influence

Unfortunately, this evaluation reveals that clinician involvement at King’s College Hospital was very poor and probably the most significant factor in the low levels of peer support usage. Only 7% of staff had ever made a referral and most of those who had referred had done so only once, with 58% of all referrals coming from just two clinicians. This isn’t because staff were unaware of the service—a recent survey showed that 89% knew about the peer support programme (Wood, 2014b)—but rather because they were not promoting it to patients. Some 82% of clinicians spoke with patients about peer support only once a month or less (Wood, 2014b).

There are many possible reasons for this lack of engagement. It is notable that the two most active clinicians were both involved in creating and maintaining the service and thus knowledgeable regarding its usage and processes, while the majority of the unit’s clinicians were unsure about how to help patients access the service and when and to whom peer support should be offered. Some were even under the misconception that peer support was only useful to and available for patients in the low clearance (pre-dialysis) stage (Wood, 2014b).

Clinicians often simply forgot to offer peer support, or believed that offering it just once was adequate (Wood, 2014b), when in fact there is no single ‘right’ time to make the offer as individuals will find it desirable and useful in different situations. It has also been shown that many patients need time and repetition to accept the offer of help (Taylor et al, 2015). Some clinicians may have become discouraged when patients said they do not want it the first time it was offered (Hughes et al, 2008), while others may have doubted the safety and appropriateness of allowing patients to support each other (Bui et al, 2002; Curtis et al, 2007; Steginga et al, 2007).

Enhancing education

Challenging and overcoming these barriers is vital to obtain clinician endorsement of and patient participation in peer support programmes. Fortunately, they are easily addressed through providing clinicians with information, particularly targeted towards increasing their understanding of the practicalities of the service and the benefits of peer support. Clinicians can easily be reminded that the impact of the service at King’s College Hospital on its users was found to be very positive (Hughes et al, 2009), and that other investigations have shown the benefits for peer supporters themselves to be similarly constructive (e.g. Brunier et al, 2002).

Education should also aim to increase clinicians’ motivation to promote peer support by demonstrating how pivotal their involvement can be. Although peer support at King’s was directly advertised to and accessible for patients, only 4% of referrals came from patients themselves, with 96% of peer support activity dependent on clinician referral. A recent study of renal patients showed that this is because many want their clinician to explicitly confirm that it is acceptable for them to receive peer support (Taylor et al, 2015).

Staff referrals

The fact that no referrals have ever been received from band 5 nurses or junior doctors is surprising, particularly as they are the most numerous staff groups. It is unfortunate that, for practical reasons, they were omitted from the concurrent evaluation of clinicians’ attitudes (Wood, 2014b), and so the reasons for their lack of participation can only be hypothesised. It is likely that they were less knowledgeable of the service, and may not even have been aware that their participation would be valued, as junior staff are not usually encouraged to independently refer patients for interventions. Work targeted at understanding and educating these groups should be prioritised, particularly as their frequent and continuous contact with patients means they have the potential to significantly impact on participation.

Patient characteristics

This study did not explicitly measure levels of desire for peer support among the unit’s patients. However,
Taylor et al (2015) interviewed 26 renal patients and carers and reported that the majority (23) felt it could be useful to them, suggesting that desire among renal patients is high. It will not, however, be universally attractive and perhaps uptake at King's College Hospital has been low because peer support is not desired by the types of patients dominant there.

Across long-term conditions, peer support participants are generally young (Campbell et al, 2004; Grande et al, 2006). The current evaluation revealed the same pattern with the average age of peer support recipients being 10 years below that of the unit’s population. In addition, a heavier demand was found among women than men—a gender difference that is common, though variable (e.g. Grande et al, 2006).

The fact that the population at King's is skewed towards older men may help account for low levels of participation. However, it is also common for studies to report greater participation of and benefit for white than ethnic-minority patients (e.g. Krizek et al, 1999; Campbell et al, 2004). As King's College Hospital has a large non-Caucasian population (Table 1), this might be a factor in the low participation rates. In fact, this analysis revealed the opposite pattern: black patients were twice as likely to have participated as whites. Interestingly, the only randomised controlled trial of peer support in a renal population demonstrated a greater benefit among Black-African patients than whites (Perry et al, 2005). A further pertinent finding comes from Krizek et al (1999), who reported that, although men were much less likely than women to join a support group, when participation rates among patients who recalled being told about the support groups were compared the gender difference was much smaller. This suggests that differences in participation rates may in part be a result of clinicians recommending peer support services more to some groups than others. Therefore, it is vital that clinicians avoid making assumptions about which patients will benefit from or desire peer support and offer it frequently and routinely to all patients. Services should also ensure that all demographic groups have equal ease of access and suitable supporters available.

Benefits and risks
It is important to balance promotion of peer support with acknowledgement of the risks and caution that it does not benefit every patient. Clinician education should stress the importance of allowing recipients to decide for themselves whether to participate—the two renal patients whose anxieties were increased by peer support in Hughes et al’s (2009) study had both reluctantly agreed to take part. Non-engagement can be a deliberate strategy of self-preservation; some patients may not want to hear about other’s experiences or share their own, believing this likely to provoke unhelpful feelings such as guilt, fear, envy or false hope (Locock and Brown, 2010; Skea et al, 2011).

Clinicians should not simply be asked to refer more patients into the service. Rather, the focus should be on building their understanding of and enthusiasm for peer support so that they more frequently and effectively promote it to patients.

Part two
Method
The study used a before and after design. From October 2010 to March 2012 (the ‘before’ period), the peer support service was run with no explicit service promotion or clinician education. From April 2012 through to September 2013 (the ‘intervention’ period), the lead nurse for the service implemented the interventions summarised in Box 2. All peer support referrals were recorded prospectively throughout. The interventions emerged from the evaluation described in part one of this article and a previous study of the attitudes and behaviours of the unit’s staff (Wood, 2014b). They aimed to enhance clinician engagement by raising awareness and confidence in the safety, quality and usefulness of peer support, and improving knowledge specific to the practicalities of the service at King's College Hospital.

Results
Average referral rates during the 18-month intervention period were double the rates of the previous 18 months (3.6 per month compared to 1.8 per month) (Figure 1). This was due to wider clinician engagement, as shown by the fact that the number of individual referrers per 6-month period almost doubled from an average of 5 to 9.7 (Figure 2).

Discussion
Service promotion
Implementation of this package of interventions correlated with a doubling of referrals and active clinicians. This demonstrates that targeting promotion of services towards clinicians can...
significantly increase patient participation. This may appear obvious, but in fact it is often assumed that such services, once established, ‘run themselves’. These findings provide evidence for the importance of ongoing promotion of peer support to clinicians.

Study design
The weak evaluative design of this study provides no proof of a causal relationship or any indication of if it was all or just one of the interventions which was effective. However, the package of interventions is straightforward, low-cost and requires only a moderate amount of time to implement. Therefore, it would appear worthwhile to ensure its incorporation into the strategies of all peer support services to optimise clinician engagement and ensure more patients who might benefit from peer support have the chance to do so.

Conclusion
Many renal units have invested time and resources into peer support services, but have been disappointed by low participation rates. Professional involvement can influence success; if few clinicians engage with peer support, few patients will be made aware of services or encouraged to participate. Active promotion of and education about services targeted specifically at clinicians can significantly increase their engagement and thus numbers of patients who take part. Clinicians should be encouraged to promote peer support equally and routinely to all patients. Areas for future research include assessment of interventions not included here, particularly those targeted towards junior clinicians.

References
Day, C. (2012). ‘I felt that I was not alone, someone else understood what I was going through’: Our kidney patients-peers support programme. Poster presentation, British Renal Society, 1 May 2012, Manchester
King’s College Hospital Renal Unit. (2012). 2011 annual report. King’s College Hospital Renal Unit, London