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Evaluation of the peer worker programme at Cambridgeshire and Peterborough NHS Foundation Trust

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Prepared for Cambridgeshire and Peterborough NHS Foundation Trust
The research described in this document was prepared for Cambridgeshire and Peterborough NHS Foundation Trust.
In May 2010, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) began training peer workers for employment in teams delivering mental health services throughout the Trust. CPFT defines a peer worker as "someone with significant experience of mental distress, who works alongside others with similar difficulties in order to facilitate recovery through promoting hope and providing support based on common experiences". The CPFT programme was one of the earliest, and is now one of the largest, of its kind in the United Kingdom.

CPFT asked RAND Europe to evaluate the early stages of the programme’s implementation. The findings of this evaluation, which took place between January 2011 and May 2012, are set out in this report. The evaluation focuses on the perceptions of different stakeholders of the programme’s impact and the successes and challenges of its implementation. As part of this work, we set out a logic model, developed in collaboration with CPFT, to describe the theory of change underlying the peer worker programme, in order to inform future planning of the programme and ongoing performance measurement.

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Executive summary

Peer workers are individuals with personal experience of mental health challenges who are employed in mainstream organisations. They support those currently receiving services and give hope of recovery. The peer worker programme at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) began training peer workers in 2010, and is now one of the longest running and largest of such initiatives in the UK.

CPFT asked RAND Europe to evaluate the early stages of the programme’s implementation to establish its early impacts and set out how progress can be monitored in future. The evaluation focused on different stakeholders’ perceptions of the programme’s impact, and the successes and challenges of its implementation. We addressed these questions through interviews with people receiving services and individuals involved in programme implementation, and used focus groups to explore the views of peer workers themselves and other members of staff who work alongside them. We then worked with CPFT to develop a logic model to describe the “theory of change” underlying the peer worker programme and to identify key performance indicators for monitoring and evaluating future progress.

What are the early impacts of the peer worker programme?

Indications from interviews and focus groups suggested that the programme is having a positive impact on people who receive services and peer workers, with positive impacts also suggested for the teams in which peer workers are employed and the Trust more widely. Very few negative impacts were mentioned.

What is the CPFT peer worker programme?

CPFT defines a peer worker as “someone with significant experience of mental distress, who works alongside others with similar difficulties in order to facilitate recovery through promoting hope and providing support based on common experiences”. The peer worker programme began in 2010, with training initially delivered by representatives of the US organisation Recovery Innovations. Six cohorts of training have been completed to date, from which 80 peer workers have successfully graduated. As of July 2012, 37 peer workers are employed full or part-time in 42 posts within the Trust. Peer workers are employed both in inpatient and community-based teams, and the first posts in specialist services settings, such as police stations, have recently been appointed.
Positive impacts were indicated for peer workers from both the training and employment. The peer worker training was seen to have a positive impact on peer workers’ own recovery. Peer workers also reported increased self esteem and confidence as a result of being in employment and felt that they had developed practical skills.

A positive impact on people receiving services was thought to result from engagement with peer workers. People receiving services considered peer workers to be approachable and flexible, as well as able to provide friendly advice, both regarding mental health challenges and practical aspects of care. The specific nature of a peer worker’s own mental health experience was not considered important by people receiving services.

There were early indications of cultural change in peer workers’ teams and in the organisation more widely. CPFT staff reported early indications of a cultural change in some areas of the organisation, with increased focus being placed on recovery and a greater awareness of the perspective of those using services. However, it was acknowledged that this change may be a lengthy process. Beyond the peer worker programme, CPFT’s broader Recovery Strategy may also be contributing to such changes.

What are the challenges in implementing the peer worker programme, and how can any challenges be addressed to further improve the programme?

A number of challenges emerged from focus groups, but many of these may be consequences of the introduction of a new programme, rather than problems with the programme itself. These challenges, which are reflected more generally in the existing peer support literature, suggest four main areas to focus on:

- Supporting the transition of peer workers from people receiving services to employees, and supporting other staff in understanding this transition. The challenge of the movement of peer workers from receiving to delivering services was highlighted in focus groups and some staff expressed uncertainty about how to treat peer workers joining their team.

- Clarifying the role of peer workers and ensuring that expectations of both peer workers and other staff are in line with the reality of the job. Peer workers and other staff commented that peer worker roles were loosely defined and varied by team. Although some flexibility is required to retain the unique benefits of peer workers, both peer workers and other staff felt that greater clarity would be useful.

- Providing more practical experience and ongoing support to peer workers. It was suggested that new peer workers may benefit from further practical work experience before they enter employment. Additionally, assigning a mentor when they begin work (a suggestion made by both peer workers and other staff) may assist both in helping them develop their roles and with ‘technical’ aspects of the job that may not have been covered in training.
Ensuring ongoing and timely communication around the programme. Providing more information on the programme’s objectives and the training could help manage expectations of teams in which peer workers are placed, particularly regarding the roles that they expect peer workers to take on. Communication is also vital in addressing negative perceptions that may exist among some CPFT staff around issues such as the suitability or preparedness of peer workers for their roles.

**How do you monitor implementation and evaluate effectiveness of the peer worker programme on an ongoing basis?**

A logic model is a representation of how a particular programme is expected to produce results. The peer worker programme logic model was developed together with CPFT staff, and outlines the role of peer workers, setting out the activities they carry out and the inputs necessary for the programme to operate effectively. It then maps out the direct outputs of the programme and the longer term outcomes and impacts expected as a consequence of these.

From the outputs, outcomes and impacts identified, we worked with CPFT to identify a range of performance indicators, and to classify these according to their importance to the programme and the feasibility of measuring them. These are illustrated in Figure 2 and provide a starting point for CPFT to build a more comprehensive picture of the programme and its impact on the various stakeholders involved.

**Figure 1: Key performance indicators**

There remain many unanswered questions regarding peer support and peer worker programmes. Some of these relate to how the peer support relationship works, while others concern the best way of organising a peer worker programme (for example, around the intensity and timing of support). As programmes such as that implemented by CPFT become more established we will become better equipped to answer such questions.

“It just felt like they were going from the passing out parade straight to the front”

Member of staff (non-peer worker)
We gratefully acknowledge the participation of all of the CPFT staff and people receiving services in the Trust who offered their time to take part in the evaluation. We particularly thank Sharon Gilfoyle for her guidance and support throughout the project, Cheril Barks for arranging focus groups and interviews, and the project’s steering committee for valuable direction. Finally, we would like to thank our RAND Europe Quality Assurance reviewers, Ellen Nolte and Christian van Stolk, for their constructive feedback and timely advice.
The concept of peer support has long existed both in the mental health field and throughout society more widely. However, over the past thirty years, it has developed as a more structured and formalised means to support people receiving mental health services in their recovery. This development has taken place alongside wider trends such as deinstitutionalisation, which highlighted the need for more comprehensive mental health services in the community, and the growth of the consumer movement, through which people who receive services have been able to take a more active role in decisions around their own care and the kinds of services they wish to receive (see, for example, Davidson et al., 1999). In this context, peer support has been defined as “social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change.” An alternative definition focuses on the promotion of wellness and recovery, rather than illness “a system of giving and receiving
help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful”.3

Peer support has evolved in a number of distinct formats, which can be broadly categorised into self-help (or mutual support) groups, peer-run services and peer employees (e.g. Ley et al., 20104). Self-help groups, whether formally or informally organised, have existed in various forms for a long time, and as a result much of the literature focuses on these. Although originally conceived of as providing face-to-face support, technological advances have allowed for more remote support in recent years and many peer support services now operate online.2 There is also a substantial body of literature around the operation of peer-run services. These are programmes which are planned and delivered by peers, and include services such as drop-in centres, vocational services and crisis lines. Finally, peer employees are individuals with personal experience of mental health challenges who are hired into mainstream positions or designated positions within mainstream organisations on the basis of this experience.

The peer worker programme at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) falls into the third of these groups, and is now one of the longest running and largest of such initiatives in the UK. Peer workers are trained and recruited as employees into existing teams throughout the Trust, contributing to the teams’ work from their experience of both mental health challenges and recovery. CPFT defines a peer worker as “someone with significant experience of mental distress, who works alongside others with similar difficulties in order to facilitate recovery through promoting hope and providing support based on common experiences”.5 The peer worker position at CPFT is paid full or part-time employment.
The peer worker programme at CPFT forms part of a Trust-wide “Recovery Strategy”, the goal of which is to implement recovery principles throughout the Trust. These principles focus on challenging stigma associated with mental illness and giving hope to people experiencing mental distress. The Trust aims to help people acquire more active control over their lives, focusing on strengths and wellness rather than illness and symptoms.

The approach to peer support taken by CPFT was informed by systems in place in the United States, in particular the peer support programme implemented by Recovery Innovations in several US locations. This organisation provides a range of recovery-focused programmes, including crisis response, education, physical health, community living and vocational services, all of which include a peer support component. After meeting with representatives of Recovery Innovations, CPFT planned a series of training cohorts to be led by one of the Recovery Innovations trainers during a visit to the UK.

Peer worker training positions were advertised through NHS Jobs, through mental health charities and internally within CPFT. Those considering peer worker training were first invited to attend an orientation day, where they found out more information about the course and how to submit an application. Following the orientation days, 94 people gained a place on the training, which was delivered in six cohorts from May 2010 to June 2011. An early achievement of the programme was the training of two peer educators who have subsequently led much of the training. Overall, 80 people have graduated from the training programme. As of June 2012, 37 graduates are employed by CPFT in 41 posts (four work in more than one role). A further 25 people are still awaiting peer worker posts to become available. Recently the Trust has begun appointing new posts within specialist service contexts, such as the police service, where there are currently six roles. Recruitment in child and adolescent services is also planned to begin shortly.
CHAPTER 2  Methodology and evaluation framework

CPFT asked RAND Europe to evaluate the early stages of the peer worker programme, examining both the processes and structure of the programme and early indications of its impact. We framed our evaluation around four key questions:

1. What is the peer worker programme and how does it fit into the wider context of peer support?
2. What are the challenges in implementing the peer worker programme, and how can any challenges be addressed to further improve the programme?
3. What are the early impacts of the peer worker programme?
4. How do you monitor implementation and evaluate effectiveness of the peer worker programme on an ongoing basis?
We used a number of different methods to address these questions. In order to gain an overview of the programme, to understand the reasoning behind its conception and to inform the evaluation process, we began with a scoping stage, in which we explored both the background and structure of the CPFT programme and where it sits within the wider field of peer support in mental health. This first stage took the form of a brief, targeted review of relevant academic literature, a review of documents related to the CPFT programme (for example, training materials, course evaluations), and informal interviews with key staff involved in the programme’s set-up and running. The intention of this initial phase was to provide a framework for the remainder of the project, helping to define the objectives and context of the programme, and highlighting some of the key areas for the evaluation to focus on.

For the second and third research questions, it was important to gather the perspectives of people receiving services, peer workers and other members of staff, and to capture their views on the possible impacts of the peer worker programme. Informed by the tasks conducted in stage one, an interview protocol and focus group guide were developed. Focus groups were conducted to capture the views of peer workers and the CPFT staff who work alongside them, while individual interviews were conducted with people receiving services. More details on these parts of the project are provided in the following chapters.

The final phase of the project aimed to provide a basis for the ongoing development of the programme, as well as a structure by which its progress might be systematically monitored and its effectiveness measured. Again this was informed by our findings from stage one of the evaluation. We worked with the CPFT team to construct a logic model of the peer worker programme, identifying the various components that are essential to its implementation, and elucidating the ‘theory of change’ underlying the programme.

Because of the involvement of people receiving services and staff in the evaluation, and the potential for sensitive topics to be raised in focus groups and interviews (although we did not ask about participants’ diagnosis, treatment history or other personal information), it was essential for us to ensure that the project was in full compliance with research ethics guidance. As such, the approach, methods and materials for involving people receiving services and CPFT staff in the project were approved by the National Research Ethics Service (NRES) Committee East of England (REC reference: 11/EE/0251).

All participants signed a consent form after receiving a comprehensive information sheet setting out what participation in the project would involve. The information sheet for people who receive services is provided in Appendix A. Information sheets for other groups in the study were tailored to their particular involvement, but covered the same issues. These also highlighted the right of participants to withdraw at any time and emphasised that all information provided would be treated in confidence, including anonymisation of any quotes used in reporting the evaluation’s findings. We asked permission from participants to record their comments (to help ensure we could accurately capture their views) and all agreed for us to do so. Where necessary, participants were assisted in reading the information sheet, either by a member of staff, carer or member of the research team.

People receiving services were reimbursed for their time, and where appropriate, travel costs, in accordance with CPFT’s guidance “Payments for Service Users and Carers Involvement”.6
In the chapters that follow, we set out the key findings of the research. In Chapter 3, we present details of our targeted literature review. In Chapter 4, we highlight the findings from our interviews with people who receive services. Chapter 5 details the outcomes of focus groups with peer workers and other staff. Chapter 6 presents a logic model relating to the role of peer workers and some possible performance metrics for the future of the programme. The final chapter sets out the evaluation conclusions and recommendations.
One of the first tasks undertaken in the project was to conduct a targeted review of the relevant academic literature. The aim of this was to answer the first of our evaluation questions; that is, to explore where the CPFT programme fits within the wider field of peer support in mental health and to identify some of the issues that we would then explore further in the focus groups and interviews.

The review was carried out in April 2011 using a range of databases containing journals relating to mental health and psychology (Academic Search Elite, CINAHL, MEDLINE, PsycARTICLES, PsycINFO and Social Sciences Abstracts). A range of search terms relevant to peer support programmes were used to search article titles (including, for example, “consumer delivered”, “peer worker”, “peer provided”), alongside subject terms to specify mental health publications (“psych*” or “mental”). A number of the initial search results related to other fields, leading us to exclude papers with some specific search terms (for example, “burn*”, “cardiac”, “hiv infection”). After removing duplicates and conducting an initial review of titles and abstracts, a set of 77 articles remained. As only a
targeted, rapid review was necessary in this instance, we selected from this list those articles which were most relevant to peer employees, provided recent empirical evidence, or reviewed wider findings in the field.

We found that relatively few articles focus on peer employees, with most of the evidence coming from the US, possibly because self-help groups and peer-run services have a much longer history (although our review will not have captured publications within the last year or so). Some studies focus primarily on process aspects of peer employment programmes and many of these discuss barriers to successful implementation extensively.

One of the main challenges discussed relates to the changing nature of the peer workers’ role, and how these changes affect the way they relate to others around them.8,9 Moving from receiving services to being a service provider means that those who were their peers may now perceive them in a very different way. Carlson et al. (2001)8 pointed out that some of these peers might still be part of vital support networks for the peer worker. Shifting relationships to an unequal footing may disrupt this support. At the same time, colleagues (or peer workers themselves) may not consider peer workers as fellow professionals, a situation which Shepard (1992)10 describes as leaving peer workers in ‘no man’s land’. From the perspective of staff working alongside peer workers, the boundaries of ‘sick’ and ‘well’ can become somewhat blurred, leading to them assuming a therapist role.8

A second challenge highlighted in the literature is the difficulty of preventing or challenging misconceptions that other members of staff may hold about peer workers.1, 9, 11 These may be doubts relating to the expertise or experience of peer workers, or they may relate more to aspects of a peer worker’s mental health, including the extent of their ‘recovery’, their ability to handle stress or the perception that they might frequently be on sick leave.

The studies that do examine outcomes instead of, or in addition to, process measures often looked primarily at the effects of programmes on peer workers themselves. These studies tended to find substantial benefits, including increased self-esteem, development of interpersonal skills, and improved quality of life.11 Studies looking at programme impact also tended to find outcomes for people receiving services that were at least as good as those achieved in usual care. Solomon and Draine (1995)12 reported peer-provided services to be as effective as non-peer with regard to symptomatology, clinical and quality of life outcomes, while Felton et al. (1995)13 found that people receiving services who received support from teams including peer workers showed greater improvements in quality of life measures than those in teams with no peer worker. While some studies demonstrating improved outcomes for people receiving services confound the provision of peer support with the provision of simply more support, conclusions are broadly positive. However, there remain many unanswered questions about how peer workers can best be used in teams, what the key differences are between the support provided by peer and non-peer workers, and in which settings peer support is most effective.14-15
Following the initial scoping stage of our evaluation we engaged with key stakeholders in the CPFT peer worker programme through interviews and focus groups, to address evaluation questions two and three. This involved looking at the challenges in implementing the programme and the early impacts on different stakeholders, exploring their experiences and trying to identify any positive and negative aspects of the programme, as well as to explore how the support that peer workers can provide differs from that otherwise available within CPFT.

We carried out five interviews with people who receive services. Although we would ideally have spoken to a larger sample of people, the views offered in these interviews were very consistent across the set, giving us confidence in their reliability. The interviews were all carried out by the same member of the research team, which helped ensure consistency in the approach.
Interviewees were selected from a range of services, including both inpatient and community teams, as well as in both Peterborough and Cambridge. All interviewees reported having worked with at least one peer worker for at least six months. In several instances, interviewees had either experience of several wards or of working with more than one peer worker in the same service. Interviews took place in April and May 2012 and were all carried out on CPFT premises. All interviewees were given the option of having a friend, relative or other individual present, but none chose to do so.

Interviews were conducted face-to-face, using a semi-structured interview protocol. The protocol was informed, in part, by our review of programme documentation and discussions with staff involved, while also allowing interviewees to raise any points they felt it was important for the evaluation to capture. Topics discussed included the kinds of interactions people receiving services have with peer workers, how these differ from interactions with other staff, what the most and least helpful aspects of the peer worker role are, and ways in which the programme might be improved.
Overall, all interviewees were very positive about the aims of the peer worker programme and their own experiences of it. Although people receiving services were asked specifically if there were parts of the programme that they felt worked less well or areas which could be improved, no such issues were raised. This does not appear to have been due to a general unwillingness to criticise, as some interviewees did refer to other services or aspects of their care in a negative way.

All five interviewees expressed the view that it is easier to relate to and more comforting to speak to someone who has experienced a similar situation to their own. It was also mentioned that this personal experience enables peer workers to offer suggestions that might help people receiving services cope with particular feelings or situations, but importantly, this knowledge is used only in providing ideas, not in instructing the individual on how to behave.

Interviewees also commented that peer workers are more approachable than other members of staff, as the flexibility they are afforded allows them the time to listen when an individual feels they need someone to talk to. It was generally recognised that the role of peer workers does not differ much from other staff in terms of the actual tasks carried out, but that peer workers might approach these responsibilities differently and prioritise different aspects.
Linked to the previous suggestions that peer workers might be easier to relate to and have more time to listen, interviewees also commented that they sometimes find them less intimidating than other staff. The relationship was described as more akin to a friendship than a traditional ‘staff-patient’ relationship. One interviewee stressed that this can be particularly valuable in a ward environment, where many people receiving services find it difficult to trust staff.

Given that people who receive services reported being better able to relate to those who had experienced a similar situation, we thought it important to explore just how similar this experience needed to be. Interviewees were asked whether the specific experiences of the peer worker are important in how effectively they are able to carry out their role. All five reported that this is not the case, instead suggesting that the most important aspect of the role is the inspiration that peer workers provide and the idea that they can represent “the glimmer of hope”. There is also a more practical aspect to the support they provide however. Some interviewees commented that it is helpful to be able to talk to someone who has practical experience of ‘the system’, such as routines on wards.

As there are a number of groups who might potentially in some way benefit from the peer worker programme, we asked people receiving services where they felt the main focus of the programme should lie and who the main beneficiary group should be. Interviewees were quite clear in their belief that the primary objective should be to benefit people receiving services. This might suggest that although interactions with peer workers might resemble friendships, people receiving services do still consider peer workers to be members of staff whose role is in delivering services.
However, although interviewees felt that the programme *should* primarily benefit those receiving services, there was also a wide recognition that it can also bring benefits for the peer workers themselves. Interviewees commented that being able to return to employment and help others through their own experiences is likely to be helpful for peer workers in their own recovery, while the apparent enjoyment they get from their role was also highlighted by several people.

One interviewee mentioned that she is sometimes concerned about what she can talk to a peer worker about. She commented that she had been worried in the past that talking about some of her own experiences might resurface issues which for the peer worker were in the past. However, she did add that on mentioning this, the peer worker had reassured her that this was not a problem, suggesting at least in this instance that the peer worker was suitably prepared to deal with such concerns. Nevertheless, this may be an issue which it would be valuable to ensure is highlighted in the peer worker training as a potential concern of people receiving services.
Key findings from interviews

• Very positive feedback on the programme

• People who receive services felt that the benefits of peer workers included:
  – they have had similar personal experiences
  – they have time to listen
  – they are less intimidating than other staff
  – they have experience of ‘the system’
  – they provide inspiration and hope

• The specific nature of the mental health challenges personally experienced by a peer worker was not thought to be important for carrying out their role

• People who receive services felt that the aim of the programme should be to benefit patients, but that peer workers themselves might also benefit from being involved
Focus groups were conducted with CPFT staff, including both peer workers and other members of staff, from December 2011 to February 2012. We sought to obtain views on evaluation questions two and three, looking at the challenges in implementing the peer worker programme and the early impacts on different stakeholders. Focus group participants were selected to represent a range of services, teams, locations (Cambridge or Peterborough) and professional roles. Potential groups of participants were identified by the peer worker programme manager and were sent an invitation from the Trust to attend a focus group, together with further information.

Five focus groups were conducted with a total of 21 staff. One focus group was made up of only peer workers, one with human resources and employment services staff, and the remaining three focus groups brought together Trust staff working alongside peer workers. Focus group members came from a range of services, including older people’s services,
adult acute inpatient services, rehabilitation and recovery services, personality disorder services, eating disorders services and young people’s early intervention services.
We developed a focus group guide that was informed by the initial scoping interviews and the document review. This is presented in Appendix B. Introductory questions allowed participants to introduce themselves and the extent of their contact with peer workers.

A first set of questions covered focus group participants’ understanding of the peer worker programme, including how they were introduced to this programme, what they understood to be the role of peer workers, and the objectives of the programme. Participants were also asked about any changes which had occurred since the beginning of peer worker employment. Each focus group then considered the impacts of the peer worker programme on each of the different identified stakeholders. Finally, focus group participants were asked to suggest changes that could be made to improve the programme.

While the focus groups broadly followed the topics within the focus group guide (Appendix B) there was also opportunity for the discussion to move in different directions. Some of these included training of peer workers, relationships between peer workers and their colleagues, the nature of the support provided to peer workers and communication of all aspects of the programme.

Below, we have presented the findings of the peer worker focus group, followed by the focus groups conducted with wider staff.
The members of the peer worker focus group described a lack of clarity of understanding of the role of a peer worker that they found among the other staff. Peer workers commented that they found it difficult to communicate their role to the other staff in their team.

This difficulty was highlighted by examples of tasks that peer workers were asked to do which they felt that they were unqualified for, such as conducting memory tests or taking blood pressure, as well as tasks they felt conflicted with the peer support aspects of their role. An example of the latter was being asked to persuade a person receiving services to go outside, even if this was against the individual’s wishes.

Despite the difficulties some peer workers found in establishing their role, this lack of a prescribed job description was also seen as a strength in some instances. Some focus group participants commented that this allowed them to shape the role themselves, using their unique skills where they would be most beneficial in the context of the specific team.

Among the peer workers there was very strong approval of the training process and of the trainer who came from Recovery Innovations to deliver the training. In addition to the content of the training, peer workers described the benefits they experienced from the safety of the group environment, which allowed them to grow in confidence and to build strong relationships with other trainee peer workers.

Some peer workers mentioned the disparity between the support provided in the training and the support available after they had completed the course, either during a gap between the training and starting work, or once they had begun work. It was suggested that when they began work at CPFT, assignment of a mentor for each peer worker would be beneficial. Similarly, those who do not immediately gain employment following the
training course may also need some form of ongoing support as they move from a time of intense and focused training to a much more uncertain period.
Peer workers were asked to express their views on the impact of the peer worker programme on four different groups: peer workers themselves, the teams they work in, the organisation as a whole, and people who receive services.

Peer workers felt that the programme had benefits for themselves, their teams and people receiving services. For peer workers themselves, the benefits of gaining meaningful employment were highlighted, with peer workers expressing the extent to which they are happy to be able to perform their current role. In terms of benefits to people who receive services, peer workers believed that they could act as role models, giving hope of recovery, but also that they have an important role in supporting individuals on a day-to-day basis, giving them someone who is always available to talk to. Peer workers suggested that they can act as a bridge between people receiving services and the other staff, overcoming the distrust or apprehension of staff which can sometimes exist. They also felt that their presence was useful as a reminder to other staff of the possibility of recovery.

Peer workers were asked to discuss the changes which they felt had taken place as a result of the peer worker programme. It was acknowledged that changes take place slowly and that gaining acceptance of the peer worker role and changing attitudes in the team was a long process. However, those who had been in their roles for some time felt that they had become more accepted by the team and had had some success in changing the language used both within the team and with others, reducing jargon and bringing it more into line with the recovery focus of the Trust.
Turning next to the focus groups with wider staff involvement, one group was made up of those working in Human Resources and Employment Services, and the remaining three groups included a mixture of consultants, managers, occupational therapists, nurses and support workers.

Staff attending each of the focus groups were asked their opinions on the intended objectives of the peer employment programme. The objectives mentioned varied widely, from encouraging cultural change, embedding the idea of recovery from mental health conditions more firmly within service delivery, and a move towards valuing the experience of mental illness, to more specific objectives such as providing hope for people who receive services. More than once it was suggested that the aim of the programme was actually to benefit those employed as peer workers, i.e. to help those with a recent history of mental illness back into employment. This is consistent with the observation from both peer workers themselves and people receiving services that peer workers believe that they do benefit from being in meaningful employment, although as discussed earlier, the latter generally also highlighted that the primary aim of the programme should still be to support those who receive services.

When asked to comment on the role of the peer worker, staff members instead discussed the lack of clarity of the role, and the evolving nature of this role. When peer workers first began to be employed staff reported that there was some confusion over what their role would be, and that this role was left fairly open, to be determined by the peer worker themselves and the team in which they found themselves. This lack of clarity of role resulted in some conflict between team and peer worker expectations, but staff also mentioned the benefits of having a loosely defined role. It was agreed that the role has evolved over time, and differently in different situations, to suit the individuals and teams
who have been involved. This has allowed the peer workers to establish their own role, based on their experience, the training and the environment in which they found themselves working. The diversity of the Trust means that the peer worker role differs substantially in different teams.

There was some discussion among participants about the designation of peer workers within the salary structure. Given the different nature of their experience from other members of staff, it appears that not all staff initially understood why they were placed in the same salary band. Focus group participants commented that it might be appropriate for some peer workers to be in either a higher or lower band, and that more flexibility in this might be necessary to allow career progression of peer workers.

Some participants had concerns about the extent of some peer workers’ recovery, commenting that they felt that they had to be extra sensitive to the workload and stresses placed on peer workers because of their previous experience of mental health challenges.
An issue which frequently emerged throughout the focus group discussions was that of relationships between the peer worker and the rest of the team. Staff were concerned about engaging with peer workers as colleagues and ensuring that they did not treat them as 'patients'. This was related to another concern that peer workers were working in areas where they had previously received services, or that if they became ill again they would find themselves being treated in the same services in which they worked. There was concern that peer workers would feel uncomfortable with this. Staff felt that there was little support from occupational health and human resources services in how to deal with these situations.

The relationship between the peer worker and people who receive services was also discussed, and the concept of boundaries was mentioned several times. Staff felt that peer workers did not always understand where the boundaries should be in their interaction with people receiving services, for example, the extent to which they should become friends with, could hug or touch people, and that it would not be appropriate for them to suggest treatments. This topic was also commented on in the peer worker focus group, where it was suggested that other staff needed to understand that their role is different from that of other staff, since ‘befriending’ is an important part of providing peer support.

The staff view of the training was very different from that of the peer worker focus group. While peer workers were in general very positive about the training programme, other staff highlighted areas in which they felt peer worker training was lacking. Staff commented that they believed the training to be quite philosophical and possibly not practical enough to allow peer workers to deal with the day-to-day tasks required when in employment. Staff were concerned that peer workers were not taught about different mental health
conditions and hence would have little knowledge of conditions other than from their own experience.

Suggestions for improvement to the training course included increasing the length of the work experience required before peer workers can become full-time employees to allow them to gain more practical experience, and the assignation of a mentor to support the peer worker once they had entered employment.
There was some concern among staff about the level of support available for peer workers, both in their day-to-day employment and if they became unwell. It was emphasised by human resources staff that the same policies apply to peer workers as apply to all other staff, and that this is necessary for fair treatment. However in a similar manner to other professional groups, peer workers do have group shared learning sessions, which Sharon Gilfoyle, the Peer Employment Project Manager, runs in conjunction with the peer educators.

Some staff spoke of the challenges which presented themselves in the management of peer workers, and commented on there being limited support available from occupational health services or HR. However, from the HR perspective it was felt that these relationships should be no different from usual employer/employee relationships and it was suggested that some managers required extra encouragement to engage in these discussions.

The fundamental issue raised here was whether or not there should be more comprehensive support provided for peer workers working in this context. However, some participants in focus groups pointed to a wider issue of support provision in general for people with mental health challenges. This was perceived as a general problem across the Trust.

Communication was an area which was highlighted as an area of concern throughout the focus group sessions. It was suggested that better communication would be beneficial at the beginning of the programme, to help other staff members understand the role of the peer worker, the rationale for the selection of peer workers for the course and the nature of the training they had received. Communication problems were also highlighted when peer workers were away on sick leave. Staff expressed concern for peer workers who were off
work due to sickness, as they did not know what support they were receiving, and frustration that they were not informed as to when absent peer workers were expected to return.

Once again it was commented that communication of new initiatives was a problem across the trust, and that this problem was not specific to the peer worker programme.

Turning next to the views of staff on the impacts of the programme, each focus group was asked to consider the impact of the peer worker programme on four different groups: peer workers themselves, the teams the peer workers work in, the organisation as a whole, and people who receive services.

**Impacts on peer workers themselves**

When considering the effects of the peer worker programme on peer workers themselves, staff suggested that there was a positive impact, in terms of the continued improvement of peer workers’ mental health (recovery), the return to employment and the support network built up among peer workers in each cohort.

**Impacts on teams**

There was a range of views concerning the impact of peer workers on the teams that they work in, and this seemed to depend on individual peer workers and the nature of their teams. Some peer workers were used primarily in support worker roles, and did not make as much use of their individual experiences as others, in which case their impact was thought to be limited. In cases where the peer worker was on sick leave, or did not have the confidence to share their experiences or challenge the views of other staff, there was limited impact on the team.

In other focus groups it was felt that the team benefited from the complementary skills and experience which peer workers brought to the team. It was suggested that one positive factor was the time which peer workers were able to devote to speaking to and supporting people who receive services.

Peer workers were also seen to be useful in changing the attitudes and behaviour of the team. It was suggested that they act as a reminder to the team that it is possible to recover from episodes of mental illness, and could encourage other staff to think differently about the way in which they talk about, and talk to, people who receive services.

**Impacts on the wider organisation**

The impact of the programme on the organisation was again seen as positive, both in terms of changes to service delivery that might result from the programme, and in terms of the positive publicity created. However it was mentioned that there was some conflict between the recovery focus of the peer worker programme, and the risk-focus of the Care Quality Commission inspection which was taking place during the data collection phase of the evaluation.

**Impacts on people who receive services**

The perceived impact of the peer worker programme on people who receive services was two-fold. Firstly the presence of peer workers was thought to be a comfort to people receiving services in terms of providing them with physical evidence that it is possible to recover from a mental health condition, gain employment and return to a normal life. Secondly the peer workers were thought to be able to support people receiving services...
better than other staff are able to do, due to the increased trust and acceptance of peer workers and through people receiving services knowing that peer workers have been through similar experiences. In some cases, it was thought that peer workers had less impact than had been expected – this may relate to other comments about peer workers being on sick-leave or lacking confidence in using their experience.

Focus group participants were asked to describe any wider changes that they had seen take place since peer workers began to be employed. Some participants mentioned the beginnings of cultural changes, such as changes in the language used within teams, and also that some people who received services appeared to benefit from the recovery-focused philosophy. Another example was given of peer workers running recovery groups which received positive feedback from those who attended them. However, once again a small minority of respondents felt that the peer workers had had little effect in the teams in which they worked.
Based on the preceding discussions, focus group participants suggested ways that the current programme could be improved upon. Participants suggested that the aims and intentions of the programme could have been better communicated before it started, and also commented on the support available both for peer workers and their managers, and the need for systems to be in place for when problems arise.

Focus group participants were also asked about other areas of their work that might benefit from the involvement of peer workers, in order to maximise the potential of the role. One particular suggestion here was that it may be beneficial to involve them more in care planning.

Although the peer worker programme in general was viewed as a positive initiative, it was suggested that the Arizona model might not be entirely appropriate for CPFT due to differences in culture. It was also recognised that due to current job cuts, there was a need to manage the expectations of those recruited to training regarding how quickly they might be able to obtain a job following the training process.
**Key findings from focus groups**

- Improved communication needed about the programme and the role of peer workers
- The training of peer workers was viewed positively by peer workers, but other staff had suggestions for improvement
- The transition from receiving services to delivering services is difficult and both peer workers and other staff would like more support to understand and manage this transition
- Positive impacts were identified for people who receive services, peer workers, teams and the organisation
Since the peer support programme in 2012 is now reasonably well-established, a workshop was conducted to develop a logic model relating to the peer worker role, involving staff from CPFT and the RAND Europe evaluation team. The purpose of developing this logic model was to provide greater insight into all aspects of the peer worker role itself, to clarify the wide range of activities that the peer worker engages in and to set out the expected impacts and outcomes in the short, medium and longer term. Thus, development of the logic model aimed to further clarify question one, setting out the structure of the peer support programme, as it has evolved, but also allowed us to begin to approach question four, to better understand how the programme might be monitored and evaluated on an ongoing basis.

A logic model helps to clarify the “theory of change” within an initiative and presents a series of fundamental assumptions about how and why an intervention will work and with
what outcomes. This includes setting out the building blocks needed to deliver on a programme’s goals, through a pathway of activities, and based on a range of assumptions about the underlying logic on the types of activities which can result in desired outcomes.20-21 A realist approach emphasises the importance of context – it asks not only what works, but for whom, why, how and under what circumstances.22 Understanding what a programme is trying to achieve, and of the causal relationships that are expected to unfold in the process of implementation, is essential for building more robust evidence about what works and what does not. But understanding expectations and assumptions - although necessary - is not a sufficient condition for improved outcomes. It needs to be accompanied by efforts to identify if these expectations are actually being met through the implemented processes, and why (or why not).22

Logic models are particularly useful to help identify, specify and organise thinking around: the expected outcomes (longer-term expected consequences) of activity; expected direct outputs (shorter term achievements); core interventions (processes) through which outputs and outcomes are being pursued; and the variety of input resources in place to pursue them.23

In real-time evaluation (i.e. evaluation during a programme’s life, as in this case), logic models, together with the narratives that accompany and contextualise them, can provide a guiding structure for establishing a core set of specific, ‘measurable’ (qualitatively or quantitatively), achievable and relevant, time-bound (i.e. SMART) indicators for evaluating performance. These indicators should reflect multiple evaluation aims, and allow the evolution of a programme and projects, and performance against their own plans to be reflected on, learnt from, and acted on.24 Over time, process indicators and measures will tell us whether things are going according to plan, and output and outcome indicators will tell us what is being produced and whether activities are contributing to the longer term goals. This also enables observation of causal effects and mechanisms.

The workshop was attended by five staff from CPFT and three staff from RAND Europe. Participants worked in small groups and worked through the identification of inputs, activities, outputs, outcomes and impacts of the peer worker programme. Linkages and pathways across these were then identified. The complete logic model developed during this workshop is shown on the next page.
Following the development of the logic model and causal linkages across the pathways within this, the workshop participants reviewed all possible ways of measuring progress of the peer worker programme. They then classified these based on the ease/difficulty of collecting such data and the relative importance of those data. This matrix of performance indicators, together with the logic model, provides a solid foundation for ongoing evaluation and review of the impact of the programme. Effectively evaluating and measuring impact will enable ongoing improvement to be made and facilitation of knowledge transfer to other contexts.
The evaluation of the early stage of the peer support programme suggests that overall, the peer worker programme is viewed positively by both people who receive services and peer workers. Focus group participants also had positive comments and made suggestions for improvement on the current programme. We conclude by revisiting the core questions which framed the evaluation and looking towards the future and outstanding research questions.

**What are the challenges in implementing the peer worker programme, and how can any challenges be addressed to further improve the programme?**

A number of challenges and barriers to the successful implementation of the peer worker programme were highlighted by participants in focus groups. However, many of these may relate more to the introduction of a new programme than actually reflect problems with the programme itself, for example, the transition from receiving services to being a member
of staff that peer workers must make, the evolving understanding of the peer worker role, the need for additional processes to be put in place to support peer workers and those managing them, and the communications issues associated with all of these. Many of these challenges resonated throughout the evaluation and are reflected more widely in the existing peer support literature.

Firstly, as discussed in Chapter 3, the need to understand and support the changing nature of peer workers’ relationships with both people receiving services and colleagues has been mentioned in a number of studies (e.g. Carlson et al., 2001; Gates & Akabas, 2007). This shift from “being discussed in a team meeting” to “sitting in a team meeting” was highlighted by focus group participants, and some staff expressed uncertainty about how to treat peer workers joining their team. Providing support for peer workers through this transition may be particularly important given Carlson et al.’s (2001) observation that peer workers may lose some of their own support network (of other people receiving services) in their new roles as members of staff. There were some concerns from focus group participants that existing support within the Trust may not be sufficient in this respect.

Secondly, in relation to the day-to-day role of peer workers, (non-peer) focus group participants highlighted perceived mismatches, both between the role expectations of peer workers and other staff, and between the content of the training programme and the reality of roles peer workers subsequently took on. These issues may also link closely to some of the difficulties around changing relationships: specifying roles more clearly may help naturally define the relationships associated with those roles. In defining roles, however, it is important not to lose the unique elements of peer work that were identified by people who receive services and peer workers themselves as important, such as affording them the flexibility to prioritise the needs of people receiving services as they see fit.

Thirdly, of relevance throughout many of the areas where improvements were suggested was the belief that communication around the programme could be improved. Providing more information on the objectives of the peer worker programme and the training provided could help manage expectations within the teams in which peer workers are placed, particularly in terms of the roles they might expect peer workers to take on. Similarly, peer workers mentioned that they often find it difficult to communicate their role to colleagues, something which they could perhaps be supported with, either as part of the training or through a mentoring relationship once they are in employment (a suggestion raised by both peer workers and other staff). Communication is also vital in addressing some of the negative perceptions that may exist among other CPFT staff around issues such as the suitability or preparedness of peer workers for their roles. Similar misperceptions are described in the wider peer support literature (e.g. Davidson et al., 1999; Gates & Abakas, 2007; Gerry, 2011).

A number of specific improvements relating to these areas were discussed in focus groups. They can be broadly summarised as:

- Clarifying the role of peer workers and ensuring that expectations of both peer workers and other staff are in line with the reality of the job.
- Supporting the transition of peer workers from people who receive services to employees, and supporting other staff in understanding this transition.
- Assignment of a mentor to peer workers when they enter employment, to assist both in helping them develop their role and in assisting with more ‘technical’ aspects which may not have been covered in the training.
- Communicating more effectively the more practical aspects of the programme, in particular around roles, training, and the support available.

**What are the early impacts of the peer worker programme?**

Early indications from interviewees and focus group participants suggest that the peer worker programme is having a positive impact on people who receive services and peer workers in particular, with positive impacts also suggested for the Trust as a whole and the teams in which peer workers are employed. Very few negative impacts were mentioned.

The early impacts identified for peer workers were broadly in line with reports in the existing literature. For example, as found by Gerry et al. (2011), peer workers reported the training to be beneficial in helping them advance along their own recovery journey. Similarly, feedback forms completed by graduates of the training course (and reviewed alongside other programme documentation as part of our initial scoping phase) suggested that many course participants reported increased self-esteem and confidence, as well gaining more practical skills, particularly through the work experience phase.

While considering longer term objective outcome measures for people who receive services was beyond the scope of this evaluation, views provided in interviews by people receiving services were universally positive. Interviewees commented that it was beneficial to have someone to talk to in more of a ‘friend’ role, highlighting the advice peer workers are able to provide and the time that they are able to devote simply to talking and listening. These observations were generally supported by the comments of both peer workers and other staff in the focus groups.

When looking at the organisation more widely, views from focus groups did suggest early indications of possible cultural change in some parts of the Trust, although it was also acknowledged that this is a long process. Beyond the peer worker programme, CPFT’s Recovery Strategy more widely may also be contributing to such changes. The role of peer workers in creating a recovery-focused organisation is discussed by Bradstreet and Pratt (2010), who caution that although peer workers can play an important part in enhancing an organisation’s recovery focus, they should not be placed in the role of ‘change agents’ with responsibility for instigating such a shift. The point in an organisation’s development at which peer workers are able to most effectively carry out their roles remains to be established.
How do you monitor implementation and evaluate effectiveness of the peer worker programme on an ongoing basis?

The logic model and key performance indicators set out a framework for further understanding of the outcomes and impacts of the peer worker programme and the way in which impact might be measured in more detail. Now that the peer support programme has gathered some momentum and has evolved and developed its work practices further, it is recognised by CPFT that agreed metrics will be increasingly important to measure success. This provides a starting point for this process.

In the field more generally, further understanding is also needed of the ways in which peer workers work differently from other staff, and how this affects people who receive services, co-workers and the organisational culture. There are also more specific questions which might lead to improvements or development of peer worker programmes, such as the effect of varying the number of peer workers who work in each team, the impact of peer workers interacting with people receiving services at different points of the care pathway, and whether specialist or generalist peer workers are more effective. A further question concerns the way in which the peer worker programme benefits the peer workers themselves, and whether there are lessons from, for example, the evidence-based supported employment literature which can be used to support the integration of peer workers into the workforce (e.g. Bond, 2004).


Appendix A: Participant Information Sheet
(people who receive services)

Evaluation of the peer employment project at Cambridgeshire and Peterborough NHS Foundation Trust.

We would like to invite you to take part in our research study. Before you decide, we would like you to understand why the research is being done and what it would involve for you. You will have the opportunity to ask questions and request further information about the study and your participation before you decide whether you would like to take part in the study. We have included the contact details of two researchers whom you can contact to discuss your participation further, ask any questions you may have and request further information about the research. In addition, if you decide to take part in the study, one of the researchers you meet will go through the information sheet with you again and answer any questions you may still have at this stage. We’d suggest this should take about 5 minutes.

As explained in this Participant Information Sheet, your participation is voluntary and you will be able to withdraw from the study at any point if you decide you no longer want to take part, this will not have any consequences for yourself and any information you have given us will be discarded.

Part 1 tells you the purpose of the study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study including data confidentiality and what will happen to the results of the study.

Please don’t hesitate to ask us if there is anything that is not clear. If you have any questions, you can contact Claire Celia at RAND Europe on 01223.353.329 or ccelia@rand.org or Jenny Newbould on 01223.353.329 or newbould@rand.org. When you get in touch with us, please let us know you are contacting us about the peer worker study.

Part 1
Do I have to take part in this study?

No, it is up to you to decide to join the study, participation is entirely voluntary. This Participant Information Sheet describes the study and what your involvement would be if you chose to take part. You will also be able to discuss your involvement when you meet one of the researchers for this study. This will give you the opportunity to ask any questions you may have about the study or your participation. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving any reason. This would not affect the care you receive.

What is the study about?

It is an evaluation of peer workers being introduced in teams by Cambridgeshire and Peterborough NHS Foundation Trust. Peer workers are people with lived experience of mental illness who are employed in teams throughout Cambridgeshire and Peterborough NHS Foundation Trust specifically as a result of their experience. Peer workers are individuals who have been trained to share their recovery journey with others and whose role it is to help motivate and encourage others in their own recovery journey.

This research study aims to find out more about what impacts the introduction of peer workers has on the people they support, the teams and organisation they work in and on peer workers themselves.

Who is undertaking and funding this research?

RAND Europe, an independent not-for-profit research organisation based in Cambridge is carrying out this research. The funding for this research has been provided by Cambridgeshire and Peterborough NHS Foundation Trust.

How did you select me?

We selected you because you have received support from a peer worker at Cambridgeshire and Peterborough NHS Foundation Trust. To explore the impacts of peer workers, the research team is looking to conduct up to 5 interviews with individuals who have experience of receiving support from one or more peer workers at Cambridgeshire and Peterborough NHS Foundation Trust.

What will my involvement in the study include?

If you are interested in taking part in this study, your involvement would include a one-off face-to-face interview of up to 60 minutes with a member of the research team. The interview will be about finding out more about your views of receiving support from a peer worker so that we can better understand the benefits and challenges of using peer workers to deliver support to service users.
What will happen to the information I disclose?

We will ask you if you are happy for us to audio-record the interview to ensure we have an accurate record of the conversation and to allow us to concentrate on the interviewing process. The audio recording will be kept confidential and will not linked to your name. If you agree to us recording the interview, you can request that the researcher stops the recording at any time, you don’t need to give any reason for this. You can also request to clarify or exclude anything you have said during the course of the conversation at any time without giving a reason for this.

We will not use your name or any other identifiable information in any of the reports or outputs of this study.

If you feel uncomfortable about being audio-recorded, you can request that the researcher does not record the interview. In this case, the researcher will take notes during the interview.

Will my taking part in the study be kept confidential?

Yes, we will follow ethical and legal practice and all information about you will be handled in confidence. This means that your answers will be treated in the strictest of confidence, they will not be passed on to doctors, nurses, care co-ordinators or any other third party.

Are there any risks to my participation in this study?

Overall, we do not anticipate any risks to your participation. However, some people can find talking about the support they have received upsetting. We want to remind you that your involvement in the study is entirely voluntary and that you are free to withdraw from the study at any time. If you become distressed during the interview, the researcher might ask you if you would like him or her to call someone on your behalf. If the researcher becomes really concerned about your welfare during the interview, they will have the option of contacting Sharon Gilfoyle who is managing the peer worker project at Cambridgeshire and Peterborough NHS Foundation Trust. The researcher would ask Sharon to advise on the situation to ensure your welfare, the researcher will tell you if they plan to contact Sharon.

How will this study benefit me?

We cannot promise the study will help you but the information we get from this study will help us understand better how peer workers can benefit service users and what other impacts they may have on their co-workers and the organisation they work in. It may help contribute to improvements in how support from peer workers is delivered which could in turn help other service users.

If I decide to take part, where will the interview take place?

You can choose whether you would like the interview to take place in your own home or at one of Cambridgeshire and Peterborough NHS Foundation Trust premises closest
to you. You can bring along a friend, relative or carer to the interview if you feel more comfortable doing so.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making a decision. This section will give you more detailed information on your participation.

Part 2

Will I receive compensation for participating in this study?

You will receive £10 cash for your time. In addition, we will pay back your travel expenses if you need to travel to the location of the interview. Where possible, we will need receipts for your travel expenses. When we make contact with you to arrange the date and time of the interview, we will ask you about your travel arrangements so that we can bring the correct amount of change with us to the interview. At the end of the interview, you will need to put down your initials on a receipt to show you have received the money.

What will happen if I change my mind and no longer want to take part in this study?

You can decide you want to stop taking part in the study at any point without giving a reason. This will not have any consequences for you or the care you receive. If you decide you no longer want to take part in the study, we will discard any information you have given us.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Dr Tom Ling, Principal Investigator for this study. Tom can be contacted on 01223.353.329 or tling@rand.org.

Will the information I disclose during my taking part in this study be kept confidential?

As indicated in Part 1 of this Participant Information Sheet, your participation will be kept confidential. We will follow ethical and legal practice and all information about you will be handled in confidence. This means that your answers will be treated in the strictest of confidence, they will not be passed on to doctors, nurses, care co-ordinators or any other third party.

Your information will be stored securely on RAND Europe’s servers and computers. This information will only be accessible to RAND Europe researchers. It is kept securely and all RAND Europe computers are encrypted to prevent third parties from accessing any information stored by RAND Europe. Your information will only be used for the direct purpose of this study. Once the study is complete, we will securely destroy any identifiable data within 12 months. At no point will identifiable data about you be passed on to anyone outside the RAND Europe research team. The only exception to this would be in the unusual situation that a researcher was concerned about your welfare or well-being during the interview. In such a situation, we would explain our concerns to you and inform you of who we will discuss this with.
What will happen to the results of the study?

We plan to communicate the findings from this study widely. Typically, this includes a report on the findings of the study that is made publicly available on the internet or in print as well as articles in specialist journals and presentations at conferences or other meetings.

If you decide to take part in this study, we will send you a copy of the report once it is published.

I want to take part in this study, what happens now?

If after reading this Participant Information Sheet, you decide you want to take part in this study or you would like to ask some questions about the study or your participation, please contact Claire Celia at RAND Europe on 01223.353.329 or ccelia@rand.org or Jenny Newbould on 01223.353.329 or newbould@rand.org.

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by the South Cambridgeshire Research Ethics Committee.
## Appendix B: Focus Group Guide

<table>
<thead>
<tr>
<th>Activity</th>
<th>Facilitators’ notes (prompts, comments, etc)</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome and outline of the workshop</td>
<td>Participants introduce themselves (names, job title, team/service they work in). Ask participants about their teams and in particular, ask them about peer workers within their team (number of peer workers, since when they have been in the team, etc)</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Finding out about the programme</td>
<td><strong>In plenary with writing of key points on a board</strong></td>
<td><strong>30 minutes</strong></td>
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<tr>
<td>a) How were you introduced to the peer employment project?</td>
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<tr>
<td>b) What are the roles of peer workers? How do these roles differ (or not) from those of other staff at the same level?</td>
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<tr>
<td>c) Identify intended objectives of the peer employment project</td>
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<td>d) What changes have taken place since peer workers were employed in teams?</td>
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<tr>
<td>Break</td>
<td></td>
<td><strong>15 minutes</strong></td>
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<tr>
<td>Mapping the impacts of the peer employment project</td>
<td>In pairs/groups: mapping impacts of peer workers on different stakeholders</td>
<td><strong>45 minutes</strong></td>
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<td></td>
<td>Pairs (or bigger groups depending on attendance) are asked to think about the impact of peer workers on different stakeholders: - Peer workers - The teams they work in - The organisation as a whole</td>
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<td>People who receive services</td>
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<tr>
<td><strong>Closing question</strong></td>
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<tr>
<td>What do you think could be</td>
<td>In plenary</td>
<td>15 minutes</td>
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<td>done differently to improve</td>
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<td>the peer employment project?</td>
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<tr>
<td><strong>Workshop closes</strong></td>
<td>5 minutes</td>
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