

Mental Health Peer Health Coaching Initiative – Evaluation

Final Report

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Executive Summary

Background

The Mental Health Peer Health Coaching Initiative ran from January to April 2017 within Camden and Islington NHS Foundation Trust. It was a co-produced project, developed and delivered by healthcare professionals and people with mental health problems. The purpose of the project was for primary care patients to receive up to three sessions of support from a peer coach, who also had experience of mental health problems. The aim was to help patients to identify how to improve their physical and mental health. Peer coaches also worked with patients to complete a personalised care plan 'Snapshot', which was then shared with patients' GPs. Peer coaches attended training delivered by the Academy for Recovery Coaching to prepare for the role. The McPin Foundation were commissioned to conduct an independent evaluation of the project, focusing on the experience of peer coaching from the perspective of patients, peer coaches and GPs.

Methodology

The evaluation used qualitative and quantitative methods. Data sources included anonymous versions of patients' Snapshots, a patient survey, a focus group with peer coaches and interviews with patients, and a peer coach. Snapshots were analysed based on whether individual questions were completed or not, and the level of detail present in completed questions. Surveys were analysed using descriptive statistics for each individual question and the three survey subscales: health; recovery; and experience of peer coaching. For the focus group and interviews, themes were extracted from the data for each participant group (e.g. patient, peer coach, GP) in turn, before all data was grouped according to key themes to identify areas of commonality and divergence.

Key findings

Patients, peer coaches and GPs all recognised a need for peer coaching. Patients described how they were struggling with their mental health before participating, peer coaches felt that the standard support available does not meet the needs of people with mental health problems, and GPs did not always feel they had the skill or capacity to work with people who have complex mental health needs.

The peer coaching project delivered benefits to all stakeholder groups. Patients could share their experiences with their peer coach and felt listened to and understood. Some also reported wider impacts on confidence, connectedness, hope and clarity on how to achieve personal goals. For peer coaches, the role gave them a sense of achievement and improved confidence, inspiring some to pursue similar roles locally. For GPs, the main benefit was the information they received about their patients via the Snapshot. GPs also envisaged that peer coaching might help them manage their workload, ensuring patients receive the support they need.

All groups spoke about the importance of peer coaches having personal experience of mental health problems. This may help patients develop a relationship with their peer coach, based on shared understanding and empathy. Other aspects of the peer coaching model could be clarified, however. For instance, there were differing views on the extent to which peer coaches should provide practical support (e.g. with housing and benefits), support people to access local activities, or engage in health promotion and facilitating self-management. A particular difference in opinion regarded the optimal length of support: GPs felt support should be short-term, whereas peer coaches and patients favoured a greater number of sessions.

Considerations for future development

We have the following suggestions about how to improve the peer coaching project, if it was to be extended:

1. Project model: consider co-developing a Theory of Change to refine project aims, peer coach activities, and the resources needed to deliver those activities. This would clarify the target patient population and length of support offered.
2. Snapshot: refining questions on the template, and considering how the Snapshot is used with other care plans used locally.
3. Training: greater time and consideration given to issues of diversity.
4. Supervision: introduction of one-to-one supervisions to promote the continuing wellbeing of peer coaches.
5. Endings: consider further training on managing endings, and whether further sessions can be offered, where required.
6. Evaluation: developing evaluation methods which are integrated into project delivery and measure longer-term impact.
7. Integration within primary care: continue co-developing systems to promote GP engagement (e.g. processes for identifying appropriate referrals; communication between GPs and peer coaches; promotion of project outcomes) and which allow peer coaches to feel they are valued within the healthcare service.

Background

About the project

The Mental Health Peer Health Coaching Initiative (hereafter, the 'Peer Coaching project') ran from January to April 2017 within Camden and Islington NHS Foundation Trust, a mental health and substance misuse service provider in London. The project was funded by the trust via funding from Health Education England. The project was co-developed and co-led by a member of trust staff (a primary care nurse consultant), and three people with experience of mental health problems, with input from a wider group of GPs and people with mental health problems.

Peer coaches, all with personal experience of mental health problems, were recruited to the role following successful completion of an online application and group interview. They obtained trust honorary contracts, occupational health clearance and Disclosure and Barring Service (DBS) checks before starting. They were required to attend training delivered by the Academy for Recovery Coaching, based on techniques from Acceptance and Commitment Therapy and coaching approaches. Eight days training were offered and peer coaches were required to attend at least four days. Peer coaches received ongoing support through two group supervisions with project leads and could contact project leads for informal supervision, as and when needed. Peer coaches were paid for their involvement in the project.

The project was available to primary care patients with an identified mental health need who were not receiving support from secondary mental health services. Six GP practices made referrals to peer coaching. In total, GPs made over 300 referrals to the project. One of the project leads (the nurse consultant) checked the patient record systems to assess referrals for risk and appropriateness. Patients were then contacted directly and asked if they wanted to receive peer coaching. Those who agreed were matched to peer coaches.

Between March 2017 and April 2017, 11 peer coaches provided up to three sessions of support to 24 patients. The aim of the peer coaching was to help patients improve their physical and mental health through increasing awareness of steps patients can take to improve wellbeing, and supporting patients to access health services and community-based support. Peer coaches worked with patients to produce a personalised care plan on a co-designed template called the Snapshot, which was then shared with patients' GPs.

About our evaluation

Camden and Islington NHS Foundation Trust commissioned the McPin Foundation to conduct an independent evaluation of the project. The purpose of the evaluation was to explore the feasibility and impact of the Peer Coaching project, considering the experience of patients, peer coaches and GPs. This report describes the findings of our evaluation.

Methodology

Approach

Our evaluation used qualitative and quantitative methods. We also used a collaborative approach to reflect the collaborative nature of the project itself. We achieved this through:

- Consulting with project leads on the outcomes they wanted to capture in the evaluation (examples are shown in Figure 1) and using this to inform data collection tools.
- Improving the patient survey in response to project lead suggestions, for example, rephrasing statements to make them clearer for respondents, and offering the option to complete the survey online.
- Involving people with experience of mental health problems in collecting survey data. Data collectors gained skills and experience, and may also have helped put respondents at ease, making people more comfortable to give open and honest feedback.
- Meeting with project leads to discuss the evaluation findings. This gave project leads the opportunity to give their reflections and comment on our provisional findings, highlighting areas of importance.



Figure 1: Photos from consultation exercise

Data collection

Data was collected through the following methods: audit of patients' Snapshot care plans, a patient survey, a focus group with peer coaches and semi-structured interviews with GPs, patients and a peer coach. A timeline of the methods is shown in Figure 2.

Snapshots

Snapshots were completed between a patient and their peer coach, and provided to the evaluation team in an anonymous form. The Snapshot included 34 questions (including sub-questions). Thirty-three of the questions were open-ended, one question asked patients to

rate their current coping on a five-point scale (question 3). The Snapshot included questions on the following topics: values and strengths; tips on getting on well with the person; current coping; health concerns and their effect on mental health; sleep; eating, diet and weight; social relationships; activity; relaxation and stress; alcohol and drugs; culture and community; mental health diagnosis and view on it; crisis information, medication; practical concerns; goals and hopes; and an open space for additional information.

Patient survey

The survey, shown in Appendix 1, consisted of 17 items on a five-point Likert scale (strongly agree – strongly disagree). These items were divided into three subscales: health (6 items), recovery (6 items), and experience of peer coaching (5 items). In addition, the survey included demographic questions and a question inviting additional comments.

Peer coaches gave surveys to patients at the end of their final coaching session. They were asked if they would like to complete the survey, and if so, whether to complete it by hand, online, or over the telephone with one of the project leads (who was independent of their peer coach). Where patients chose to complete the survey by hand, they were given the survey in a sealed envelope. We also included a pre-paid envelope addressed to the evaluation team. This allowed patients to send the survey to the evaluation team directly, without their peer coach viewing their responses, potentially reducing desirability bias. Patients were also assured that their responses would be kept confidential. Patients were offered a £10 shopping voucher for completing a survey. Where a survey was not received, the patient was followed-up by telephone to see if they wanted to take part.

Interviews and focus groups

Interviews took place via telephone at a mutually agreed time and were audio recorded. Participants were provided with an information sheet detailing factors such as confidentiality, use of information and data storage, and provided verbal consent to take part. The patients (and one peer coach) who took part in an interview were offered a £20 shopping voucher.

The focus group with peer coaches was audio recorded and lasted three hours, including a break. It involved exercises and activities designed to elicit discussion about the peer coaching experience. Peer coaches were given an information sheet and signed a consent form before taking part. They were also offered a £20 shopping voucher for their participation.

Questions on the interview schedules for both the interviews and focus groups were based on the areas of interest identified at the consultation stage, such as experience of peer coaching, the Snapshot and the impact of the project. Interview schedules were designed to be used flexibly, in response to subjects raised by participants.

Figure 2: Overview of evaluation methodology



Data analysis

Snapshots

Analyses were done by two members of the evaluation team. They independently rated each question on the Snapshot according to whether a question had been answered or not (i.e. present/absent). When a question had been answered, the evaluators rated the level of detail given in the answer. The care plan included 28 items where level of detail could be rated, and ratings were made on a scale of 1 to 3. The scores given were as follows: 1=minimal detail (a descriptive response with no specific detail), 2=sufficient detail (descriptive response with specifics of a situation/circumstances identified that provided insight into the individual) and 3=extensive detail (as above, with additional reflective detail, e.g. on why they feel or do something in a particular way, or the action they would like to take). The two evaluators met to discuss ratings. A consensus was reached where there were disagreements over ratings.

Patient survey

We calculated the mean average for each item and for each of the three subscales (health; recovery; experience of peer coaching). Where there were missing data values (which happened in two cases), we calculated a median average score across the individual patient's responses on the relevant subscale and inputted the median data point.

Interviews and focus groups

Data analysis involved the following stages:

1. Data summaries were made of each interview/focus group.
2. For each participant group (e.g. patient, peer coach and GP), the information contained within summaries was grouped according to themes. These themes related to areas identified as important in the consultation, and emerging themes.
3. Themes were cross-checked against data to ensure that views of each participant group (e.g. patient, peer coach and GP), were captured. Quotes illustrating the theme from each group's perspective were extracted.

Participants

Seven out of 24 patients who received peer coaching completed a survey, which represents a response rate of 29%. Three patients took part in a telephone interview. To recruit people for interviews, the nurse consultant contacted people on the patient list. Of the six who expressed an interest, we were unable to contact two and one no longer wished to take part. Peer coaches were invited to register for the focus group during the training. Out of the 11 peer coaches, four took part in a focus group and one took part in a telephone interview. We interviewed four GPs, all had referred patients to the project.

Demographic characteristics for the patients and peer coaches who took part in the evaluation are shown in Table 1.

Table 1: Demographics for patient and peer coach evaluation participants

	Patient survey (N=7)	Patient interviews (N=3)	Peer coach workshop/ interview (N=5)
Average age (years)	51	44	48
Gender			
- Female	4	2	3
- Male	3	1	2
Ethnicity			
- White British*	2	2	2
- Other White Background	3	1	2
- Black/Black British Caribbean	1	-	1
- Other	1	-	-

*N.B. Includes White English/Welsh/Scottish/Northern Irish

Findings

Snapshots

Twenty patients completed a care plan Snapshot with their peer coach. Twelve patients provided consent for an anonymous version of their care plan to be shared with the evaluation team. Analysis of the care plans showed which questions were most often completed and which were less often completed during the peer coaching sessions. Analyses also indicate the level of detail to which questions were answered. The results of our analyses for each item on the care plan are presented in Table 2.

Table 2: Completeness and level of detail in care plans

Item on care plan	Completeness (present/absent)	Median level of detail score (1-3)*
1. Values and strengths	12 / 0	2
2. Ways of getting on well with patient	12 / 0	1
3. Current coping/ managing	12 / 0	
4. Major health concerns	12 / 0	2
5. Ways that health concerns affect mental health	12 / 0	2
6a. Current sleeping	12 / 0	2
6b. General sleeping	10 / 2	1.5
7a. Current eating, diet, weight	12 / 0	2
7b. General eating, diet, weight	8 / 4	2
8a. Current relationships with others	12 / 0	2
8b. General relationships with others	8 / 4	1.5
9a. Current activity	12 / 0	2

9b. General activity	10 / 2	1
10a. Current relaxation/stress recorded	12 / 0	2
10b. General relaxation/stress	8 / 4	2
11a. Current alcohol/drug use	11 / 1	2
11b. General alcohol/drug use	8 / 4	2
12a. Current culture and community engagement	12 / 0	2
12b. General culture and community engagement	7 / 5	2
13. Mental health diagnosis and view on it	12 / 0	1
14. Signs that person is struggling	11 / 1	2
15. Support needed from others during crisis	11 / 1	2
16. Who to contact in case of a crisis	12 / 0	
17. Dependent people or pets	11 / 1	
18. Date that WRAP was completed	6 / 6	
19. Practical needs and help needed with these	10 / 2	2
20. Key medications	11 / 1	2
21. Date of last medication review	10 / 2	
22. Side effects of medications and perceived likelihood of side effects	9 / 3	1.5
23. Any concerns with medication recorded	11 / 1	2
24. Key goals/hopes recorded	12 / 0	2
25. Support needed from health workers to help achieve goals/hopes	11 / 1	2
26. Other workers helping person	9 / 3	
27. Any other important things	6 / 6	2

*Note: this average score includes complete (i.e. present) responses only

Overall, there were high numbers of care plans completed. Twenty out of the 24 patients who participated in the Peer Coaching project had a completed care plan. Most of the questions within the care plans were also completed, thirteen of the items were completed in every single care plan, with 27 of the 34 questions completed in at least nine care plans.

Sub-questions relating to a 'general' timeframe were completed less often than items relating to the patients' current state. For example, questions relating to diet (7b), relationships (8b), relaxation/stress (10b) and use of alcohol and drugs (11b) were completed in eight out of the 12 care plans. The sub-question relating to general 'culture of community engagement' (12b) was only completed on seven care plans. Two other items showed poor completion rates: 'date that the Wellness Recovery Action Plan (WRAP) was completed' (18), and a general open question for 'any other important things' (27). Though this was only used in half of care plans, it included personalised information, such as activities that the person enjoyed or would like to do, such as yoga and mindfulness.

The level of detail in care plans varied. The majority (22 out of 28) achieved a score of 2 out of 3, indicating that they included sufficient detail. The remaining six questions scored less than 2, indicating minimal detail. Three of these latter questions were non-time specific questions asking about sleeping (6b), relationships (8b) and activity (9b) 'generally'. Other

questions which were answered with minimal detail were: ‘ways of getting on well with me’ (2), ‘mental health diagnosis and view on it’ (13) and ‘side effects of medication and perceived likelihood of side effects’ (22). The question on ‘ways of getting on well with me’ scored lower because responses tended to lack specificity, for instance ‘listen to me’, ‘understand me’. For ‘mental health diagnosis and view on it’ and ‘side effects of medication and perceived likelihood’, the first part of the question tended to be answered, but not the second.

Patient survey

Survey respondents attended an average of 2.4 sessions with a peer coach (range 1-3 sessions). The results for the subscales are presented in Table 3:

Table 3: Survey subscale scores

Subscale	Mean score	Range	Possible range
Health	17.0	11 to 24	0 to 24
Recovery	15.3	8 to 24	0 to 24
Experience of peer coaching	17.0	14 to 20	0 to 20

Patients were positive about their experience of peer coaching. Patients felt understood by their peer coach (mean score=3.6 out of 4), that peer coaches listened to them (mean score=3.6) and that they could share experiences with their peer coach (mean=3.7). Lower scores were seen in the response to questions in the ‘recovery’ subscale: feeling more confident (mean=2.0), understanding what to do in order to get better (mean=2.4) and feeling more able to connect with others (mean=2.4).

Six out of the seven completed surveys included text in the ‘additional comments’ box. Overall, respondents were positive about the project and the support received from their peer coach, and some stated that it would be good if this type of support continued to be available. Respondents valued the approach and qualities of their peer coach, for instance friendliness, helpfulness, and being non-judgemental. People also commented on what they had gained from peer coaching, including feeling more confident, more connected and hopeful.

Interviews and focus groups

This section details our findings from interviews with patients and GPs, and focus groups (plus one interview) with peer coaches. Data are presented according to the following themes: (1) the concept behind the project, (2) training and supervision for peer coaches, (3) patient referrals (4) the peer coaching model (5) the Snapshot care plan, (6) experience and impact of the project, (7) endings and duration of support and (8) the future of the project.

1. Concept

All stakeholders identified a need for peer coaching. Patients mentioned struggling with mental ill health and needing additional support before they took part in the project. Peer coaches felt that there was a lack of support to meet people’s needs, and that peer coaching offered an alternative to traditional services. GPs did not always feel that they had the skill or capacity to work with this client group, and peer coaching offered an opportunity for their patients to receive necessary extra input.

"I really needed someone, you know, because to stay alone with all these problems that I've got is not doing me any good." Patient #1

"I have been sort of struggling quite a lot, not getting out much, and yeah, it was just a really good opportunity to try something different." Patient #2

"I don't think there's enough for people with mental health problems. I think it's very hard to access the appropriate services and I think it takes too long as well." Peer coach #1

"I think that a huge amount of our workload is mental health, and I mean, we certainly had a meeting recently, whereby there was a strong message from quite a few GPs in the room, saying that they felt a little bit under skilled to manage some of their mental health patients." GP #1

"I think that, particularly as GPs, we see people so intermittently, really in the big scheme of their life, and I think the relationship gets more vulnerable because of the turnover of doctors and the pressure on time, and I just think that having another person... I think that that is brilliant and I think it gives people another layer of, they're not alone in the world." GP #4

Peer coaches described two main motivations for becoming a peer coach: to help others who were going through a similar situation, and for their own personal development (e.g. gaining new skills and experience working in mental health).

"The reason I want to work as a peer coach...was I don't want people to suffer in the same way I suffer." Peer coach #4

"It's for my own learning perspective as well. I wanted to learn, I thought the training was excellent to enable me to help people as well. So, it was like a two-way thing really, by helping other people and learning myself." Peer coach #1

2. Training and supervision for peer coaches

Peer coaches were positive about the training they received. They enjoyed the fact that the training was interactive and drew on peer coaches' personal experiences. They also appreciated that the atmosphere was kept light and humorous, despite the difficult subject matter.

Peer coaches felt that the training enabled them to develop skills such as open questioning, active listening and motivational interviewing, sharing personal experiences appropriately, reinforcing an individual's strengths and pacing sessions. They described being able to put these skills into practice both in and outside work. Suggestions to improve the training included focusing on diversity, and providing more opportunities for practice through role play. There was also a suggestion that one-to-one supervision slots would be helpful, particularly focusing on self-care.

“What was good about the training was learning from your peers in the room, so that was really good, the different exercises that you did, it gave you a lot of opportunity to practice, make a few mistakes and then learn from that, and also getting feedback.” Peer coach #2

“I felt like they put quite a lot of humour in it, which is nice because one of the best things in life is laughing... isn't it? So, if you're talking about this heavy stuff, like mental illness or self-harm or whatever it is, I think it's really important to put some humour in it.” Peer coach #4

“I checked myself to make sure I was asking open questions, so because we'd done so much of that, it mean the training was surprisingly enough back of your mind, so when you were doing certain things, you were very aware about the pace, to make sure you were going at the pace of the client, you know, introducing things, sort of making suggestions, very much checking, is that okay? And again with sharing, sharing your lived experience appropriately, sharing it at the right times and checking, is this okay for me to share this with you?” Peer coach #2

“They could have put in a bit more about equality...you know we're coming from different places, adjusting things to suit the needs.” Peer coach #5

“Yeah it was useful in a group sense but individually, I would have liked the opportunity to...be offered little slots, where we could talk about how it was for us, that self-support, that self-care bit.” Peer coach #5

3. Patient referrals

GPs described the process through which they identified patients for the project. GPs tended to focus on patients on their Severe Mental Illness (SMI) registers, particularly people who had not attended annual health checks, or those with other long-term physical health conditions. There were, however, differing opinions among GPs about which patients were most suitable for peer coaching. Differences included the extent to which it was better to focus on people who are 'harder to reach' or those who are more likely to engage, and whether peer coaching should be for people with severe and enduring mental health conditions, or include people with other mental and physical health problems. There was agreement among GPs about the importance of determining the types of patients who should be approached for the project, to maximise potential benefits.

“It would be really helpful for us to know where this is benefitting other people across the system so we can think about the right patients, but the thoughts that I'm thinking...are those that want to engage, with a degree of insight, who perhaps need a bit more support than they're getting from traditional primary and mental health services.” GP #1

“Particularly with people with a combination of severe and enduring mental health problems and long-term conditions, because I felt that those were the ones that we particularly needed to focus on, because often they are the people at greatest risk.” GP #3

“So in terms of the patients that would be appropriate, particularly people who are isolated, I thought particularly people who were house-restricted...it could be mental health issues, but it wouldn't have to be, it was more people who were harder to reach perhaps.” GP #4

4. Peer coaching model

The fact that peer coaches had personal experience of mental health problems was seen as one of the most important elements of the project. Patients, peer coaches and GPs all discussed how patients may relate more readily to a peer coach than another healthcare professional, and that this can help to build rapport and a relationship based on shared understanding and empathy.

"[Peer coach] instantly put me at ease, and could really sort of relate to a lot of things I was saying, a lot of experiences, she was very professional, but also you know that you're not just talking to a psychiatrist or a GP or something, it's someone who's actually been through it, and it's very refreshing to have that." Patient #2

"I think that it's somebody that's been, who's had similar experiences, broadly, I don't mean the same experience but they've broadly had things that they've had to cope we've and they've come through the other end and I actually think that that can be sometimes more helpful than someone whose, you know, a professional, and may be really good at their job, but maybe hasn't experience anything personally, so yeah, I would definitely recommend it." Patient #3

"What's good about chatting to a peer, you can have those open conversations... it's real, it's authentic, peer coaching, and I think part of that role is about being real and being with somebody." Peer coach #2

"Sharing lived experience to show empathy and understanding, but in snippets, not a monologue, so you're empowering and inspiring them and showing authenticity but not taking the spotlight off them." Peer coach #3

"Peer coaching is quite powerful, really, because there's a lot of empathy there that can go between both parties, a lot of understanding and potentially it's a less threatening environment for the patient." GP #1

"Instantly there's a shared experience in a way and I think that has benefits because it can be an instant rapport builder, especially if that person's had negative experiences of services, or feels judged or feel resistant to engage." GP #4

There was, however, variation in the emphasis placed on different aspects of the project across groups. GPs emphasised health promotion, the role of peer coaches in helping patients self-manage, and completion of the Snapshot. The potential for a wider role of peer coaches, including action planning and navigating people to access services was sometimes recognised.

“The idea of patients taking a bit more control of their own illness, really...but actually patient empowerment in mental health, is just as relevant, so in terms of a bit more understanding of their condition, and what they can do for themselves.” GP #1

“This was a particularly hard to reach group and therefore by having some more targeted outreach for, we’re more likely to actually engage with these individuals and possibly help them to take a more active role in their own self-care.” GP #3

“I think that information gathering is brilliant...depending what training they’ve had, they could certainly help with goal-setting and then they could, if they were good with coaching skills, they could do action plans, based on patient goals.” GP #4

“If it’s for the purposes of having a conversation, drawing up a care plan and perhaps enabling, I don’t know to what the extent the remit is to also help somebody to access one or other of the services that’s been identified as suitable, so a bit like a navigator might do.” GP #2

Peer coaches and patients focused more on giving patients the space to be heard, after which the peer coach might work with the patient to take steps towards their goals. There were, however, differences of opinion among peer coaches about their remit. For instance, peer coaches differed in the extent to which they shared or offered suggestions from their personal experience, used specific coaching techniques and helped with practical tasks.

“The second day was more solution-based...I told him what I have done in my case in order to get better and then I started him towards motivational interviewing... so he come up with his own solutions.” Peer coach #4

“As a peer coach... obviously I’ve been through stuff myself, but I wouldn’t want to put that upon the people I’m trying to coach back into wellbeing themselves.” Peer coach #1

“And then, sharing resources and referring the person to a community navigator or a support group so that your role is very much a coaching role and trying to signpost them to the right sort of people to help with practical stuff so that we can focus on coaching.” Peer coach #3

“But also, once again, was faced with benefits sanctions...And so I was just trying to make some headway on some of those areas, and then it ended. I just felt, well I felt terrible and still think of that kind of client because I felt I could have done more.” Peer coach #2

5. The Snapshot

Peer coaches and patients explained the process through which the Snapshot was completed. Typically, peer coaches completed Snapshot sections as they arose in discussion. Patients then checked the Snapshot and modified for accuracy. Patients did not spontaneously mention the Snapshot in interviews with the evaluation team, and some struggled to remember completing it. This suggests that it was not central to their experience, although some said that they found it helpful. For peer coaches, the Snapshot provided a useful tool for summarising conversations with patients, and demonstrating that they had listened to the patient.

“It covered all the basic points, ...it categorised all the key things...so yeah, I think it was quite informative, it snapshotted all the major things that I needed to get down, you know, struggles, things that have been happening, things I want to be doing going forwards. [...] It’s good to have a copy myself and I think it’s also good for anyone, like my GP or healthcare professionals to have a look into.” Patient #2

“I mean I do remember it felt useful and helpful at the time...For others to see at what point I was.” Patient #3

“...then ran through the Snapshot I’d done in-between, which gave an opportunity to summarise everything we’d covered in the first session, and then also for them to correct any information, or add to it and help me fill in the gaps. And then that helped the patient build more trust because they felt like I’d be listening. So, I’d retained that kind of information.” Peer coach #3

GPs particularly valued the Snapshot. They felt it was a good length and provided insights across a range of areas that may not otherwise be covered in routine appointments. GPs also gave examples of how they might use this information in practice, for instance, to remind patients of things they like doing when they are not feeling well. Two ways to optimise the Snapshot were highlighted by GPs; ensuring completed Snapshots are stored somewhere readily accessible on patient records, and minimising duplication with other care plans used in the NHS.

“I like it. Simple, patient friendly, not too big, easy to read.” GP #1

“There were just little perspectives, like looking at medication through the eyes of the patient, looking at their diagnosis through their own eyes, seeing what they did say under goals, was very helpful, and there was sort of the tailored practical things, these are the daily things that I face, you know whether it’s sleeping or eating or getting out and about. And I also liked the ‘what’s the sign that I’m struggling’, I thought that was a really interesting question. It’s sort of like clues that I don’t think we’d necessarily know, as to how it is for the patient, although you build these things over time, I think there were some new questions that were clever, which elicited interesting pieces of information.” GP #4

“It will be filed in a record, as a PDF, so therefore it’s not very active, so it means that it’s potentially lost, because it’s not kind of part of the actual record... So one of the things we’re trying to do in Islington at the moment is to create a digital care plan...if it’s digital it’s part of the wider information of that individual.” GP #3

“What you don’t want, in an ideal world, is for somebody to come for their mental health plan, and then they have another appointment for their COPD plan, and then they have another appointment for their cardiovascular plan and they’re not all joined up...Ideally you want one plan which is applicable across any long-term condition.” GP #2

6. Experience and impact

Patients were positive about their experience of peer coaching, which was corroborated with the responses to the patient survey. Among the patients we interviewed, the primary impact varied from feeling listened to, having a practical issue resolved, to broader changes such as

increased confidence, increased hope, greater clarity on values and goals, and leaving the house more frequently, including to meet friends.

“When you are with someone to talk to, you feel a little bit better, I know the problem I’ve got they don’t go away, but at least if we spend the one hour with the one person, you can see things different.” Patient #1

“...realising that someone like my peer coach has been exactly the same sort of things, pretty much, but now she’s doing fantastically, and it kind of gives me hope realising that someone else who has been through similar experiences, has been in really dark places with their mental health, can actually push forward and learn to live with their mental illness, but in a positive way and get on with life.” Patient #2

“Well I was able to get the [financial support scheme] stuff done, because that actually makes a huge difference to one of the bills that I have to pay every year.” Patient #3

“I think just generally gave me a little bit more confidence, and I’ve started getting out the house, going for a few walks, just simple things like that but it just highlighted to me what I wanted to be doing and the little steps how I can get there.” Patient#2

Peer coaches described how the role had helped them, for example, being able to perform in the role successfully had increased their confidence and gave them a sense of achievement. For some, it had inspired them to pursue working in similar peer roles locally.

“I felt more relaxed and learnt I suppose I could do it and, I kind of felt hopefully I was good at it.” Peer coach #2

“My development, gave me confidence that I can gain people’s trust to talk about themselves, I thought that was quite powerful for me that. Because from the start, it wasn’t very relaxed and I felt quite nervous, I’m not getting anywhere, they don’t trust me, they think, I’m, you know, I’m not going to help them. So that eventually that’s what made me feel good.” Peer coach #1

“[Peer coaching] was the most interesting thing I’ve ever done, the training itself was just inspiring, and then actually going out, and seeing that I could do it, was confirming what I need to do in the future.” Peer coach #3

7. Endings and duration of support

Peer coaches and patients felt that a maximum of three sessions per person limited the amount that they were able to achieve together. Both groups thought there should be greater flexibility in the number of sessions on offer. With more sessions, patients and peer coaches suggested that there would be the time to link into other social and therapeutic supports and activities, tackle ongoing practical issues, or maintain motivation in making positive life changes.

"It's just a start, it's unfinished big time, it's just a beginning, it's like when you start an operation and then leave the person." Peer Coach #4

"I do find that, I have felt really enthusiastic about it, and it was really brilliant, but then sometimes you, I had sort of a mood dip and things happening,...it would be nice to sort of maybe have a little follow-up to see you're heading in the right direction or maybe to see if there's anything else they can point you in the direction of." Patient #2

"I would have liked to have had a look at places where I could have maybe gone to from a social point of view and the peer coach could have helped me phone up and find out about either going [to] some sort of social thing on a regular basis, and maybe even arrange, so that the first time, somebody could just go with me. And I don't mean them to stay with me, but just to make sure that I get to the place, and once I've been to somewhere for the first time, I'm more confident in going." Patient #3

"If they want to be referred to services, get benefits advice or a project, such as art, so even though in some cases, I was trying to get the client to make some of those calls, they were finding it difficult. If we'd had more time, the bit of the coaching could have been, could have been making some of those calls." Peer coach #2

Both patients and peer coaches felt that, in some cases, a short course of sessions could be detrimental to the wellbeing of patients. Three sessions potentially allowed patients to open up about their mental health, but may not be enough to create tangible changes. Peer coaches also explained how it sometimes affected them, where they had concerns about what happened to their patient when their support ended.

"Sometimes, it's not good that way because sometimes you try to grab to someone and then you know because all the problems, and then they suddenly disappear... It's not good to even start do it." Patient 1

"I think you are opening a can of worms bit, so that's a negative side of it, in that if you don't continue working with these people, what sort of effect does it have, you're sort of raising their hopes and then you're going again." Peer coach #1

"I think three sessions is not enough, you've just built up that rapport, built up that relationship and then it was like over, so that was a shame, because I think you could have done so much more for some people." Peer coach #2

"And it's difficult for us as well, because we're all quite emotional empathetic people and we've suddenly got to end this thing and we're left with a big question mark over whether that person's okay or not. So it's sort of on both sides." Peer coach #3

This contrasted with the opinion of GPs, who generally felt a smaller number of sessions was appropriate, although with some flexibility depending on the types of support needed by particular patients.

"In some ways it doesn't feel like very much, but then, of course, it's an infinitive percentage more than we've had historically. And equally, you know, patients aren't able in the current climate to expect ongoing peer support or care coordinator like they may have done in the past for care coordination, so putting something in for longer than three weeks, might start to raise expectations of ongoing support, so I guess it feels about right to me, but I don't know, I don't have a strong opinion on that." GP #1

"I guess it's one of those things which needs to be tried and tested, I think different patients will need different levels of interaction. I think for some people, a one-off may well be enough, and it may be that out of that, they identify there's something specific that would be useful and they can be signposted etc. For other people, a number of sessions is fantastic, and there may be a role for people who would love more than that". GP #4

"I would think one isn't enough, up to three, I think that sounds about right. Well it depends what their remit is." GP #2

8. The future

Peer coaches and GPs discussed how they felt peer coaching could be developed and improved, if it was trialled or implemented on a larger scale in future. At the core of this was how to integrate peer coaching with the existing healthcare system, particularly in primary care. GPs suggested that it would be helpful if there were systems for identifying and contacting eligible patients, and if peer coaches could flag concerns or feedback to the practice team. GPs also felt it was crucial that the project was well-promoted, e.g. through case studies and presentations, to ensure uptake.

"So that there's actually systems in place, so that we're actually proactively identifying and there's an administrator who's been trained and knows how to do this. It's not something I need to do, it's not a good use of my time to sort of, go through patient records to see if they're the right people." GP #3

"I'd want to know that there was communication so that if there was any risk around suicide, that they were not responsible or feeling that they were having to hold something that felt too much for them." GP #4

"We could do as part of our standard invitation, please book an appointment to come and see your usual GP or if you prefer, we could ask for a peer health coach to make contact with you." GP #2

"As with anything new, it needs to show some early gains and early wins, in order to get traction, because there's so many new services for all of us to keep on top of that unless something comes crashing through the wall that looks brilliant, it's very hard to remember things. That's not an improvement as such, but a way of getting its profile raised, perhaps publishing some good news stories, or some case studies about it would be probably helpful." GP #1

Peer coaches felt that peer coaching should be made available across the healthcare service. They felt that peer coaches should be part of GP teams and that coaches' expertise should be valued, as that of other professionals. Peer coaches were keen for there to be a career path, whether as employees of the trust or working on a freelance basis.

“The peer model is an effective one, it’s a powerful one, so it should be in hospitals, psychiatric hospitals, it should be in GPs, it should be offered to you, but your choice, you’ve got a choice do I want to take the option of peer support, do you want pills?” Peer coach #2

“I think that should go onto a database within GP surgeries, someone goes and sees their doctor, they could go into the database, say, right, I’ve got a peer coach, they’re based in such and such place in this borough, I’ll see if they’re available, do you want to see this person – yes- then you introduce them.” Peer coach #1

“I think it should be seen as serious, you know, and an important role, and respected as such, professionally, not just seen as like, oh that’s just the community worker that goes and sees whoever, you know, be part of the GP team.” Peer coach #5

“We need a system for reporting back... some way we could enter this report into and it went to their GP and various different services, they could at least see our opinion, and it’s our opinion, it’s not our professional report, but it’s something because we’re not professionals, we can just say, I’ve observed this, I’ve observed that, I’ve think this and I think that, do what you want with it but maybe when you go and speak to them, you can see if you think the same thing.” Peer coach #3

Discussion

The peer coaching project demonstrated feasibility within a primary care setting. Within four months, the project was designed, peer coaches were recruited and trained, patients were referred to the project by GPs, and up to three sessions of support was delivered to 24 people. This was done in a coproduced way, where clinicians and people with mental health problems made joint decisions and took responsibility for tasks on the project.

The evaluation also demonstrated that peer coaching may have benefits for patients, peer coaches and GPs. For patients, the survey and interviews showed that the experience of peer coaching was positive, particularly in providing patients with someone to talk to who listened, who they could share their experiences with and they felt understood by. For some patients, there was evidence of broader outcomes, such as feeling more confident, hopeful and connected. This is impressive given the short-term nature of the support and the fact that GPs had struggled to support or engage with the patients who they referred to the programme.

The strength of a peer coaching model, as demonstrated in this evaluation, is that peer coaching also brings benefits to coaches. Peer coaches reported having developed skills, increasing their confidence and having greater clarity on their own life direction, including pursuing similar roles locally. For GPs, the main benefit was that information was now available to them through the Snapshot care plan, which were uploaded to patient records. GPs felt this provided them with useful insights about their patients and would help guide the support they provided. GPs also envisaged that if peer coaching became available more widely, it could help with managing their workload and ensuring patients receive the additional support they need.

The key component of peer coaching, which was consistently identified across stakeholder groups, was that the support was delivered by peers, who had experience of mental health

problems. This gave patients a space to talk about their problems with someone who had been through similar situations. It allowed for open, non-judgemental conversations, which might be less likely to occur with a healthcare professional.

Our evaluation, however, revealed areas of the peer coaching model that may require further consideration. One of these is clarity around what peer coaching is, and what the role of a peer coach involves. Different people we spoke to as part of our evaluation placed greater emphasis on: i) giving patients a space to talk, ii) problem solving challenges for patients, iii) using coaching techniques to help an individual to identify their goals, iv) agreeing action plans of how to reach goals, v) linking people with activities and other support services (e.g. through researching relevant opportunities, assisting with referrals and accompanying patients to providers), vi) providing practical support (e.g. with housing, benefits and debt), and vii) gathering information for healthcare professionals (e.g. via Snapshot). Among the peer coach group, there were also differences in the extent to which they felt it was helpful to discuss their own mental health experiences.

Though there are many elements, which might legitimately be part of the role of a peer coach, and will vary according to the individual patient, decisions around which elements to prioritise can help to ensure that peer coaches have a clear understanding of their role and how this fits into the broader aims of the project. In turn, this can help to ensure that patients receive a consistent experience from different peer coaches.

While GPs favoured short-term, targeted support, peer coaches and patients felt that a larger number of sessions should be available, and that the number should be flexible to meet the needs of the patient, to avoid patients being left feeling unsupported or in distress. Clearly, the number of sessions depends on factors, such as the remit of the peer coach role, and resources, but should be agreed between stakeholders. Among GPs, there were also differing ideas about who peer coaching should be targeted at, particularly around whether it should be people who are more engaged with healthcare services, or those who they considered 'harder to reach'. Decisions should be reached about the most suitable patient cohort, to ensure benefits are maximised. Evaluation work may be useful to determine which patients particularly benefit from peer coaching, and the optimal number of sessions to achieve project aims.

Strengths and limitations

In terms of strengths, we collected data from three stakeholder groups, which allowed us to consider different perspectives and priorities when evaluating the project, identifying areas of similarity and divergence. We also collected qualitative and quantitative data. In the case of data from patients, we could compare the qualitative interview data and quantitative survey data to show a consistent pattern in how peer coaching was experienced across methods.

The number of people participating in the evaluation, particularly the patient survey, was a limitation, however. In addition, the patients, peer coaches and GPs who participated in the evaluation were self-selecting, or put forward by the project leads. Those who did not participate in the evaluation may have held different views about the project to those who

did. We were also not able to measure the longer-term impact of peer coaching, and so we do not know whether the findings discussed here, endured.

Considerations for future development

We have the following suggestions about how to improve the peer coaching project, if it was to be extended:

1. Project model: consider co-developing a Theory of Change to refine project aims, peer coach activities, and the resources needed to deliver those activities. This would clarify the target patient population and length of support offered.
2. Snapshot: refining questions on the template, and considering how the Snapshot is used with other care plans used locally.
3. Training: greater time and consideration given to issues of diversity.
4. Supervision: introduction of one-to-one supervisions to promote the continuing wellbeing of peer coaches.
5. Endings: consider further training on managing endings, and whether further sessions can be offered, where required.
6. Evaluation: developing evaluation methods which are integrated into project delivery and measure longer-term impact.
7. Integration within primary care: continue co-developing systems to promote GP engagement (e.g. processes for identifying appropriate referrals; communication between GPs and peer coaches; promotion of project outcomes) and which allow peer coaches to feel they are valued within the healthcare service.

Appendix

Appendix 1 – patient survey

Peer Coaching – Tell us about your experience!

We're carrying out a survey together with a mental health research charity, the McPin Foundation, to gather people's feedback about Peer Coaching. The survey should take under 10 minutes to complete, and if we receive your responses by Monday 24th April 2017, you'll be offered a £10 shopping voucher.

Before you start, here's some things you should know:

- It's your choice whether you complete the survey, and you can decide that you no longer want to at any point – just let us know. If you don't complete the survey, it will not affect any of the services or support you receive.
- We welcome all feedback – what's worked well and what could be done better. Negative feedback helps us to work out how to improve and won't have any consequences for your Peer Coach.
- We'll keep all information you provide secure in line with our responsibilities under the Data Protection Act (1998). Any information you give us will be kept strictly confidential and not be used in a way that identifies you.
- The only circumstances in which confidentiality might be broken, is if you reveal that you or someone else was at risk of serious harm. We would talk to you first if at all possible, and then tell the appropriate people.
- You can choose to:
 - complete this survey and return it to your Peer Coach in the pre-paid envelope provided (they will send it on to the McPin and will not see your response)
 - complete the survey and post it yourself in the pre-paid envelope
 - complete the survey online at www.surveymonkey.co.uk/r/PeerCoaching2017
 - complete the survey by telephone with someone from our team with their own experience of mental health problems. If you'd like to complete the survey via telephone, please text **SURVEY** to **07771 666307**. Someone from the project team will give you a call back as soon as possible.

If you would like more information, or you have any problems with this survey, please contact Cerdic Hall by emailing Cerdic.Hall@candi.nhs.uk or phoning 07771 666307.

By completing this survey, you are confirming that you have read this information and are happy to take part in the survey.

For each of the following statements, please tick **one** box that best describes your thoughts, feelings and activities as a result of your meetings with a Peer Coach.

Since meeting a Peer Coach...	Disagree Strongly	Disagree	Neither Agree nor Disagree	Agree	Agree Strongly
Health					
I have a better understanding of my health needs					
I have thought about how I could improve my health					
I have begun to make changes to improve my health					
I have a better understanding of my prescribed medication and side effects					
I feel more confident discussing my needs with healthcare professionals (including my GP)					
I feel more able to connect with local activities/supports					
Recovery					
I feel more confident in myself					
I feel that my life has more purpose					
I have more hope for the future					
I understand what I need to do to get a bit better					
I am motivated to make changes in my life					
I feel more able to connect to other people					

For each of the following statements, please tick **one** box that best describes your experience of your meetings with a Peer Coach.

	Disagree Strongly	Disagree	Neither Agree nor Disagree	Agree	Agree Strongly
My Peer Coach listened to me					
I felt understood by my Peer Coach					
I felt able to share experiences with my Peer Coach					
My Peer Coach has helped me to manage my health better					
The care plan 'Snapshot' that I produced with my Peer Coach reflected my needs and preferences					

Please give any additional comments you have about the Peer Coaching project here

About You

How many times did you meet your Peer Coach?

What is your current age in years?

How would you describe your gender?

Do you identify as transgender?

How would you describe your sexual orientation?

How would you describe your ethnicity? *Please circle*

White English/Welsh/ Scottish/Northern Irish/British	White and Black Caribbean	Black/Black British African	Asian/Asian British – Indian	Arab
White Irish	White and Black African	Black/Black British Caribbean	Asian/Asian British-Pakistani	Prefer not to say
White Gypsy or Irish Traveller	White and Asian	Other Black/Black British background	Asian/Asian British - Bangladeshi	Not listed
Other White background	Other Mixed background		Asian/Asian British - Chinese	
			Other Asian background	

Please give more detail if you would like to:



About the McPin Foundation

The McPin Foundation is a specialist mental health research charity based in London but working across England. We exist to transform mental health research by placing lived experience at the heart of research activities and the research agenda.

Our work includes:

- Guidance and expert support on public and patient involvement in mental health research
- Collaborative research studies in partnership with organisations interested in user focused mental health research
- Campaign and policy work to raise the profile of mental health research and improve access to evidenced based information

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