

Barriers and facilitators to implementing and sustaining peer support in kidney care

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Abstract

Introduction: Peer support offers informational, appraisal and emotional support for people with kidney disease, is recommended in national policy, yet has low engagement levels. This paper reports results of a national survey and qualitative interviews in the UK with the aim of increasing understanding of peer support availability and its barriers and facilitators.

Literature Review: A recent narrative review highlighted the barriers and facilitators to peer support uptake among people with kidney disease however called on further studies to be conducted.

Material and Methods: The survey, adapted from a 2012 version, was sent to all 83 UK kidney units. Semistructured interviews were conducted with staff, recipients and supporters from two units.

Results: Forty-four units completed the survey, and 10 staff, 7 patients and 2 peer supporters were interviewed. The most common facilitators were promotion with staff and having peer support champions. Barriers included lack of staff time, guidance/information, other projects taking priority and too few supporters.

Discussion: Little progress has been made since 2012; a proportion of units without peer support remains significant, with similar barriers identified in 2020. Services could be designed to limit the time needed for their creation and maintenance through having simpler referrals and designating staff liaisons.

Implications for Clinical Practice: Peer support programmes should have passionate staff and volunteers, involve recipients in the design, recruit an array of supporters and establish evaluations to determine the progress/outcomes. A resource toolkit was developed in response to this project.

Conclusion: Findings from the national survey and qualitative interviews showed that more peer support optimisation and prioritisation is needed to ensure benefits are maximised.

KEYWORDS

barrier, chronic kidney disease, facilitator, peer support, United Kingdom

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INTRODUCTION

Peer support (PS), an activity in which those with shared characteristics, conditions or circumstances support each other (Keck et al., 2018), can be a useful resource for people with chronic kidney disease (CKD) (Wood, 2015). PS offers a plethora of benefits including informational, appraisal and emotional support (Dennis, 2003), and has for over 10 years been recommended in national policy (NHS, 2008). However, engagement levels remain low, with many PS programmes reporting lower than expected levels of uptake (Day, 2012; Hughes et al., 2009; Taylor et al., 2016). A recent narrative review called for more studies to be carried out (Trasolini et al., 2020).

For over 10 years, PS in the UK has been considered an integral component of high-quality renal care (NHS Institute for Innovation and Improvement, 2008), with the Health Foundation (2016) encouraging more investment into PS specifically for populations with long-term conditions, such as CKD. PS can be offered in a variety of formats. Some units employ it informally, through casual patient conversations, but a more formal approach, including screening and training of volunteer supporters, is recommended to maximise safety and quality (Health Foundation, 2016; McCarthy & Mastin, 2016; Taylor et al., 2016). PS can be delivered one-on-one, in groups, on-line, face-to-face, or by telephone, and can be held in various settings, such as at the hospital, at home, or in the community. Individuals usually learn about and access PS through their healthcare providers but in some instances, can self-refer or access it through charities (Dennis, 2003; Keck et al., 2018).

Literature review

There is a range of benefits associated with PS, including a positive effect on physical and mental health outcomes and the enhancement of people's knowledge, understanding and acceptance of their condition (Dennis, 2003; National Voices, 2015). Beyond the patient-level, PS may also have positive economic benefits because it impacts when and how people use services, reducing the demand on the healthcare system (Wood et al., 2016). Additionally, PS fits with the model of person-centred care, the focus on enabling patients to play an active role within their management, a growing area of emphasis in renal care (Keck et al., 2018). Despite such benefits, PS programmes on kidney units often have low patient participation rates (Day, 2012; Hughes et al., 2009; Taylor et al., 2016). Moreover, a number of kidney units do not even provide PS services, as evidenced by a national survey of kidney units in 2012 which showed that only 19% across England had a formal service (NHS Kidney Care, 2013).

The barriers and facilitators of PS in kidney care

A recent narrative review (Trasolini et al., 2020) on the barriers and facilitators to PS uptake among people with CKD, five themes

emerged: staff barriers to utilising, patient barriers to engaging, staff facilitators to utilising, patient facilitators to engaging, and positive outcomes of engaging. Among healthcare workers, low staff referrals and difficulty matching supporters to recipients were cited as two main barriers to utilisation while increased promotion of PS helped staff refer. Concerns with the relationship dynamic and the specific format and delivery of the support session held PS recipients back from engaging, while having an inclusive service which tailored to their needs encouraged participation. The benefits of PS are clear, however further studies need to be conducted to better understand the barriers and facilitators to its uptake, so that services can be sustained and spread (Keck et al., 2018).

Study aims

This study had two parts. The first aimed to compare current availability of PS in UK kidney care with 2012 availability, via a nationwide survey. Second, we aimed to understand the perceptions of recipients of PS, peer supporters and staff regarding the barriers and facilitators to implementing and sustaining PS programmes in two renal units. Our findings informed the development of a *Peer Support Toolkit*, aimed at improving accessibility, implementation and sustainability of PS in kidney care. The aim is to spread PS more widely across the UK and other countries. We hope our findings are useful to other long-term conditions that have PS programmes.

METHODOLOGY

The study used mixed methods: a structured survey and semi-structured interviews (Kvale, 1996) in a sequential design (Creswell & Plano-Clark, 2017 p. 84).

Patient and public involvement (PPI)

Three people with kidney disease worked within the project team to develop the survey and interview questions, advise on recruitment of participants, review the findings, made suggestions about the Toolkit and advised on dissemination of the findings to patient groups. PPI is recommended for all quality improvement and health research in the UK (National Institute for Health Research, 2019).

Ethical approval

Ethical approval was not required for the national survey as consent was assumed if the survey was returned and respondents did not have to give their name. The two hospitals that enabled the qualitative interviews to take place approved the study locally as service improvement, and informed consent was attained from each participant before the interview's commencement.

National survey

The survey was adapted from a 2012 survey on PS in England (NHS Kidney Care, 2013), with additional questions added by the project team. Questions were pilot tested by sending the survey to a person unfamiliar with the project to determine appropriateness and ensure face validity. It was also completed by a member of the project team familiar with the 2012 version to ensure content validity. The survey was uploaded and published using Jisc Online Surveys. Questions included sections on PS in your kidney unit; the impact; the facilitators; the barriers. Survey respondents were asked which unit they were representing but could choose to remain anonymous. The survey took approximately 5–10 min to complete and is shown in Supporting Information Appendix 1. Data were reported on Jisc online surveys and analysed by the project assistant using descriptive statistics via the platform's analysis function. The platform provided information in the form of bar charts including both the number of responses and the percentage according to the proportion of responses. If an answer was not selected and no responses were recorded, it was not included in the overall analysis.

All 83 main renal units in the UK, both adult and paediatric, were approached to participate, with the aim of receiving one completed survey from each unit. An invitation containing links to the survey was emailed to one individual in each unit and included doctors, nurses, psychologists, and unit coordinators/administrators.

Qualitative interviews

Two semistructured interview guides—one for healthcare professionals, and one for PS recipients and supporters—were designed based on the existing literature (Trasolini et al., 2020). Questions covered the same three categories: perceptions and views of PS; format of PS; barriers and facilitators to PS; but the guides were varied slightly because of the differences between how professionals and patients can interact with PS. Questions were pilot tested and agreed upon by the project team (as shown in Box 1). Interviewees were recruited from two kidney units which were known to have established PS programmes and were local. Purposive sampling was used based on project team members' professional contacts to obtain a varied sample of healthcare professionals including physicians, nurses and allied health professionals. PS recipients and supporters were recruited from the same hospitals. People who had received PS between 2 and 14 months ago and peer supporters were given information sheets about the project and then asked if they would be willing to participate in a follow-up phone call from a member of the project team.

The project assistant scheduled and undertook interviews once consent was obtained. Interviews lasted between 20 and 30 min and were conducted either in-person or over the telephone. All interviews were audio recorded with the participant's permission, and professionally transcribed. Data were collected until there was

saturation of data (Fusch & Ness, 2015) among the staff interviews. Due to the COVID-19 pandemic however, the recipient/supporter interview schedule was delayed and impacted on the intended number of 10 recipient interviews.

Staff and patient interviews were analysed separately because it was reasonable to expect different themes to emerge from their responses. However, recipients and supporters were not separated due to the small sample sizes and as both are patients. Using an inductive reasoning approach (Hyde, 2000), data were initially coded. Among these codes, thematic analysis (Nowell & Norris, 2017) was applied to produce a comprehensive list of themes. Upon collaboration and agreement with the project team members, the transcripts were then coded a second time, yielding a more refined set of themes. These themes were then grouped according to their relation to each other to produce a finalised analysis of the data. Additional project members assessed the relevance and appropriateness of the themes.

FINDINGS

National survey findings

Of the 83 units contacted, 44 were represented in the survey (53% response rate). In contrast, the 2012 national survey had 37 out of 52 units contacted (71% response rate).

PS availability

Thirty-two of the 44 units (73%) offer some form of PS: 21 (48%) informally, and 11(25%) a formalised service (PS is provided by trained regulated patient volunteers); 12 units (27%) do not provide any type of PS (Table 1). Only five units (11%) have PS as a mandatory part of their service provision. Of units who provide PS 11 (34%) have no funding for PS, while 6 (19%) are funded by the unit's budget, 5 (16%) by the patient association, and the remaining 10 (32%) from either unknown/other sources or charity organisations. In 2012, 59% of units reported offering a form of PS for people with CKD with varying formats.

Programme aims, organisation and delivery within units where it is offered

The most common aims were (1) to provide informational support to recipients (28 units, 87.5%); (2) to provide emotional support to recipients (24 units, 75%); (3) to help recipients make treatment decisions (24 units, 75%). Of the target groups for PS, the most common were patients in the predialysis/low clearance clinic (27 units, 84%), followed by patients on dialysis (23 units, 72%), carers/family members of people with CKD (19 units, 59%) and patients with transplants (18 units, 56%) (Table 2). An overwhelming

TABLE 1 Peer support availability

	Number of units (2020)	Percentage of total responses (2020) (%)	Number of units (2012)	Percentage of total responses (2012) (%)
PS available				
Yes	32	73	22	59
No	12	27	15	41
Type of PS				
Informal PS	21	48	15	40
Formal PS	11	25	7	19
Not offered	12	27	15	41
Duration				
≥5 years	16	36	16	43.5
<5 years or unsure	16	36	5	13

majority of respondents stated they do not feel their PS service is utilised and/or maintained as much as it could be (26 units, 81%).

Most respondents seemed unsure of the number of PS recipients since their programme's commencement, with only 12/32 (37.5%) keeping a written record. Of those that did, the number of people who had received PS ranged between 7 and 300 people (mean = 153.5). The number of supporters ranged from 1 to 20. The format varied, with many offering more than one option (Table 2). Healthcare staff were the most common to lead the set-up and maintenance of PS (24 units, 75%), with nurses primarily relied upon. Fifteen units (47%) provide training for peesupporters, seven of whom have an evaluation or achievement level required before the volunteers can proceed. Two units have evaluated the impact of PS through interviews, six through surveys and the rest were either unsure or did not measure the impact. Potential recipients learnt about PS from a range of sources, most commonly directly from clinicians (27 units, 84%) (Table 2). Referrals most commonly came from clinicians (26 units, 81%) however at 10 units (31%) patients can self-refer.

Programme facilitators and barriers

Among the 32 units with PS established, the most common factors reported to help clinicians sustain momentum and create engagement with the service were promoting PS with healthcare professionals (15 units, 47%), and having PS champion staff members and volunteers (14 units (44%) and 12 units (27%), respectively) (Figure 1).

Among the units with PS, common barriers to utilisation and maintenance are lack of staff time (19 units, 59%), lack of guidance/information on how to optimise PS (14 units, 44%), other projects taking priority (12 units, 37.5%) and too few patients volunteering to be supporters (9 units, 28%) (Figure 2). Similarly, in comparison, the 2012 survey showed that lack of staff time (51%), uncertainty about how to establish a formal service (38%), other projects taking priority

(32%), and lack of guidance/information on how to set up a service were the most prominent barriers (32%).

Among the units without PS, the barriers most commonly referenced which impede the set-up of a service include other projects taking priority (12, 100%), nobody coming forward/being available as a lead to make it happen (11, 92%), uncertainty about how to establish a formal service (11, 92%) and staff time (11, 92%) (Figure 3).

Staff interview findings

Ten interviews were conducted; interviewees included physicians and senior nurses. Analysis revealed five themes: perceptions of PS, the referral journey, service features, implementation challenges and improvement strategies.

Perceptions of PS

Most interviewees were in favour of PS due to the perceived benefits. Staff commonly mentioned that PS can provide practical and realistic support, especially when making decisions about treatment options. For instance, recipients may be better able to translate and validate medical information following a PS interaction:

...a clinician can say the information 10 times and then a recipient will go and talk to a peer supporter about it and the peer supporter will say it, and all of a sudden it will sink in, it will make sense or it will be listened to, it will become valid. (Participant 7—staff)

Staff expressed how supporters are relatable, understanding, nonmedicalised individuals who patients can feel comfortable sharing with and thus benefit emotionally.

TABLE 2 Unit specific peer support characteristics

	Number of units (2020)	Percentage of units with PS (2020) (%)	Number of units (2012)	Percentage of units with PS (2012) (%)
<i>Aims (multiple options could be selected)</i>				
Informational support	28	87.5	35	95
Emotional support	24	75	24	65
Help with treatment decisions	24	75	30	81
Self-manage CKD effectively	22	69	25	67
Role for patients to help others	19	59	17	48
Social support to patients	13	41	23	62
<i>Target groups (multiple options could be selected)</i>				
Predialysis/low clearance clinic	27	84	N/A	N/A
Individuals on dialysis	23	72	N/A	N/A
Carers/family members	19	59	N/A	N/A
People with transplants	18	56	N/A	N/A
People receiving maximal supportive care	15	47	N/A	N/A
Prospective kidney donors	13	41	N/A	N/A
Patients with early CKD	12	37.5	N/A	N/A
<i>Format (multiple options could be selected)</i>				
Individually face to face	28	64	35	95
Individually over the phone	21	48	27	74
Individually by email	7	16	8	21
In groups face to face	15	34	16	42
By social media	8	18	N/A	N/A
<i>Hearing about PS (multiple options could be selected)</i>				
Promoted through clinicians	27	84	N/A	N/A
Group education	20	62.5	N/A	N/A
Targeted at specific time points	17	53	N/A	N/A
Posters/newsletters	17	53	N/A	N/A
<i>Method of referral (multiple options could be selected)</i>				
Clinician referral	26	81	32	86
Self-referral	10	31	16	43

It's just feeling that they're not on their own, they're not the first person who has faced these problems. (Participant 3—staff)

The appraisal support benefits highlighted included provision of a sense of control over one's condition, a positive role model, and help with long-term acceptance:

...having some hope and having a role model for the future and being able to think about the future differently as a result of seeing someone who's successfully dealing with life, with kidney disease. (Participant 7—staff)

Supporters and staff were also perceived to benefit. Supporters find volunteering a fulfilling and empowering experience:

The majority of patients who put themselves forward as peer supporters are those who really want to give back anyway and they see this as one way they can contribute to the care that they have been given. (Participant 6—staff)

Additionally, interviewees claimed PS gives staff an extra tool which can positively impact the patient-provider relationship dynamic:

That just gives us another tool that we can offer to show them that we are trying to make whatever they're going through a little bit easier. (Participant 2—staff)

Limited drawbacks were suggested for PS programmes. However, it was noted that service leads should be conscious of potential negative emotional impacts on recipients, supporters giving incorrect or biased information and there being a lack of personal boundaries.

TABLE 3 Staff interviewee characteristics

ID	Gender	Profession	Trust
1	Female	Consultant nephrologist	1
2	Female	Consultant nephrologist	1
3	Female	Consultant nephrologist	1
4	Female	Clinical nurse	2
5	Male	Consultant nephrologist	2
6	Female	Transplant matron	2
7	Female	Nurse consultant	2
8	Female	Clinical nurse	1
9	Female	Clinical nurse	2
10	Female	Consultant nephrologist	2

TABLE 4 Recipient and supporter interviewee characteristics

ID	Gender	Classification	Trust	Renal characteristics at time of receiving peer support
1	Female	Recipient	2	CKD5
2	Female	Recipient	2	CKD5
3	Male	Recipient	2	Haemodialysis
4	Female	Recipient	2	Haemodialysis
5	Male	Recipient	2	CKD5
6	Male	Supporter	1	Transplanted
7	Male	Supporter	1	Unknown

The referral journey

Discussions also covered referral indications and processes. Interviewees most commonly offered PS to people with anxiety, new and/or young patients and individuals in treatment option discussions, though many believed that support should not be restricted to just one target group or point in the care journey. When probed about potential reasons for staff's low levels of PS utilisation and promotion, lack of awareness of the service's details and the positive outcomes associated with PS were cited, in addition to commonly held misconceptions:

There will be some people who have misconceptions about what peer supporters can do, who they're available to, whether they're overburdened or not, which patients will benefit...there will be a lot of clinicians out there who don't promote it...because they believe something inaccurately about the service. (Participant 7—staff)

Interviewees usually moved to ideas for how to increase clinician referrals. Common suggestions included having reminders, making the referral process simpler (i.e., fewer steps, self-referral option), and promoting positive outcomes of PS among staff:

...recently I saw a patient and there was an electronic note on their file saying 'Consider peer support' and that did absolutely trigger me to think about whether that patient should be referred. (Participant 5—staff)

Opinions on service features

Numerous interviewees suggested specific service features. For instance, having multiple methods of PS delivery (i.e., one-on-one

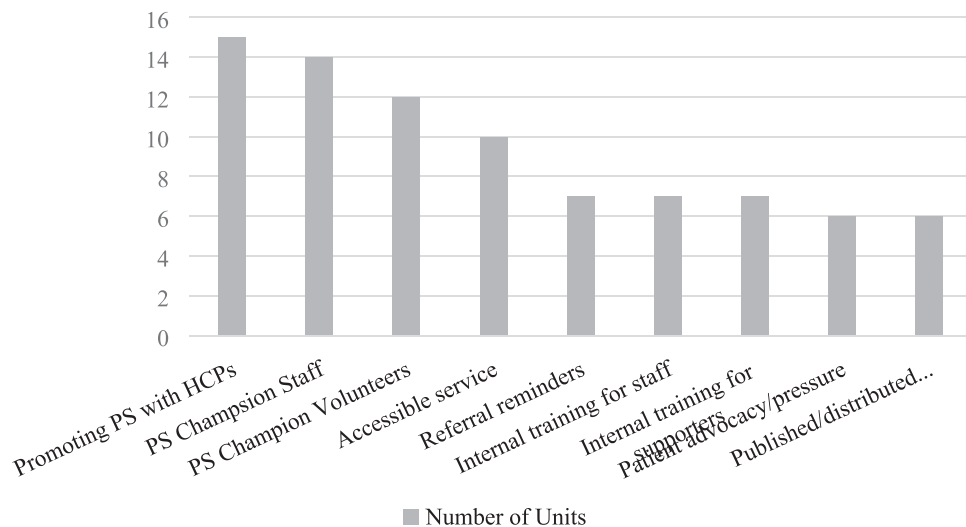
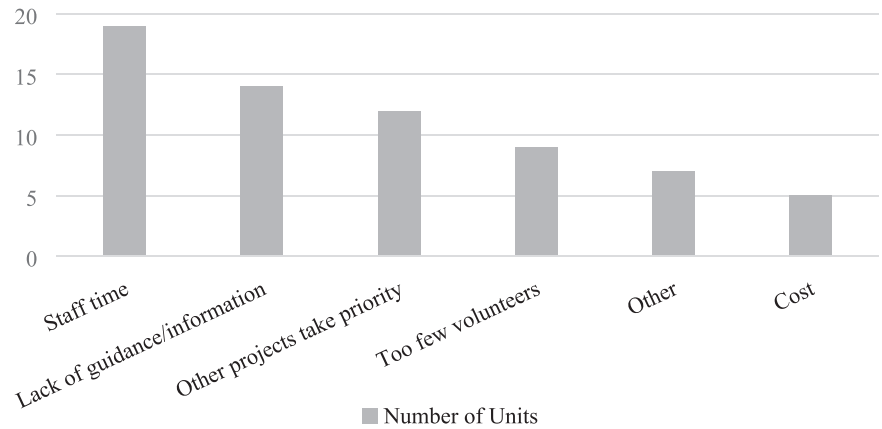
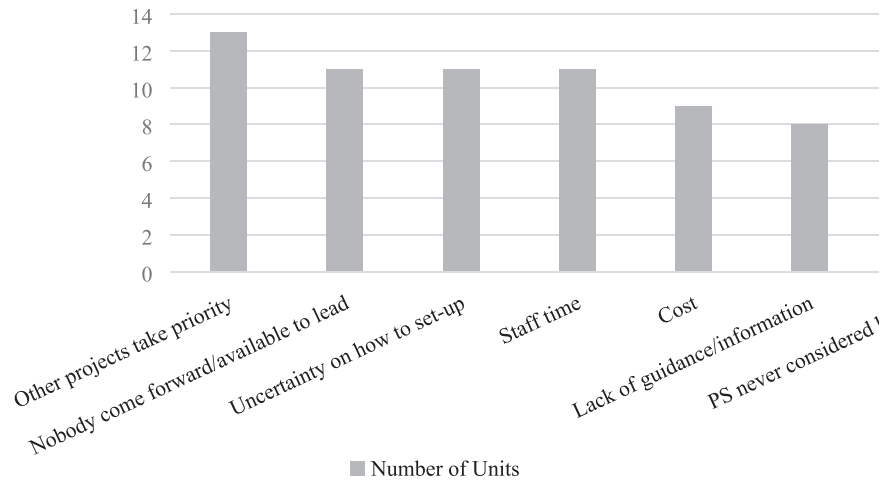


FIGURE 1 Drivers for success

FIGURE 2 Barriers to success (PS units)**FIGURE 3** Barriers to success (non-PS units)

support, group sessions, face to face meetings, support over the telephone or internet) so they could be tailored to recipient preference. Participants also expressed opinions on important peer supporter training focuses, including emphasising the goals and expectations of the programme, the scope and boundaries of their supporter role, and having a practical component (i.e., practice scenarios):

I think we have to train our peer supporters quite carefully in terms of what we're trying to achieve, what they're trying to achieve, what the purpose and their role is. (Participant 1—staff)

Implementation challenges

Interviewees reported many challenges to establishing and sustaining a PS service. Firstly, there are supporter pool-specific obstacles, such as limited diversity in the peer supporter pool, and supporters failing to be available for interactions:

You have some peer supporters that you train up and then their lives experience changes...or they might get unwell themselves and therefore not be in a position to do peer support, so they will drop in and out. (Participant 3—staff)

...when they don't turn up to the appointment that's been arranged, or when they don't phone someone who they said they'd phone, and that is a massive source of frustration and disappointment for the recipient... (Participant 7—staff)

There were also clinician-specific barriers. Clinicians' promotion of PS was felt to be limited by time pressures and misconceptions (such as fear of overworking PS volunteers), and concerns of the supporter providing misinformation or skewing information:

There is an inherent bias from the person giving peer support but of course that is always a danger, that's the same when you are dealing with a clinician as well. (Participant 5—staff)

Barriers inherent to the service itself included challenges sustaining the momentum of the programme, with accessibility and time-consuming administrative tasks.

Strategies to improve service success

Methods to improve access and efficiency of PS programmes were suggested. Clinicians believe increased promotion to patients is crucial, comprising clinician endorsement and involving patients and supporters in service design. In turn, many of the recipient-challenges could be addressed:

In an ideal world, I would like our peer support services to grow to the point where they're almost organic within the unit so that the patients know about it, there is information everywhere and they'll know about it from other patients and they will just actively seek it. (Participant 3—staff)

Designating staff members to be responsible for the service but providing them resources and time so they are not the sole leaders also emerged:

You've got to have a system in place that is not dependent on a single individual and you've got to make sure you resource it and that it's valued, and someone has got time to spend on it. (Participant 3—staff)

Supporter-specific facilitators included having a diverse supporter pool, often suggested through targeted recruitment. From a service-level perspective, sustained momentum and support from upper Trust management is beneficial.

PS recipient and supporter interview findings

Seven patient interviews were conducted; two included individuals who had delivered PS previously. Three PS recipients who initially expressed interest ultimately did not participate: one refused following learning more about the project aims and two did not respond to interview set-up inquiries. The analysis shed light on peoples' experience when first hearing about PS, their motivation for choosing to engage in the service, their experience of receiving and/or delivering PS, what they feel the impact was, and their reflections after taking part.

Hearing about PS

All participants initially heard about PS through a staff member talking about it; most were told it was a resource for answering questions or a way to better understand their condition. A majority

believed staff viewed PS positively, with one feeling they were neutral towards it. Some felt the service was not talked about enough by clinicians, for instance because staff are too busy. Only two participants mentioned having a choice in either their supporter and/or the location of the interaction.

Motivation for engagement and the impact of taking part

Three common reasons emerged for PS recipients choosing to get involved: (1) seeking information; (2) hearing first-hand experiences; (3) getting reassurance to feel less scared and alone:

I thought okay, somebody can give me some information regarding what the process is and how it was done first-hand. It would ease my tension quite a lot and I would be less apprehensive. (Participant 5—recipient)

Among the two supporters interviewed, their primary motivation for volunteering was to give back to make a difference:

I know exactly what it's like so I just want to be there for other people, telling them what it's like, what it is and you know that there's light at the end of [the] tunnel. (Participant 7—supporter)

Participants articulated positive outcomes of PS such as insight into first-hand, relatable experiences and informational support that helped inform decision-making:

I was trying to look up things on the internet...there was nobody who had actually gone through it where I could actually say right, okay, that could possibly be me, that I could relate to. (Participant 5—recipient)

Other common positive outcomes that interviewees mentioned included receiving practical support, being provided companionship, feeling a sense of empowerment and confidence, and having a more positive outlook afterwards:

...it's having somebody there who you can talk to, you don't seem as if you're alone, so it's just talking to somebody who you know can give you a bit of comforting answers. (Participant 5—recipient)

Perceived drawbacks were mentioned; two PS recipients explained a long period between an initial meeting and a follow-up session could be challenging. Although none had personally experienced this, a recipient worried PS might be a time-consuming process and a supporter stated there is potential for some people to get overly attached to their supporters.

The experience of receiving/providing PS

Interviewees had a variety of opinions on format options and matching preferences. The location of PS interactions varied, with most occurring in a clinical environment and some in a nonclinical setting (i.e., coffee shop), where one interviewee mentioned this helped them be themselves more. Opinions on methods of delivery were varied with one participant explaining that face to face is preferred because you can see the body language of the other person, while another said although in-person could be useful, they often do not have the time to attend a regular meeting. Almost all had a strong preference for matching characteristics:

Well, I think that patients need to be asked what kind of person would be suitable for them. People have different personalities and that could clash for a start.
(Participant 3—recipient)

The specific characteristics to match ranged widely and included: religion, activity level, treatment experience, health condition, ethnicity, cultural background, gender, age, occupation, personality and language.

Reflection on experiences

All recipients received PS on one single occasion, however most felt this was sufficient with either positive or neutral views towards having a single session. No interviewees had previously been asked for feedback on their experiences. Participants voiced suggestions for strategies to help PS services thrive. Some reflected on flexibility being helpful, for example, the format being accommodating of their work schedule:

I would not want somebody to say, 'Right, you must contact your peer support once a week', or something like that. I think it needs to be an ad hoc, as you need it, kind of thing. (Participant 3—recipient)

Another strategy was better timing of when to engage recipients. For example, ensuring PS is routinely offered throughout the care journey and that follow-up sessions are suggested. Lastly, some individuals felt reminders of the service would enable better engagement:

I think that if peer support sent me a reminder text, for example, maybe like once every three months or something like that, then that might be something that's useful. (Participant 3—recipient)

Conversations led to barriers and included lack of staff time to manage the service and staff not talking about it enough to potential recipients:

They didn't talk about it, that's the problem, you go to an appointment and you discuss your problem, but at the end they could just spend one minute..., maybe they don't have time to do this and that is so sad.
(Participant 2—recipient)

DISCUSSION

It is clear from both the national survey and qualitative interviews that while PS is generally well received and acknowledged as beneficial for people with kidney disease, more optimisation and prioritisation is needed, especially as it appears that little progress has been made since 2012 to establish formal PS as an integrated part of kidney care.

Barriers to setting up and sustaining PS

The proportion of renal units in the UK without any PS remains significant (41% in 2012 and 27% in 2020). In the 2020 survey, the top barriers were lack of staff time (59%), lack of guidance/information on how to optimise PS (44%), other projects taking priority (37.5%), too few supporters (28%). The qualitative data supported these assertions. These findings could be explained by the challenges faced with establishing or maintaining a service, as well as less availability for staff time to dedicate to the set-up involved. A systematic review (Ibrahim, 2019) found that organisational culture including role support (training, role clarity, resourcing and access to a peer network) and staff attitudes to PS are critical. Heisler (2010) calls for PS interventions to have clear and realistic programme goals, adequate training and support for peer supporters and effective evaluation, as without these elements the sustainability of PS programmes is at risk.

Facilitators to setting up and sustaining PS

PS services could be designed in a way which limits the amount of time needed for their creation and maintenance through strategies such as having a simple and accessible referral system and designating staff members to be liaisons for the service. In both the recipient/supporter as well as clinician interviews, it was mentioned that services could benefit from clinicians talking about it more and enhanced service promotion. In turn, this could increase the number of referrals (Trasolini et al., 2020).

Patel and Pagel (2018) identified factors that are important for sustaining PS. These factors included confidence that the service is safe, confidential and high quality; evidence that the service makes a positive impact and belief that PS would improve health and well being. The conclusions of a report from the United States (Boston University School of Public Health, Health & Disability Working Group, 2015) on successful PS in HIV, which include developing an internal champion; tailoring the PS strategy to the organisation's

needs; creating an infrastructure that includes peers and evaluating the programme, concur with our findings about PS in the UK.

Limitations

Purposive sampling was employed throughout the project which inherently can have a degree of bias. Some survey questions had the option to select more than one applicable answer so results could be slightly inflated. The 2012 survey covered only England and the 2020 survey the whole of the UK, which may reduce the reliability of direct comparisons. Although the interviews included staff from a variety of roles, there were no allied health professionals involved. Additionally, no junior doctors were interviewed, an important point given they spend more time with patients and are often less knowledgeable about PS. Recruitment was affected by the COVID-19 pandemic and fewer recipient and supporter interviews conducted. Moreover, paired with a 52% survey response rate, and given the qualitative nature of this study, the results should not be considered generalisable to the greater population. Lastly, thematic analysis was employed, and although a rigorous and thorough process was used, there is some degree of subjectivity.

Implications for practice

Having passionate staff members and volunteer PS champions are critical in setting up a PS programme. They need to have dedicated time for their role. Involving past and future PS recipients in the design of such programmes would highlight what specific features of the service should be prioritised and could help with its success (NHS Kidney Care, 2013). Recruitment of a diverse array of supporters is also an essential element which will increase availability for who can support recipients as well as allow for a more efficient and accurate matching process. Ensuring the programme is available and offered to all people with kidney disease, including those with advanced kidney disease is important. Increasing promotion of PS to clinicians is a vital first-step. Lastly, evaluative processes need to be implemented to determine the progress and outcomes of PS programmes and to understand if features need to be changed or adapted to allow for a more useful service.

PS toolkit

In response to the findings of this project, a PS Toolkit has been developed and can be found here (<https://www.kidneycareuk.org/health-professionals/peer-support-toolkit/>). During development, all the top barriers were addressed: the Toolkit demonstrates why PS should be prioritised and how programmes can be optimised, including ready-to-use downloadable resources to help save staff time, particularly in the recruitment and training of supporters. It also points users towards facilitators of PS including the importance of and how to promote PS services.

CONCLUSION

Our study contributes to the literature that explores the barriers and facilitators to PS programmes for people with kidney disease. Findings from the national survey and qualitative interviews have shown that whilst PS is generally well received and acknowledged as a beneficial service for people with kidney disease, more optimisation and prioritisation is needed to ensure its benefits are available to maximum numbers of service users. Our findings have informed the development of a Toolkit which we hope will be used widely to support implementation and sustainability of this important intervention for those with kidney disease.

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CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

AUTHOR CONTRIBUTIONS

Conceived and designed the study, involved in survey and interview recruitment, contributed to analysis of survey and interviews, contributed to, and checked manuscript before submission: Eleri Wood. *Responsible for survey and interview recruitment, conducted qualitative interviews, undertook analysis of survey and interviews, wrote manuscript:* Andrew Trasolini. *Conceived and designed the study, contributed to analysis of survey and interviews, contributed to, and checked manuscript before submission:* Nicola Thomas.

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SUPPORTING INFORMATION

Additional Supporting Information may be found online in the supporting information tab for this article.

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