What is the volume, diversity and nature of recent, robust evidence for the use of peer support in health and social care?

Protocol for a systematic evidence map

Version 2

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Produced by	Exeter HS&DR Evidence Synthesis Centre College of Medicine & Health South Cloisters St Luke's Campus Heavitree Road Exeter EX1 2LU UK
Authors	**Liz Shaw,** Systematic Reviewer [1] E.H.Shaw@exeter.ac.uk **Michael Nunns,** Systematic Reviewer [1] M.P.Nunns@exeter.ac.uk **Simon Briscoe,** Information Specialist[1] sb519@exeter.ac.uk **Latika Ahuja**, Systematic Reviewer[1] l.ahuja@exeter.ac.uk **Anna Price**, Systematic Reviewer[1] a.price@exeter.ac.uk **Alison Bethel**, Information Specialist[1] a.bethel@exeter.ac.uk **Naomi Shaw,** Information Specialist[1] n.shaw2@exeter.ac.uk **Rob Anderson**, Senior/Academic Lead[1] r.anderson@exeter.ac.uk **Jo Thompson Coon**, Senior/Academic Lead[1] j.thompson-coon@exeter.ac.uk [1] University of Exeter
Correspondence to	Anna Price a.price@exeter.ac.uk 01392 726026
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1 Background

1.1.1 Background

The financial pressure on the NHS is increasing, with the impact of slower growth in NHS funding[1] exacerbated by increased demand from an aging population.[2] Increased prevalence of long-term conditions such as diabetes and heart disease has led to renewed focus on supporting members of the public to manage their various lifestyle risk factors such as smoking and obesity (for example in the NHS Long Term Plan)[3] and it is estimated that if no efficiency savings are made alongside flat real terms funding, there will be an annual funding shortfall of almost £30 billion within the NHS by 2020/21.[4] These pressures are mirrored within social care services, which have sought to reduce the impact of reductions in funding and increasing costs associated with complex care by reducing service availability, tightening eligibility criteria and reducing payments to providers.[5] Despite these measures and an injection of ring-fenced funding totalling £10 billion between 2017/18 to 2019/20, it is estimated that by 2019/2020 there will be a £1.5 billion funding deficit.[6]

A part of the policy response to these pressures is increased focus on enabling patients and carers to support themselves more effectively. The NHS Long Term Plan outlines an intention to empower patients through increasing their involvement in their own care, focusing on patients' own health and wellbeing goals, improved access to information and peer support within the community.[3] Integrated Personal Commissioning is a partnership between the NHS and local government services which aims to promote a "Community capacity" building approach, encouraging delivery of increasingly personalised care by supporting people to draw upon their individual strengths and social networks, thus taking responsibility for their own health and wellbeing and reduce their reliance on formal health and social care services.[7]

The potential to make use of the 'renewable energy' of the individuals and networks available within the wider community has been recognised within formal services for people with long-term physical conditions such as HIV and diabetes,[8] with guidelines and research to support the development of peer support initiatives also being developed for other population groups, including people living with dementia,[9] those experiencing mental health difficulties[10, 11] and women requiring peri and/or postnatal support.[12, 13] In addition to the potential to reduce this demand on services through improved condition management[7] and reduced emergency admissions,[14] some participants of peer support interventions also report benefits such as reduced social isolation,[15] and reduced mental ill-health.[16]

1.1.2 What is peer support?

Whilst there are many different definitions of peer support, they all appear broadly consistent with the one used within the 2015 report published by Nesta and National Voices, on *Peer support: what is it and does it work?*:

> Peer support involves people drawing on shared personal experience to provide knowledge, social interaction, emotional assistance or practical help to each other, often in a way that is mutually beneficial[17]

Many of the existing definitions of peer support emphasise the importance of peer-supporters who have experience of the condition or difficulty the people they are supporting seek help for. However, there is a huge variety in both the content and mode of delivery of peer support interventions.[17]

Dennis[18] outlines how the different ways people can access peer support lie upon a continuum, from the lay support provided by family members within the person's embedded social network, through to support provided by para-professionals, trained and supported by formal care services.

As well as different delivery formats, including face-to-face groups or one-to-one contact, online forums, telephone, and email,[19] there is variation in the degree to which peer support interventions are supported by, or associated with formal health and social care services. The dilemma here is that the desire to professionalise peer support and maintain standards through increased accreditation and training, conflicts with the wish to maintain the "authenticity" of peer support services by maintaining their separation from formal services.[20] Peer supporters can be paid employees recruited through health or third sector agencies, or volunteer workers.

The content of peer support interventions also varies, influenced by the needs of the population, structure of existing services, resources available and intended outcomes.[17] For example, interventions may focus on providing information and education, emotional support or a combination. Qualitative evidence provides some insight into the underlying mechanisms or processes which may influence the perceived effectiveness of peer support interventions. In their scoping review synthesising evidence regarding the processes or mechanisms underlying one-to-one peer support for adults using mental health services, Watson[21] identified five mechanisms: "lived experience, love labour, the liminal position of the peer worker, strengths-focussed social and practical support, and the helper role." Bailie and colleagues[22] focus on the core role of the relationship between the professional peer support worker and service user, emphasising how developing a shared sense of identity

can be developed through disclosure of past experiences can deepen the relationship and help the service user feel understood. An understanding of the cultural background of the potential participants of proposed peer support interventions may be also beneficial.[23]

This variability in intervention delivery, content and underlying actual or intended mechanisms represents a challenge to commissioners and services who may wish to identify evidence of effective peer support interventions relevant to the needs of the community they wish to support and is consistent with the structure of existing services in the area.

1.2 Existing evidence

Background scoping reveals an abundance of evidence about peer support distributed between peer-reviewed academic journals, and so-called 'grey literature' sources such as government or non-governmental reports, service evaluations and charity reports. For evidence about the effectiveness of peer support in specific populations, there are already numerous systematic reviews of specific populations such as people living with HIV,[24] breast cancer,[25] or mental health difficulties[26] and people needing supporting with breastfeeding;[27, 28] or caring for someone with dementia,[29] or in the critical care setting.[30] However, for overviews of peer support across populations or modes of delivery, there is a dearth of high-quality, peer-reviewed academic evidence. Notable exceptions include two systematic reviews of evidence from the US about peer support for health promotion and disease prevention[31] and peer support for 'hardly reached' populations.[32] While these reviews crossed some population groups and modes of peer support, they were restricted to the US and both reviews imposed population restrictions.

The grey literature features several key reports produced in recent years, which attempt to provide readers with a much broader picture of peer support programmes than has been provided by the academic literature. However, while these key reports highlight the variety and perceived value of peer support interventions being implemented across multiple populations and settings, the confidence that can be placed in this research to inform future research and intervention development is less certain.

1.2.1 National Voices and Nesta (2015): Peer Support: What is it and does it work?[17]

In 2015, National Voices and Nesta published a review of research, mapping studies evaluating a range of peer support interventions.[17] The aim of the review was to produce a 'typology' of common forms of peer-support interventions. Authors searched a variety of online databases and grey literature sources for research of any type published anywhere in the world between 2000 and January 2015. Whilst processes used to search for and analyse

the literature were systematic, this review was not intended to be exhaustive. Evidence from systematic reviews and randomised controlled trials (RCTs) was prioritised for inclusion and the identification and inclusion of new studies was halted after more than 1000 studies were identified and data saturation achieved, although it is not clear from the reported methods how this was operationalised. The authors mapped the features of the peer support interventions, including content, broad target outcomes, delivery method, place of delivery and characteristics of the peer supporter (e.g. volunteer, paid, associated with health services or third sector agencies). Given the volume of evidence identified, the depth of this review was limited, with no quality appraisal being undertaken and minimal data extraction.

The authors concluded that it was not possible to identify which method of delivery was most effective, as the majority of studies identified did not compare different modes of delivery to one another. Furthermore, the evidence pertaining to the cost-effectiveness of peer support interventions was inconclusive. They recommended that future research focus on factors which may influence people's decision to participate in peer support interventions, implementation of peer support interventions, evaluating the long-term and cost-effectiveness of peer support and identifying factors which could influence the effectiveness of peer support interventions.

1.2.2 MIND (2013): Mental health peer support in England: Piecing together the jigsaw[19]

In 2013, the mental health charity MIND conducted a "scoping study" to map the peer support interventions available across England and the different ways they are described, as well as collating the experiences of peer support groups with a view to supporting the development of other peer support projects.[19] The authors identify several key issues, including the lack of evidence regarding use of peer support in minority and marginalised communities, the sustainability of funding to continue delivery of peer support interventions, the need for adequate training, support and supervision for peer intervention deliverers and whether management of peer support interventions is overseen by services or whether this is more devolved, with service users taking on this responsibility. The authors acknowledge that the map of existing peer support interventions was not intended to be comprehensive, and acknowledged that their efforts focused on identifying peer support interventions within the voluntary sector. Whilst the report provides detailed information on what data was collected, it is not clear how this information was analysed.

1.2.3 Nesta and the Health Foundation (2016): At the heart of health: Realising the value of people and communities[8]

This report sought to identify ways in which the NHS can support people with long-term physical conditions to manage their health and care needs and was informed by a scoping review conducted at Newcastle University.[8, 33] This review focused exclusively on systematic reviews and (also) comparative studies from the UK and excluded qualitative research, as well as studies which didn't indicate a statistically significant benefit on at least one outcome in the abstract. There were five interventions which were deemed "promising", one of which was peer support.

An economic modelling tool was developed as part of the Realising the Value project intended to support commissioners to evaluate the impact of investing in person/community centred approaches and incorporate these into commissioning plans. The model was informed by academic literature and data from five partner sites within the UK and calculates the impact of person/community-centred approaches across financial, health/wellbeing and social outcomes. It indicated that peer support appeared to cost the least of the identified approaches, with evidence suggesting the greatest financial benefits within the area of mental health and greatest health and wellbeing impacts among people living with HIV. The authors acknowledge that the model is conservative and does not consider long-term impact, meaning that the potential benefits to the approaches evaluated could be higher than documented within the report.[33]

1.2.4 Keck, Patel & Webb: Q Lab Essay – Learning and insights on peer support: What we learned from the year-long project[20]

The Q-Lab group worked with people with experience of peer support to improve understanding of how the peer support approach works well and in what areas it could be improved. Whilst not a comprehensive literature review, this reflection piece incorporates existing literature to define peer support and identify evidence regarding its use and key issues regarding the different approaches for implementation. One example of a key tension is the desire to identify exactly which formats of peer support are effective for which populations versus the wish for the format of the service delivered to be adapted to the needs of the individual population it is intended to serve.

1.3 Overall aims and objectives of the review

To identify, appraise and map recent, high quality evidence on the effectiveness and cost-effectiveness of peer support across health and social care.

We have chosen to focus on mapping evidence of the effectiveness and cost-effectiveness of peer support mainly because this was the identified need in the two research commissioning briefs we were directed to (one to NIHR from the HIV Clinical Reference Group; the other to the Department of Health R&D Committee, on perinatal peer support for mental health). It was also the expressed priority for evidence synthesis in our conversations with relevant policy, commissioner and clinical contacts during scoping. We therefore focus on summarising evidence from comparative, quantitative evaluation studies (or systematic reviews of such studies) rather than qualitative research.

By mapping the evidence we mean we will use tables and graphical methods to convey the volume, diversity and key characteristics of evaluative research evidence. Rather than synthesising the findings of the identified research studies, the aim of the map is to enable users to identify and locate the research evidence (or evidence gaps) most relevant to their patient/intervention/health condition or social care support focus.

1.4 Research Questions

What is the volume, diversity and nature of recent, robust evidence for the use of peer support interventions in health and social care?

Specific research objectives:

- Map the recent, robust evidence for effectiveness of peer support interventions across health and social care.
- Map the recent, robust evidence for cost-effectiveness of peer support interventions across health and social care.

Our definition of peer support is the same as that provided by the 2015 Nesta report[17] and stated above; with the additional condition that there is an identifiable peer support worker role which is ongoing and formalised in at least one of the following ways: they have received training to fulfil the peer support role; they receive ongoing support to fulfil the peer support role; they are paid or have a contract to fulfil the peer support role.

2 Methods

2.1 Identification of studies

The search for studies will be conducted in two stages.

1. Stage 1 will search for systematic reviews of peer support interventions published from 2015 to-date
2. Stage 2 will search for RCTs and health economics studies of peer support interventions not included in recent, high quality systematic reviews

The bibliographic database search strategies for stages 1 and 2 will be developed using MEDLINE (via Ovid) by a team of information specialists (SB/NS/AB) in consultation with the review team. The search strategy for stage 1 will combine search terms for peer support and appropriate synonyms with search terms for systematic reviews. The search strategy for stage 2 will be determined when stage 1 is complete; however it is likely to combine search terms for peer support with an RCT search filter such as the Cochrane RCT search filter[34] and an economic studies search filter (NHS Economic Evaluation Database filter).[35]

The search strategies for stages 1 and 2 will use both controlled headings (e.g. MeSH in MEDLINE) and free-text searching. Search terms will be partly derived from the titles and abstracts of pre-identified systematic reviews of peer support and the primary studies included therein, the search strategies of pre-identified systematic reviews, and from a search of health and social care news publications via the Nexis UK (www.nexis.com/) resource. Terms thus identified will be supplemented by an appropriate selection of synonyms. Results will be limited to English language studies and the stage 1 search will be date limited from 2015 to-date. The date cut-off for the stage 2 searches will be determined following the completion of stage 1.

We anticipate searching the following health and social care bibliographic databases:

- Cochrane Central Register of Controlled Trials (CENTRAL) (via the Cochrane Library)
- Cochrane Database of Systematic Reviews (via the Cochrane Library)
- CINAHL Complete (via EBSCO)
- Embase (via Ovid)
- MEDLINE (via Ovid)
- MEDLINE In-Process & Other Non-Indexed Citations (via Ovid)
- APA PsycINFO (via Ovid)

- ASSIA (via ProQuest)
- ProQuest Dissertations & Theses (via ProQuest)

We will also search Epistemonikos (www.epistemonikos.org) to identify systematic reviews in stage 1.

A provisional stage 1 search strategy for the MEDLINE (Ovid) bibliographic database can be seen in Appendix A. The stage 2 search strategy will be partly determined by the results of the stage 1 search and will use the same terms for peer support as stage 1 (lines 1-14).

Web searching will be conducted via Google Scholar and OpenGrey (www.opengrey.eu/). Because we anticipate that our evidence map will include a large number of different population groups, we are not planning to identify and search the websites of topically relevant health and social care organisations for each individual population group.

Manual checking of references and forward citation searching using Scopus or Web of Science will be conducted on studies that meet our inclusion criteria if time and resources allow. Ongoing studies will be identified through searches of CENTRAL (via the Cochrane Library) and trial registers (e.g. ClinicalTrials.gov).

2.1.1 Inclusion and exclusion criteria

The inclusion criteria and exclusion criteria (according to the PICO categories) to be applied to the studies identified through the search strategy are detailed below:

Participants/population:

Include:

- Users of adult services with a defined health and/or social care need.

Exclude:

- Users of child and adolescent services.
- Populations without a clearly identifiable health or social care need.

Interventions

Definition of peer support

Interventions must involve delivery of peer support as defined below:

Peer support involves people drawing on shared personal experience to provide knowledge, social interaction, emotional assistance or practical help to each other, often in a way that is mutually beneficial. We are interested in peer support of this nature, which is delivered by (an) identifiable peer supporter(s) in a formalised and ongoing role. This may be evidenced by one or more of the following: they have received training to fulfil the peer support role; they receive ongoing support to fulfil the peer support role; they are paid or have a contract to fulfil the peer support role.

Include:

Peer support delivered in any format (such as face-to-face, online, group, individual, mixed modes etc.) and with any content, delivered by paid or unpaid peer supporters.

Exclude:

Interventions not meeting the definition of peer support stated above, or which are described poorly enough to preclude assessment of intervention type.

Peer support delivered outside a health or social care context, e.g. in education.

Comparator(s)/control

Any comparator eligible for inclusion. Examples may include: wait-list control, treatment as usual, education. Studies may also compare different forms of peer support, such as internet vs face-to-face delivery, or educational peer support vs emotional peer support.

Outcomes

All reported outcomes are of interest.

Study design

Stage 1: Systematic reviews

Include:

High quality, recently published systematic reviews which aim to evaluate the effectiveness and/or cost-effectiveness of peer support interventions.

Further qualification of the above:

The definition of peer support used by systematic review authors may not exactly match our definition, therefore we will judge whether we believe the interventions sought within the systematic review are aligned with our interest. Where systematic reviews seek multiple

intervention types (i.e. peer support and non-peer support interventions), we will only include reviews which we believe are mainly interested in peer support. This will be judged at the level of the systematic review aims.

Systematic reviews may seek to evaluate RCTs, non-randomised controlled trials, controlled and uncontrolled before-and-after trials and interrupted time series designs.

Only high quality systematic reviews as determined by performance on selected critical domains in the *A MeaSurement Tool to Assess systematic Reviews*[36] tool will be included in the evidence map. These critical domains will be determined following discussion within the review team.

Only systematic reviews published in 2015 or later will be included in the evidence map. This cut-off date has been chosen to focus on reviews of evidence that include studies published after the National Voices and Nesta (2015)[17] evidence review and MIND scoping study (2013)[19]. Also to manage the high volume of relevant research expected, due to the broad inclusion criteria.

Exclude:

- Systematic reviews of only qualitative or non-comparative evidence.

- Systematic reviews which do not evaluate effectiveness or cost-effectiveness.

- Systematic reviews which do not meet the criteria for 'high quality'

- Systematic reviews published before 2015

Stage 2: Randomised controlled trials & health economic studies

Include:

Randomised controlled trials (RCTs) of peer support interventions (to include ongoing research), in populations or for modes of peer support delivery, that have not been included in a recent, high quality systematic review (defined above). We will also include economic evaluations (cost-effectiveness analyses, cost-utility analyses, cost-benefit analyses) and comparative costing studies which compare the costs of delivering peer support with interventions not using peer support, or different types or models of peer support.

The date cut-off for this search will be determined when stage one is complete.

Context

Studies reported in English, conducted within any high-income countries as defined by the World Bank list. This is to ensure that included studies are as relevant as possible to the UK focus of the commissioning briefs informing this research.

2.1.2 Process for applying inclusion criteria

As an initial calibration exercise of inclusion judgments and the clarity of our inclusion criteria, all reviewers will apply inclusion and exclusion criteria to the same sample (e.g. n=100) of search results. Decisions will be discussed in a group meeting to ensure consistent application of criteria. Where necessary, inclusion and exclusion criteria will be revised to enable more consistent reviewer interpretation and judgement.

The revised inclusion and exclusion criteria will then be applied to the title and abstract of each identified citation independently by two reviewers. The full text will be obtained for papers where either reviewer indicates that it appears to meet the criteria, and those for which a decision is not possible based on the information contained within the title and abstract alone.

The full text of each record will be assessed independently for inclusion by two reviewers. Disagreements will be settled by discussion with a third reviewer. EPPI-Reviewer4 software will be used to support study selection (EPPI-Centre Software, London, UK). A PRISMA-style flowchart will be produced to detail the study selection process and reason for exclusion of each record retrieved at full text will be reported.[37]

2.2 Data extraction

A standardised data extraction coding set will be developed in EPPI-Reviewer4 software and piloted by the review team on a selection of included studies. It will be used to collect the following information from each included full text. Items will be defined as a single study (sample), which may include multiple reports/publications. Data extraction will be performed by one reviewer and checked by a second, with disagreements being settled through discussion, recruiting a third person as arbiter, if required.

Stage 1: Systematic reviews

Examples of data which will be extracted at Stage 1 include:

- Authors
- Publication year

- Month and year of searches
- DOI/citation
- Date of search
- Review question(s)
- Population(s)
- Included (or sought) study designs
- Number of includes
- Types of peer support intervention(s) (mode of delivery)
- Types of comparators included
- Type of SR (e.g. effectiveness, cost effectiveness or both)
- Type of synthesis (e.g. descriptive, MA, other)
- Outcomes

Stage *2: Randomised controlled trials & economic studies*

Examples of data which will be sought for at stage 2 of the review include:

- Authors
- Publication year
- Data year(s)
- DOI/citation
- Study design
- Sample size
- Population
- Outcomes (including types of costs included, for economic studies)
- Setting
- Country
- Name of peer support intervention
- Aim of peer support intervention
- Mode of delivery (e.g. face-to-face, online)
- Category of peer supporter (e.g. paid, voluntary, third sector)
- Comparator
-

2.3 Study quality assessment strategy

Stage 1: Systematic reviews

The quality of all systematic reviews identified as eligible following full-text screening will be appraised using the AMSTAR2 quality appraisal tool for systematic reviews of primary studies of randomised and non-randomised study designs. The use of quality appraisal in study selection is detailed in section 2.2.

Stage 2: Randomised controlled trials

We will use the Cochrane Risk of Bias (ROB) tool to assess risk of bias.[38] Ratings will inform the evidence map, and not be used to exclude studies.

Stage 2: economic evaluations and costing studies

We will use the CHEC list for assessing the quality of economic evaluations (the Consensus Health Economic Criteria List, from Maastricht University): https://www.maastrichtuniversity.nl/research/school-caphri-care-and-public-health-research-institute/our-research/creating-value-11) and published as Evers et al 2005.[39]

Stage 1 and Stage 2: Quality appraisal of both systematic reviews, randomised controlled trials and economic studies will be performed by one reviewer and checked by a second, with disagreements settled by a third reviewer.

2.4 Data analysis and presentation

Studies will be entered into an interactive evidence map in order to visually represent the distribution of evidence across health and social care domains. The map will have multiple layers, such that studies can be identified by population group, type of peer support and outcome.

The 'surface' or initially visible layer of the map will display recent, high quality SRs in a matrix of broad population vs broad outcome (e.g. mental health, physical health, quality of life, perceived support, connectedness, social relationships, service use/engagement, treatment adherence, cost-effectiveness, health behaviour). All cells in the matrix will be clickable, leading the map user to the next layer of the map, focusing on the available evidence for that particular population/outcome combination. The map user will see a graphical representation of the evidence, in the form of a 'bubble' or 'doughnut' with

dimensions (e.g. bubble diameter) and colours determined by the number, type and quality of studies available. One example of such an interactive map may be viewed here.

Within the second layer of the map, greater detail will be provided about either: a) the breakdown of the population (where broad groups existed in the top layer of the map, such as physical conditions), or b) who delivered the intervention and how. In the case of a), clicking on cells in this second layer will lead to the breakdown of studies described in b). When in the map layer in b), clicking on cells in the map will take the user to an overview box listing the studies found therein. Clicking on any study listed in the overview will take the user to the summary box for that study.

Examples of the data detailed within the summary box obtained during data extraction will include:

Stage 1: Systematic reviews

- DOI and full citation of review
- Quality of review (AMSTAR2 score)
- Research questions
- Population(s) of interest
- Stated intervention(s) of interest/definition of peer support
- Number of included studies
- Date of searches
- Outcomes of interest

Stage 2: Randomised controlled trials & economic studies

- Study details
- Quality appraisal
- Research question
- Population
- Intervention aim and name
- Type of peer support
- Mode of delivery and setting(s)
- Comparator
- Outcomes evaluated

The above description of how we will collate and present data is provisional, and may be revised depending on the number of studies identified and pending new ideas for the presentation of data, and stakeholder feedback. We may for example, following consultation with stakeholders, decide to present separate maps for effectiveness evidence (reviews/RCTs) and economic studies.

In addition to the interactive evidence map, which will be accessible by URL, there will be a narrative summary of key findings. This will involve mapping data by population group, intervention category or outcome domain, and considering the distribution of evidence.

Identification of 'gaps'

In order to structure our map and identify populations where peer support interventions are being used, or modes of delivery and outcomes of interest, but where academic evidence is not available, we have consulted various sources. This includes consultation with stakeholders, searching grey literature and key reports (e.g. Nesta report),[17] consulting Nexis UK to identify reports of peer support services which might not be found in the academic literature, reading qualitative synthesis and broad background scoping searches. This strategy has been undertaken to limit the extent to which we are driven by what we find in the research, thus increasing the utility of the map.

Please note that the evidence map WILL NOT:

- Provide summary outcomes or describe the findings of systematic reviews or primary research
- Provide information on the detailed nature of peer support interventions beyond a basic description of the mode(s) of delivery (and setting)
- Provide a synthesis of primary research

3 Stakeholder and patient/public involvement

3.1 Stakeholder involvement

Stakeholder involvement will be incorporated throughout the review, from outlining the preferred scope of our research questions and development of the protocol to helping us identify key populations and outcome categories to include within our map. Stakeholder feedback will be sought to ensure our interactive map is accessible and provides the level of information that will be useful to the intended audiences and will also play a key role in shaping the format of our 'second layer' map.

We will use online feedback tools to share the interactive map with stakeholders to obtain views on the presentation of information and the usefulness and accessibility of the map. Feedback will be incorporated into subsequent versions of the map.

Stakeholders are likely to include policy makers, commissioners, health care professionals, third sector organisations, online providers of peer support resources e.g. the Peer Support Hub, patient support groups and members of the public. We will use word of mouth and snowballing techniques to identify relevant individuals.

3.2 Patient and public involvement

The specialist Peninsula Public Involvement Group will support us to develop the project webpage, ensure that our evidence map is accessible and help write the plain language summaries describing our review and its findings. Meetings will be arranged by the core research team in consultation with the stakeholders and PPI group to suit project progress and stakeholder availability.

4 Dissemination plans

Access to the evidence map will be shared with NHS England policy makers, hospital managers, service commissioners (e.g. CCGs) and clinical teams responsible for providing peer support programmes, as well as more widely via the Peer Support Hub (https://www.nationalvoices.org.uk/peer-support-hub). Dissemination will be facilitated by the stakeholders involved in the project.

Academic outputs/reports:

The dissemination plan consists of three main components; plain language summaries, academic journal articles and presentations at key national and regional meetings. We plan to engage with stakeholders in the co-production of these materials, which will also be promoted via the Exeter Evidence Synthesis Centre webpage and social media. The plain language summary will form the basis of the Exeter Evidence Synthesis Centre briefing paper (the Briefing), a podcast and a blog post. The dissemination plan will be developed further as the findings of the review emerge to allow for the key messages and delivery mechanisms for each audience to be identified.

The results from this review will also be published as an (Open Access) Health Services and Delivery Research Topic Web Report, and in journals identified as being relevant to stakeholders for this review.

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Appendix 1. Search strategies

Stage 1 MEDLINE (Ovid) search strategy

Ovid MEDLINE
Database: Ovid MEDLINE(R) ALL <1946 to September 29, 2020>

Search Strategy:

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1 (peer* adj3 (administer* or adviser* or advisor* or advocate* or coach* or co-facilitat* or cofacilitat* or consultant* or counsel* or deliver* or educator* or expert* or facilitator* or group* or helper* or instructor* or leader* or led or listener* or mentor* or navigator* or network* or program* or provider* or specialist* or support* or trainer* or trained or tutor* or worker*)).tw. (17015)

2 ("peer-based" or "peer based").tw. (423)

3 "peer to peer".tw. (1394)

4 peer group/ (20749)

5 (buddy or buddies or befriend*).tw. (1078)

6 ("service user*" adj1 (involv* or led or run)).tw. (381)

7 (consumer* adj (deliver* or provider* or led or run)).tw. (329)

8 ((lay or voluntary or volunteer) adj2 (adviser* or advisor* or advocate* or coach* or consultant* or counsel* or educator* or expert* or facilitator* or helper* or instructor* or leader* or led or listener* or mentor* or provider* or specialist* or support* or trainer* or trained or tutor* or worker*)).tw. (5047)

9 "lay health care worker*".ti,ab. (25)

10 (("social support" adj5 intervention*) or "support group*").tw. (8568)

11 ("support network*" or "mutual aid" or "mutual support").tw. (4051)

12 (expert adj patient*).tw. (262)

13 "shared experience".tw. (365)

14 *Self-Help Groups/ (5250)

15 or/1-14 (54295)

16 ((systematic* or systematized or integrative or mapping or rapid or scoping) adj3 review*).tw. (207271)

17 ((evidence or interpretive or meta or quantitative) adj1 synthes?s).tw. (7427)

18 ((evidence adj2 map) or "systematic map").tw. (443)

19 ("mixed method*" adj3 review*).tw. (572)

20 ("meta-analys?s" or metaanalys?s).tw. (179152)

21 systematic review.pt. (135796)

22 meta-analysis.pt. (120248)

23 (cost* adj3 review*).tw. (3218)

24 (data adj extraction).ab. (22169)

25 (narrative adj (review* or synthes?s)).tw. (14659)

26 or/16-25 (348857)

27 15 and 26 [systematic review search] (1851)