Evaluation of the pilot of dual substance use and mental health peer support workers in Nottinghamshire Healthcare Foundation Trust

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EVALUATION CONTACTS

Evaluation lead	Bryony Lloyd, Specialty Registrar in Public Health Nottinghamshire Healthcare NHS Foundation Trust (NHNFT), bryony.lloyd@nottshc.nhs.uk
Evaluation team	Jane Bethea, Public Health Consultant (NHNFT) Lori Edwards Suarez, Principal Mental Health Transformation Analyst (NHNFT), Laurie Hare Duke, Public Health Specialist (NHNFT)
NHFT governance lead	Wendy Smith, Research and Evidence Team, wendy.smith2@nottshc.nhs.uk, 07826398579

ROLE OF EVALUATION SPONSOR AND FUNDER

The sponsor and funder of this evaluation is Nottinghamshire Healthcare NHS Foundation Trust (NHNFT). NHNFT contributed to, and had the final decision over, the evaluation design, conduct, data analysis and interpretation, manuscript writing, and dissemination of results.

ROLES AND RESPONSIBILITIES OF THE EVALUATION MANAGEMENT GROUP

The evaluation was overseen by the Substance Use/Mental Health Pathway Development Group. This group reviewed and approved the evaluation protocol but were not involved in delivery, data analysis or report writing. Members of this group included representatives from the following organisations: Change Grow Live; Double Impact; Nottingham City Council; Nottingham and Nottinghamshire CCGs; Nottingham Recovery Network; Nottinghamshire County Council; and Nottinghamshire Healthcare NHS Foundation Trust.

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Executive Summary

Introduction

A new care pathway was developed for adults with co-existing mental health and substance use conditions in Nottingham and Nottinghamshire. As part of the pathway, dual substance use and mental health (SU-MH) peer support workers were introduced as part of a pilot in Mid Nottinghamshire local mental health teams (LMHTs). These peer support workers work with patients to identify goals for change, build individual capabilities and confidence, share their lived experience to build trust and offer an example of recovery, link patients to mental health and substance use services and support networks, and provide practical support. The model itself is based on joint working with a local voluntary and community sector organisation (Double Impact). They employ and support the staff, and the staff then work in Nottinghamshire Healthcare NHS Foundation Trust (NHFT) with joint line management and support provided by both the Trust and Double Impact.

Methods

The evaluation had a mixed methods approach involving analysis of care records and qualitative interviews. Before/after patient outcomes (mental health, substance use and wider social outcomes) and use of urgent mental health services were also explored.

Patients and staff were recruited for one-to-one interviews. Peer support workers and wider staff were interviewed. Participants shared their experiences of receiving peer support or working alongside peer support workers, as well as recommendations for its future development.

Results and discussion

Peer support workers supported 64 patients with co-existing substance use and mental health conditions between May 2022 and May 2023.

All interviewed patients reported positive experiences of peer support and said it added something different to their care, not already provided by other professionals. Patients interviewed reported a positive impact on mental health, substance use and wider social outcomes. Patient experience was very positive, with 100% of patients rating the peer support as excellent and reporting that they would recommend peer support to another service user.

There were small or no differences observed across most clinical outcomes assessed. The exception was a small drop in substance use. However, due to limitations in available data, patient outcomes remain unclear and longer follow-up is required.

There was a substantial reduction in the number of patients using urgent mental health care services, which may suggest stabilisation of the group or earlier access to support. However, no firm inferences can be drawn due to the short length of follow up. Patients who met peer support workers twice or more appear to be those who are already highly engaged with their LMHTs, so further work is needed to ensure that peer support is meeting the needs of those who struggle most to engage.

Wider staff reported positive views of SU-MH peer support. Peer support workers are valued by local mental health teams and have increased LMHT staff confidence and capacity to support SU-MH patients, increased understanding of substance use and the services available to support patients, and made valuable contributions to MDTs and risk assessment.

Peer support workers see the value of their role and report good levels of support and job satisfaction. They have concerns about the short-term nature of current contracts and the lack of pay parity with NHS-employed peer support workers may be a risk to recruitment and retention.

The innovative model of cross-working between Nottinghamshire Healthcare NHS Foundation Trust and Double Impact works well overall. Line management and support by Double Impact is valued by PSWs and the dual approach to induction is seen as particularly valuable. Clinical supervision overall is working well. The relationship between the Trust and Double Impact is good and brings benefits to the pilot. There are opportunities to improve recruitment, to streamline line management and clinical supervision and to ensure greater consistency across teams.

Conclusion

Substance use and mental health peer support is working well and is valued by patients and the teams they are working with. Patient and staff experiences were very positive. Peer support workers, with their lived experience, are offering patients something different that is not already provided by other professionals. There are some issues relating to implementation that should be considered in terms of the wider roll out of the model and this would include streamlining some aspects of line management and recruitment. It would also be useful to look again at the patients that do and do not engage with peer support, as the patients in this evaluation tended to have good pre-existing levels of engagement. Targeting those with poor engagement with the service could bring even greater benefit.

Introduction

Purpose of the evaluation

To evaluate the pilot of dual substance use and mental health (SU-MH) peer support workers in Nottinghamshire Healthcare Trust.

Aim

The aims of the evaluation are:

- To understand if this pilot has a positive impact on patient outcomes and experience, service provision and system outcomes;
- To identify what needs to be in place for the best outcomes to be achieved to inform pilot roll out in other areas;
- To inform decisions about future funding and expansion of this approach within the Trust and across the Integrated Care System.

Objectives

1. To provide a narrative that describes the dual substance use-mental health peer support pilot in Mid Nottinghamshire
2. To determine if a substance use-mental health peer support intervention improves:
    a. patient mental health outcomes
    b. patient substance use outcomes
    c. patient wider social outcomes
    d. patient experience
    e. service provision
    f. system outcomes and staff experience
3. To provide recommendations to inform continuation and further roll out of dual substance use-mental health peer support

Background

Co-existing mental health and substance use

Co-existing mental health and substance use refers to people with a severe mental illness (including schizophrenia, bipolar disorder and severe depression) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage).[1] Co-existing mental health and substance misuse has historically been known as *dual-diagnosis*.

Recent studies have estimated that 20-37% of people in secondary mental health services and 6-15% of people in substance misuse settings have co-existing mental health and substance misuse issues.[2] However, this is an estimate it is difficult to know with real certainty how many people in the UK are experiencing severe mental illness alongside substance misuse problems. There is though, an increasing awareness that individuals with these issues experience some of the worst health, wellbeing and social outcomes, and are among the most vulnerable in society.

[1] National Collaborating Centre for Mental Health (2016). Coexisting severe mental illness and substance misuse: community health and social care services - Review 1. Available at nice.org.uk

[2] Carrà G, Johnson S. Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK. Social psychiatry and psychiatric epidemiology. 2009;44:429-47.

The *Independent Review of Drugs* (2021) by Dame Carol Black outlines how for many people, mental health problems and trauma lie at the heart of their drug and alcohol dependence. However, this group can sometimes be excluded from mental health services until they resolve their drug problem and may be excluded from drug services until their mental health problems have been addressed.[3] For this reason, the report urges commissioners of substance misuse services and NHS mental health services, to work together to ensure that individuals do not fall between the cracks.

Guidance and policy

There are existing National Institute for Clinical Excellence (NICE) clinical guidelines for how services for people with co-exiting mental health and substance misuse should be organised and delivered, and these are summarised in Appendix 1. Some key points include:

- Jointly agreed care pathways should be in place, as should joint strategic working between service providers and commissioners
- Staff should have good support and development opportunities to provide the right treatment and care
- Services should be non-judgemental, inclusive and be able to engage with people from diverse cultural and ethnic backgrounds
- People experiencing co-existing substance misuse and mental health issues should have a clear care plan in place

Local context

From a local perspective, there have been Regulation 28 Coroner Reports to Prevent Future Death that highlight issues in relation to care for people with co-existing substance misuse and mental health. Two Preventing Future Deaths reports have been issued to date, one in 2016 and one in 2021. The key areas of concern raised included:

- A need to ensure continuity of care for people who have both a substance misuse problem and a mental health problem
- A need to share information between organisations where this is relevant to patient care
- Knowledge and understanding of services by staff working in primary care
- Commissioning arrangements for substance misuse/mental health services and how these need to be more co-ordinated

Service structure

The pathway

A new substance use-mental health pathway has been developed that:

- **Supports people accessing Local Mental Health Team (LMHT) services who have substance use issues**, by having:
    - A specialist **substance use-mental health practitioner** embedded in the LMHT team. This SU-MH practitioner supports LMHT staff and the patient themselves, and has the ability to undertake joint assessments and care planning with LMHT staff.
    - **SU-MH peer support workers** embedded in the LMHT team who understand their situation and the barriers to accessing substance use treatment and mental health services, and help them to engage with local services.

[3] Home Office (2020). Independent report: Review of drugs phase two report. Available at Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)

- **Supports people accessing substance use services who have mental health issues** so that the provider has the right specialist mental health expertise available to support that person and the staff working with that person. The SU-MH practitioner will undertake a comprehensive assessment and then act as a trusted assessor for secondary mental health services creating a seamless pathway into services.
- **Supports people in inpatient mental health settings who have substance use issues** including support into treatment services when they leave the inpatient setting.
- **Supports staff working in mental health settings to have a better understanding of substance use** and how to support people with substance use issues.
- **Supports staff in substance use settings to have a better understanding of mental health** and how to support people with mental health issues.

To set up the new model, the following posts have been created using mental health transformation funds:

- Six SU-MH practitioners
    - Three working with substance misuse providers
    - Three working in LMHTs
- Two substance misuse workers supporting inpatient wards.
- Five whole time equivalent SU-MH peer-support workers working in LMHTs

Peer support

The pilot of dual substance use and mental health (SU-MH) peer support workers (PSW) in Nottinghamshire Healthcare Trust was introduced as part of the development of a new dual substance use and mental health pathway. The pilot took place in mid-Nottinghamshire, in the local mental health teams of Mansfield, Ashfield and Newark & Sherwood.

It was funded as part of the Trust's mental health transformation programme. Peer support workers were employed by Double Impact, an addiction recovery organisation, and seconded into the Trust.

The pilot started in February 2022 and finished in March 2023.

Governance

Corporate governance for the pilot was provided through the NHNFT Co-existing substance use and mental health pathway group and the NHNFT Local Mental Health Transformation Board. The pathway group linked to the NHNFT dual diagnosis clinical strategy group. Externally, the Trust report to the Integrated Care System Mental Health Partnership Board.

Clinical governance of the peer support workers was provided by clinical leads in each LMHT who reported to the adult mental health service manager.

Line management was provided by Double Impact as employers of the peer support workers.

Logic model

A logic model was developed as the pilot began, and is included in appendix 1.

Methodology

The evaluation had a mixed methods approach using both qualitative and quantitative data collection.

The evaluation was guided by the Co-existing substance use and mental health pathway group, a group of stakeholders from the Trust, local substance use providers and local authority public health. The group supported development of the methodology, took part in interviews and reviewed findings. They will also be central to implementing recommendations from the report and sharing findings.

Prior approval for the evaluation was obtained through Nottinghamshire Healthcare Trust's research and evidence team.

Quantitative data collection

Service level data from Rio electronic health records was gathered from May 2022 to May 2023 to describe the service in terms of number and demographic characteristics of patients receiving peer support; the duration of support; the length, number and location of appointments; activities undertaken; appointment attendance, engagement and DNA rates; use of urgent care services.

Clinical data was used to understand changes in patient mental health, substance use and wider social outcomes from the Health of the National Outcome Scale (HoNOS). HoNOS is a clinician reported outcome measure for those aged 18-64 years old with severe mental illness. It comprises 12 questions measuring behaviour, impairment, symptoms and social functioning. Each question is on a 4 point scale from 0 (no problem) to 4 (severe to very severe problem).

Interviews with patients also provided some quantitative data. The INSPIRE patient-rated experience measure (PREM) was used to assess patient's experience of the support they receive from the peer support worker for their recovery and the relationship. Patients were also asked to rate their experience of peer support and rate whether they would recommend SU-MH peer support to another service user.

Qualitative interviews

Staff and peer support worker interviews

The qualitative element of the evaluation focused on semi-structured interviews to understand current experience of the peer support model to inform service development and potential future roll out of SU-MH peer support.

Staff participants were purposively sampled to ensure that those working directly in and with the service were given the opportunity to share their views.

Staff identified as potential participants were sent information about the evaluation and what their participation would involve. Verbal consent was obtained from staff members which was recorded during interview.

A member of the research team, who was a member of Trust staff with no direct relationship to the service, conducted semi-structured interviews on MS Teams. On average interviews lasted 30-40 minutes. All interviews were recorded and auto-transcribed.

Interview data was then analysed using a qualitative, thematic analysis approach and involved reviewing transcripts in depth to extract key points and identify themes.
Interviews were conducted with 13 members of staff:

- Trust
  - LMHTs (4)
  - Substance Misuse/Mental Health pathway (2)
  - Transformation team (1)
- Peer support workers (3)
- Double Impact (2)
- Change Grow Live (1) – substance use service

Patient interviews

A broad sampling frame was developed and all patients who had had 3 or more contacts with a peer support worker were invited to take part in an interview. This included current and discharged service users. The minimum contact threshold intended to exclude patients with whom the peer support worker had only been introduced or met during shadowing visits with another professional.

Patients identified as potential participants were approached by their peer support worker and provided with information about the evaluation and what their participation would involve. Written consent was obtained for patients prior to interview, and then reconfirmed verbally during the recorded interview.

A member of the evaluation team, who was a member of Trust staff with no direct relationship to the service, conducted semi-structured interviews face-to-face or by phone. On average interviews lasted 30-40 minutes. All interviews were recorded and auto-transcribed. Interview data was then analysed using a qualitative, thematic analysis approach and involved reviewing transcripts in depth to extract key points and identify themes.

No identifiable information was collected.

Interviews were conducted with 11 patients.

Results

Patient characteristics

The tables below provide information about the number of patients supported by SU-MH peer support workers and the demographic characteristics of those patients. This data represents the period from 4th May 2022 to 15th May 2023.

Number of patients

The total number of patients having contact with peer support workers was 94. However, some of these only had one contact in the form of an introductory meeting or where a peer support worker shadowed another professional on a visit, for example a CPN visit.

The number of patients having meaningful contact with a peer support worker, meaning two or more contacts, was 64.

Table 1: Total number of patients

	All patients	Patients with meaningful contact (2 or more contacts)
SU-MH peer support	94	64

Patients by demographic characteristics

Table 2 gives the actual number and proportion of all patients by gender, age group, ethnicity and level of area deprivation.

Patients were more likely to be male (69.1%), aged between 26-55y (79.7%), of white ethnicity (91.5%) and living in areas of high deprivation (49% in IMD deciles 1 and 2).

Table 2: Demographic characteristics of patients receiving peer support

Demographic	**Number of patients**	**Percentage**
Gender		
Female	29	30.9%
Male	65	69.1%
Age		
18-25	4	4.3%
26-35	24	25.5%
36-45	32	34.0%
46-55	19	20.2%
56-65	11	11.7%
Over 65	4	4.3%
Ethnicity		
Black or Black British	2	2.1%
Mixed	3	3.2%
Other Ethnic Groups	1	1.1%

Unknown	2	2.1%
White	86	91.5%
Deprivation - IMD Decile Note: IMD Decile 1 represents the most deprived 10% of small areas in England. Where IMD decile is NA, we do not have an English address, e.g. if they are homeless		
1	23	24.5%
2	23	24.5%
3	11	11.7%
4	9	9.6%
5	8	8.5%
6	9	9.6%
7	5	5.3%
8	2	2.1%
9	1	1.1%
10	1	1.1%
NA	2	2.1%

Due to incomplete data, we are unable to describe the disability status or sexual orientation of patients receiving peer support.

Patients by diagnostic group

Table 3 shows the most recent HoNOS super cluster of patients which indicates whether a patient's mental health condition is psychotic or non-psychotic. Slightly more patients having meaningful support from peer support workers had non-psychotic clinical presentations.

Table 3: Patients by diagnostic group

Diagnosis (HoNOS)	Number of patients	Percentage
Non-psychotic	33	51.6%
Psychotic	30	46.9%
Unknown	1	1.6%

*Note: Patients receiving meaningful peer support of at least 2 contacts

Patient level of substance use

Of patients who had meaningful contact with peer support, the average (median) HoNOS score for substance use was 2 (on a 4 point scale) meaning "mild problem but definitely present".

Table 4: Patients substance use

HoNOS score	Average (median) score
Substance use	2

Service description

The following data describe the dual substance use-mental health peer support pilot in Mid Nottinghamshire. All data relates to patients who received meaningful support from peer support workers (at least 2 contacts) during the period 4th May 2022 to 15th May 2023.

Number of staff

The pilot originally funded and recruited 5 full-time-equivalent (FTE) peer support workers for a period of approximately 6 months. Two peer support workers had their contracts ended shortly after starting. Therefore, the funding for 5 FTE posts was used to extend the contracts of the 3 PSWs to 13 months.

Table 5: Staffing

Staff type	Number of FTE peer support workers
SU-MH peer support workers	3
Double Impact line manager	0.6

Number of patients by Local Mental Health Team

Table 6 shows the number of patients receiving peer support in each local mental health team. There were 26 patients in Mansfield LMHT, 21 in Ashfield LMHT and 15 in Newark & Sherwood LMHT.

Table 6: Patients by Local Mental Health Team

Team	Number of patients
LMHT Ashfield	21
LMHT Mansfield	26
LMHT Newark & Sherwood	15
Coexisting SU-MH Pathway	2

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Length of appointment

Table 7 shows the average length of appointments. The most common duration of appointment was 60 minutes. On a small number of occasions appointments lasted a full day or half a day, which increases the mean average.

Table 7: Appointment duration

Peer support worker	Mean (minutes)	Median (minutes)
PSW 1	78.9	60
PSW 2	69.2	60
PSW 3	71.8	60

Location of Appointments

Table 8 show the location of appointments. Most appointments were conducted at patients' residences (64.6%), followed by community locations e.g. cafes (27.2%). A small number of appointments were conducted a Trust sites, e.g. LMHT offices (5.9%) or virtually e.g. by phone (2.3%).

Table 8: Appointment location

Location	Number	Percentage
Community location	188	27.2%
Trust site	41	5.9%
Patient residence	447	64.6%
Virtual	16	2.3%

Frequency of appointments

Patients interviewed reported that they saw their peer support worker weekly or 2-weekly. The frequency of contact was generally felt to be enough

Activities undertaken

Peer support workers described their main activities as:

- Sharing their lived experience, to connect, engage and inspire hope.
- Talking with a patient about:
  - Their current situation and challenges
  - Their ambitions, goals and hopes for the future
- Building a patient's confidence, often through identifying strengths
- Going out with the patient, for example with patients who are very socially isolated
- Supporting patients to access services and with practical needs e.g. housing, access to substance misuse services, Double Impact, educational and training opportunities

This aligned with the range of support described by patients in patient interviews, involving:

- Talking about their current situation at home or in a public place.
- Going out together to the park, café or various clubs/groups.
- Support to access local groups and services, for example Mind, Alcoholics Anonymous, Double Impact services, Rhubarb farm, the gym and a peer support worker led pool club.
- Support to access and attend healthcare appointments with mental health teams or GP.
- Practical assistance, for example to claim benefits, go shopping, pay bills.

Table 9 shows the type of activity assigned to appointments in Rio data. The most common activity was peer support, followed by lifestyle, care coordination, and therapeutic interventions. There was variation between peer support workers in how activity was recorded.

Table 9: Activities undertaken

Activity	PSW 1	PSW 2	PSW 3
Assessment	20	18	4
Care Coordination	33	36	6
Family / Carer	2	4	0
Lifestyle	44	33	14
Medicinal	16	13	2
Other	2	11	0
Peer Support	120	380	216
Therapeutic Intervention	39	10	3

Length of support

Of those patients presumed to be discharged from peer support, who have received no contact in the last 6 weeks, the mean average length of time they were supported ranged from 4.1 to 4.4 months.

Table 10: Length of peer support of discharged patients (first to last contact)

Peer support worker	Average duration (months) Mean	Average duration (months) Median
PSW 1	4.4	3.7
PSW 2	4.1	3.6
PSW 3	4.3	2.9

Of those patients still being supported by peer support, who have had contact in the last 6 weeks, the mean average length of time they have been supported so far ranged from 8.5 to 9.4 months. Those patients are still open to peer support and so the duration of support will continue to increase.

Table 11: Length of peer support of current patients (first to last contact)

Peer support worker	Average duration (months) Mean	Average duration (months) Median
PSW 1	9.3	9.7
PSW 2	9.4	10.6
PSW 3	8.5	10.1

Number of appointments

The table below shows that the average number of times a peer support worker sees a patient ranged from 7.3 to 18.1 times. This includes patients who are still open to peer support, so the average number is likely to increase over time.

Table 12: Number of appointments

Peer support worker	Average number of appointments Mean	Average number of appointments Median
PSW 1	7.3	4.0
PSW 2	18.1	8.5
PSW 3	10.8	6.5

Peer support appointment attendance

Table 13 shows the number and proportion of appointments attended ('seen') and where the patient did not attended ('DNA'). Most appointments with peer support workers were attended (74%), although a quarter of appointments were missed (25%).

Table 13: Peer support appointment attendance

Appointment attendance	Number	Percentage
DNA	236	25%
Seen	692	74%
Unoutcomed	1	0%

Of those appointments where the patient did not attend (DNA), it was slightly more likely if the appointment was scheduled in a community location (e.g. café) or hospital location (e.g. LMHT office), rather than if it was at the patient's home residence or virtual (i.e. by phone).

Table 14: Peer support appointment attendance by location

Appointment location	DNA	Seen
Community location	28.5%	71.5%
Trust site	28.1%	71.9%
Patient residence	24.2%	75.8%
Virtual	11.1%	88.9%

Patient Outcomes

The following data describe patient outcomes. Unless specifically stated, all data relates to patients who received meaningful support from peer support workers (at least 2 contacts) during the period 4th May 2022 to 15th May 2023.

Mental health outcomes

In patient interviews, patients were asked if peer support had had an impact on their mental health. A total of 9 out of 11 patients described that peer support had a positive impact on their mental health. This was attributed to having someone to speak to and getting out more.

"It's helped me to see other things, to avoid spiralling down" (Patient 5)

"I feel clearer, that somebody at last is listening to me" (Patient 7)

Clinical data, outlined in Table 15, shows the change in patient mental health outcomes based on clinician reported outcome measure HoNOS. Due to the infrequency of HoNOS completion, this table is based on 12 patients who had a HoNOS score in the period before peer support (since 1st January 2021) and after peer support started. There are 12 questions in 4 subscales measuring behaviour, impairment, symptoms and social functioning. Each question is on a 4 point scale from 0 (no problem) to 4 (severe to very severe problem). A change in score which is a negative number represents a decrease in severity.

The average change in mental health score for the behaviour and impairment subscales was -0.1 suggesting a slight improvement. The average change in score for symptoms was 0.2 suggesting a slight deterioration.

Table 15: Patient outcomes: HoNOS scores

HoNOS subscale	Qu	Description	Previous (mean)	Current (mean)	Change (mean)	Subscale previous (mean)	Subscale current (mean)	Subscale change (mean)
Behaviour	1	Aggression/ Overactivity	0.6	0.7	**0.1**	**0.9**	**0.8**	**-0.1**
	2	Self-Harm	0.3	0.2	**-0.1**			
	3	Substance Use	1.9	1.5	**-0.4**			
Impairment	4	Cognitive Impairment	0.6	0.6	**0**	**0.9**	**0.8**	**-0.1**
	5	Physical Impairment	1.2	1.1	**-0.1**			
Symptom	6	Hallucinations/ Delusions	0.7	1.3	**0.6**	**1.5**	**1.6**	**0.2**
	7	Depression	1.5	1.3	**-0.2**			
	8	Other mental / behaviour problems	2.2	2.3	**0.1**			
Social	9	Relationships	1.2	1.1	**-0.1**	**1.1**	**1.0**	**-0.1**
	10	Daily Living	1.1	1.1	**0**			
	11	Living Conditions	0.6	0.4	**-0.1**			
	12	Occupation/Activities	1.4	1.3	**-0.1**			

Substance use outcomes

In patient interviews, 8 out of 11 patients reported that peer support had led to reduced substance use. Of the remaining 3 service users, 2 said there was no change as they were already abstinent.

"If I didn't have peer support, I'd have carried on drinking. [When I relapse] to stop after a few days is good compared to in the past when it would have been months." (Patient 5)

"[The PSW] helped me get off the drink for 4 months, and that's the first time in 13 years". (Patient 7)

"I've cut down dramatically with the alcohol, though I still drink, it's nowhere near what I used to drink. That's since I've been seeing [the PSW] and since going to AA…. If it wasn't for [my PSW] I'd still be drinking 3 litres of whiskey a week". (Patient 8)

In clinical data outlined in Table 15 above, the average change in HoNOS score for question 3, relating to problem drinking or drug taking, was -0.4 suggesting a slight improvement.

Wider social outcomes

In interviews with patients:

- The majority of patients (8 out of 11) felt that peer support led to reduced social isolation, through talking to the peer support worker and going out more.
- Several service users (3 out of 11) reported that they were now engaged in or trying to get into employment or voluntary work, as a result of peer support.
- Other impacts included improvements to physical health through support to access the gym and reducing smoking.

In addition, when patients were asked about if they would do things differently in the future as a result of receiving peer support:

- The majority of service users (9 out of 11) said they would do things differently, including reducing substance use, going out more, engaging in physical activity, attending support groups, and adopting a more positive outlook.

"I want to sort my life out, my mental health, and try to get on with my life" (Patient 11)

"I want to change my life. I have two lovely grandchildren. I want to be around for them." (Patient 8)

Wider staff interviews also identified that peer support:

- Service and social engagement – can help patients to engage with services as well as going out into the community
- Increase motivation and confidence - they increase the motivation and confidence of patients and their quality of life

In clinical data outlined in Table 15 above, the average change in HoNOS score relating to social outcomes was -0.1 suggesting a very slight improvement.

Patient experience

Patients interviewed had high levels of satisfaction with SU-MH peer support.

- 100% of service users rated the peer support they had received as 'excellent'.
- 100% of service users would recommend peer support to another service user (10 out of 11 service users said 'yes, definitely' and 1 out of 11 said 'yes, maybe').
- Service users described the support as helpful, appreciated having someone who listens without judgment, who fully understands their situation and they valued their lived experience.

"In 13 years being involved in hospital, this is the best thing that's happened to me." (Patient 7)

All patients (100%) interviewed felt that peer support added something different to their care, that is not already done by other professionals. This included:

- Greater understanding of the service users situation due to their lived experience
- Listening in a non-judgemental way enabling the service user to trust and open up
- Increased time to support
- Being more human and less clinical
- Providing practical support, for example to make and attend appointments
- Being more accessible by phone or text
- Being an inspiration and example of what recovery could look like

"The massive difference is [the PSW] has lived experience – the experience of what you're going through. On the substance misuse side he understands" (Patient 6)

All patients (100%) interviewed believed that it was important that the peer support worker had experience of both mental health and substance use as this enhanced their understanding of, and ability to relate to, their problems.

"You can get degrees, but if you don't know what it's like, I don't want to talk to [you]. Personal experience stands up a lot more than qualifications" (Patient 9)

"It's nice to talk to someone who has been in your situation. [They've] been there and done it, [they] can open up to people and help people who are going through it." (Patient 11)

Patients interviewed completed the INSPIRE measure, a validated patient-rated experience measure (PREM) used to assess a service user's experience of the support they receive from a mental health worker for their recovery. It has two sections:

- The Support section identifies the level of worker support for the items rated by the service user as important for their recovery, for example feeling motivated to make changes and in control of their life.
- The Relationship section assesses the relationship between the service user and the mental health worker, for example whether they feel listened to and respected.

The average scores given by patients were:

- Support - 82% (compared to 72% average in INSPIRE validation studies).
- Relationship - 95% (compared to 78% average in INSPIRE validation studies).

Both scores are higher than the average scores in validation studies.

Interviews of wider staff also identified benefits for patients relating to patient experience as:

- **Lived experience** – the PSW can share their lived experience, for example to build trust in a way that is difficult for other professionals
- **More time and flexibility of appointments** – compared to other professionals

Service provision

Engagement

Engagement with mental health services

In patient interviews, most patients (7 out of 11) felt that their peer support worker had helped them to engage with their mental health team, for example by accompanying individuals to appointments, emailing professionals for additional support, and encouraging attendance.

"It makes it more comfortable when [the PSW] is there with me [in appointments with CPN / psychiatrist]. [My PSW] talks openly about stuff that should be spoken about and makes me feel comfortable" (Patient 4)

"If the PSW didn't take me to appointments, I probably wouldn't go." (Patient 2)

"[The PSW] has attended appointments to see my psychiatrist. Never really know what to expect when going to meet with the doctor… so it's good to have a conversation with someone who has been through the system on a personal level to prepare" (Patient 9)

For patients interviewed who did not feel their peer support worker had helped them to engage with their mental health team (4 out of 11), they all stated that they were already getting sufficient support from their mental health team to engage and didn't need additional support.

In interviews with wider staff, staff identified that peer support helps to improve patient engagement as it is an additional route to reach patients if they are not engaging.

Service data for all patients who had contact with a peer support worker, including those who had only one contact, showed that DNA rates at LMHT appointments, for example meetings with CPNs or psychiatrists, was approximately 15% in the before and after period.

Table 16: LMHT appointment attendance – all patients

Appointment attendance	Before	After
DNA	15%	15%
Seen	85%	80%
Unoutcomed	0%	5%

For patients who had meaningful contact with peer support worker (at least two contacts), LMHT appointment attendance was higher with 5% DNA before peer support and 4.5% DNA after starting peer support.

Table 17: LMHT appointment attendance – patients who received meaningful peer support

Appointment attendance	Before	After
DNA	5%	4.5%
Seen	95%	95.5%

Engagement with substance use services

In patient interviews, some patients (4 out of 11) reported that peer support had helped them to engage with substance use services.

The majority of patients (7 out of 11) felt that peer support had not helped them to engage with substance use services because they didn't want to engage at the moment (4 out of 11) or they weren't using substances at the moment (3 out of 11).

Discharge from LMHT

Table 18 shows the reason for discharge from LMHT for patients receiving peer support. The majority of patients, 57 out of 64, are still open to LMHT ('no data').

Table 18: Reason for discharge from LMHT

Discharge reason	Number of patients
Assessment completed	1
Client did not engage	1
Moved out of area	2
No data	57
Other reason	1
Transferred to another service	1
Treatment complete	1

Use of urgent care services provided by the Trust

The Trust has a range of urgent care services, such as the Crisis team (via 24/7 phone line), Liaison in A&E, Liaison and Diversion in court and police settings and Street Triage.

Table 19 shows the number of patients who had contact with urgent mental health care services per month before and after the start of peer support. This shows a reduction in the number of patients interacting with urgent care from 37 patients to 15 patients per month.

Table 19: Use of urgent care services – number of patients

Time period	Average number of patients per month
Before	37
After	15

The table below shows the rate of use of urgent mental health care services before and after starting to receive peer support. The rate of urgent care use increased in the period after peer support started for Crisis, Liaison and Diversion and Liaison in A&E.

Table 20: Use of urgent care services – rate by service

Service	Rate per month Before	Rate per month After
Crisis Resolution & Home Treatment	0.06	0.18
Liaison & Diversion (Criminal Justice System)	0.04	0.12
Liaison (in A&E in Acute Hospital)	0.11	0.23
Street Triage	0.03	0.00

Staff experience and system outcomes

Staff experience

The wider staff experience of working alongside SM/MH PSWs was:

- Overwhelmingly positive
- They described PSWs as very motivated and genuine
- They felt that PSWs work well in teams and make valuable contributions to meetings e.g. MDTs.

All peer support workers described feeling:

- Positive about the job role and felt it was suitable as a long term position
- Positive about the impact on future prospects and would like further opportunities for progression.
- Supported and embedded in their teams
- That peer support was generally highly valued
- That their lived experience is valued
- The LMHT team has been key support to them being able to do their role

"I have a passion for helping people. I was one of those people that everybody said is hopeless and never going to change.. it's a gift that just keeps giving because every day I love my job".

Areas for improvement identified by peer support workers included:

- **Lack of pay parity** between these roles employed by Double Impact and peer support workers employed directly by the Trust following the NHS pay deal.
- **Uncertainty and short-term contracts**

LMHT staff upskilling and capacity

In interviews with wider staff, LMHT staff identified the main benefits of SU-MH peer support to the LMHT as:

- Raising the profile of substance misuse in the team
- Increasing capacity of the LMHT to support SM/MH patients
- Increasing LMHT staff understanding of the needs of this patient group
- Increasing LMHT knowledge of services and support for substance misuse, including through closer working with Double Impact.
- Improving the quality of risk assessment by making LMHT staff feel more confident to ask questions about substance use and by reporting to the LMHT if further risks are identified during peer support visits.

Functioning of the model / pathway

Recruitment

In wider staff interviews a strong theme was that the three PSWs in place are well suited to the role and having a positive impact on patients and their teams.

Challenges relating to recruitment processes included:

- **Lack of Trust involvement**– it was felt that greater in recruitment from the Trust could have helped ensure PSWs had the Trust core values, understood the job role, and may have helped to avoid the issues that resulted in two PSW recruits being dismissed
- **Time scales -** Recruitment took longer than expected
- **Working across organisations added to delays -** Once PSWs were recruited by Double Impact, there were delays getting DBS checks completed to enable Trust honorary contracts to be put in place. This delayed PSWs starting in post

Induction training

Wider staff described the induction training as:

- **Strong and of good quality** - this included recognition that various elements are accredited
- **Beneficial and relevant to work**

Peer support workers found the induction training:

- **"Extremely helpful"** – All PSWs rated both Double Impact and Trust induction training as "extremely helpful"
- **Relevant to the role -** they felt that both sets of training were very relevant and useful to their role
- **Good mix of format/methods -** They appreciated the balance of more practical courses with ones more focused on reading and reflection
- **Complementary –** All PSWs said that the Double Impact peer mentoring and Trust peer support training complemented each other well, rather than duplicated

- **Good trainers** – Two PSWs described the Trust peer support trainers as 'brilliant' and 'excellent'

Challenges identified by peer support workers about the induction process included:

- **The long timescale in terms of starting the role**– this was linked to delays in getting honorary contracts
- **Duplication of some health and safety and GDPR type mandatory training** – which it was acknowledged probably can't be avoided

Implementation of SM/MH peer support across LMHTs

Wider staff & peer support workers were positive about the implementation of SM/MH across LMHTS as described in previous sections.

However, a challenge identified by both was:

- **Inconsistent approaches to how peer support workers work in different LMHTs** – for example, in how they accept referrals and what patients they see. While this responded to the reality that each LMHT works slightly differently, it was also recognised as a weakness as PSWs may get conflicting messages.

Supervision and line management

Line management is provided by Double Impact and clinical supervision is provided by the Trust LMHTs. There is further support from the Trust peer support team.

Wider staff described that:

- **Currently there may be too many people involved in overall supervision and management** – "there's too many people… pulling them in different directions"
- **Potential mixed messages** to peer support workers
- **No one person having oversight** of their clinical caseload or trends in referrals
- **A lack of having one team** for PSWs which could lead to them feeling isolated

Peer support workers said that:

- **Too many people involved in overall supervision, management and support** – this needs to be clearer, with key points of contact for specific issues and closer joint working

Line management from Double Impact

Wider staff described the line management from Double Impact as:

- **Working well** - Several wider staff, both in LMHT and the pathway, expressed that line management from Double Impact was working well and provides valuable support to PSWs:
- **Issues handled well** - when there were difficulties with a peer support worker who was dismissed, Double Impact managed that very well

"[The PSWs] get unique support within Double Impact for their lived experience that I'm not sure whether we would be able to provide within the Trust"

Wider staff outlined the following challenges:

- **Access to the Trust clinical system –** The Double Impact line manager is unable to access clinical records and this was seen to be an issue. This was related to not having a more in depth knowledge of the cases and specific work of the PSWs.
- **Knowledge around secondary care mental health services -** Double Impact are a third sector community-based organisation and as such have limited exposure to how secondary care services such as LMHTs are organised and delivered, and how issues with GDPR and sharing information are organised and resolved
- **Oversight and integration** – Although line management from Double Impact was described in very positive terms, two participants suggested bringing line management into the Trust to either the LMHT, to provide greater oversight and contact, or to the existing internal peer support team

Peer support workers described line management from Double Impact as:

- **"Extremely helpful"** - All PSWs rated the line management from Double Impact as 'extremely helpful' and something that had support them in their role as a PSW
- **Open and honest** – "I don't have to hold anything back"
- **Supportive** – "My manager is always there whenever I need her"
- **Good communication** – line manager communicates to them about everything and is very accessible, even on her days off

Clinical supervision in LMHTs

Feedback from wider staff and peer support workers about clinical supervision were mixed.

Wider staff described the clinical supervision in LMHTs as:

- **Going well in some LMHTs** - with monthly supervisions and the PSWs coming to discuss things on an informal basis in between.

Wider staff outlined the challenges as:

- **Not going as well as it could in one LMHT** – largely due to a large gap in supervision meetings and a lack of informal contact in between
- **Limited by lack of expertise in substance misuse –** One LMHT felt it was less effective if a clinical supervisor does not have specific substance misuse expertise
- **Inconsistency of clinical supervision across LMHTs –** different clinical supervisors in different LMHTs may contribute to inconsistent approaches

Peer support workers described the clinical supervision as:

- **Going well in most LMHTs** - Two PSWs rated their clinical supervision as 'extremely helpful' and described it as very supportive. They valued their clinical supervisor being very experienced, knowing their clients really well, supporting their development and that they were based in the LMHT

Peer support workers identified the following challenges:

- **Not going as well as it could in one LMHT** - One PSW rated their clinical supervision as 'slightly / somewhat helpful'. This was influenced by the infrequency of supervision appointments and little support when issues were raised e.g. by email
- **Frequency** - Two out of three PSWs raised that they would like more frequent clinical supervision
- **Risks of potential change in clinical supervision** - One PSW was concerned that if clinical supervision moved from the LMHT to the SU-MH Practitioner, the practitioner may not have capacity to supervise across all PSWs/teams and may not have sufficient knowledge of the LMHT patients across a large area. It may also create a barrier between PSWs and the LMHTs, with whom they have developed strong relationships, which could delay or block referrals.

Risk management

Overall risk was perceived to be reasonably well managed, particularly now that clearer boundaries have been put in place about who PSWs can and cannot work with. This was echoed by PSWs.

Weaknesses in **risk management** highlighted by wider staff included:

- **Work outside boundaries** - On occasion some PSWs had been asked to do work outside their role. This was more at the start of the pilot when clinicians were unclear on what a PSW could and could not do, but is to some extent an ongoing matter
- **Not following risk advice** - There have been occasions when the PSW has not followed risk assessments and advice given. This related to the PSW who was dismissed as well as one other PSW
- **Risk to PSW recovery** – Some interviewees highlighted the need to understand and manage risk to the PSWs in their own recovery and ensure appropriate support

Joint working across the Trust and Double Impact

Wider staff:

- Strength of collaboration - There were several comments from wider staff about the strength of the collaboration and cross working with Double Impact
- Double Impact's experience and knowledge of working with this client group is an asset – Therefore, closer working between the Trust and DI will have a positive impact on our patients.
- The willingness of the Trust and Double Impact to work together was also highlighted

Peer support workers:

- Positive – All PSWs found working across the two organisations as very positive, and could see benefits for patients.

Continuation of funding

- Wider staff interviewed identified that a disadvantage of the current model is the short-term nature of funding and the risk of peer support being withdrawn.
- Peer support workers also described the uncertainty and short-term nature of contracts a challenge.
- Patient suggestions for how the peer support could be improved all related continuing and increasing funding for this peer support both to continue the existing service, expand this

peer support to other areas and provide some more individual and group activities for those receiving peer support.

Discussion of key findings

Patient characteristics

The SU-MH peer support pilot reached a total of 94 patients, and provided meaningful support (at least two contacts) to 64 patients, between 4th May 2022 and 15th May 2023.

Patients were more likely to be male (69.1%), aged between 26-55y (79.7%), of white ethnicity (91.5%) and living in areas of high deprivation (50% in IMD deciles 1 and 2). This is broadly in line with what we know about our local population health need in the area of Mid Nottinghamshire where the pilot took place.

Patients' substance use was most often a 'mild problem but definitely present' before starting peer support. Patients' mental health conditions were slightly more likely to be non-psychotic (51.5%) than psychotic (47%).

Service description

In terms of the service, a total of 64 patients were meaningfully supported and this varied by LMHT from 15 in Newark & Sherwood to 26 in Mansfield. This reflects differences in the setup of the service, with a longer induction and shadowing period for the peer support workers in some areas.

Appointments were generally weekly or two-weekly, lasting on average 60 minutes and were conducted in homes (64.6%) followed by community locations (27.2%). They focused on: discussing the patient's current situation and steps to make change; going out with the patient; supporting the patient to access mental health services as well as other local services and support groups; providing practical support. For patients who are still receiving peer support, the average length of support so far ranged from 8.5-9.4 months and will continue to increase, suggesting peer support is a long-term support offer.

In terms of engagement with peer support, approximately 25% of appointments were not attended (DNA) by patients receiving meaningful support, and this was slightly more likely in community locations (28.5%) and hospital/LMHT office locations (28.1%) than home (24.2%) or by phone (11.1%).

The DNA rate was higher for peer support worker appointments than for LMHT appointments with other professionals, such as psychiatrists and CPNs, which was 5% before peer support and 4.5% after peer support started.

The reasons for this are unclear. One factor could be that appointments with peer support workers are more frequent than appointments with other professionals, often weekly or two-weekly, so the impact of missing some may feel lower. Another factor may be that not attending LMHT appointments may attract a negative consequence as the patient could be discharged from mental health services due to non-engagement.

Patient outcomes

Mental health outcomes

The majority of patients (9 out of 11) reported that peer support had a positive impact on their mental health during interview. However, HoNOS data showed only a very slight improvement (-0.1) in behaviour and impairment, and a slight deterioration (0.2) in symptoms. This is not surprising as HoNOS scores are done infrequently so there were very few patients with a before and after score (12 patients), and the follow up time during the pilot is short (12 months maximum). Even if a

change in HoNOS score was detected, without a comparator group without peer support, we would not be able to determine if any change was a result of peer support.

Substance use outcomes

The majority of patients (8 out of 11) reported that peer support had a positive impact on their substance use, helping them to reduce substance use as well as respond differently when they relapse. HoNOS data also suggests an improvement, with an average change of -0.4 in score for problem drinking and drug taking.

Wider social outcomes

The majority of patients identified that peer support had a positive impact on wider social outcomes such as social isolation (8 out of 11), employment and volunteering (3 out of 11) and physical health.

Staff also identified that peer support supported patients service and social engagement, motivation and confidence. However, the HoNOS data available suggests only a very small change of (-0.1).

Patient experience

Patient experience of peer support was very positive. In patient interviews, 100% patients rated the peer support they'd received as 'excellent' and 100% would recommend to another service user. Patient's also felt that peer support added something different to their care.

A key strength repeated throughout the interviews was that patients appreciated having someone who listened in a non-judgemental way and who really understood their situation as they had lived experience. They also appreciated the peer support worker being more human and less clinical, and having more time to support.

This finding was supported by the scores from INSPIRE, a validated patient-rated experience measure. The INSPIRE scores for support provided by the peer support worker (82%) and relationship with the peer support worker (95%) were both well above average scores in validated studies (72% and 78% respectively).

These positive findings are very promising. However, they represent the views of only 11 patients out of 64 who had meaningful support from peer support workers. It is possible that patients who had a more positive experience were more likely to agree to interview, introducing selection bias.

Therefore, routine capture of patient satisfaction with peer support through embedding regular capture of INSPIRE score in clinical practice, or another measure of patient experience, would provide more complete and robust evidence.

Service provision

Engagement with mental health services

The findings relating to peer support impacting engagement with mental health services were mixed.

In interviews many patients (7 out of 11) felt that peer support helped them to engage with their mental health team. Wider staff also identified that peer support helped them to reach patients if they weren't engaging.

However, service data suggests that patients receiving meaningful peer support already had very good engagement rates before peer support (5% DNA) and this improved very slightly after peer support (4.5% DNA). In comparison, LMHT DNA rates for all patients met by peer support workers was 15% (including those met only once). Overall DNA rates for LMHT patients in 2021 were 15%

(19% for patients with high drug & alcohol HoNOS scores (2, 3 and 4) and 13% for patients with low (0 or 1)).

Therefore, the data suggests that while patients with significant drug and alcohol problems accessing LMHT usually have poorer engagement, there is variation within the patient group. In this pilot, patients who have engaged with peer support (two or more contacts) appear to be those who already engage well with LMHT. Although patients interviewed suggested peer support helped them to engage with LMHT further, this is not yet evidenced in the service data. Further work to understand why some patients did not engage with peer support is needed to identify how this peer support intervention can better meet the needs of those who struggle to engage with LMHT.

Engagement with substance use services

Some patients (4 out of 11) reported that peer support had helped them to engage with substance use services, however for most people it had not helped them as they did not want to engage (4 out of 11) or weren't currently using substances (3 out of 11). Unfortunately, we were unable to get linked patient data from the CGL, substance use service, to understand service access.

Use of urgent care services provided by the Trust

The number of patients accessing urgent mental health care services after starting peer support reduced by 59%. This may suggest many patients receiving peer support are more stable and getting the support they need earlier, before they require urgent care, which is positive.

However, the overall rate of urgent care use increased in the period after peer support started, which suggest the smaller group of patients still needing urgent care are accessing it more. It is unclear why this is happening. One possibility may be that for patients in crisis, peer support workers encourage them to access urgent care support when they need it to stay safe. Therefore, this may be an appropriate increase in service access to meet need.

Staff experience and system outcomes

Staff were overwhelmingly positive about their experience of working alongside peer support workers in LMHT. The PSWs are valued by the teams they are working with. They are seen as providing a range of benefits for patients that include helping promote motivation, engagement in treatment and support, and helping to build patient confidence.

The PSWs felt that they were well supported and embedded in their clinical teams, highly accepted and valued both as peer support workers and for their lived experience. Feedback on the induction was very positive. All peer support workers found line management and support from Double Impact 'extremely helpful'. All peer support workers were very positive about their role and its impact on their future career prospects.

Some challenges were identified, particularly in the initial stages of the pilot, relating to defining the job roles, agreeing which patients could be supported by PSWs and agreeing referral processes. There was consensus that the recruitment process could be improved, particularly by closer involvement of the Trust in any future recruitment. Peer support workers also had concerns about the short-term nature of current contracts

The innovative model of cross-working between Nottinghamshire Healthcare NHS Foundation Trust and Double Impact works well overall. Line management and support by Double Impact is valued by PSWs and the dual approach to induction is seen as particularly valuable. Line management and support may be impacted by the lead manager within Double Impact not having access to the Trust

clinical system. Line management may be strengthened by the Double Impact line manager working more closely with clinical teams. The relationship between Nottinghamshire Healthcare NHS Foundation Trust and Double Impact is good and this brings benefits to the pilot.

Clinical supervision overall is working well but there are some inconsistences across Local Mental Health Teams (LMHTs) that need resolving, and overall PSWs would value access to more frequent clinical supervision. A number of options for improvement have been suggested, including for example that one LMHT lead supervisor with substance misuse experience provides clinical supervision across all LMHTs.

Overall, there are several people involved in working with PSWs in relation to line management (Double Impact), clinical supervision (LMHT) and support (Trust peer support team). Several wider staff and PSWs suggested that this may benefit from being streamlined/bought together. Views as to how this could be achieved were varied, with strengths and weaknesses identified in the current elements.

Ongoing support to LMHTs around the focus of the PSW role and more broadly around the pathway and the issue of substance misuse, would be beneficial and support consistent working across LMHTs.

Limitations

The main limitations of this evaluation were:

Lack of comparator – Unfortunately, we were unable to find a suitable comparator for this evaluation due to differences in the demographic characteristics of neighbouring areas (e.g. Nottingham City LMHT) and the impact of COVID measures on service provision in the same LMHT in an earlier time period (e.g. 2020/2021). Therefore, this limited our ability to use statistical analysis to identify impact, or to attribute any observed changes to peer support.

Trust data

- Patient outcomes
    - HoNOS is completed infrequently (e.g. yearly). This meant:
        - We had very few patients (12 out of 64) who had before and after scores
        - 'Before' scores could be as early as 1st January 2021, which may not be a good reflection of someone's recent presentation just before starting peer support.
        - It will require a longer follow up period to analyse change in outcomes using HoNOS
    - HoNOS substance use score not a reliable measure of substance use.
    - DIALOG (patient reported outcome measure) data was not completed sufficiently for us to use in this evaluation.
- Service data
    - Referrals and discharges - Service data does not show dates that patients are referred to or discharged from peer support. This limited our ability to analyse the proportion of referrals accepted, waiting times, reasons for discharge etc. It also made it difficult to identify current and discharged patients.
- Patient characteristics
    - Due to poor data quality we were unable to describe the patient characteristics by disability status or sexual orientation.

Substance use service data

It was not possible to obtain anonymised linked patient data from substance use service CGL due to information governance issues raised by the Trust Research and Evidence and Information Governance teams. This limited our ability to review detailed information on patient substance use, substance use service access, engagement and treatment, and substance use outcomes from National Drug Treatment Monitoring System (NDTMS) and Treatment Outcomes Profile (TOPs) data.

Small number of patients

The number of patients supported during the pilot (64) was too small for us to analyse equity of access or outcome. It also meant that statistical analysis of change in outcomes was not feasible.

Short length of follow up

The average length of time current patients have been supported by a peer support worker is 9 months. Mental health and substance use are long term, complex conditions which may involve periods of relapse and HoNOS scores are completed infrequently (e.g. once every 12 months). Therefore, the relatively short follow-up time in this evaluation may limit our ability to about changes in outcome.

Patients who did not engage

At the start of the pilot as part of the induction process, peer support workers often shadowed other professionals to appointments. To ensure that our patient interviews focused on patients who received meaningful peer support, we excluded patients who had met the peer support worker less than three times or only alongside other professionals. However, this means that this evaluation has not captured the views of patients who met a peer support worker and decided not to engage after one or two contacts.

Conclusion and recommendations

The results of this evaluation found that peer support has a positive impact on the mental health, substance use, wider social outcomes and patient experience of some patients and is adding something different to their care that is not provided by other professionals. However, further work is needed to determine how common this experience is, with a larger group of patients.

The results also indicate that peer support has had a positive impact on the local mental health teams in which peer support workers are located, in particular as a result of increasing staff confidence and capacity to support SU-MH patients, increasing understanding of substance use and services available, and making valuable contributions to MDTs and risk assessment.

Recommendations

1. **Streamline clinical supervision**

   This needs to include to improve consistency of approach, provide a more joined up monitoring of PSW case-loads and issues, ensure appropriate referrals and reduce inconsistent messages to PSWs. Potential options suggested were:

   - Option 1: One LMHT lead with substance misuse experience provides clinical supervision across LMHTs
   - Option 2: SM/MH practitioner provides clinical supervision across all LMHTs
   - Option 3: Maintain separate LMHT clinical leads but have clear and agreed policy across LMHTs to reduce inconsistency in approach

2. **Streamline line management**
   This relates to the need to improve joined up clinical supervision and line management, and reduce inconsistent messages to PSWs. Options suggested for change included:
   - Option 1: Double Impact continue to provide line management with work to streamline approach through:
     - Bringing the line manager more into the Trust and involving in pathway development
     - Consider honorary contract and Rio access if appropriate
     - Improve communications between the DI line manager and the clinical supervisor about ongoing issues to feed back through line management

3. **Ensure clarity of job roles and boundaries.** Ensuring very clear job descriptions and clear boundaries would help provide structure to all of those involved.

4. **Education and support for LMHTs about peer support.** This would enhance team understanding of the peer support worker role and boundaries of peer support to ensure appropriate referrals. Also this could increase team understanding of the benefits and value of peer support and lived experience and so help embed the roles within teams.

5. **Consider if we are missing opportunities to work with wider patients –** this included looking the following suggestions:
   - Patients with SM/MH who do not need a care coordinator, as are lower risk
   - Patients with historic SM/MH when at risk of relapse

6. **Improve the recruitment process** – this could still be led by Double Impact, but with greater involvement of the Trust (LMHTs, Transformation, Peer support team). This would help to ensure that new staff are clear on the role and the core values of the Trust, and will be a good fit for the teams in which they will sit. The onboarding process e.g. DBS process and honorary contracts also needs to be quicker if at all possible.

7. **Continue good induction process –** There is clearly good practice in place in relation to induction and this needs to continue.

8. **Improve communication –** this includes communication between multiple partners e.g. Double Impact and the Trust, the Trust leads and LMHTs in which PSWs sit, the Trust leads and PSWs/Double Impact about changes.

9. **Recognise that the lack of pay parity of SU-MH peer support workers (employed by Double Impact) compared to peer support workers employed directly by the Trust may be a risk to staff retention.** The SU-MH peer support worker post may be less attractive as it is not aligned to the NHS pay terms and conditions.

10. **Education and support for LMHT and wider Trust staff about substance use.** Ensure all Trust staff have a trauma-informed and non-judgemental approach to substance use with appropriate training for how to support patients with co-existing substance use and mental health conditions.

11. **Training for peer support workers to provide brief advice relating to healthy lifestyles.** This will link to the Trust's prevention strategy and actions to embed routine brief advice on smoking, alcohol and eating & moving well for health routinely and opportunistically within all patient care.

12. **Consider opportunities to provide additional patient activities as part of peer support**, either within existing peer support worker capacity or through linking with wider support available locally, for example through social prescribing.

13. **Explore if any further support is needed to enable patients receiving peer support to access substance use services** where appropriate

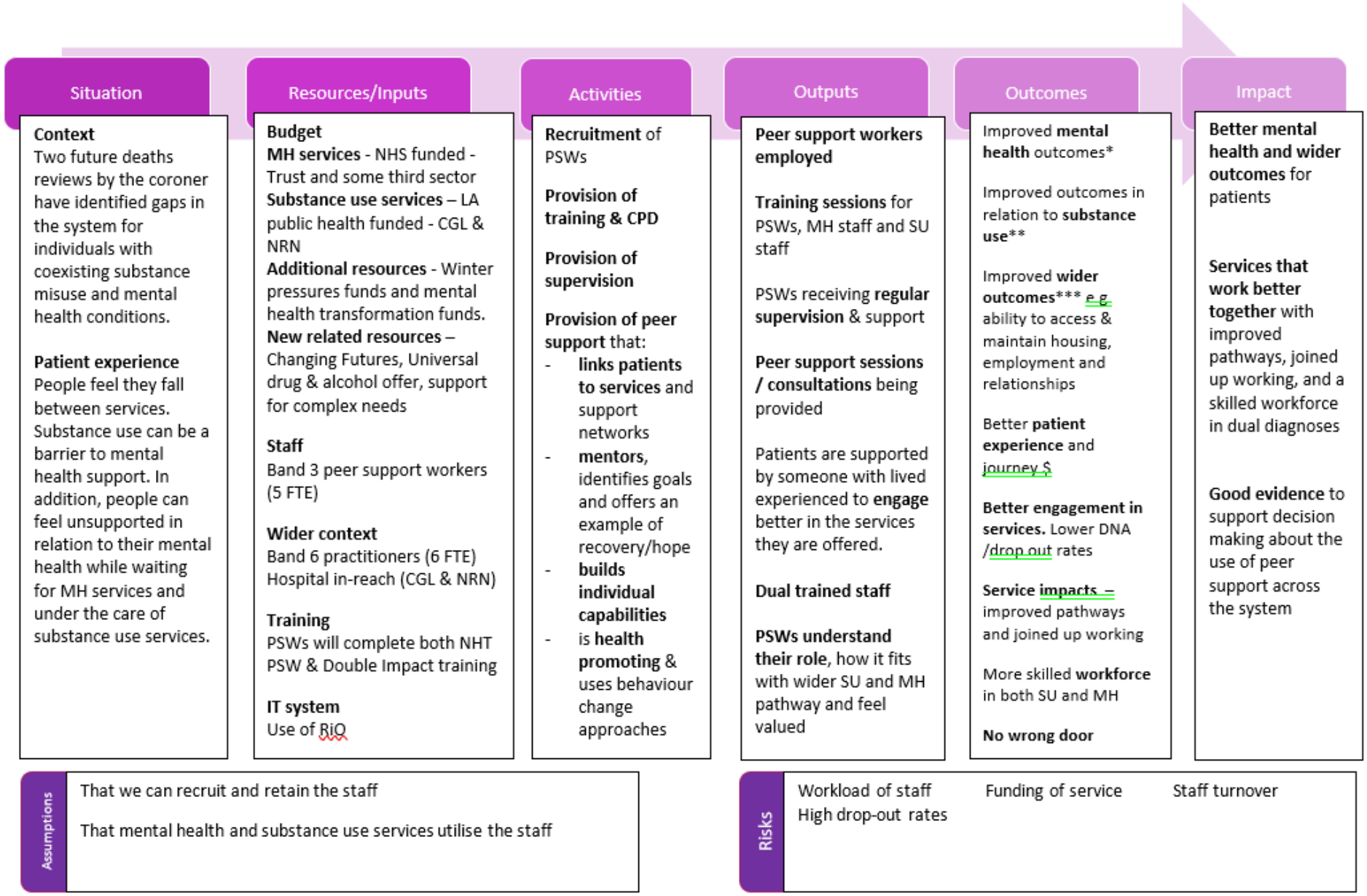
14. **Undertake further research and evaluation**
    - **To investigate if peer support is meeting the needs of all SU-MH patients**, particularly those with poorer engagement with LMHT. This could involve rapid targeted patient engagement, to understand why some patients are not engaging with peer support, and identify what we can do to better meet their needs.
    - **Regular evaluation** – To understand the experience of more patients, with longer follow up and more complete outcome data. This would ideally use a comparator and would have access to linked substance use service data.

15. **Improve Trust data collection and quality**
    - Patient outcomes: Increase the frequency of completion of outcome measures, for example HoNOS and DIALOG.

- Patient demographic characteristics: Improve the completeness of demographic characteristics data such as disability and sexual orientation to enable equity analysis.
- Service data: Consider options to improve the quality of peer support service data to enable better understanding of the flow of patients through peer support, including referrals and discharge.
- Patient experience: Consider routine use of INSPIRE, or another patient reported experience measure, to monitor patient experience of peer support.

16. **Improve data sharing between partner organisations in the service pathway for evaluation purposes**. Anonymised linked patient data would allow better understanding of the impact of peer support on patient engagement with substance use services and substance use outcomes.

Appendix 1: Logic model for substance use and mental health peer support



* HoNOS (CROMs) change ** NDTMS outcomes *** HoNOS (CROMs) change $ DIALOG plus time to first appointment, time to treatment, retention