

## **PCCS Peer Support Framework**

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Peer Support is an umbrella term applied to different models of providing support through shared experience. Individuals may be considered peers if they have the same job, work in the same area, or have the same difficulty (such as in mental health peer support). Peer support offers a systematic, strategic approach to intervening to sustain staff who are coping well and to provide initial support to those who are struggling, a stepped model of care<sup>i</sup> as recommended by the 2017 Stevenson Farmer Review<sup>ii</sup>. It can be delivered in a variety of ways.

This document contains information about a range of different peer support tools that a team, unit or organisation may choose to utilise as part of a staff wellbeing programme. These tools have been grouped together under three headings; one to one peer support, group support after trauma and group reflective peer support.

Inclusion of a peer support tool or model within this framework does not imply a recommendation – different teams, units or organisations will have different needs and resources but we hope that this is a useful reference resource for those who are planning to develop a peer support system. Any model needs to be subject to local governance structures and have clinical psychology oversight. Training and keeping skills up to date with appropriate supervision for facilitators is essential.

**There are some common themes across all peer support approaches:**

- Clear pathways to professional services need to be provided no matter which approach is used.
- Those engaged in peer support should be aware of local services to which they can signpost peers.
- Peer support is voluntary; people engage or disengage as they choose.
- Dignity, respect and social inclusion: acknowledging the intrinsic worth of all people, whatever their background, preferences or situation, is of primary importance at all times. Peers should feel able to express themselves and be themselves in any peer support situation.
- Integrity, authenticity and trust: confidentiality, reliability and ethical behaviour underpin every peer support interaction.
- Respect for professional boundaries is important; do not contact the peer supporter outside of agreed working time, offer a confidential service, and do not discuss any issues raised within peer support outside of peer support or supervision without the explicit permission of the peer. Agreed lines of communication that would be used to access your peer support network with guidance provided regarding access and timescales for a response.
- Despite the supporters being peers, many might prefer to go straight to a mental health professional.

**Potential complexities of adopting peer support approaches:**

- All three of these groups of peer support tools described in this framework need to be established within a range of other wellbeing initiatives - if used in isolation they may not succeed.

- Although rare, there may be times when risk to the peer or to a patient is noted, and establishing a duty of care is important. For example, when setting confidentially boundaries at the beginning of a session, it is important to note *“This session is confidential, however if I am worried about you or others being at risk, I might need to get others involved for your support, but would always discuss this with you first”*.

### Psychological Support Time Line

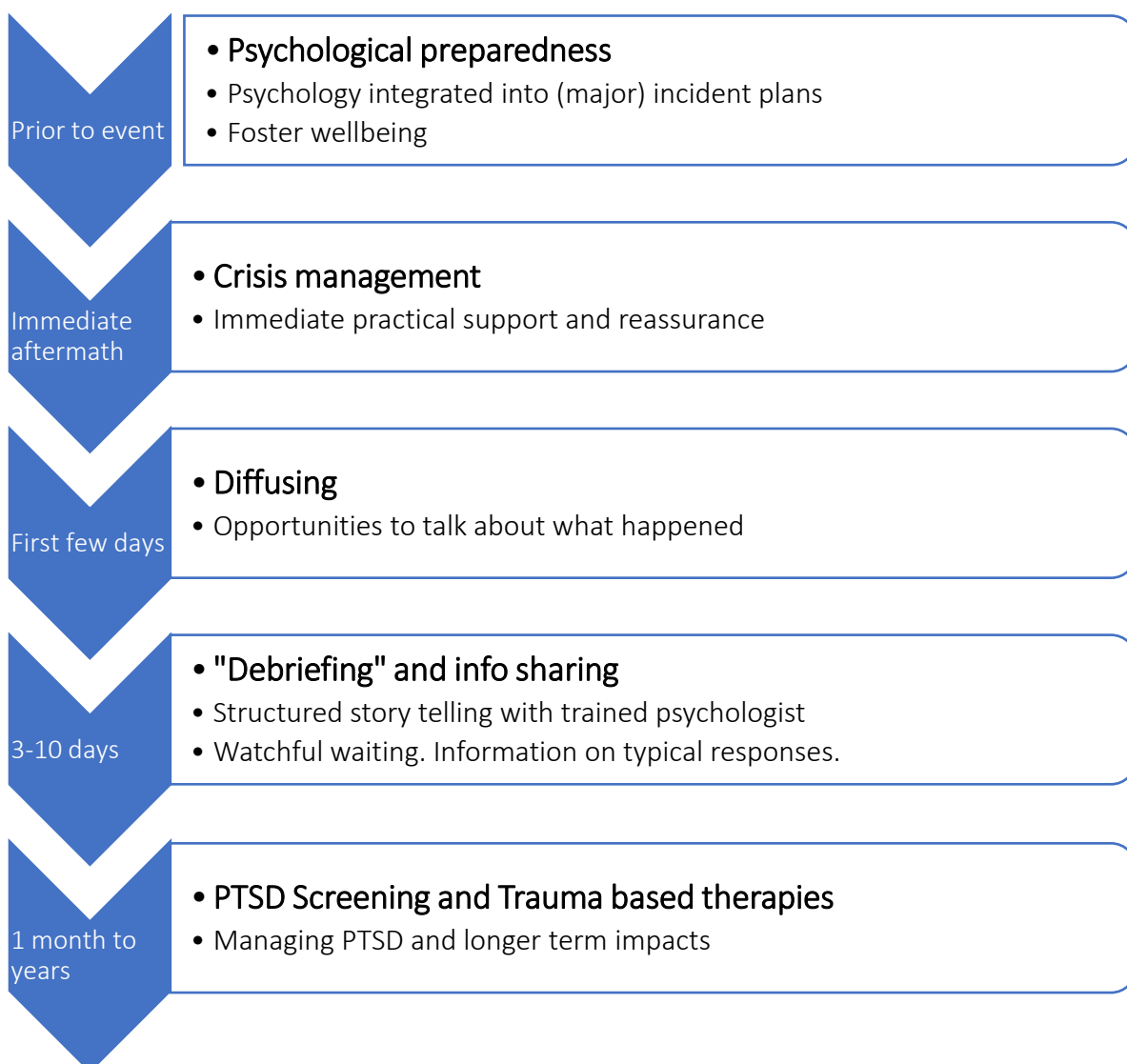


Figure 1. Different options exist for peer support over time relative to a critical event or incident, taken from Noreen Tehrani, Managing Trauma in the Workplace: Supporting Workers and Organisations.

## One to One Peer Support

### What do we mean by 1:1 Peer Support?

Peer support was developed within the field of mental health, where those with lived experience use that experience to support another. In the NHS context, peer support describes the work of healthcare practitioners who provide emotional and social support for colleagues who share a common work experience in the same specialty.

Peer Support is a way of having supportive conversations with staff in the workplace. As a colleague, the shared experiences of work enable people to speak freely from a common ground. This describes support provided to an individual by a trained peer supporter.

### Examples of 1:1 Peer Support models

**The ICS model<sup>iii</sup>:** This model is derived from Williams and Kemp's model of Peer Support. Supporters are trained and supervised to offer 1-1 supportive conversations within the workplace. Interventions are to sustain staff who are coping well and to provide initial support for those who are struggling. It is not an assessment model. It can happen either after an incident at work, or on an ad hoc basis. It incorporates elements of psychological first aid.

**SAFER-R model<sup>iv</sup>:** This is a structured crisis support intervention delivered 1:1. It is delivered by trained peers. (Stabilize, Acknowledge, Facilitate understanding, Encourage adaptive coping, Restore functioning or, Refer). approach used within the Critical Incident Stress Management approach provided by the International Critical Incident Stress Foundation.

**TRiM<sup>v</sup>:** This is a structured trauma risk assessment model, based on the principles of watchful waiting in PTSD and is intended as a specific tool following critical incidents at work. It is delivered 1:1 by trained peers.

**Psychological First Aid<sup>vi</sup>:** Developed by the World Health Organisation as a supportive and practical approach for those exposed to the immediate aftermath of disasters and serious crisis events. It can be delivered by a range of volunteers, who are not necessarily the peers of those exposed to crisis.

**Mental Health First Aid<sup>vii</sup>:** This was first developed to train the public in providing help to adults with mental ill-health problems. Recently there has been an increase in undertaking MHFA training in workplace settings. It is a way of raising awareness and signposting individuals in the workplace with mental health concerns.

### What are key considerations when implementing 1:1 Peer Support

- 1:1 Peer Supporters are not trained mental health professionals and should not be considered a substitute for trained professionals when required.
- No matter what the model used, Peer Supporters should have training and they should have routine clinical supervision from a suitably trained mental health professional.

- Peer Support is based on personal psychology, and assumes the natural resilience of the individual to promote a positive outcome through self-determination: having belief that each peer wants to achieve a positive outcome and will be able to identify what most suits them and their needs.
- Empathic and equal relationships: Peer support in this context is offered in the context of a shared work experience. Experience in common: peers share similar backgrounds, experiences, interests, or goals.

#### **What are potential concerns or hurdles to overcome in delivering 1:1 Peer Support?**

- There may be issues to resolve around accessibility, acceptability, and trust in the Peer Support process.
- Be aware of pre-existing relationships with peers, and have a choice of peers available. As peers are also likely to be friends and co-workers, clear boundaries need to be established, this can be overcome by creating a peer support network with other departments.
- Accessibility of local clinical supervisors may be a limiting factor.
- Be aware that in small systems such as a PCCU, the Peer Supporters are experiencing impacts of the work in situ with their peers, and may need to step back at times, or access additional support themselves.

### Group Support after Trauma

#### **What do we mean by group support after trauma?**

Interventions designed to support the clinical team (as a group) after a traumatic event can have a wide range of goals from offering an opportunity to review clinical performance, identify errors, prevent trauma, or to act as a forum for staff support or as a space for reflection. It is important to distinguish between clinical and psychological debriefs. This also provides an opportunity to identify best practice and successes - positive analysis is equally important.

Prior to the covid-19 pandemic, the NICE recommendation was against the adoption of formal group support after trauma programmes with the express purpose of preventing or treating Post-Traumatic Stress Disorder (PTSD). However, acknowledgement of the psychological impact of traumatic events and the provision of practical and emotional support is important. It is also important that measures for primary prevention of harm around times of trauma are in place in all workplaces, in addition to secondary interventions of training to support self-management of workplace stress and formal employee assistance programmes.

#### **Examples of group support after trauma that are available**

**Psychological Debriefing:** Usually occurs within 48hrs of a traumatic event. Follows a clear structure with trained facilitators, at least one of whom will be a trained mental health professional. A Cochrane review demonstrated some evidence that this approach may be damaging to the individual, potentially due to the mandatory nature of some methods used (VIII). This review, however, was found to be methodologically flawed. In recent years there has been an increasing body of evidence to demonstrate the effectiveness of early interventions – see summary document from Public Health England & The British Psychological Society. ([CDT Scoping Review Early Post Trauma Interventions in Organisations Report 09052019 FINAL.pdf \(bps.org.uk\)](https://www.bps.org.uk/cdt-scoping-review-early-post-trauma-interventions-in-organisations-report-09052019-final.pdf) )

**Critical Incident Stress Debrief:** Group structured debriefing led by a trained facilitator. Participation must be voluntary and is often viewed positively by users if performed as a forum for sharing and validating feelings of distress. CISD is one of a number of potential options that can be used within a Critical Incident Stress Management (CISM) Toolbox depending on the specifics on the scenario and the group involved.

**Time Out Model<sup>viii</sup>** A standardised method of providing support after any event that has the potential to cause distress. It can be requested by anyone. It is delivered by a clinical member of the team who has received facilitator training. It works best delivered after an acute event and before the shift has ended. The meeting should last around 20 minutes. Facilitators receive in house training, on-going support and supervision meetings.

**‘STOP 5’ Hot debrief:** Performed immediately after a traumatic event – A facilitator Summarises key events, identifies Things that went well, flags Opportunities to improve and Points to action. Brief and targeted – can range from an informal huddle to a formal gathering but would usually occur in the same shift as a traumatic event.

The Psychological First Aid approach is intended for individuals, however can be used as a framework within group peer support

#### **What are key considerations when implementing group support after trauma?**

- Group support after trauma can take a variety of different forms, from support immediately after the event to group sessions sometime after the event, and it can be led by trained individuals who may or may not be mental health practitioners depending on the model.
- Those offering group support after trauma should have routine clinical supervision from a suitably trained mental health professional.
- Attendees need to know what they are attending in advance. Choice and control matter and there may well be a range of different agendas to meet.
- Group support after trauma should go at the pace of the most vulnerable member of the group.

#### **What are potential concerns or hurdles to overcome in delivering group support after trauma?**

- The group trauma support model needs to be established within a range of other wellbeing initiatives- if used in isolation there is a chance of causing additional harm.

#### Group Reflective Peer Support

##### **What do we mean by Group Reflective Peer Support?**

Group reflective peer support allows staff to explore the social and emotional aspects to their clinical work. It encourages participants to problem solve and suggest solutions, enabling learning points to be identified that can be shared with the wider team.

Group reflective peer support discussions encourage a learning culture which embraces change and puts patient safety at the forefront of care<sup>1</sup>. It encourages a supportive team work environment that will

consider new ideas, demonstrates it wants to improve and helps staff feel valued<sup>ix</sup>. Group reflective peer support interventions should be considered separately to interventions aimed at supporting staff following a traumatic incident. These approaches can potentially break down perceived barriers between management and front-line staff.

#### Examples of Group Reflective Peer Support that are available

**Schwartz rounds:** Created by the 'Point of Care Foundation', these interventions focus less on clinical events and more on the staff members social and emotional responses to their work<sup>x</sup>. They are aimed at organisations which can sign up to become affiliated with the Point of Care Foundation which provides training and mentorship for those members of staff facilitating the Schwartz rounds. Their 2018 report makes the case for employee engagement across the NHS<sup>xi</sup>.

**Team Time:** A peer reflective support model run by the Point of Care Foundation and aimed at smaller teams rather than organisations<sup>xii</sup>.

**Compassion Circles:** Created by Frameworks 4 Change<sup>xiii</sup> engage "*in an ongoing enquiry into compassion in health and social care, and the conditions that allow it to flow*"<sup>xiv</sup>.

**Appreciative Inquiry:** Takes a positive approach to change within organisations or teams. It aims to "*search for the best in people, their organizations, and the strengths-filled, opportunity-rich world around them*"<sup>xv</sup>. It has been applied successfully in a number of fields including education and business.

#### What are the key considerations when implementing group reflective peer support?

- These interventions have great potential to benefit individuals, however there is risk of causing harm<sup>xvi</sup> mitigated against by being performed and lead by trained individuals.
- Any group reflective peer support model utilised should include revalidation and update training for those facilitating and delivering the sessions, with robust governance structures in place.
- Group reflective peer support is not psychological debriefing; signposting for staff to a trained practitioner psychologist is paramount<sup>xvii</sup>.
- How staff access group peer support will be influenced by their role, grade, clinical experience, beliefs and needs<sup>xviii</sup>. Departments are encouraged to have an easily accessible collection of written information and signposting advice for staff who may feel comfortable accessing support in a more anonymous way.

#### What are potential concerns or hurdles to overcome in delivering group reflective peer support?

- A financial cost is involved to the organisation which includes initial sign up and fee and on-going subscription to the Point of Care Foundation. Many larger NHS trusts may already have a subscription.
- A time commitment is required to start and maintain reflective peer groups, and support and training for those individuals is important.
- Logistics around making staff available in their paid work time to attend reflective group meetings should be considered. This will require buy-in from ward managers and clinical leads.



- Reflective concepts can fit in to what is already on offer within a department. The benefits exist of working across the MDT, putting faces to names and building connections between ‘front line’ staff and management.

### **Useful Links**

Schwarz rounds

<https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/>

Trauma Risk Management (TRiM)

<https://strongmindresilience.co.uk/courses/trim-trauma-risk-management-an-overview/>

Intensive Care Society Peer Support Program

[https://ics.ac.uk/ICS/ICS/Wellbeing\\_resources/Peer\\_support\\_programme.aspx](https://ics.ac.uk/ICS/ICS/Wellbeing_resources/Peer_support_programme.aspx)

Psychological First Aid

<https://www.who.int/publications/i/item/9789241548205>

### **References**

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<sup>i</sup> ‘Peer Support’ Information summary from RCP and RCPsych, Accessed May 2021

<https://www.rcplondon.ac.uk/file/21541/download>

<sup>ii</sup> Thriving at Work: a review of mental health and employers Stevenson, D. & Farmer, P. (2017)

<https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers>

<sup>iii</sup> Intensive Care Society Peer Support Program,

[https://www.ics.ac.uk/ICS/ICS/Wellbeing\\_resources/Peer\\_support\\_programme.aspx](https://www.ics.ac.uk/ICS/ICS/Wellbeing_resources/Peer_support_programme.aspx)

<sup>iv</sup> Roberts, Albert R. Assessment, Crisis Intervention, and Trauma Treatment: The Integrative ACT Intervention Model, Brief Treatment and Crisis Intervention(2002),2(1):1

<sup>v</sup> Norman Jones, Howard Burdett, Kevin Green & Neil Greenberg (2017) Trauma Risk Management (TRiM): Promoting Help Seeking for Mental Health Problems Among Combat Exposed U.K. Military Personnel, Psychiatry, 80:3, 236-251

<sup>vi</sup> Psychological first aid: Guide for field workers <https://www.who.int/publications/i/item/9789241548205>

<sup>vii</sup> Summary of the evidence on the effectiveness of Mental Health First Aid (MHFA) training in the workplace <https://www.hse.gov.uk/research/rrpdf/rr1135.pdf>

VIII Rose S, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database Syst Rev. 2002;(2):CD000560. doi: 10.1002/14651858.CD000560. PMID: 12076399



<sup>viii</sup> Cooper S, Winton M, Farrington-Exley J, Fifteen-minute consultation: Time Out as an alternative to toxic debrief, Archives of Disease in Childhood - Education and Practice 2020;105:270-275.

<sup>ix</sup> Scoping Review: Early Post-Trauma Interventions in Organisations, February 2019, The British Psychological Society, <https://www.bps.org.uk/sites/www.bps.org.uk/>

<sup>x</sup> Point of care foundation; Schwartz rounds <https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/>

<sup>xi</sup> Point of care foundation report, 2018 [https://s16682.pcdn.co/wp-content/uploads/2018/09/Point\\_of\\_Care\\_Report\\_2018.pdf](https://s16682.pcdn.co/wp-content/uploads/2018/09/Point_of_Care_Report_2018.pdf)

<sup>xii</sup> Team time from the point of care foundation; <https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/team-time/>

<sup>xiii</sup> Frameworks 4 Change, <https://www.nesta.org.uk/feature/new-radicals-2012/andy-bradley-frameworks-4-change/>

<sup>xiv</sup> Closing the compassion gap in health and social care, Journal of holistic healthcare, Volume 13 Issue 1 Spring 2016 [https://bhma.org/wp-content/uploads/woocommerce\\_uploads/2017/06/13.1.6-Closing-the-Compassion-Gap.pdf](https://bhma.org/wp-content/uploads/woocommerce_uploads/2017/06/13.1.6-Closing-the-Compassion-Gap.pdf)

<sup>xv</sup> Appreciative Inquiry website, <https://appreciativeinquiry.champlain.edu/>

<sup>xvi</sup> Hollingsworth CE , Wesley C , Huckridge J , et al . Impact of child death on paediatric trainees. Arch Dis Child 2018;103:14–18.doi:10.1136/archdischild-2017-313544

<sup>xvii</sup> Rose S , Bisson J , Churchill R , et al . Psychological Debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database Syst Rev 2002;CD000560.doi:10.1002/14651858.CD000560

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