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Learning from the experience of peer support facilitators and study nurses in diabetes peer support: a qualitative study

Abstract

Objectives

We report on the experiences of Peer Support Facilitators (PSFs) and study nurses who participated in a large trial of peer support for type 2 diabetes. The support was led by volunteer PSFs, who were trained in overcoming barriers to diabetes care, motivational interviewing, listening skills and setting up and running group support sessions. There is currently a distinct lack of qualitative evidence on what works in peer support.

Methods

The PSFs and study nurses completed open-answer questionnaire items on what worked well and less well, problems encountered and how they were resolved, group dynamics and suggestions for improvement. We also collected data from end of study meetings. Inductive thematic analysis was used to allow the emergent themes to be strongly based in the data.

Findings

We find that process factors, PSF and peer characteristics, their relationships with each other and group dynamics are all fundamental for effective peer support. Sustaining and ending support also emerged as a key theme.

Discussion

Given the increasing interest in peer support, these findings will be useful to those interested in running groups in the future. Training programmes should help PSFs develop confidence whilst emphasising that peer support ideally entails an equal, democratic dynamic. More attention is needed on to how to end groups appropriately.

Introduction

In recent years much research and policy has focused on self-management of chronic illness. Peer support, where people with the same condition support each other in managing their health is increasingly popular. The number of citations for peer support has increased around tenfold in the last ten years.[1] Despite this increased attention, there is a lack of qualitative research on peer support.

Background

Peer support is a process where people who have experiential knowledge of an illness or condition support each other, in contrast to clinical care delivered by a health professional[1]. In type 2 diabetes, peer support typically centres on the day-to-day challenges in self-managing one's diet, exercise, medication, and monitoring glucose levels.[2] Much existing literature pertains to cancer peer support, where emotional dynamics are instead forefronted.[3] In this paper, we report the experiences of volunteer Peer Support Facilitators (PSFs) and research nurses from the RAPSID (RAndomised controlled trial of Peer Support In type 2 Diabetes) study,[4] on what made for successful peer support groups. The clinical outcomes of the trial are reported separately.[4] We sought to answer the research question: 'What do peer support facilitators and study nurses see as important for successful diabetes peer support groups?'

What is peer support?

Peer support entails group or 1-on-1 interactions, either face-to-face, over the telephone or electronically, where people who typically have the same illness or condition support each other. Dennis offers a popular definition:

> Peer support, within the health care context, is the provision of emotional, appraisal, and informational assistance by a created social network member who possesses

> experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population, to address a health-related issue of a potentially or actually stressed focal person.[5]

The emphasis is therefore on emotional, appraisal and informational support derived from experience, as opposed to professional medical healthcare (however groups can involve health professionals, typically nurses, to provide backup support[6]). Although the term 'peer' emphasises that all participants are equal, groups are typically led by PSFs, who are responsible for organising and running sessions, including publicising the group and encouraging attendance, planning activities, and gathering information during sessions. In their peer support programme for psychiatric care, Jacobson et al.[7] found that there was approximately a 50/50 split between 'direct' and 'indirect' duties. PSFs commonly share their role so that each individual may not need the whole set of skills[7], which may prevent burnout.[8] It has been suggested that retaining PSFs is an issue when they also have full time jobs, and that asking volunteers to carry out administrative work is difficult without remuneration.[9]

Existing qualitative research on peer support

Existing research focuses on three factors: PSF characteristics, peer characteristics, and practical issues. In terms of PSF characteristics, the overriding message is that being warm, friendly and caring is fundamental.[10,11] Empathy is important, and is more likely when groups are homogenous according to key characteristics.[12] The literature is unclear on what characteristics matter most, though demographic and illness factors (e.g. length of diagnosis or severity of complications) are often cited.[12] On the other hand, some evidence suggests that heterogeneous groups are more creative and better at problem solving.[13] Participants tend to have mixed views on whether matching e.g. by ethnicity and gender would encourage

participation.[32] Group composition is clearly fundamental to peer support groups and the mixed picture in the literature warrants further research.

Flexibility is also helpful since peer support entails relationships that do not follow clinical boundaries, meaning that relationships and groups are varied.[14] Without flexible boundaries, there is a risk of re-creating the power structure of the clinical relationship[14], something peer support is explicitly meant to avoid. In terms of other PSF characteristics, resilience is needed when groups suffer low attendance, which is common and often causes disappointment.[15] Based on six nurse interviews, Costello[16] describes four values seen as positive in diabetes groups: having a philosophy of shared authority; seeing diabetes as complex and interconnected with all areas of life; focusing on quality of life; and regarding perfectionism as impossible and undesirable.

Peers vary according to their health, treatment regimes, socio-demographic characteristics, needs, motivations, personalities, and availability. These influence whether they feel suitable for and participate in support e.g. stage of illness influences uptake and retention.[17] In Sandaunet's[18] study of an online cancer support group, people sometimes did not feel 'ill enough' to participate, struggling to find their position and felt a need to share values of courage, optimism and quality of life to fit in. Perceived need for peer support can also depend on the quality of support from existing social networks (e.g. friends and family).[19] More widely, peers (and PSFs) come from varied social contexts[14]. They will vary according to their responsibilities e.g. with regard to employment or providing informal care for others. They might experience comorbidities and other difficult circumstances or stressful situations, such as in relation to their families or relationships. Their dispositions and comfort with discussing personal issues in a group setting will also vary. Relatedly, each support group takes place in a unique local setting with its own policy, healthcare, and deprivation

96 characteristics.[20] Peer support groups are likely to benefit from a sensitivity to the social
97 context of participants' lives[14] as well as the wider policy and cultural context.[21]

98

99 Motivations to attend support groups are important. Butow et al.[10] surveyed 50 cancer
100 support groups and found the main reason for attending was to not feel alone. Other
101 motivations were to hear about research and medications, learn how others cope, and relax
102 with others going through cancer. Groups will be more successful if they can meet multiple
103 needs and foster a sense of community; essentially, people are motivated by the social nature
104 of groups, and learning about the practical aspects of illness management is only possible if
105 groups flourish socially[11].

106 Low attendance and withdrawal is common in peer support. Sandaunet[18] suggested that
107 changing health, avoiding painful details, and other commitments are key reasons. Luke et
108 al.'s[22] analysis highlighted the concept of 'member-group fit'. They distinguish between
109 those who drop out after one or two meetings and those who attend longer, suggesting initial
110 impressions are crucial. The first meeting should elucidate who the group is for, find out
111 reasons for joining, and recognise the need to change if something about the group is off-
112 putting. Dropout may reflect reduced need (e.g. after initial diagnosis), but need may return.
113 Complex patient needs mean that moulding groups to fulfil varying stages is challenging.[22]

114 Peer support also requires a substantial focus on practical and organisational issues such as
115 venue and timing. Venues should have easy access and be comfortable, have good lighting,
116 low noise and facilities for refreshments.[20] They should be local or have good public
117 transport links, room for growth and be cheap or free.[11] The timing of meetings should be
118 consistent, suiting as many group members as possible.[15] If the group has to fundraise, this
119 can be exhausting, contributing to burnout. To attract interest, groups must be seen as

credible by health professionals, which can cause frustration as they often fail to gain this credibility.[8] Support groups often invite guest speakers, depending on group preferences.[23,24] In Butow et al.'s[10] study, most participants thought that 9-15 members was the ideal group size . Maintaining such numbers given inevitable attrition is challenging; thus initial over-recruiting is essential.

In this paper we build upon the existing literature by reporting findings from our study of peer support for type 2 diabetes. As noted, this condition requires proactive, responsive management, including changing health behaviours and taking medications, so for many the burden of treatment is great. People who attend groups have wide-ranging needs related to disease progression, complications, comorbidities and treatments, as well as non-diabetes commitments. This raises particular challenges for type 2 diabetes peer support groups. In this study we sought to understand what peer support facilitators and study nurses saw as important for successful diabetes peer support groups.

Method

Study setting and overview

RAPSID was conducted in small towns and rural communities in the East of England where type 2 diabetes is largely managed in general practice, with group-based education offered at diagnosis. Participants were mainly recruited via letters from their general practices and the study was organised in clusters, based on small local government areas to facilitate commonality. All participants were offered group-based education and those not in the control group were invited to take on the PSF role. Those interested were assessed for suitability according to how they talked about their diabetes and interacted with others during recruitment and education, and we also asked for an assessment from patients' general practices, as well as carrying out Criminal Records Bureau checks. Those deemed suitable

were invited to attend a two-day training programme, delivered by trained diabetes educators. More detail on the trial including the selection and training has been reported separetely.[4]

Groups were asked to meet monthly for 6 months and optionally for another 6 months if they wanted to, and were asked to run sessions for 90 minutes maximum. PSFs were given a list of peers to contact in their local area who had enrolled in the trial and an agenda for the first 6 months, and then were allowed to have an open agenda afterwards. Venues were arranged by the PSFs who had local area knowledge. The PSFs were unpaid volunteers. A study nurse met with groups of PSFs monthly, where they could share experiences and discuss issues. The nurses were also contactable by telephone during office hours, and attended peer support meetings when the PSFs requested. The scale of the trial meant that rich data could be collected from PSFs and study nurses on what they thought made for successful groups.

Altogether 106 PSFs trained to lead sessions, and 652 participants engaged in support. 62% of PSFs were male, the average age was 65, and 78% were from professional and managerial backgrounds – much higher than the national average, which we discuss further below. There were 65 groups, and 52 of these met for 5 months or longer. Typically two or three PSFs led sessions but sometimes they were led by a single PSF. Maximum group size was 15.

Data collection

We collected three types of qualitative data: written reports from the PSFs, written reports from the nurses, and notes from end-of-study meetings. Data was collected as the groups were finishing or had finished. The first part of the reports asked PSFs to evaluate their approach, what worked well/less well, problems encountered and how these were resolved. The second part asked about the group as a whole, dynamics between the PSFs, what could have been done better and any other comments. The nurses were asked the same questions. Typically, the answers given by both PSFs and nurses were a few sentences long for each

question, though nurses generally gave more detail. The PSFs were sent invitations to fill in the report, to be returned by freepost, handed to the nurses, or completed online. A reminder was sent after 1-2 weeks. 81 PSFs returned completed forms. Nurses completed reports for 54 of the 65 groups. All PSFs were invited to attend one of eight end-of-study group meetings and 63 did so. These were facilitated by the researchers and study nurses, and PSFs discussed experiences and shared ideas on how to keep groups going or reflections on setting up groups in the future. Detailed notes were taken at these sessions by a researcher.

Analysis

The reports and end-of-study meetings were transcribed and entered into NVivo (QSR International PTY Ltd) for coding and qualitative analysis. The analysis was conducted inductively in stages, with the researchers triangulating data from the different sources and comparing interpretations as themes emerged. Inductive thematic analysis allows the emergent themes to be strongly related to the data without imposing a pre-conceived framework, and is appropriate for investigating a diversity of experiences.[25] Two researchers (DH and JPG) read the transcripts and independently drafted coding frames by arranging text relating to particular concepts and themes. Given that formal measures of inter-rater reliability are of questionable utility in qualitative research[26], we did not calculate this, and instead report on how we arrived at the final coding frame. DH initially identified the following themes: group dynamics and atmosphere; external factors; things PSFs and peers had in common; how PSFs undertake their role; knowing what peer support is/expectations. JPG initially identified three main themes with subthemes: individual factors (personal factors; motivations; expectations); relational factors (common ground/pre-existing relations; atmosphere of session/interpersonal dynamics); process factors (support for groups; group process). After comparing coding frames, differences were discussed until agreement was reached. The agreed analytic framework comprised the following: process – setting up and

running groups; PSF characteristics; peer characteristics; PSF's working relationships; group dynamics; topics covered and group atmosphere; nurse support; ongoing and ending support.

Once the coding frame was agreed, DH coded the data in NVivo by applying the agreed codes. Summaries were produced by theme and all authors then discussed these, in particular considering inter-relationships between themes. DH and JPG subsequently collated and redrafted these, selecting illustrative quotations.

Ethics

Ethical approval was obtained within the framework of the larger study [reference blinded for review] from [blinded for review] Ethics Committee (reference number [blinded for review). Participants signed written informed consent sheets during the training programme.

Results

Process - setting up and running groups

The initial contact PSFs were asked to make with peers was seen as the first 'motivational hurdle' and for some this induced anxiety. Often there was not enough initial peer interest, which some PSFs felt responsible for. PSFs were given mobile telephones to facilitate communication. Reception was mixed, with some PSFs reporting frustrations with unanswered calls or that initially establishing rapport was difficult, and others reporting telephones as useful for following-up peers or arranging appointments.

Garden centres, cafes and village halls worked well as venues, so long as they were relatively quiet – it was difficult to maintain discussion in busy public places. PSFs reported success arranging chairs in a circle to facilitate discussion. A proactive approach to meetings, for example by giving peers reminders, printing slips with meeting times, or following up

discussions raised in the group encouraged attendance. Setting dates for several meetings in advance made it easier for people to attend.

Setting ground rules to cover the aims of the sessions, confidentiality and taking turns to speak was helpful. PSFs reported that a set agenda enabled them to rein in over-talkative people, and a theme for each meeting ensured that the group covered the main issues.

PSFs were broadly positive about the training programme, especially as it offered an opportunity to meet others taking on the role. As the study nurse commented:

> If the PSFs had not trained together it would have been hard to get them to bond as they are all different characters and there is a big age difference (Nurse comments cluster 617).

PSF characteristics

A range of PSF characteristics were seen as contributing to success, including their professional backgrounds, experience, motivations, personality, expectations, shared norms and values, and illness characteristics. The main reasons PSFs gave for volunteering were wanting to learn more about diabetes and to help others. From the study nurses' perspective, the most engaged PSFs took an interest in diabetes and were conscientious patients. They had a general belief in the power of shared action. Nurses noted that successful PSFs were: good at listening, empathetic, gregarious, sympathetic, caring, community-spirited, did not overplay their knowledge, were genuinely interested in "what makes others tick", and were confident and encouraged confidence in others.

Indeed, lack of confidence or shyness – or being overbearing or dominant – was the main PSF characteristic that was seen as problematic by both the study nurses and PSFs. This was partly seen to reflect personality; as a study nurse commented: "she has amazing fortitude and

seas of emotional energy". Another PSF simply stated that he was "not a good leader". Other difficulties related to the concept of peer support and running groups appropriately. One PSF was positive to start with, but grew disappointed that there was no-one in the group to discipline those with poor self-management, as there would be in a formal setting. In another case, a nurse was critical of a PSF letting the session run for two and half hours, despite repeated advice.

Nurses observed that PSFs had skills in different areas, influencing their approach, with some better at the social and emotional aspects and others at organisation and administration. PSFs with a professional occupational background were often well-versed in the skills required for peer support e.g. they tended to have experience of group work or in some cases, experience of using counselling techniques. As one nurse said:

> As the main PSF has a great deal of professional experience in dealing with a learning and sharing environment she came to each meeting with a structure of how the session might go. Also she came with the feedback from the last session and what they covered so peers could review what they talked about last time (Nurse comments cluster 750).

On the other hand, one PSF was a retired teacher and set out the group like a classroom, implying a power differential between himself and his peers. Overall, in their reports the nurses emphasised that being good at listening and being empathetic were the most important attributes.

Peer characteristics

As well as PSF characteristics, peer characteristics and especially their needs, also affected participation in the groups. When peers experienced medical complications this presented a

challenge for some PSFs who felt that they could only identify with whose condition was similar to their own:

> One of my two remaining peers has much more severe diabetes than me. She is consequently much more knowledgeable than me. I am not sure that matching this lady with me has helped either of us very much (Male, 63).

Several PSFs also thought that most of those who attended were already committed to managing their diabetes, whereas newly diagnosed patients might need more support. As one put it:

> We were preaching to the converted! The people we were seeing were knowledgeable and controlled. Our experiences might have been more profitably shared with newly diagnosed diabetics who were struggling with the system (Female, 60).

Similarly, another PSF suggested that:

> We need to find a way to attract those people who either don't know about us or think there is nothing to learn (Female, 58).

Some peers were explicitly motivated by the social element of peer support, which frustrated some PSFs (e.g. one described a “very elderly” lady who “wanted company and tea”). Others felt their peers wanted clinical advice or education, which peer support is not intended to offer. One commented that the process could be “like the blind leading the blind”. Although the study team attempted to be clear about what peer support is, many appeared not to fully understand this. When there was mismatch between expectation and experience, peers often withdrew.

The social context of peers’ lives influenced their orientation towards peer support. A recurring theme from PSFs was that the retired had different schedules, with more time for

meetings; the idea of relaxed group chats was at odds with busy careers. Often peers had more pressing concerns, such as caring for others, bereavement, or family issues. One PSF commented “much of what I dealt with was impacting on diabetes control but hinged on some rather tough circumstances hidden under the surface”.

Peers also differed in their orientation towards support, in whether they were comfortable talking about diabetes or wanted a more practical approach. For example, one PSF suggested that his group were not keen on peer support because they “were just not talkers”, and some peers reported frustration that the group was not *doing* anything. In other words, some peers expected the groups to mainly involve practical activities rather than simply talking about diabetes.

PSFs’ working relationships

The way in which PSFs worked together was crucial to success. Some PSFs noted they were committed to the same ends, or that they simply liked each other. Their skills also influenced working relationships, with some better at emotional aspects and others better at organisational aspects. When two PSFs had complementary skills, there was often an effective division of labour. As a study nurse said of one pairing: “they complement one another's skills and realise this too”. Finally, we found that it was better to have two or three facilitators in case of absence or withdrawal. Inevitably some peer/PSF relationships work better than others, so having more than one PSF allows peers choice in establishing relationships.

Group dynamics

A sense of commonality amongst peers was perceived as fundamental to the peer support working:

> All of the people I met on a regular basis had similar characteristics. They have had diabetes for approx. ten to twenty years. They are all very interested in diabetes and keen to find out more. We shared a lot of information that we had found out through books, newspaper articles and the internet. We had some very good discussion. They said they were pleased to talk about diabetes with someone with the same condition. (Female, 67).

Gender and age may also influence relationships. One study nurse reported that some male PSFs worked well with female PSFs, and also that some PSFs got on well because they were the same age.

Some PSFs stated they were on "completely different wavelengths", whilst others thought differences were an opportunity for learning e.g.:

> Peers came from 2 villages and 2 surgeries plus peers were at different stages of disease development from diet only to insulin user with significant complications. We were therefore able to share experiences at all levels (Male, 64).

The sociality of the groups influenced whether they flourished and endured, reflected by PSFs who said they started off covering practical aspects, but over time familiarity developed and the groups became a social gathering. This may have helped maintained attendance. In terms of peer numbers and group dynamics, study nurses reported that fewer peers made discussions repetitive, with the ideal size felt to be 8-9 peers. If people could not attend, group sizes could drop rapidly. Therefore, recruiting a larger group to allow for non-attendance and dropout is sensible.

Topics covered and group atmosphere

Many of the groups' discussions related to day-to-day management e.g. diet, exercise and medications. Often content evolved from being surface-level, e.g. mutual interests/hobbies through to more practical aspects of managing diabetes, to social support/friendship groups. A good starting point for some was to establish things in common as an icebreaker exercise.

How PSFs steered the discussion was central to this transition. Many reported that some structure was helpful to keep discussion on track. To help with this, the study team provided information about the barriers to diabetes care reported by trial participants in the area, a suggested curriculum and booklets about local resources. Participants also brought in items to discuss e.g. newspaper stories. They also arranged (as they were encouraged to) their own activities together, such as carpet bowls, though this tended to happen most when groups flourished rather than being common across all groups.

PSFs reported the need for balance between letting the groups run freely and controlling discussion. Being flexible was important so that the core subjects were covered without the groups feeling rigid. For example, one PSF set a theme for each meeting, but allowed discussion to flow around it. PSFs also reported the challenge of striking a balance between being a professional and friend.[1] In some cases, the groups were felt to just 'ramble', or people dominated the conversation. One PSF wrote:

> Certain peers were only interested in talking about themselves, so when they had talked themselves out, they stopped coming. I felt that there was no peer support as such (Male, 66).

Peers clearly liked to talk about clinical care. Consequently some were more confident in approaching their doctors, but this sometimes turned into 'NHS bashing'. Groups sometimes ran out of conversation, or kept returning to the same topics. Some structure to discussion but also flexibility according to the needs of the group is important. When things went well there

was a relaxed atmosphere of equality, respect and mutuality. Some described developing relationships as 'diabetes friends'. Inviting in guest speakers e.g. dietitians or nurses was felt to be positive to keep the groups interesting.

Sustaining and ending peer support

The programme envisaged people meeting with a structured programme over the first six months, and an unstructured programme for the next six months. During this time, attendance diminished, and some groups came to an end. There were a range of comments about how the groups changed over time, and what sort of groups kept people engaged. Sometimes groups stopped because they had fulfilled their purpose – people attended, compared experiences and found they were doing OK. As noted, the groups that carried on offered a social benefit to attendees. This depended on whether people "gelled" and whether the experience was socially positive. Sometimes illness or other commitments stopped people attending. Several emphasised the importance of the project organisation and the need to secure ongoing external funding. Others emphasised a need for 'buy in' from general practice surgeries. The need to end groups appropriately was also flagged:

> There needs to be a clear way to withdraw at the end of the time with peers because I don't want to leave people in a dependent state when I stop doing this (Female, 58).

Discussion

This study investigated what makes for successful diabetes peer support groups from the perspective of PSFs and study nurses. Overall, groups that took an organised approach and encouraged peers to share their experiences and support members in a friendly atmosphere worked best. Effective PSFs were able to guide this process and the most successful were genuinely interested in helping others. The fact that people saw learning about their condition

as fundamental reflects the work needed in managing diabetes, especially in terms of diet and medications. The issue of peers' varying needs recurred in our findings and some appeared to expect input from a health professional. Outlining what peer support is (and is not) needs stressing in training programmes. Training should help PSFs develop confidence but should also emphasise that peer support entails an equal, democratic dynamic. Sustainability seems to require support at the programme level – which in our case was delivered by nurses – to support the PSFs.

Our finding that having multiple PSFs per group so they can continue in case of absence echoes Boyden et al.[27] A factor not much considered in previous studies is PSFs' relationships with each other. PSFs work well together when they complement each other's skills, and are fond of each other, which was corroborated by nurse observation. Dividing up tasks clearly at the outset is one way to facilitate an effective division of labour. Attending training together enables PSFs to establish good working relationships. Whether or not PSFs related to each other (and to peers) was influenced by their age, gender and occupational/educational backgrounds. In thinking about the skills they bring to the role, it would be beneficial for PSFs to draw on their occupational experience.

Ending support groups is rarely discussed in the literature[28], though Embuldeniya et al.[29] have mentioned the difficulty of severing relationships. One exception comes from Watson[30], who reflected on her experiences of ending peer support and the guilt involved with this, which was echoed in our findings. She also notes that people vary in how they end relationships, making it difficult to suggest universal guidelines. Nonetheless, the topic of ending support needs to be addressed from the outset, and where possible plans need to be in place for continuation. Our finding that continued attendance was motivated by the sociality of the groups is supported by previous research.[31] However, we have shown that peers are mixed in

terms of whether they saw the groups as a way to socialise, which may depend on their personalities or be related to the other social networks they are a part of or supported by.[19]

The characteristics of peers attending groups, in terms of illness, motivations, expectations, personality and socio-demographics, influenced how successful the groups were. As noted earlier, the literature suggests various possibilities regarding the homogeneity of groups in terms of these key characteristics, with some studies suggesting that homogenous support groups engender understanding, empathy, and help,[12] and others that heterogeneous groups are more creative and better at problem solving.[13] In addition to the above factors, we also found that amount of free time available, related to engagement with the labour market, is important for peer support groups. This should be kept in mind if groups are to be matched, especially as chronic conditions tend to develop in later life. Our results suggest this is not a straightforward issue however, as we found that if PSFs and peers were very different to each other it was difficult to find common ground; on the other hand, if there were very few differences, groups presented fewer opportunities for learning from each other. Differences were more easily overcome when PSFs were skilled in managing the complexity of the groups, echoing previous research[16], and re-iterating the importance of training. Finally, as discussed in previous studies[20], the local setting also has an influence. To some extent, the small village community setting in our study aided commonality. The dynamics of urban-based groups may be different in this respect.

Our study has several strengths and limitations. The PSFs tended to be from professional and managerial backgrounds, and different issues might affect a more culturally diverse population. Fewer of those who dropped out returned reports, meaning that we were less likely to hear negative experiences. The nurse reports however provided useful data on the groups that had lapsed. Triangulating data from different sources allowed us to get a rich understanding of PSFs' and study nurses' perspectives, though we were not able to get their

feedback on the data or analysis due to resource constraints. Despite these limitations, to our knowledge RAPSID is the largest diabetes peer support study to date, and the experiences we report should prove informative to others planning to establish groups. We have summarised our findings into key lessons in Figure 1 which may be useful PSFs, trainers, intervention developers or researchers.

[Figure 1 here]

Conclusions

Peer support is a potentially valuable means to encourage self-management in diabetes and other conditions. This paper has outlined key issues PSFs and nurses found most important in establishing and running diabetes peer support groups. The most successful tended to have strong social relationships with productive dynamics and a good group atmosphere. This is likely to emerge when PSFs are committed and genuinely interested in helping others. Training can help PSFs who might facilitate groups together to develop a common approach. We found that many participants were positive about the benefits of peer support but the efforts of those who volunteer to assist in this cannot be taken for granted. Given that there is a paucity of research on this topic we encourage those establishing future peer support groups, including for diabetes but also other conditions, to conduct further research on this topic. In particular, there is a lack of information on how to effectively match group members and end peer support groups, including when this appropriate.

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Declaration of conflicting interests

The Authors declare that there are no conflicts of interest.

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