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Exploring the Perceived Effectiveness, Impact and Benefits of a Work-Based Cancer Survivorship Peer Support Programme: A Qualitative Descriptive Study

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ABSTRACT

Aim: To explore the perceived effectiveness, impact and benefits of a work-based cancer survivorship peer support programme for healthcare employees who have experienced or are experiencing cancer.

Design: A qualitative descriptive study.

Methods: Purposive sampling was used to recruit 33 participants (10 peers, 12 peer supporters, 4 line managers and 7 members of the governance group). Data were collected between October 2024 and February 2025 through individual interviews and focus groups. Data were analysed using reflexive thematic analysis.

Results: Four themes were generated: Programme Reach and Adoption, Implementing the Programme, Programme Effectiveness and Impact and Programme Maintenance and Growth. Challenges included the pilot status of the programme impacting awareness and uptake, potential reluctance to share diagnoses and the impact of cancer on colleagues. The approach of peer supporters was considered central to the programmes' success. Peer supporters valued training and continuous practice development opportunities.

Conclusion: Demonstrated benefits, including satisfaction and the value of peer support, were evident. To ensure programme maintenance, increased recruitment and training of peer supporters and clear communication regarding the programme and referral pathways are essential. Financial support is required to maintain training and address dissemination challenges.

Implications for the Profession: Work-based peer support programmes can help cancer survivors reintegrate into the workforce more effectively, rebuilding confidence, fostering resilience and navigating workplace expectations. Enhanced staff well-being may also positively influence retention, performance and health-related disruptions.

Impact: Findings from this underexplored area of work-based peer support within a healthcare setting have the potential to influence healthcare leaders, policy makers and future research. Improving staff's' quality of life on return to work benefits the individual, the organisation and care delivery by ensuring a healthy, supported workforce.

Reporting Method: The Standards for Reporting Qualitative Research (SRQR) checklist and the Template for Intervention Description and Replication (TiDieR) checklist were utilised.

Patient or Public Contributions: No patient or public contribution.

Mohamad M. Saab and Josephine Hegarty are joint senior authorship.

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Contribution to Wider Global Clinical Community

What is already known?

- Long-term consequences of a cancer diagnosis and treatment cause concerns for returning to work and affect employees' working ability.
- Peer support may help with the fear of cancer recurrence, coping with anxiety and promote confidence in cancer survivors.

What this paper adds?

- Reinforces the pivotal role of cancer survivorship peer support.
- Deepens our understanding of the need and benefit of peer support within the workplace.
- Work-based peer support improves emotional, practical and psychological well-being.

Implications for practice/policy

- Clear, transparent policy and governance structures are essential for the success of peer support programmes.
- These programmes can improve inclusivity and compassion, strengthening team cohesion and organisational trust.
- Organisational commitment to safety, health and wellbeing can be enhanced through supporting cancer survivors' return to work.

1 | Introduction

Cancer remains one of the most significant global health challenges, with close to 20 million individuals diagnosed each year (Deo et al. 2022). Advances in early detection, treatment and supportive care have led to improved survival rates (Siegel et al. 2022). As a result, increasing attention is being given to the experiences of individuals living with and beyond cancer. Such experiences encompass the physical, psychological, social and economic aspects of survivorship, beginning at diagnosis and continuing through the person's' life (Miller et al. 2019).

2 | Background

The transition from active cancer treatment to survivorship presents unique challenges. Many cancer survivors experience long-term and late effects of treatment, including fatigue, cognitive impairment, pain and an increased risk of secondary malignancies or chronic illnesses. Psychological concerns including anxiety, depression and fear of recurrence can persist long after treatment ends. These late effects impact overall well-being and quality of life, compounded by unmet supportive care needs (Hemming et al. 2024; Paterson et al. 2023).

Social and economic factors further shape the survivorship experience. Cancer can disrupt employment, financial stability and social relationships, leading to challenges in reintegration into everyday life (Mudaranthakam et al. 2023). Peer support has emerged as a valuable component of survivorship care. It is defined as 'a system of giving and receiving help, founded on key principles of respect, shared responsibility and an agreement of what is helpful' (Mead et al. 2001, 135). Peer support offers a sense of shared experience, emotional support and practical guidance as individuals navigate post-treatment life (Canella et al. 2023; Hoey et al. 2022). Peer support programmes have been shown to support active coping behaviour, reduce anxiety, cultivate hope and help cope with the fear of cancer recurrence or progression (Ziegler et al. 2022; Zhang et al. 2002). These services not only benefit the person receiving support but also positively impact the supporter by fostering a sense of purpose, improved emotional well-being and deeper personal insights into survivorship (Hemming et al. 2024). Organisations that facilitate peer support programmes also benefit by enhancing patient engagement, improving overall survivorship outcomes and creating a community-driven approach to cancer care (Sleiman et al. 2024). There is however a paucity of evidence examining peer support for cancer survivors in the workplace, and less where organisations have taken a lead in providing structured support for staff.

In Ireland, where the current study was conducted, 1 in 2 individuals is expected to develop cancer in their lifetime and the incidence is projected to double by 2045 (National Cancer Control Programme [NCCP] 2019). By the end of 2021, 215,000 people—nearly 4% of the Irish population—were living with or beyond cancer, although survival rates vary widely depending on the cancer type (NCCP 2019). This number is expected to double over the next 25 years due to advances in early detection and treatment (NCCP 2019), highlighting the growing importance of survivorship care.

As cancer survival rates increase, a growing number of survivors are returning to work following diagnosis and treatment. Work is a meaningful aspect of cancer survivors' life, requiring support systems and coping ability to deal with work-related difficulties (Duijts et al. 2017). This will inevitably impact employers and employees. Staff returning to work can expect to be supported by their employer as they navigate specific challenges in returning to work after cancer treatment (International Labour Organisation [ILO] 2022; Xu et al. 2023; Zhao et al. 2025).

The Health Service Executive (HSE), Ireland's main provider of health and social care services, is one of the largest employers in the state, with over 150,000 employees (Central Statistics Office 2025). Services are organised into six health regions overseen by five national service delivery divisions (acute hospitals, social care, mental health, primary care and health and wellbeing). Nurses constitute the largest proportion of staff, with physicians, allied health professionals and support services employed across numerous hospital and community settings. Given the centrality of staff to the effective functioning of the HSE, their health and wellbeing is significant.

Managing safety, health and welfare at work is mandated, including minimising psychosocial risks (e.g., lack of support from colleagues or management and job insecurity) which may arise following a cancer diagnosis (Doyle et al. 2024; ILO 2022). Because of the projected trends in cancer survivorship, there will also be greater demand on healthcare services which

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has implications for nursing and allied health care practices. Ensuring staff are available for work is paramount to meet this demand. To this end, the HSE, in partnership with The Marie Keating Foundation, (a voluntary cancer awareness and support organisation), developed the 'For Survivors, By Survivors' cancer survivorship peer support programme. The programme was devised for health service employees to support them in their recovery and return to work following a cancer diagnosis and treatment.

The non-clinical programme centred on one-to-one listening, befriending, emotional and practical support and signposting to external resources. The programme was provided by peer supporters, a group of staff who themselves had experienced cancer, working to a defined peer support role, supporting other staff who had subsequently received a cancer diagnosis. All potential peer supporters undertook specific training (hybrid approach over 3.5 days) with access to ongoing professional development and supervision once they commenced their role. Training content included cancer survivorship, peer supporter role and psychological safety, listening skills and practical workshops. File S1 TiDieR checklist includes detail on the training provided. The peer support programme began in January 2024, following peer supporter training with 24 peer supporters who were available to meet with peers online or in person. Prior to engaging with peer support, potential peers and peer supporters were matched based on the peer's preferences relating to mode of peer support engagement (online, in-person, telephone) and gender. A total of 30 peer support sessions were undertaken over a 12-month period.

Given the complexity of living with and beyond cancer, research has increasingly focused on survivorship care models, rehabilitation strategies and interventions to enhance quality of life. Direct provision of peer support within the workplace, initiated by employers, represents a novel approach and remains relatively unexplored. While peer support in general may improve psychosocial outcomes, its impact on return-to-work and occupational integration has been largely unexamined. Therefore, there is a need to examine and evaluate the effectiveness and impact of these programmes for all stakeholders involved: the peer supporter, the person being supported (peer) and the organisation providing the service. Understanding how these programmes contribute to survivorship experiences can inform policies, healthcare practices and psychosocial support mechanisms that address the multifaceted needs of this growing population.

3 | The Study

3.1 | Study Aim and Objectives

The overall aim of this study is to explore HSE employees' experiences of a pilot work-based cancer survivorship peer support programme and to evaluate whether the programme effectively meets participants' workplace support needs. The objective was to explore the perceived effectiveness, impact and benefit of this programme from the perspective of (i) the person being supported (peer), (ii) the peer supporter and (iii) the organisation (line managers of peer supporters and programme governance group).

4 | Methods

4.1 | Study Design and Theoretical Framework

This study is the main component of an independent evaluation of the 'For Survivors, By Survivors' cancer survivorship peer support programme. A qualitative descriptive approach was used, drawing on naturalistic inquiry to study real-world situations as they unfold naturally (Sandelowski 2010). This ensured that understanding of the phenomenon of interest was developed from the participants' perspective. Qualitative descriptive approaches are useful in obtaining answers to questions of importance for participants and enabling a comprehensive summary of events in everyday terms (Sandelowski 2010). The training programme undertaken by peer supporters to prepare for their role was described using the Template for Intervention Description and Replication (TiDieR) checklist to promote transparency and replicability (Hoffmann et al. 2014) (File S1). The Standards for Reporting Qualitative Research (SRQR) checklist was used to report this study (O'Brien et al. 2025) (File S2).

An overarching Logic Model was developed to scaffold the study (Moore et al. 2015). Logic modelling enables the examination and evaluation of important contexts, components and assumptions underlying a programme/intervention. This guided the researchers throughout the study in defining and clarifying what should be measured and when. Figure 1 indicates the overarching Logic Model developed to capture the situation, inputs/outputs, plausible outcomes and assumptions associated with the programme. This was reviewed and discussed with key governance stakeholders at agreed timelines as part of the programme evaluation.

The updated Practical, Robust Implementation and Sustainability Model (PRISM) incorporating Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) Outcomes Framework guided this study (Glasgow et al. 2024). PRISM examines contextual factors that interact with an intervention or programme and implementation strategies to produce RE-AIM outcomes. The four key contextual PRISM concepts are (i) perspectives on the programme, (ii) characteristics of the implementers, their settings and those receiving the intervention or programme, (iii) external environment (policies, resources health and social system structure and coverage) and (iv) implementation and sustainability infrastructure (i.e., resources, capacity, staff roles and responsibilities, monitoring and evaluation systems) (Glasgow et al. 2024). As seen in Figure 2, these contextual factors with the RE-AIM outcomes guided the study design, exploration of participants perspectives on the programme outcomes and the interpretation of results. This was achieved through a consideration of: (i) who the project was reaching (reach), (ii) how effective was the project, (iii) programme adoption and delivery (planned/actual), (iv) how the programme was implemented and (v) whether the programme can be maintained.

4.2 | Study Setting and Recruitment

Non-probability purposive sampling was used to recruit participants. The sampling criteria were: (i) HSE staff working in any

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Situation	Inputs	Activities	Outcomes
Living with and beyond cancer is an important part of the caner trajectory with 4% of the population experiencing cancer survivorship in Ireland. Stage of survivorship include acute, transitional, extended and permanent. From diagnosis, through treatment, follow-up and rehabilitation can be traumatic, with informational, emotional and psychological needs for those diagnosed, living with and surviving cancer. Peer support programmes have inherent benefits to support active coping, reduce anxiety and cultivate hope. The Cancer Survivorship Peer Support Programme "For survivors By Survivors" within the HSE is a new initiative to address unmet needs of employees diagnosed with cancer by providing a non-clinical support service by people with lived experience of cancer. The evaluation of the pilot programme seeks to understand reach, effectiveness and contextual factors aligned with the programme.	**People & Partnerships**: Involvement of project stakeholders - evaluation subgroup, research team. Trained peer support workers with support mechanisms in place. **Time, Budget, Research Data**: Time for data collection; budget for researchers; governance and leadership infrastructures. Recruitment of participants for data collection (surveys, interviews)	**Research Activities:** Development of data collection tools **Operational Planning:** Regular meetings with key stakeholders. Overarching Logic Model review at agreed timeframes. Participant recruitment. **Reach:** Proportion of peer supporters completing training and post training interactions. **Effectiveness**: Surveys & qualitative interviews. **Adoption, implementation, maintenance & PRISM factors:** surveys & qualitative interviews **Dissemination:** final report of findings including executive summary, conclusions & recommendations.	Implement, review & evaluate the peer support programme guided by PRISM and RE-AIM frameworks. Experiences of the programme from key perspectives. Respond to identified ways to enhance reach, effectiveness, adoption, implementation and maintenance of the programme. Maintain peer supporter ability to provide the cancer survivorship peer support programme. Increase interest in the peer support programme among all stakeholders & participants. Widely disseminate the programme findings to maximise impact and sustainability.
Assumptions		**External factors**	
By ensuring clear communication and regular meetings with key project stakeholders the programme evaluation will remain on target and in budget. Peer supporters and those being supported will be matched appropriately and set their agenda. Peer supporters will receive sufficient training, CPD and necessary supports within their workplace to provide peer support. Managers will be aware of the programme and how to refer. Sufficient external/internal resources will be available to allow signposting by peer supporters. The person being supported will experience improved emotional wellbeing, understanding of additional support resources, the ability to talk with colleagues about their experience and increased self-confidence.		Service up-take: interest and concerns or anxieties of those recently diagnosed with cancer and ability or comfort to talk with colleagues. Mode of delivery: face to face/online Increasing number of cancer survivors nationally. Potential of reccurrence or second cancers. Availability of external, additional resources or supports – fiscal influences. Recruitment embargo.	

FIGURE 1 | Overarching logic model guiding this study.

health profession including nursing, (ii) aged 18 years or older, (iii) of any gender, (iv) working within the identified pilot areas and (v) having engaged with the peer support programme in one of the following roles: peer (individuals receiving support), peer supporter, line manager of a peer supporter or member of the governance stakeholder group. The governance stakeholder group membership included representatives from national HSE Health and Wellbeing, Public Health, National Library Service, the Marie Keating Foundation and the peer supporters' group.

The voluntary cancer organisation acted as gatekeeper for recruitment, circulating a standardised email to all eligible individuals, including detailed information leaflets. The governance group was invited to participate by the research team as part of the oversight process for the programme implementation and monitoring.

There is no gold standard for determining sample size in qualitative descriptive research. Data saturation is often described as the point at which no new themes or insights emerge (Guest et al. 2006). However, this concept has been critiqued for emphasising data redundancy and for its limited applicability to interpretive approaches, such as reflexive thematic analysis used in the current study, where meaning is actively generated rather than simply discovered (Braun and Clarke 2021). In contrast, Malterud et al.'s (2016) concept of information power proposes that sample adequacy depends on the richness, relevance and specificity of participants' information in relation to the study aims. Given the clearly defined participant group and the rich, detailed accounts closely aligned with the research aim and objectives, information power offered a more appropriate and theoretically consistent rationale for determining sample adequacy in the current study.

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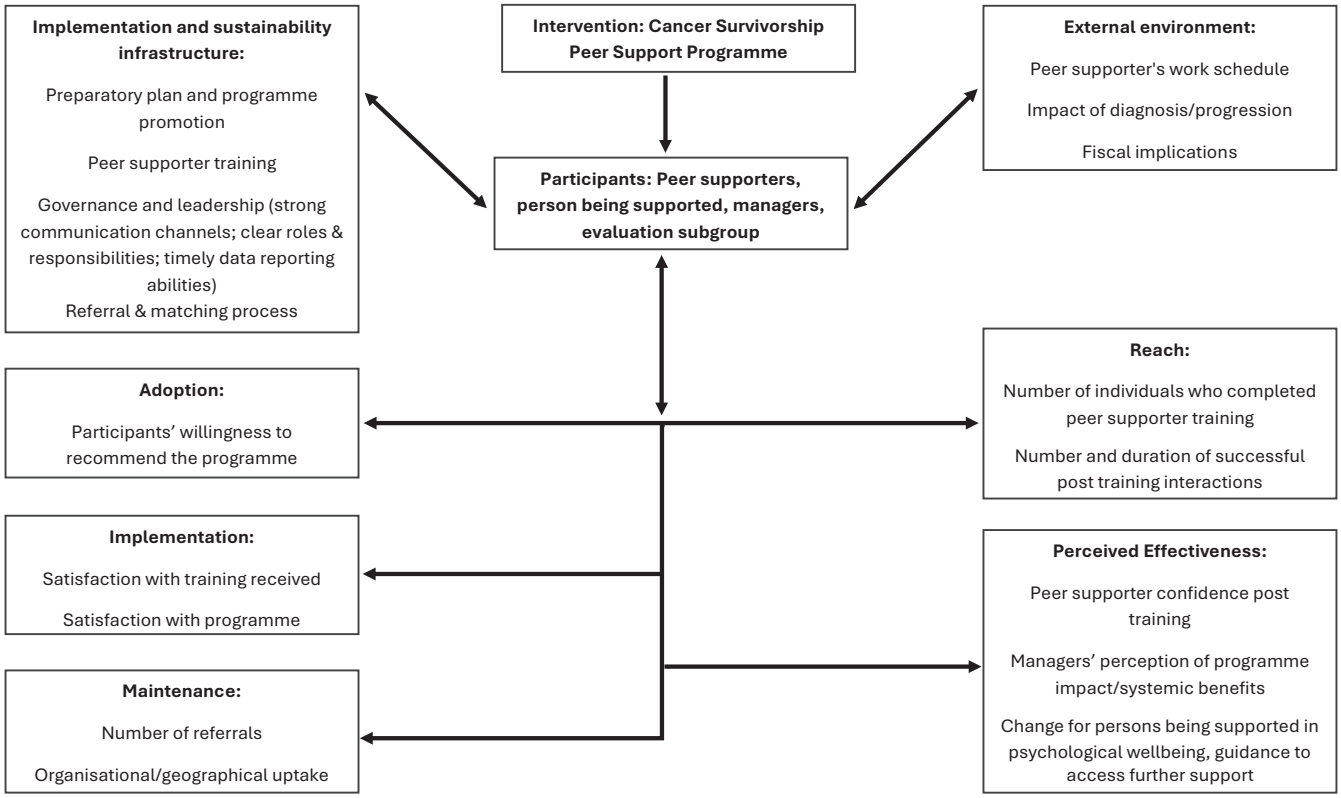


FIGURE 2 | PRISM framework guiding this study.

4.3 | Data Collection

Participants contacted a member of the research team via email, indicating their willingness to take part in an online interview or focus group. Because of the potential sensitivity of the topic, participants were offered the option of individual interview or focus group. Using both qualitative data collection approaches is known to enhance the depth and richness of qualitative data and help achieve methodological triangulation (Lambert and Loiselle 2008).

All those who expressed an interest provided written consent. A semi-structured interview schedule was developed reflecting the aim of the study (Table 1). Although guided by overarching research questions, interviews were steered by participants' responses. Discussions were generated from five key areas: (i) who was intended to benefit and who actually participated in the programme, (ii) what were the most important benefits aimed for and what were the programme outcomes, (iii) where the programme was applied and who applied it, (iv) how consistent was the delivery of the programme, including barriers and facilitators to implementation and (v) how the programme might be sustained.

Data collection occurred between October 2024 and February 2025 virtually on MS Teams with transcripts automatically generated. Duration of individual interviews and focus groups ranged from 22 to 63 min. Transcripts were cross-checked against the original video file for accuracy, and the original file was then deleted. Participant demographics, including age range, gender and profession/role, were recorded using a standardised data collection form hosted on the Qualtrics platform.

4.4 | Data Analysis

Data analysis was guided by Braun and Clarke's (2021) reflexive thematic analysis. Three researchers (MOM, TW, SK) were primarily involved in the initial analysis. All individual interview ($n = 14$) and focus group ($n = 3$) transcripts were first read repeatedly by these three researchers to facilitate immersion in the data.

Each transcript was manually coded line-by-line, using Microsoft Excel, with initial codes generated inductively from the data (bottom-up). Interviews and focus groups were analysed separately during this phase to capture context-specific insights (O'Reilly et al. 2021). Two of the three researchers (M.O., T.W.) independently cross-checked a subset of coding to ensure consistency, and discrepancies were resolved through discussion until consensus was reached.

Following inductive coding, a deductive analysis was applied to address the research questions, using the PRISM framework to guide interpretation. RE-AIM outcomes—reach, adoption, implementation, perceived effectiveness and programme maintenance—were considered in refining themes, though not in a strictly linear sequence (Glasgow et al. 2024).

Once individual analyses were complete, interview and focus group findings were compared, contrasted and synthesised to achieve methodological triangulation. This process allowed for integration of the multiple data sources into a coherent set of overarching themes, capturing holistic participant perspectives while enhancing credibility and validity (Johnson et al. 2017; Noble and Heale 2019).

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TABLE 1 | Indicative interview and focus group guides per participant group.

Participants	Questions
Peer supporters	Can you tell me about the training you received to become a peer supporter?
	Can you tell me about your experience in providing peer support since completing the training?
	What benefits, if any, do you think the service has had?
	What have been the challenges or barriers for you in providing the service?
	What impact did the service have (positive or negative) for the person being supported, for you as a peer supporter or your organisation?
	How can the service be sustained in your view?
	Is there anything else that you would like to say about how the service might grow and develop in the future?
	Do you think you might recommend involvement with the service to a colleague?
	Is there anything else you would like to add about your experience with the cancer survivorship peer support service?
Line managers	Can you tell me about your experiences and thoughts about the cancer survivorship peer support service?
	Can you tell me a little about the referrals to the service?
	Do you have staff providing peer support? What is your experience relating to this?
	In your opinion has the peer support service had an impact in your department?
	In your opinion is the peer support service is effective in addressing the needs of staff experiencing a diagnosis of cancer?
	How can the service be sustained in your view?
	Is there anything else that you would like to say about how the service might grow and develop in the future?
	Do you think you might recommend involvement with the service to a colleague?
	Is there anything else you would like to add about your experience with the cancer survivorship peer support service?
Peers	Can you tell me about your experiences of the peer support service?
	Can you talk about your overall experience of engaging with the peer support service?
	Can you tell me if you noticed any change in how you feel, manage or cope having engaged with the service?
	In your opinion should the service be continued? And if so, how might the service be sustained in your view?
	Is there anything else that you would like to say about how the service might grow and develop in the future?
	Do you think you might recommend involvement with the service to a colleague?
	Is there anything else you would like to add about your experience with the cancer survivorship peer support service?

The final set of themes and the conceptual model were developed collaboratively by the full research team. Initial themes from the inductive phase were discussed in team meetings, iteratively refined and mapped onto the PRISM and RE-AIM frameworks to construct the final model. All decisions regarding coding, theme development and model construction were documented and the final amalgamated data were reviewed and signed off by the full research team (M.O., T.W., S.K., C.K., C.E., M.M.S., J.H.).

Table 2 summarises the steps in the analysis process.

Data source and methodological triangulation aimed to uncover holistic participant perspectives, while also enhancing the credibility and validity of the findings (Noble and Heale 2019). Data from each interview and focus group were analysed separately and then compared and contrasted, with interview and focus group data combined at a later stage to achieve methodological triangulation (Johnson et al. 2017).

4.5 | Ethical Considerations

The study obtained ethics approval from the HSE Research Ethics Committee (RRECBO624), and the Social Research Ethics Committee affiliated to the researchers' university (2024-084A1). All participants received information leaflets and provided written informed consent prior to data

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TABLE 2 | Reflexive thematic analysis steps and description.

Reflexive thematic analysis steps	Application in the current study
Familiarisation with the data	Researchers immersed themselves in the data by reading and re-reading the individual transcripts to understand the depth of experience made available in the data
Generating initial codes	Interesting features across each transcript were identified, staying close to the data. Interviews and focus groups were examined separately. Meaningful sections were labelled and initial codes generated. This involved re-organising and rationalisation of codes over time
Searching for themes	Codes from each participant group were collated into potential themes, cross-checked and organised into overarching themes. Relationships between codes were reviewed independently by two researchers, which led to the generation of initial descriptive themes
Reviewing themes	Themes were checked to ensure they aligned with the coded extracts and represented the data accurately
Defining & naming themes	Themes were debated and refined until consensus was reached. Some themes were combined, resulting in the generation of four overarching themes
Producing the report	The findings were summarised, presented and written up in a coherent and considered manner

collection. They were assured that non-participation or withdrawal from the study would not affect their employment or engagement with the service. To protect participants' rights and privacy, identities were pseudonymised in all study documents and reports and data were stored securely in accordance with institutional and GDPR requirements. No participants received financial or other compensation. A distress protocol was developed in the event of a person experiencing distress, although this was not required.

4.6 | Reflexivity

Interviews were conducted by three researchers. Each focus group was facilitated by two researchers, to ensure the voices of less communicative and outspoken participants were heard and all participants had the opportunity to contribute. One researcher acted as the lead facilitator and the second researcher assisted in picking up on verbal and non-verbal cues, probing participants and seeking clarifications. All the researchers had academic and clinical backgrounds in nursing and were formally trained and experienced in conducting qualitative research (M.O., T.W., C.E., S.K.). None of the researchers had prior relationships with the participants and were not known to them. Immediately following each focus group, interviewers reflected on the focus group process and clarified whether iterations were needed in subsequent focus groups. This process enhances researcher reflexivity in qualitative research (Braun and Clarke 2021).

4.7 | Trustworthiness

Trustworthiness of the findings was ensured through multiple strategies aligned with credibility, dependability, confirmability and transferability (Lincoln and Guba 1985). Credibility was supported through team-based verification, with the research team (M.O., T.W., S.K., C.K., C.E.) independently reviewing and discussing initial codes and sub-themes, resolving any discrepancies through consensus to ensure interpretations accurately reflected the data. Dependability was enhanced by maintaining a detailed audit trail documenting all decisions, coding procedures and theme development steps. Confirmability was addressed by including participant quotations to demonstrate how conclusions were grounded in the data, while transferability was facilitated through detailed contextual information about participants, the programme and the study setting. Data source triangulation, achieved by analysing interviews and focus groups separately and then synthesising the findings, strengthened the robustness of the results (Noble and Heale 2019). Ethical integrity was maintained throughout by consistently applying core principles of biomedical ethics (respect for autonomy, beneficence, non-maleficence and justice) (Beauchamp and Childress 2013).

5 | Results

5.1 | Participant Characteristics

A total of 14 individual interviews were conducted, 10 with peers and 4 with line managers. Three focus groups were also held: two with peer supporters (one with 5 participants, one with 7 participants) and one with 7 members of the governance group (Table 3). This resulted in a total sample size of 33 participants.

Of the 10 peers who engaged in the peer support programme, the majority ($n = 6$) were nurses and five of the eight peer supporters were also nurses. Furthermore, half of the line managers were from a nursing background. No participant withdrew from the study. Participant characteristics are presented in Table 4.

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TABLE 3 | Number of individual interviews and focus groups conducted per participant group.

Participant group	Number of participants	Number of individual interviews	Number of focus groups	Number of participants per focus group
Peers	10	10	—	—
Peer supporters	12	—	2	5 and 7
Line managers	4	4	—	—
Governance group	7	—	1	7

TABLE 4 | Participant characteristics.

		Peer (*n*)	Peer supporter (*n*)	Line manager (*n*)	Governance group (*n*)
Variable	Values				
Age	18–29 years	0	0	0	
	30–39 years	0	0	0	
	40–49 years	3	5	1	
	50–59 years	7	4	2	
	≥ 60 years	2	1	1	
	Missing response(s)	1	1	0	
Gender	Female	10	10	3	7
	Male	4	0	1	0
	Prefer not to say	0	2	0	0
Profession/Role	Administration	0	1	0	1
	Environmental/ Occupational	3	2	0	1
	Health promotion	1	1	0	1
	Management	4	1	4	3
	Medicine	1	0	0	0
	Nursing	5	5	4	1
	Teaching	0	1	0	0

Results are presented under four themes: Programme Reach and Adoption, Implementing the Programme, Programme Effectiveness and Impact and Programme Maintenance and Growth (Table 5). The letter 'P' is used to present findings from individual interviews with peers (those being supported), 'LM' is used for individual interviews with line managers, 'PS' is used for focus groups with peer supporters and 'Gov' is used for the focus group with the governance group.

5.2 | Programme Reach and Adoption

Programme reach explored the factors that contributed to participation or non-participation in the programme and considered what might have been done to increase the target audience. The following two sub-themes were generated: (i) Programme need: impact of cancer diagnosis and (ii) Programme awareness: communication and accessibility: enablers and challenges.

5.2.1 | Programme Need: Impact of a Cancer Diagnosis

All participants highlighted the importance of a cancer survivorship programme for individuals diagnosed with cancer, their colleagues and the organisation. Peers and peer supporters reflected on their cancer journey, their 'fear' (P9), 'vulnerability' (P1), 'uncertainty' (P3), 'being alone' (P1), their reluctance 'to share' their diagnosis with colleagues (P2) and generally 'feeling a little bit all over the place' (PS1):

> You can't even remember what you're supposed to do or what you are to do. You're like, a lot of it, even going

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TABLE 5 | Summary of themes and subthemes.

Themes (incorporating RE-AIM)	Sub-themes	Sample codes	Sample excerpts
Programme reach & adoption	Programme need: impact of cancer diagnosis	Emotional journey Psychological response	'you can't even remember what you're supposed to do' (P2)
	Programme awareness, communication and accessibility: enablers and challenges	Busy work environment Pilot status of programme	'because it's only a pilot, it's not national' (PS1)
Implementing the programme	Training and programme modifications	Peer supporter boundaries Changing approach	'They [peers] really wanted to know how we felt as people' (PS2)
	Increasing awareness and referrals: strengths and obstacles	Impact of comms method Uncertainty re: roles/purpose	'they may not have seen the email, or been aware or it' (Gov)
Programme effectiveness & impact	The essence of peer support influencing outcomes	Peer supporter attributes Sharing experience	'a really lovely person, very easy to talk to' (P3)
	Programme impact: emotional, psychological and practical.	Affirmed in coping style Change in behaviour	'I just felt like a weight off my shoulder' (P1)
Programme maintenance & growth	Sustaining the programme: A vision for the future	Cost implications Programme expansion	'this great service needs to be communicated to all regions' (LM3)

> back when I think of it, I don't remember half of what happened.
>
> (P2)

Not knowing where to access information or practical advice was highlighted, particularly when working in a large company such as the HSE, with 'so many rules and regulations' relating to sick leave and pay (P3): 'It's not easy to know what is available and what's not? It's not easy to find, it's not easy to get hold of somebody' (P4).

Participants reflected on the impact a colleague's diagnosis and their absence from work can have. The person may be uncontactable or very ill and colleagues 'can be left quite devastated' (LM2):

> One thing I'm noticing is I haven't really talked to anybody myself as a line manager about all the instances of cancer we've had in the department and I'm feeling quite emotional just talking about it.
>
> (LM1)

Participants' experiences of their cancer journey or their exposure to colleagues' ill health and struggle motivated involvement with the programme. Connecting with individuals at the early stages of their cancer diagnosis was seen as important for supporting coping strategies and enabling future planning. Other participants lamented its absence previously, 'it should have been there sooner for people' (P8) and how this influenced their decision to become involved: 'When they were looking for volunteers, I think for me it jumped out [...], that is what I wish I would have had before I came back to work' (PS1).

Peer supporters and line managers also emphasised organisational responsibility to 'support staff in their time of need' (LM4), particularly in a large organisation that will 'inevitably have many staff' who receive a diagnosis of cancer (LM3):

> If people are able to come back to work more ready, knowing what's ahead of them, and you know for the organisation, your managers and staff, to understand that kind of thing, it's hugely beneficial to both sides.
>
> (PS2)

5.2.2 | Programme Awareness and Accessibility: Enablers and Challenges

Prior to the programme launch, governance structures were established and a communication plan and training programme for peer supporters were developed. Most communication about the programme, its remit and how to access it was via email or online article submissions. Participants spoke of the challenges associated with email in particular, 'sometimes the emails just can get so overwhelming' (LM3) and 'staff may not read them' (P7). Information about the programme may not resonate with people until cancer impacts them personally: 'They may not read or be aware of it [programme], and

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most people wouldn't be aware of it until it becomes an issue for them' (LM1).

Thirty peer supporters commenced training. At the time of the study, 24 were active. Not all peer supporters had been matched with peers; communication processes were seen as a key factor in this. Participants noted that there was an expectation they would be 'inundated with referrals' (PS1); this did not happen, largely due to how the 'programme was being promoted' (PS2). National communication strategies could not be employed, constraining the programme's reach: 'One of the real challenges has been that the pilot is for 20 counties and that means we cannot do universal communications' (Gov).

Participants reflected on the factors that might encourage peers to engage with the programme, and potential barriers that limited its reach. There was a concern that staff would be reluctant to speak with a colleague about their cancer diagnosis, 'familiarity can be a little bit uncomfortable' (PS1). Another noted that individuals 'may not be in the mindset to want to reach out' (PS2). Feeling 'vulnerable' (P1) and a desire to maintain privacy may also limit staff engagement:

> I was completely overwhelmed and not wanting to acknowledge how I was feeling, saying to my peers that everything was fine [...], I was so private, and I didn't want to link in with supports close by home [...] I didn't want everyone talking about me.
>
> (P7)

The needs of peer supporters and the expectations placed on them were also considered by participants. As this is a 'job plus role, they do it in their own time' (Gov), peer supporters must negotiate time to support peers with their line managers, while also managing their workload:

> I suppose the only drawback, and it's not proven to be a real concern, is the impact on her time, you know, and her workload, [...], if it was taking a lot of her time and preventing her doing the majority part of her work, I might be a bit concerned.
>
> (LM3)

Participants felt many of the challenges affecting engagement with the programme were unavoidable due to its pilot status. Issues with reach may not be resolved until the programme becomes widely available and finds 'a structural home', allowing 'universal communications' (Gov):

> I think for it to succeed it should be fully national [...] I understand the idea or the concept of having it as a pilot in certain areas, but I think for us [peer supporters] to work and even for the information to go out, it needs to be in all services [...].
>
> (PS1)

Participants identified ongoing communication and promotion of the programme as key to its reach and adoption. Peers shared a range of experiences regarding how and when they accessed the programme. Some found the process well-structured, clearly signposted, 'very straightforward, basically I clicked on the link' (P1). However, other participants expressed concern that communication was inconsistent, relying on access to work e-mail or line manager's awareness of the programme:

> Only for I was on e-mail, but a lot of people in the hospital wouldn't have emails, e-mail addresses or they don't check them, or they wouldn't have time to check them. I think it should actually be managers should, the minute somebody's diagnosed say, listen, here's the peer support group we have [...].
>
> (P2)

Between March 2024 and March 2025, 30 matches were recorded across the pilot areas. Informal or 'corridor chats' (PS1) with colleagues who have not been referred to the programme also occurred. This may affect the accuracy of data collected:

> When you are face to face with someone, it's very hard not to just deal with them there and then [...], rather than say you need to put this in a referral form [...] I think we are probably supporting far more people than are actually recorded in terms of referrals.
>
> (Gov)

Workloads and work demands influenced adoption of the programme. Line managers in particular noted the 'overwhelming' volume of emails received (LM3). Because 'there's so much going on' (LM2) it can be challenging to recall available supports:

> I wouldn't have routinely thought about it. When I'm going through the stage of someone coming to me and saying I have this diagnosis or something's happening [...], you're not really sure what's going on at first. And you know, in the middle of all of that, you might not remember this service.
>
> (LM1)

5.3 | Implementing the Programme

Participants were asked to reflect on their experiences regarding the implementation of the programme. Their feedback revealed modifications, barriers and contextual factors influencing delivery. The following two sub-themes were generated from the findings: (i) Training and programme modifications and (ii) Increasing awareness and referrals: strengths and obstacles.

5.3.1 | Training and Programme Modifications

Prior to commencing their role, peer supporters attended specific training. Overall, they responded positively to the training

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received. Content was considered to be 'informative...well structured....supportive' (PS2). An appropriate balance between skills practice and expert input was noted: 'We had a few sessions of role-play that was helpful, we were learning from each other [...] and then the trainers, I found them to be absolutely excellent' (PS1).

However, delays between training and programme commencement led to role uncertainty and diminished confidence. Participants were aware that 'they [corporate level] weren't ready to go with it at a national level' (PS2). This impacted their sense of preparedness to support peers:

> I had a long wait to be connected with anyone, [...] it was so long since I had my training until I was put in touch with a referred person that I began to wonder, oh, you know, am I still trained?
>
> (PS1)

Peer supporters highly valued the informal aspects of the training and subsequent continuous practice development (CPD) meetings. Having the opportunity to share experiences and seek guidance from each other and the programme coordinator strengthened their confidence:

> I think having like all of the other peer supporters around is really, really good, that we could actually talk to each other and kind of go OK, look, this is what we're going through [...], and the coordinator is unreal, we can go to her with anything.
>
> (PS2)

However, following the training, some CPD meetings were held online. Peer supporters stressed the importance of in-person sessions to maintain informal support and connection with one another:

> I found the online quite challenging. I think in person face to face training was better because of the nature of what we were, I suppose assisting people with, it was good to be able to talk to the person beside you and learn from their experience.
>
> (PS1)

Some modifications to the peer support approach were undertaken. Initially, peer supporters were discouraged from sharing their personal cancer experiences. As matches progressed, it became clear that appropriate self-disclosure was key to building connections, 'they really wanted to know how we felt as people' (PS2). It was then agreed that limited personal sharing was appropriate and valuable:

> [...] you have to give a little bit of yourself to connect with someone. If you are saying, oh, I can tell you nothing, nothing is quite cold. So, then we were saying you can say what you're comfortable with.
>
> (PS1)

5.3.2 | Increasing Awareness and Referrals: Strengths and Obstacles

Governance structures were established prior to commencement of the programme to monitor its implementation. These included operational guidelines and the establishment of a steering committee and evaluation subcommittee. Their remit was to provide a solid foundation for decision-making and oversight:

> One of the first things we did was develop a fairly substantial governance document, so there is strong governance [...], I was fairly happy with the structure that was set up.
>
> (Gov)

As a pilot programme not available in all areas, there were challenges with information sharing. This was particularly due to limited visibility and reliance on the cascade function for dissemination. While the project was promoted face to face in some areas, this was not always possible, resulting in missed information-sharing opportunities:

> We don't have an all-staff email for example and have to rely on our staff health and well-being mailing lists [...], they may not have seen the email or been aware of it [the programme].
>
> (Gov)

Despite these limitations, there were some communication campaigns undertaken. Each time this occurred there was a 'spike' (Gov) in referrals. A cautious approach was necessary to avoid promoting the service in areas where it was not available: 'You have to be really careful that you're not advertising it in places where it's not available because that's not fair' (Gov).

Participants also reflected on who the key stakeholders were to promote or advertise the programme. Both peers and peer supporters raised concerns about limited awareness. They suggested rethinking the use of work emails and deeper involvement of line managers in sharing information:

> If you were off work, you probably wouldn't get them, maybe there's some work to be done there. I guess you're relying on local management or something, you know, making their employees aware of what's available really.
>
> (P4)

Participants shared views on the peer matching process. Challenges due to the high turnover of peer supporters were noted, which led to ongoing cycles of recruitment and training: 'They will have higher sick leave themselves and may even exit the organisation at some stage' (Gov).

While peer supporters and their line managers acknowledged the challenges associated with implementing a pilot programme, they perceived a lack of traction and support for the programme. Line managers identified 'low awareness and

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slow uptake' (LM3) and a 'lack of consistent communication' (LM1) as significant. This resulted in less knowledge about the programme and fewer referrals: 'There hasn't been sufficient traction to have, like a word of mouth, I don't think yet, you know where others have been speaking to others about the programme' (PS1).

5.4 | Programme Effectiveness and Impact

The programme's effectiveness and impact were explored, based on how well it met its goals. Participants were asked to reflect on the programme's ability to address the needs of those diagnosed with cancer. The following two sub-themes were generated: (i) The essence of peer support influencing outcomes and (ii) Programme impact: emotional, psychological and practical.

5.4.1 | The Essence of Peer Support Influencing Outcomes

Participants emphasised that peer support offered something distinct from the help provided by family and friends. While loved ones were supportive, they often lacked a true understanding of the cancer experience, 'they love you... but they don't understand' (P1). The shared lived experience with a peer supporter fostered a strong sense of being understood and increased the programme's appeal: 'You need somebody who's gone through cancer to really understand' (P9).

This connection brought comfort, normalised fears and created space for open, informal conversations, to 'have a laugh' (P1), 'just chat' (P4) or ask 'sensitive questions' (P2). Peer supporters also valued the immediate camaraderie formed within their group, grounded in mutual experience: 'People who've had cancer don't need an introduction—it's already there' (PS1).

Peers and line managers considered the attributes of the peer supporters. Peer supporters were 'full of empathy' (P6), 'committed and dedicated' (LM2). Peer supporters' skills and knowledge created a sense of 'absolute trust' (LM4) in their ability to respond to peers' needs:

> It was informal which is kind of what you want. There was no rush in the conversation. I definitely felt very well listened to and helpful suggestions were given to me.
>
> (P6)

The 'flexibility' (P6) of peer supporters' approach, the 'open-ended contact' (P5) and the 'invitation to ask anything' (P3) enhanced participants experience with the programme. This set it apart from other formal or bureaucratic services:

> Generally, people want to tell you that everything is going to be ok or tell you the right thing. Maybe that's not what you need to hear at the time. There was none of that with them [peer supporter], that was kind of refreshing.
>
> (P4)

5.4.2 | Programme Impact: Emotional, Psychological and Practical

The peer support format and approach led to meaningful emotional, psychological and practical outcomes, as reflected in participants' experiences. Peers described the positive impact of their interactions with peer supporters. Receiving 'validation' (P2), 'emotional support' (P6) and 'reassurance' (P9) during discussions about their diagnosis or work-related concerns were valued: 'She did say look after yourself, don't worry about work, get better. I suppose she reassured me that everything takes time, and she is here if I needed her' (P5).

Practical support and advice relating to work issues were appreciated. Peer supporters offered suggestions or ideas about further supports or services that peers had not 'really considered' (P3) or were 'unaware of' (P4). Talking through these practical issues brought clarity: 'it's just good to talk it out with somebody. Clear your head a bit and get it off your chest' (P6).

Through their engagement with the programme and the supportive presence of peer supporters, participants described feeling a sense of relief, a 'weight lifted' (P1), a sense of 'refuelling' with a 'perk in my step' (P2). The active listening and empathetic understanding offered by peer supporters fostered a feeling of being genuinely 'rooted for' (P5): 'I just found it incredibly helpful to be understood by somebody, you know, having cancer, having the fears around it, the fear of, is it really gone?' (P9).

Participants reported shifts in how they related to colleagues. They felt more comfortable discussing their diagnosis and more confident in offering support to others:

> At the start, if somebody would text me or something like that, [...], I was kind of reserved. I didn't really want people knowing or that kind of thing [...] yeah, I've told my colleagues now.
>
> (P1)

> Since I've gone through it, I have to, you know if I see somebody or somebody's going through it I just, I tell them all about these services. I say, well it is the practical stuff people need to know as well.
>
> (P2)

Outcomes for peers were largely positive. There was some divergence, suggesting that certain peer needs could not be met through the signposting and befriending ethos of the peer support programme. One participant felt their supporter was 'as helpful as she could be' but ultimately 'couldn't help' or may have 'needed more training' (P3), a limitation also considered by peer supporters: 'What they needed was a really

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in-depth HR [human resources] discussion, that was outside my remit' (PS1).

5.5 | Programme Maintenance and Growth

Ways to sustain and grow the pilot programme were explored with participants, including whether they would recommend it to colleagues. The theme 'sustaining the programme: a vision for the future' captures their reflections.

5.5.1 | Sustaining the Programme: A Vision for the Future

Participants 'strongly endorsed' (LM4) the programme, the 'flexibility and approach of the peer supporter' (P7) and would 'highly recommend it' (P4). However, they also highlighted key factors for its continuation, most notably the need for strong organisational support and leadership: 'And I suppose again it's a bit of a, you know, a domino effect because the uptake will depend on how well it's marketed out there' (LM3).

Participants had suggestions regarding ways the programme could be communicated within the organisation. All acknowledged the limitations associated with it being a pilot and reaching staff 'who are logged off' (Gov). Local champions were suggested, whose role would be to communicate and coordinate the programme internally and develop connections with community and voluntary organisations:

> If you're going to have a project in an organisation, you need to have support.

> So I don't know whether there needs to be an assigned WTE [whole time equivalent], like it's very hard if people are trying to do this on top of, if it's on top of you know their work role.
>
> (PS2)

Increasing the awareness of the programme and referral process through human resources and occupational health were considered central; both potentially have a role with staff throughout their cancer journey:

> I asked them [occupational health] would they be giving out any of the information. I said, did they have the leaflets? He was totally unaware of the service. He didn't have the foggiest idea of what I was talking about.
>
> (PS1)

Line managers were identified as important points of contact for staff, they 'might be in contact with staff who need this' (P3) and appreciate having somewhere to 'refer their staff' (PS1). 'More involvement in day-to-day processes rather than accommodation only' (LM4) might strengthen awareness and promotion and due to busy work environments, 'prompts' (LM3) and 'training' (LM1) would be useful going forward:

> [...] that back to work interview and there's this documentation that you go through and so it would be useful to have some sort of prompts in there as well around resources available including this programme.
>
> (LM3)

Participants also recommended future communication methods including newsletters, team meetings, conferences or webinars. The potential of 'face to face' (PS1, PS2) opportunities to spread the word was emphasised, increasing visibility similar to other health promotions programmes such as smoking cessation or heart health:

> I just feel like it's sitting there on the outside a little bit. If you look at the smoking cessation in the HSE, we get those emails all the time and it's always out there, and there might often be stalls at the hall of whatever hospital you're in or whatever centre you're working in.
>
> (PS1)

Participants emphasised the role of peer supporters in fostering engagement, building trust and providing relatable, experience-based support. Providing adequate support to peer supporters was considered essential for the programme's long-term success and continued development: 'Part of the sustainability as well is supporting the peer supporters, because if they are not looked after, you are not going to have any service users' (Gov).

Being recognised for the 'valuable work' (LM3) undertaken by peer supporters should include 'protected time for training' (Gov), including financial and workload support to access 'in person CPD days' (PS2). Participants expressed some concern for the potential impact of the role on 'paid workload and personal time' (LM1) and considered the potential of full-time peer support roles to mitigate this:

> I'd love to see down the line that for someone like [peer supporter], or the other peer supporters that they would do that on a full-time basis. And you know, if that's what they wanted to do or if somebody wanted to do it, I think it would be fantastic to develop it that far.
>
> (LM2)

Participants identified the 'financial supports needed' (LM2) to maintain the programme. These included the need to ensure the programme was marketed adequately, was available to all staff and that peer supporters received 'ongoing training' (P2). Financial recognition for their work and 'supervision' (P4) were needed:

> I would in an ideal world love to see that in the future there should be some form of financial recognition [...], something that is small that it is not a motivation for joining the network but a recognition of the role that the network plays.
>
> (Gov)

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6 | Discussion

This study explored peers, peer supporters and their line managers and the governance group's experiences of a pilot cancer survivorship peer support programme. All participants reported satisfaction with the programme, including recommending it to a colleague. The programme was considered helpful, and peer supporters described a sense of achievement in their role. Line managers and the governance group placed a high value on the programme, though challenges in referral and communication processes were noted.

The peer support approach had particular significance for participants in this study. Validation, understanding and guidance were elucidated by peers as being beneficial to their wellbeing and coping. Participants spoke of an environment of understanding and acceptance, knowing that someone else has faced similar challenges and emerged stronger, provided hope and reassurance. Peer supporters emphasised the need to share insights into their experience as requested by the peers they supported. This change in the original approach to the peer supporters' role enhanced the programme's perceived benefit. Gains from peer support programmes are evident in the wider literature including connecting and belonging, mutual understanding, emotional support, practical advice and a sense of relief and empowerment (Canella et al. 2023; Joo et al. 2022; Toija et al. 2019).

The fact that cancer survivors have unmet supportive care needs is well established (Doyle et al. 2024; Kiemen et al. 2023; Paterson et al. 2023). Psychological, informational and physical needs tend to be the most commonly unmet needs which affect a person's quality of life. These needs often evolve over time. At diagnosis, information and emotional support may be key; later, physical and practical support may dominate. Cancer survivors have particular needs when returning to work following a diagnosis and treatment. Reaching people in their time of need by delivering timely information and psychosocial support is essential (Hemming et al. 2024). These considerations are reflected in the findings of this study; participants expressed their sense of disappointment that the programme was not available sooner, when they received a diagnosis or were trying to navigate back to work.

Although limited, evidence points to the potential effect of peer support interventions to guide and support individuals in addressing their unmet needs (Hemming et al. 2024). Initially, informal peer support programmes were evident. In recent times programmes have been established in more formal settings such as clinics, hospitals, communities and schools, usually outside the remit of the organisation (Van Iseghem et al. 2023). Workplace peer support programmes can benefit the individual and the workplace, in retaining an active contributing workforce while enhancing their experience and wellbeing. This is significant given the relationship between the stress and motivational processes described by Schaufeli (2017) and colleagues Jobs Demands-Resource (JD-R) Model. Every job has demands, where these exceed resources available, negative outcomes are inevitable such as sickness or poor motivation. Peer support programmes, embedded in the work environment, are particularly relevant for policy makers or health system managers, considering the additional challenges faced by cancer survivors. Increasing resources (i.e., easy access to peer support) and reducing high job demands can prevent burnout, increase adaptation and work engagement on return to work (Ramaci et al. 2024; Zhao et al. 2025). Such interventions also match the international focus on living with and beyond cancer, whereby people should have access to support networks beyond traditional models (Mollica et al. 2024).

According to Panaite and colleagues (2024), a conceptual multiplicity of peer support exists that can be daunting and interfere with its potential to bridge knowledge gaps between communities and formal health care providers. Ensuring a common language, with clear peer supporter roles, including functions, levels of formality, affiliations and settings of practice can alleviate confusion or uncertainty. This study reflects these considerations. Peer supporters received standardised training enhancing peer readiness, clear protocols and governance were established and suitable matching of peer and supporter occurred (Kiemen et al. 2023; Panaite et al. 2024).

The uptake of this programme was small. Potential barriers noted in the findings included its pilot status, disrupting programme communications and advertising. There was concern that individuals may be reluctant to discuss health issues with a colleague or peer. Trust in the potential effectiveness of peer support needs to be clearly communicated. Confidentiality, peer supporter limitations and understanding peer preferences for support (competence, gender, age, mode of delivery) may address some of these concerns (Clougher et al. 2024). Sufficient funding and knowledge to scale up programmes are also required (Joo et al. 2022).

6.1 | Strengths and Limitations

This study has several strengths because measures were taken to enhance trustworthiness and reflexivity. Including four different populations allowed for a range of perspectives on the programme. A theory-driven approach was used for data analysis and presentation, adding to this study's robustness.

The study is not without limitations. Online interviews made it possible to recruit participants from across Ireland. However, this format limited the depth of interaction and reduced the human element of qualitative research. Male participants were underrepresented, affecting transferability of findings. In keeping with gender, while participants were asked about their preference for a male or female peer supporter during the matching process, it was not always possible to accommodate this preference. Although this was not highlighted as an issue by current study participants, it could potentially have influenced communication, support methods and emotional expression between the groups. The sample size, while holding sufficient information power (Malterud et al. 2016), does limit transferability to other organisations with diverse experiences. Interviews were conducted shortly after the programme ended, providing useful insights. However, the long-term impact of the programme remains unknown.

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6.2 | Implications

This study has several implications for policy, practice and research. Our results suggest that implementing cancer survivorship peer support programmes would require a structured, policy-backed programme with executive sponsorship, formal governance, clear recruitment and training standards and defined referral pathways that ensure all those returning to work are aware of a support programme and how to access it. For example, during return to work processes, staff should be given detail in relation to such programmes and asked if they would be willing to engage. Mechanisms to ensure psychological safety, risk management and incident reporting would need to be included.

From a practice perspective, integrating peer support programmes into routine survivorship pathways would require clear referral processes and communication protocols to ensure key stakeholders are aware of the programme, how to access it and ensure timely referrals. As there are financial implications to maintain the programme, a sustainable funding model is needed to support training, supervision and ongoing evaluation activities. This funding may be through organisations' budgets or partnerships with non-governmental organisations. While the programme may alleviate some supportive care demands on clinical staff, new roles such as peer support coordinators may be required to effectively manage recruitment, pairing, monitoring and administrative oversight.

Future research should explore optimal models for training peer supporters, programme delivery and evaluation longitudinally. Further research focusing on help-seeking behaviours among men with cancer is needed. The existing literature shows they are less likely to seek help and may face different barriers than women (Saab et al. 2021).

7 | Conclusions

This study identified benefits for the cancer survivorship peer support programme including satisfaction, helpfulness and the value placed on peer support. However, reach, adoption and implementation were not without challenges. Being a pilot initiative hampered global communications. Key personnel such as line managers and Occupational Health seemed unaware of the programme and there were challenges with future responsibility for the programme. To support the ongoing sustainability of the programme it will be necessary to increase the recruitment and training of peer supporters, alongside the development of clear accessible communication and referral pathways. While generally considered cost-effective, the programme will require financial support to maintain training and CPD for peer supporters and address challenges noted in the findings including increasing the programme's' visibility and accessibility for those who may be out of work or not on email systems.

Author Contributions

Maria O'Malley: conceptualisation, methodology, validation, formal analysis, investigation, data curation, writing – original, review and editing, project administration and funding acquisition. **Teresa Wills:** conceptualisation, formal analysis, investigation, writing – original, review and editing, funding acquisition. **Sean Kelleher:** formal analysis, investigation, writing – original, review and editing, funding acquisition. **Ciaran Evans** and **Caroline Kilty:** formal analysis, investigation, writing – review and editing. **Irem Koc:** visualisation, project administration, writing – review and editing. **Olga Cleary:** methodology, writing – review and editing. **Helen Forristal:** writing – review and editing. **Mohamad M. Saab** and **Josephine Hegarty:** conceptualisation, methodology, validation, writing – review and editing, funding acquisition.

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Ethics Statement

The study obtained ethics approval from the HSE Research Ethics Committee (RRECBO624) and the Social Research Ethics Committee affiliated to the researchers' university (2024-084A1). All participants received information leaflets and provided written informed consent prior to data collection.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Peer Review

For transparency, the peer review documents associated with this article are available at https://doi.org/10.1111/jan.70623.

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