

# Report on the

## Exploration of the influences on developing and maintaining a successful mentorship process: An investigation of mentorship from multiple perspectives

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## Summary of findings of the influences of developing and maintaining a successful mentorship process

- Mentors reported many positive personal and professional benefits to the mentorship role.
- The motivation to 'keep up to date' and the opportunity to learn from students were identified as key benefits of mentorship.
- The mentorship course is considered to be effective in equipping mentors with the necessary insight into teaching and learning in the practice setting.
- A preference for further strategies to support student mentors in developing the skills to deal with difficult situations in their mentorship role was expressed by some participants.
- The mentorship course is viewed by mentors as a requirement for career progression and linked with pay bands.
- Readiness to become a mentor is not always recognised as a pre-requisite to undertaking the mentorship course.
- Discussions about how the mentorship course may be linked to a CPD pathway are not consistent across all Trusts and many student mentors report being unable to undertake a module that reflects their choice of credit rating.
- Health care professionals who had undertaken 30 credit mentorship modules and linked this to their CPD aspirations were enthusiastic about their mentorship role and felt valued by their organisation.
- Student mentors who were degree level registrants considered that the current level of mentorship modules available preclude inclusion in an appropriate CPD pathway (Masters Level).
- Mentors believe that time to mentor in the workplace is not acknowledged, with documentation often being completed in personal time rather than work time.
- Mentorship is considered to be tiring and stressful, with mentors reporting the combination of supporting and assessing students to be emotionally draining.
- Sign-off mentors report that colleagues still fail to take responsibility for the failing of weak students prior to the final 12 week placement.

- Mentors believe that all qualified staff have a responsibility to support and develop the future workforce.
- Trust education leads are not consistently notified of failing student mentors until it is too late to provide appropriate support.

## Recommendations

- Readiness and personal attributes required for mentorship should be assessed before a health care professional is recommended for the mentorship course.
- Discussion with all prospective mentorship students around the specific credit level of their mentorship module should occur prior to the student registering on the course.
- A variety of strategies to support student mentors in developing the skills to address the difficult situations experienced in mentorship should be more evident in mentorship courses (This has already been actioned).
- Mentorship should not be portrayed as a requirement for career progression above all other learning but should be discussed with staff in relation to their CPD interests.
- Mentorship as an integral part of a CPD pathway may support the development of a culture of education in practice.
- Masters level mentorship modules should become part of the Masters level framework to accommodate registrants with existing first level degrees who wish to include mentorship in their pathway.
- Creating time to mentor effectively in the workplace is essential if mentors are to remain motivated, feel supported and valued in their role.
- A robust system, alerting Trust education leads (in a timely manner) about student mentors who are experiencing difficulties in achieving the requirements of the mentorship course should be developed.
- All registered health care professionals should share the responsibility for facilitating learning and shaping the future workforce. This should not be linked to any pay band but a requirement of all professionals.
- Registered health care professionals who choose not to undertake the mentorship course should attend a coaching workshop to prepare them for their responsibility as coach in supporting learners (their future colleagues) and their work colleagues who are acting as mentors /sign-off mentors.
- Inter-professional coaching workshops would support the development of a strong educative ethos in the workplace amongst and between all professions.
- The role of coach should form part of all registered health care job role descriptions to support the concept of responsibility of teaching and learning of others in the workplace.

- Any registered healthcare professional who is not acting as a mentor / sign-off mentor to a student should be considered as a 'coach' at that point in time and may be allocated as part of a coaching team, to support student's to meet the required competencies of their placement. Coaches will also inform the allocated mentor / sign-off mentor of the student's progress, to support assessment decisions of the mentor.
- All mentors should become 'sign-off' mentors to align nursing with the midwifery profession and prevent mentors using their sign-off colleagues as a 'safety net' in their decision to pass or fail a student.
- Students should be 'signed off' at the end of each year of their course to confirm fitness to progress to the next year.
- The introduction of a 'Lead Mentor' role in practice settings to co-ordinate and facilitate practice learning, support mentors / sign-off mentors with their decisions, promote an environment conducive to practice education and monitor the quality of mentorship has the potential to address a range of current issues inherent in practice learning.
- A new model of support for mentors and learners in practice should be introduced as follows:
  - 'Lead Mentor's co-ordinating / facilitating practice learning, promoting the value of practice education, providing support for coaches /sign-off mentors and monitoring the quality of the learning environment and mentorship.
  - Sign-off mentors providing mentorship for learners and participating in progression decisions at the end of each year of the learner's course.
  - Coaches supporting sign-off mentors by contributing to the skills acquisition and development of students.

See page 50 for diagram and proposed parameters of framework to support students and mentors in practice.

## 1. Introduction

The role of the mentor in health care practice is pivotal to the development of a workforce that can deliver high quality care (Willis, 2012). Preparation and support for this role lies with both Higher Education Institutions (HEIs) and health care organisations, however, the provision of these elements alone does not guarantee effective mentorship.

For the mentorship role to have greatest impact, mentors must be selected for their knowledge, skills, attitude and motivation; be adequately prepared; well supported; and valued, with a recognised status (Teatheredge, 2010; Willis, 2012). Undertaking such a role may be incredibly rewarding (Wroten and Waite, 2009) but the ability to function effectively as a clinician, whilst meeting the demands of mentorship is also extremely challenging (Moseley and Davies, 2008, MacLaren, 2012). Factors present in the current context of NHS health care policy and debate may be further compounding these challenges. The ongoing reorganisation of health care provision in England, has dovetailed with the requirement for substantial efficiency savings in the NHS. This has occurred within a context of increased scrutiny of healthcare organisations and of healthcare professions, following a spate of reports highlighting poor care and institutional failure. These drivers have reinforced and reaffirmed the need for a culture change in healthcare spearheaded by positive role models, delivering high quality, values based care, albeit during a period of instability, job insecurity and change.

This report looks at the motivation, attitudes, perceptions and experiences of mentors in preparing for the role of mentor and providing learners with a positive mentorship experience. It also includes a review of why some health care staff are less than satisfied with the mentorship experience. The report was commissioned by a Local Education and Training Board (LETB) and focuses on the views of mentors, trainee mentors and health care education managers in a specific geographical region in England.

## 2. Background

For a nurse or midwife to enter the professional register, they are required to undertake 2300 hours of supervised learning. During this time, the learner must be attached to a qualified mentor / sign-off mentor, responsible for guiding their practice, assessing and monitoring their progress and confirming their competence to become a registrant with the Nursing and Midwifery Council. Whilst all registered nurses and midwives must meet the defined requirements of the NMC Code (2008) and 'facilitate students and others to develop their competence', a mentor is required to have undertaken an approved mentorship preparation course.

To support pre-registration health care student commissions and increase placement capacity to accommodate these, the commissioning of mentorship courses by the LETB has been sustained. However, concern relating to the numbers of mentors who actively choose not to maintain their mentorship qualification has led to the commissioning of this project.



The table below indicates the number of staff from the four identified Trusts who undertook the mentorship course in the two year period, Sept 2011- Sept 2013. Of these, 120 staff members with a mentorship qualification are no longer on the local live mentor register. Initial reasons identified by Trust leads include; no longer working for the Trust, change of job role, maternity leave, incomplete triennial review, non-placement areas and deceased.

**Table 1: Number of successful student mentors (Sept 2011-Sept 2013) and those who remain active and on 'live' mentor register**

| TRUST    | PLACE OF STUDY | NO. OF SUCCESSFUL STUDENTS | NO. OF LIVE MENTORS |
|----------|----------------|----------------------------|---------------------|
| CHUFT    | ARU            | 58                         | 41                  |
|          | UoE            | 48                         | 38                  |
|          |                |                            |                     |
| SOUTHEND | ARU            | 63                         | 32                  |
|          | UoE            | 59                         | 41                  |
|          |                |                            |                     |
| SEPT     | ARU            | 25                         | 14                  |
|          | UoE            | 21                         | 11                  |
|          |                |                            |                     |
| NEPFT    | ARU            | 28                         | 20                  |
|          | UoE            | 30                         | 15                  |
|          |                |                            |                     |
| Total    |                | 332                        | 212                 |

### 3. Project Aim and Objectives

The aim of this project was to establish the motivation, attitudes, perceptions and experiences of mentors in preparing for the role of mentor and providing learners with a positive mentorship experience.

#### 3.1 Key objectives

- To explore trainee mentors' motivation and reasons for undertaking the mentorship course, including the credit level of the course.
- To consider the preparation needed prior to undertaking the role of mentor.
- To explore the tensions in the role of being a trainee mentor in own work environment.

- To review the criteria of Practice Education Providers in supporting registered nurses to undertake the mentorship course and choosing the level of course commissioned.
- To consider how the mentorship role is maintained and the support needed to remain 'live', whilst offering positive mentorship experiences to others.
- To explore the perceived value and profile of the role of mentor.
- To explore the views of staff who were unsuccessful in completing the mentorship course.
- To explore the support mechanisms available to failing student mentors (perceived, potential and actual – work related and University).

## 4. Methodology

The methodology decided upon for this project was based on an 'appreciative inquiry' approach (hereafter referred to as AI) which is grounded in reality and is designed to consider the positive attributes of the area under study. The methodology is considered by some to be derived from an organisational change management perspective (Cooperrider & Whitney 2005) and therefore sits well within a project grounded in the practices and processes that develop and support mentorship across organisations and within work based health contexts.

By looking at those processes and functions that work effectively or efficiently, the emphasis in AI is on what is right rather than what is wrong, thereby creating a potential for further positive development of a pathway focusing on successful structures and frameworks. The project is therefore concerned with organisational strengths, abilities and values and of those individuals working within the Trusts, in supporting and developing the workforce. It is also concerned with what Bushe (2007) describes as the focus of AI in looking at the positive: "it can support generative thinking" (transformational new ways of thinking and new ways of operating or considering new options), "it can support the change process and it can make planned culture change possible" (p.30). For this project, the general focus centres on the area of continuing professional development and is specifically constructed around mentorship.

Whilst considering the development of the data gathering methods from which the findings are derived, the project team discussed how to capture the positive, effective, productive and valued aspects of mentorship education and provision across Essex. A number of NHS Trusts were identified and formed the basis of the population for the project. By using an AI approach, the methods were designed to be sensitive enough to capture a range of qualitative data and to acknowledge the potential for change within and across organisations.

## 5. Population and Sample

Four NHS Trusts across Essex were included in the project: Colchester Hospital University NHS Foundation Trust (CHUFT), Southend University Hospital NHS Foundation Trust, South Essex NHS Partnership Trust (SEPT) and North Essex Partnership NHS Foundation Trust (NEPFT).

These Trusts were chosen to support representation of mentors across disciplines and health care settings.

In November 2013, students undertaking the mentorship course from the four identified Trusts were provided with participant information sheets and invited to participate in the study by attending a short focus group interview. In total, 15 students representing the four identified Trusts agreed to participate in the focus groups (five students per focus group). The students were registered health care professionals from the following professions:

Adult Nursing

Child Nursing

Mental Health Nursing

Midwifery

To obtain the health care organisations' perspectives on mentorship, Education Liaison Managers (ELMs) from each of the identified Trusts were invited to participate in individual interviews. All four agreed to participate.

12 registered health care professionals, who had undertaken the mentorship course in the last two years and were on the local 'live-mentor' register, were also invited to participate in the study. Participant information sheets and letters were sent to the work addresses of these mentors, inviting them to a short interview to discuss their experiences of mentorship. This group of mentors were purposely chosen to ensure all four identified health care Trusts and all available mentorship modules (0 credit, 15 credit and 30 credit) were represented. Six had undertaken the mentorship course at Anglia Ruskin University and six at the University of Essex. Unfortunately only one mentor responded and agreed to participate in the study.

To determine the views and experiences of active mentors who were on the local mentor register, mentors who were no longer active and staff who had been unsuccessful in completing the mentorship course, a survey questionnaire was prepared for each group. The initial target population for this aspect of the study focused on staff from the four local health care Trusts who had undertaken the mentorship course within the last two years. As the non-credit bearing module had only been delivered in the past 2 years, this offered the opportunity to obtain feedback in relation to the range of mentorship modules (0 credit, 15 credit and 30 credit).

Contact details (work addresses) of this population were retrieved from the local live mentor registers. Contact details for 'non –live mentors' and staff who had been unsuccessful in completing the mentorship course, were provided by all but one Trust specific ELM.

At the beginning of January 2014, the survey was sent (with a stamp addressed envelope for ease of return) to the work addresses of the following 235 staff:

- 205 'live mentors'
- 19 'non-live mentors'
- 11 registered health care professionals who had been unsuccessful in completing the mentorship course.

With a return rate of only 8% (n=16) from 'live mentors' and 0% from both 'non-live mentors' and health care professionals who had been unsuccessful in completing the mentorship course, the strategy for retrieving data had to be reconsidered.

Adhering to the ethical dimensions approved by university ethics committees and the agreement of each Trust's Research and Development Departments, the target population was widened to include all mentors within the four identified health care Trusts attending annual mentorship updates during the months of February and March 2014. This supported the retrieval of further data from the following:

- 24 'live' mentors with less than two years of mentorship experience (resulting in a total of 34 completed questionnaires)
- 75 'live' mentors with more than two years of mentorship experience

In total, 109 questionnaires were completed by mentors on the 'live mentor' register.

Table 2 summarises the population and sample, alongside the range of methods used to retrieve data.

**Table 2: Summary of data gathered using a range of methods within and across each Trust**

| <b>Trust</b>    | <b>Method<br/>(Identified and invited to participate)</b> |           | <b>Sample Size<br/>(Actual respondents)</b>   |
|-----------------|---|-----------|---|
| <b>CHUFT</b>    | Questionnaire: active (live) mentor                       | <b>79</b> | <b>6</b>  |
|                 | Questionnaire: unsuccessful mentor trainee                | <b>1</b>  | <b>0</b>  |
|                 | Questionnaire: inactive (non-live) mentor                 | <b>8</b>  | <b>0</b>  |
|                 | Focus group student mentors (one group)                   | <b>4</b>  | <b>4 student mentors</b>  |
|                 | Individual interview with Education Liaison Manager(ELM)  | <b>1</b>  | <b>1 ELM</b>  |
|                 | Individual interview (live / active mentor)               | <b>3</b>  | <b>1</b>  |
| <b>SOUTHEND</b> | Questionnaire: active (live) mentor:                      | <b>66</b> | <b>4</b>  |
|                 | Questionnaire: unsuccessful mentor trainee                | <b>1</b>  | <b>0</b>  |
|                 | Questionnaire: inactive (non-live) mentor                 | <b>9</b>  | <b>0</b>  |
|                 | Focus group (two focus groups)                            | <b>9</b>  | <b>4 student mentors in first focus group<br/>5 student mentors in second group</b> |
|                 | Individual interview (ELM)                                | <b>1</b>  | <b>1 ELM</b>  |
|                 | Individual interview (live / active mentor)               | <b>3</b>  | <b>0</b>  |
| <b>SEPT</b>     | Questionnaire: active (live) mentor                       | <b>25</b> | <b>2</b>  |
|                 | Questionnaire: unsuccessful mentor trainee                | <b>9</b>  | <b>0</b>  |
|                 | Questionnaire: inactive (non-live) mentor                 | <b>2</b>  | <b>0</b>  |
|                 | Focus group (one focus groups)                            | <b>1</b>  | <b>1 student mentor</b>   |
|                 | Individual interview (ELM)                                | <b>1</b>  | <b>1 ELM</b>  |
|                 | Individual interview (live / active mentor)               | <b>3</b>  | <b>0</b>  |
| <b>NEPFT</b>    | Questionnaire: active (live) mentor                       | <b>35</b> | <b>4</b>  |
|                 | Questionnaire: unsuccessful mentor trainee                | <b>0</b>  | <b>0</b>  |
|                 | Questionnaire: inactive (non-live) mentor                 | <b>0</b>  | <b>0</b>  |
|                 | Focus group (one focus group)                             | <b>1</b>  | <b>1 student mentor</b>   |
|                 | Individual interview (ELM)                                | <b>1</b>  | <b>1 ELM</b>  |
|                 | Individual interview (live / active mentor)               | <b>3</b>  | <b>0</b>  |

## 6. Recruitment

The initial identification of these participants were from the relevant University and NHS data bases detailing active mentors (live), inactive mentors and NHS staff members who had been unsuccessful in completing the mentorship course. Permission to access the data for these purposes was granted from the 'gatekeepers' at Health Education East of England. Access to mentors attending annual mentor updates was agreed by ELMs.

## 7. Ethical Considerations

Ethical approval was obtained by the Faculty Research Ethics Panel at Anglia Ruskin University on 24<sup>th</sup> October 2013 and by the Faculty Ethics Committee at the University of Essex on 4<sup>th</sup> November 2013.

A number of issues were highlighted for consideration within this process. These will be discussed below:

For those participants who received a questionnaire, the risks were considered to be minimal. Those participants had the right not to respond and were not followed up. Completion of the questionnaire was considered to imply consent. As a stamped-addressed envelope accompanied the questionnaires, it was thought to be impossible to establish from whom the original had been sent. The questions contained within the questionnaire for the experienced (active) participants required minimal demographic information only i.e. the name of the Trust for whom they worked, how long they had been a mentor, employment band (See 'Appendix 1' for example of questionnaire distributed to active mentors). The completed forms conformed to the principles of anonymity as there were no identifiable characteristics other than the stated demographics.

For those completing the 'inactive' or 'unsuccessful' questionnaires: the demographic data was similar to those sent to the 'active' mentors, and again, there were no names or other identifiable features. The questions were worded as sensitively as possible so as not to provoke a negative emotional response. The focus was on practical aspects and processes of facilitation and support rather than the inactivity or failure of the participants. If participation evoked uncomfortable emotions, participants were invited to contact the researcher if they felt they required support.

All participants completing questionnaires generated a personal reference number (on the questionnaire itself) which they would be able quote in future correspondence should they wish to withdraw from the study.

For the interviewees: At the start of the interview, all participants were informed of their right to withdraw, without giving a reason. Prior to the interview each person was asked to complete a consent form. If this was not completed, the interview would not take place. The participants were informed that there would be no negative recourse for those who decided to withdraw. Participants were also informed that no data would be used from those who have withdrawn and on their request; this would be destroyed or given to the participant in accordance with the Freedom of

Information Act (2000). For those who did participate: they were informed that they could request a break or stop the interview. They were also informed that they did not have to respond to all questions. Each interviewer observed the participant during the interview and took notice of any signs of distress that the subject area may have caused. Consent was obtained for the interviews to be audio-recorded and transcribed verbatim.

For the focus group attendees: these participants received the consent form via the mentorship course lead and only those who had signed the form were eligible to participate in the focus group. The right to withdraw at any time was afforded to these participants, with an emphasis on the fact that should they remain as participants or could withdraw, having no material effect on their studies whilst undertaking the mentorship programme. As two researchers were present, they were able to observe any areas of stress or potential conflict. An in-built support strategy was introduced: should conflict or stress be observed, depending on the observed behaviours, the group would have been disbanded and support sought or, following the group activity, support would have been offered / sought for those individuals involved. Consent was obtained for the interviews to be video-recorded and transcribed verbatim.

The gatekeeper for initial access to the participants of this project was the Partnership, Development and Performance Manager at Health Education East of England. Access to the use of the data for the purposes of the project and the requirement to approach the potential participants had been agreed.

All data has been kept confidential: any accidental use of names of colleagues, peers etc. has been removed from transcriptions and will not feature in any dissemination activity.

Participants were advised to use a pseudonym during the interview and that any accidental use of actual names was removed from transcriptions.

As previously stated, the questionnaires contained only self-devised codes.

Although member checking has not been undertaken given the timeframe, some researcher-checking activity has been undertaken to ensure some degree of credibility and trustworthiness has been taken into consideration. By not undertaking member-checking, the transportation or exchange of information was kept to a minimum. Researcher-checking was held where the data were stored (at either university).

All electronic data was held on an encrypted, code protected memory stick and hard copies (questionnaires) were kept in a locked filing cabinet accessible by one of the researchers (at either Anglia Ruskin University or University of Essex).

## 8. Data Analysis

Data were analysed using appropriate methods for each set of data. For the focus group interviews with student mentors, individual active mentor interview and individual ELM interviews, a thematic approach was selected, working within the guidelines as proposed by Smith (1995). The approach given below is a synopsis of the process that was followed, with the analysis based on pre-defined semi-structured questions, the focus of which was:

Support

Personal engagement

Perceptions

Experiences

The above were considered pertinent as they were areas on which little evidence has previously been derived.

The emergent codes on which the themes were developed will be discussed within the findings section.

| Activity and Stages of Analysis               |
|---|
| Generate data                                 |
| Initial reading of transcripts                |
| Noting key words and emerging code titles     |
| Development of emerging codes                 |
| Master codes                                  |
| Across scripts, development of initial themes |
| Refined themes                                |



## 9. Findings

The a priori clusters under which the findings are presented formed the basis of the semi-structured interview questions for individual and focus group interviews, as well as the questions in the survey questionnaire for each target group.

### 9.1 Focus group interviews (Student Mentors)

#### 9.1.1 Support

##### ***Support from Trust staff***

Student mentors reported variances in their experiences of support from Trust staff.

One participant discussed the optimum support:

*“I’m lucky enough to be funded with my degree....I get one study every week as well as my days to attend university...I spend a lot of time with my mentor....she’s very, very supportive.” (3A1)*

However, other participants appreciated the support they received in being allocated days to attend university and undertake the on-line learning components of the mentorship course but considered their own experience of being mentored in practice to be less than satisfactory. Whilst many had worked hard to ensure that they had a mentor and had spent some time with them, they reported this to be minimal and outside of shift times. Participants further acknowledged that a good mentor could make a significant difference, as they often have expert knowledge, but identified support to be mainly in the form of informal discussions:

*“We’re in a massive ward, it’s really, really busy so it’s difficult to get anything signed off. We just don’t have the time...it’s very on the hoof.” (4M1)*

*“I’m constantly trying to meet up with my mentor...but you’ve got your patients to fit in and they come first. It just never happens, so it’s a real struggle.” (4C2)*

Unfortunately some students reported that they had received no study leave at all and were undertaking the course in their own time, with only the possibility of time back ‘in lieu’. For some the opportunity to work with their mentor was also non-existent. When asked if being a student mentor in an alternative placement to their own workplace may have supported their learning and allowed them to adopt the role of ‘student’, participants felt this to be an unsuitable option:

*“I don’t know how you would successfully mentor a student not working in your own area.” (4M1)*

*“I don’t think that would be possible, especially in my line of nursing...it’s so specialist...I don’t think it would be viable for me.” (3A1)*

Most student mentors did not access support from lead managers, believing this to only be appropriate if something was wrong. By inference, they did not consider difficulties they experienced in accessing mentor support to be wrong but accepted that whilst this was frustrating, it was the norm.

Participants recognised the potential for bias in assessment when choosing their own mentor but felt it important to be able to choose someone with the most time to offer and whom they deemed approachable and enthusiastic. Perhaps unsurprisingly, senior staff undertaking the mentorship course were less accepting of a mentor who was junior to them and considered their pride to be the barrier to this.

### **Support from university**

Participants reported the course to be excellent preparation for their mentorship role and appreciated that class discussions gave them an opportunity to reflect, whilst sharing ideas and knowledge. They also recognised that in undertaking the mentorship course they had become much more familiar with the support available for their university colleagues:

*“I didn’t realise about link lecturers and education champions... just didn’t realise just how in depth it was really.” (4M2)*

*“I didn’t realise there was so much communication and support for mentors.....so many links between the university and the hospital.” (4A3)*

### **9.1.2 Personal engagement**

#### **Reasons for undertaking course**

A variety of reasons for undertaking the mentorship course were provided by participants, highlighting issues around expectation of employers, readiness to become a mentor and career progression.

Some participants were proactive and specifically requested to undertake the mentorship course.

*“I told my manager that I really wanted to do a mentorship course....I mean we have a lot of students coming in, so I just wanted to have an idea how exactly I should be doing it”. 4A2*

*“I was told in my appraisal that I had to do a course, so I thought mentorship would be the one to do...so I asked to go on the course. It will be useful to have a better insight into teaching a student”. 4A3*

One participant disclosed that she had to “fight” to get on the course and acknowledged the benefits in doing so:

*"I really wanted to do it, so I have waited and now I am just glad to be on the course....First course I have done since qualifying, so good for my personal learning, giving back to others. It helps me to evaluate my own learning"* 2A4

Many participants, however, reported that they were undertaking the mentorship course as they believed it to be a requirement of their employer, irrespective of their personal interest in the mentorship role:

*"It is mandatory in my Trust."* (2A1)

*"Following appraisal I had to come on it. I have managed to get away with it for 15 years; I don't want the pressure of being a mentor."* (2A2)

*"I thought we had to do it if I'm honest. We were led to believe we had to do it."* (4M2)

*"I feel like I was forced a little bit to do it. I don't particularly feel that I was ready to do it."* (4M3)

Whilst others referred to their career progression as the motivating factor:

*"[Doing the course is good] to improve student experience and to further my own career."* (2A1)

*"To get to a band 6 we have to do mentorship...but whether I would've done it at this moment in time.....not so sure."* (4M4)

*"I got away with it for years.....slipped under the radar, but now as a specialist nurse I need it and wanted to do it , as the role involves a great deal of teaching."* (2A3)

### ***Development as a student mentor***

Participants were asked if they felt able to influence the skills and behaviours of students that they were mentoring as part of their course. In response to this, the importance of role modelling as a mentor was regularly referred to by many participants but positively influencing students' learning was considered to be the responsibility of everyone in the practice setting. A heightened consciousness of learning opportunities in their clinical environments was also evident and opportunities to maximise learning were discussed. Many participants also commented positively on how the mentorship course had supported them in their view and delivery of mentorship:

*"I understand how, like, accountable I am and make them [students] prove to me that they've done it....I'm more aware of the importance of the learning environment and how important it is to prepare for students before they arrive."* (3A1)

*“Doing the course makes you feel like you’re doing it properly. You’re doing a proper course where you’re learning as well, you take more responsibility for them [students].” (4M1)*

Whilst some participants, acknowledged significant learning around learning styles and the environment, they appeared apprehensive about providing negative feedback to their students. They discussed their preference for more emphasis on how to address the under-performing student in the practice setting.

Frustration about the lack of time to undertake the actual mentorship role and put into practice key learning from the mentorship course was also evident:

*“We learn some really good stuff about learning styles and the mentorship course is excellent...but the actual implications of putting it into practice...to actually spend the time with that student...it’s really difficult.” 4M2*

For some participants, the length of time that the student was allocated to the placement further impacted on their experience of facilitation of student learning. Short placements appeared to put mentors under pressure:

*“[I] try to cram everything in, but that is not meaningful learning.” (1A)*

Personal positive and negative experiences as (pre-registration) learners had impacted on the participants’ own style of mentorship and enhanced their self –awareness. Some reported being terrified as students and used terms such as “disempowering” and “belittling” to have featured in their own experience. One participant recalled her negative experience to have been the result of:

*“Appalling mentors who made me feel stupid.” (2A3)*

Participants in all three focus groups were keen to avoid such behaviours in their mentorship role and desperate to provide students with a positive experience. Many acknowledged that working in busy practice areas meant that students may be “used as an extra pair of hands” and expressed their frustration at being unable to protect students from this situation. The tension between delivering patient care and supporting students led participants to discuss how they felt guilty when prioritising patients resulted in neglecting students. ‘Throwing students in at the deep end’ was not an unusual phenomenon. Whilst noting that many students were very eager to please they reflected on the negative repercussions of this and noted that students could become immersed in the HCA role. Learning from this type of experience was seen to be dependent on the students’ stage of training but participants recognised the socialisation of students in practice and their ‘need to belong’ to be a strong influence on their response to the situation:

*"[Students] learned to behave that way, to fit in, but that is not what they are there for." (2A1)*

Some participants further believed their responsibility as a mentor to include shaping (or re-shaping) the student's work ethic, if deemed necessary. They discussed how they challenged students whose attitudes to work were perceived to be incongruent with their own. For some participants, their own work ethic appeared to be reflective of the 'busy' culture of health care and their expectation of students was aligned to this:

*"They [students] were just standing around doing nothing, but from my experience I knew if you kept yourself busy...even if it's just tidying up or restocking, it was seen as good." (4C1)*

*"Mm, do some cleaning." (4M1)*

Others commented that the allocation of final year students was easier in this respect as they required less support and were seen to be 'better' than having first year students allocated. This reduced the tension they experienced in mentoring whilst also managing and delivering health care to their own patients.

*"If they're further on and advanced in the course, at least you could say 'Could you just go and do this for me?' " (4M3)*

### ***The context of mentorship in CPD***

For many participants, the decision to attend the mentorship course had been decided at their appraisals, however, this was rarely linked to their career plans. Participants debated the best time to undertake a mentorship course, identifying that more recently qualified staff may be more empathic with the student role, whilst those more experienced in their role may be more comfortable with the additional mentorship role.

Entering mentorship directly from preceptorship was also contentious; some considered this to be too soon but others reported concerns about delaying this:

*"The longer you leave it, the more daunting it becomes." (2A3)*

The actual timing of the mentorship course within their personal careers appeared to be dependent on their own confidence in their clinical practice. Many opted to attend short clinical based courses to support their own perceived skill deficits prior to undertaking a mentorship module:

*"I purposely deferred doing a mentorship course...how could I mentor a student when I actually didn't know much about the area I was working in myself?" (3A1)*

*"I could have applied earlier but I chose to do things like suturing and cannulation, so though it [mentorship] was important, I was more focussed on the practical skills based course."* (4M1)

*"Mentoring is a high issue...but it's not top of the list".* (4M4)

When asked about the credit level of their course, several commented that they had not been consulted about their preferred credit level and would have chosen an alternative if provided with the option. Others noted that they had been unable to complete the module of their choice:

*"I originally asked to do the credits because I wanted it towards my degree, but I was told that they [local Trust] don't fund it, so we're doing a non-credit."* (4C1)

*"I was told if I wanted to do a credited module you have to pay extra money for yourself."* (4A2)

Another participant reported having little choice, though was funded to complete a 30 credit module:

*"I asked to do a mentorship course and then I was automatically put onto a 30 credit."* (3A1)

However, the discussion around varying credits led one participant to divulge that she was unaware that different credited modules existed:

*"I didn't know there were different credits until I came here."* (4M1)

Two participants however, reported that they were satisfied with being sent on a zero credit module as this suited their needs at this point in time.

### **9.1.3 Perceptions**

#### ***Perceptions of role of mentor / mentorship***

Participants acknowledged how their perceptions of the role of the mentor had changed since commencing the mentorship course:

*"I don't think I appreciated just how much was actually involved in being a mentor and the responsibility attached to it."* (3A1)

Good mentors were described as those who, *"Made it look easy."* (2A2)

Confidence and being able to articulate rationale for care were seen to be important to the role of the mentor. Participants recognised the need to keep their knowledge up to date to be able to fulfil these tenets:

*"I think it's a lot more in depth than I realised. I think I was more blasé before. I know I have to keep up with changes in practice."* (4M2)

The concept of 'value' was explored, with most participants believing their role to be valued by students who were viewed to be 'grateful' for their input. Their perception of 'value' by employers and colleagues was less positive and participants acknowledged that this had a more pragmatic element in that they were valued for being able to share the workload of students and support more students in the clinical setting. However, many participants did not feel that the time it takes to mentor students effectively was valued and this impact on their workload was rarely acknowledged. Those who were employed in part-time positions further believed the time to mentor effectively to be compounded by their part-time status.

*"You can't just get on with your work, it is time consuming."* (2A1)

#### **9.1.4 Experiences**

Participants reported feeling generally well prepared for their new role as mentor but the actual experience of mentoring a student whilst working and delivering care was considered by several students to be challenging:

*"I don't want to sound rude, but I just think it's difficult enough for me to do my job on a daily basis without having a student anyway. I'm not in a position to facilitate a student's learning because of the demands of my job role. When you're on a ward counted as a member of staff, it isn't a priority."* (4M2)

The participants also discussed the difficulties they experienced in having their own practice documentation completed and viewed this as a task that required more time than the workplace permitted.

*"I'm meeting up with her [mentor] tomorrow on both our days off to do some of the practice document. Every time we schedule time in something happens."* (4A3)

*"Trying to get a shift where it's you, your mentor and then your student as well and it's a struggle most days really."* (4C1)

*"I had to go in on a day off and sit in the office and she [mentor] had to come in for 10 minutes, sign a bit and go back out to a patient and come back."* (4M1)

When asked if they would encourage future colleagues to undertake the mentorship course, the overall agreement was positive, as was their view of the course itself. However, reasons for

encouraging others to undertake the course were primarily to support the increase in numbers of mentors to share the current workload.

*“We’re so short of mentors. It’s such a scrap to try and find mentors to have students, so we’re having people who aren’t mentors taking students, not for any amount of time, but that’s the only way we can do it.” (4M4)*

## **9.2 Interviews with ELMs**

### **9.2.1 Support**

The organisational support offered by the various Trusts to trainee and qualified mentors varied greatly across Essex. The specific findings are offered under emergent themes:

#### ***Trainee support***

Some trainees were allowed, together with the ward manager, to select their mentor. This selection could be based on the trainee’s prior knowledge of that mentor’s ability, a pre-formed relationship or friendship, whilst other trainees were assigned a named experienced mentor. The position of the ELM was variable within each Trust support mechanism, but often took on the role of a distant organisationally based contact, offering support to relevant ward managers.

#### ***Organisational systems***

A hierarchical business model of initial trainee selection was more or less complex across the Trusts. Each Trust had criteria on which projected potential numbers of mentors were highlighted and subsequently selected. This was undertaken according to service need and support capacity. A “*training gap analysis*” (ELM 4) was submitted according to the CPD need of the staff on each ward. These criteria would also be based on an expectation of attendance, where the mentorship programme would be viewed either as forming a CPD pathway or as a mandatory means to an end, where,

*“on appointment of a nursing post, they [trainee mentors] would be told that [undertaking training in] mentorship is a requirement.” (ELM 3)*

Once the mentee had been identified, the hierarchical model of combining support within a management framework would be followed.

#### ***Mentor support***

A number of strategies were uncovered, including; a drop-in forum, annual and triennial mandatory updates, mentor moderation, an educational forum, ward-based educational links, link-lecturer input and mentor focus group. The forms the support strategies took were both virtual and face-to-face. It was agreed by the ELMs across all Trusts that the universities supported the mentors well;



*“Actually, both universities have got fantastic information to support [them] as mentors.” (ELM 1)*

The identified ‘problem’ was the lack of time: to access the available support and for the *“completion of the documents”* (ELM 4) of the trainee mentors, the student nurses and the annual update paperwork.

### ***Supporting the failing and unsuccessful trainee mentor: a failing system?***

This was a complex area, where systems were reliant on effective communication within the Trust and between the Trust and each relevant university. The identification of a failing trainee relied on the managers’ interpretation of the reason for failing and on any information from the universities whilst the student was on the course. One ELM stated that,

*“Unfortunately I do not get any information [of the trainee] while on the course.” (ELM 3)*

The ELM or manager therefore may have lacked an awareness of the failing trainee and the process of support from the ELM to the manager(s) would be reliant on timely pastoral or academic input. One ELM described a systematic approach to providing practical support; of confidence building,

*“needing more help with actually writing the assignment...[recognising] it might be a time issue.” (ELM 1)*

Within this process-driven model, usually an ELM became involved when a trainee moved beyond the failing stage to becoming identified as an unsuccessful trainee. Here, whilst the result was awaited from the Awards Board of the relevant university, the term ‘support’ focused more on consequences of non-achievement than actual support. Whilst one Trust stated that the unsuccessful trainee would not be excluded from other CPD activities, another stated that the trainee could be, particularly if the course had been failed more than once or due to non-submission of academic work. There was a consensus across the ELMs that there would be a review of each unsuccessful trainee’s suitability to become a mentor and that issues such as timing in putting forward a trainee to complete the course, as well as Trust pressure to become a mentor, were factors that would be taken into consideration.

## **9.2.2 Personal Engagement**

### ***The ELMs involvement***

The personal engagement from the ELMs was dependent on the organisational demands and processes that supported the transition from trainee mentorship, to being on the ‘live’ mentor register, to becoming a sign-off mentor under the auspices of a number of quality assurance mechanisms. For example, one ELM described a RAG rating system, where mentors are

*“either coming up to needing an annual update or triennial review...so you are either green, or if you are yellow you’re 60 days away, if you’re amber you’re 30 days away and if you’re red, you’re over.” (ELM 4)*

Where such effective administration was in place this ultimately supported the maintenance of the live register of mentors, the process of monitoring was more efficient and ELMs were aware of any issues that might impact on the register. Again this experience was variable, as were the effective links between managers and mentors, and consequently between the managers and the ELMs.

### ***The trainee interface***

The personal engagement of the trainees was influenced by a number of factors: the relationship with the ‘live’ mentor supporting their development and the credit rating of the mentorship course to which they were ascribed. Motivation was intrinsically linked to the personal engagement of each trainee and vice versa. Two ELMs stated that trainees were not offered choices regarding the credit rating of their CPD mentorship activity:

*“We do not allow zero credit, because [we] believe that is only a certificate of attendance and we don’t want that...so it will be either 15 or 30 credits.” (ELM 3)*

*“I bulk bought mentorship courses and split them equally between Essex and ARU, zero credit...I also commissioned a small number of places that had 15 or 30 credits where people had it on their pathways...all mentorship should be zero credit, because we’d get more for our money.” (ELM 4)*

Here it was clear that the perception was that the CPD pathway would equate to effort which would equate to warranting a credit-worthy course or not, as perceived by each Trust/ELM.

## **9.2.3 Perceptions**

### ***The value and perceived role of mentors within the Trusts***

A question relating to the definition of a mentor brought about similar perceptions from each of the four ELMs. One ELM highlighted the clearly defined learning focus and valued role of the mentor in relation to the workforce future. A pragmatic perception was of the specific need that mentors must make available a minimum of 40% of their time to students whilst on clinical placement. This was the ideal, but the actual time and contact could be variable. During any contact time, mentors

*“provide our students and learners with guidance ...obviously supporting them to acquire the skills and the knowledge that is required for them to fulfil their cluster skills...very much someone for advice and support and guidance.” (ELM 1)*

Also, there was a fit between the university and clinical contact which was thought to be the application of these components. The sharing of expertise and the focus on the student was thought to be paramount, where standards were reviewed, maintained and

*“it helps them [students] to understand how to deal with difficult situations...when they come together with other mentors [they] can share that expertise.” (ELM 2)*

At times however, the shift system was said to influence or determine the support offered and bureaucratic processes could get in the way of effective mentorship. Whilst having mentors was considered to be of financial benefit to the Trust as it was ‘Learning and Development Agreement’ related, it also provided a good learning environment and promoted service values.

### ***The inactive mentor phenomenon***

The ELMs perceived this as being problematic in so far as they were not able to control such activities as: staff movement or mobility, the readiness (or lack of) staff entering new training areas, a guarantee of 40% minimum contact, mentors keeping up-to-date, mentors becoming specialists within a clinical area, incomplete reviews and non-placement areas. These were all included in the ‘inactive’ staff profile. It was acknowledged that the mentorship profile was variable, but one area that was thought to put mentors ‘off’ was the perception that the annual review was demanding

*“most of the ones that are inactive are because they haven’t completed their triennial reviews properly...they see it [paperwork] as a bigger task than it is.” (ELM 2)*

## **9.2.4 Experiences**

### ***Trust and University communication***

The interface between the universities and the ELMs was generally positively described. However, the issue of timeliness of disclosure was thought to be crucial in supporting failing students and feeding into the current processes that the ELMs have developed. One ELM highlighted the need for greater speed and detail when liaising with the Trust regarding a failing trainee and that there is a reliance on the university notifying changes in trainee performance. The support is

*“obviously from the university... but they [trainee] also needs to speak to the manager or someone within the Trust.” (ELM 1)*

When a trainee had failed the course, one ELM’s experience was more proactive, where the university advised the ELM of any issues at the time of the problem. However, conversely, there was thought to be an excessively long delay between the trainee taking the course and the ELM and trainee being notified of his/her success:

*“it would be better if somehow... that I can know for sure who’s passed...because there’s people today that are only just going on the register that were in the January ’13 intake.” [interviews Dec. 2013] (ELM 4)*

### **CPD alternatives**

As many of the ELMs have experienced trainees who had not submitted work or for other reasons had been unsuccessful on the mentorship course, they considered alternative CPD activities. One ELM highlighted that due to the mandatory approach to mentorship, this may have meant an increase in failure rates, a lack of ownership and a reduction in CPD opportunities in the future. With the expectation to succeed, the trainees would be expected initially to repeat the mentorship course on a lower credit level (if applicable) and

*“I would send them to the HEI which offers more support...dangle some more carrots to say, you can have a degree pathway or when you finish you cannot do anything else unless you have passed the mentorship course.” (ELM 3)*

Providing equitable provision is not an easy task, particularly where mentorship is concerned. One ELM stated that failure on such courses was rare and that personal suitability was paramount. The service-dependent nature of the provision meant that the assessment of the team profile, the staff needs, the gaps and the skill mix were all required to fulfil CPD requirements. CPD might be better focused on clinical expertise for some as they might not be ready for the mentorship responsibilities. For some,

*“it may be that it’s more useful for them [staff member] to do a CPD course...than to actually do the mentorship...[if] updating from a diploma to a degree...we would expect them to do mentorship, [but] it might not be the first thing.” (ELM 2)*

An unsuccessful trainee mentor could [still] train students as he/she would have the skills of a nurse, therefore mentorship should be seen as one route to developing the workforce, and not necessarily the first CPD activity.

## **9.3 Individual interview with ‘Live Mentor’**

### **9.3.1 Support**

#### ***Support from Trust***

The participant reported feeling well supported by her immediate colleagues, but not by the wider organization:

*“Very rarely I have time... that’s the major issue, there is no protected time for us to sit down and not be disturbed, and it irritates me...you do it as you go along. What can you do? Colleagues, on*

the other hand, do help out and cover for each other... on our ward all the nurses are brilliant...I am very fortunate."

### ***Support from university***

The participant advised that she had received no feedback from the universities about her ability to mentor and therefore welcomed the opportunity to be interviewed and to have someone listen to her thoughts. She did, however, acknowledge that the student learning contracts were very useful in supporting mentors in their role and that the annual mentor updates were helpful in keeping mentors current with aspects of mentorship.

### **9.3.2 Personal engagement**

#### ***Reasons for undertaking the course and views on the course***

The participant's motivation focused on the learning activity, stating that she really enjoyed the course and felt that it prepared her well for the role:

*"It gives you the tools...It empowers you to criticise as well as praise...had a lovely time, the sessions were lovely...a brilliant tutor"*

The participant believed that the course should be compulsory for all nurses, as she had learned so much whilst undertaking it. She acknowledged that her colleagues were always grateful when another nurse did the mentorship course, ultimately as they would have fewer students and therefore spreading the load. As this participant already had a degree, she undertook the non-credit bearing module, however, her preference would have been to undertake a module with credit, to fulfil her enjoyment of writing essays. She appreciated that the other students may prefer non-credit bearing modules, as this was perceived as being less work.

#### ***Pride in mentorship***

The participant felt that mentorship was important and felt privileged to be a mentor:

*"So when I have students, they're my flock. I look after them...they bring me chocolates...I say, no bribery, get away from here...I enjoy it, I thoroughly enjoy it.....It makes me feel important...I have achieved something....you feel very important suddenly that you are teaching...the money is not important – they don't pay you any more."*

#### ***Influence of mentor on students***

The participant discussed how mentors have a significant influence on students and that this can be negative or positive. She offered examples of mentors that she had been allocated in her own training and considered how one of these in particular had prepared her for her first staff nurse role, by treating her as one of the team:

*“M...was a brilliant mentor. One of the best mentors I had...She was dynamic...and sometimes I want to be like her...and I always, always have her up there in my mind...she was interested in teaching.”*

The participant also talked about poor mentors and how she would never forget them. One mentor told her she was “too old to train” to be a nurse. On another occasion she arrived on a ward with another student and was dismissed by the mentor. This led the participant to believe that not everyone should be a mentor.

### ***Context of mentorship in CPD***

The participant discussed the importance of lifelong learning and CPD, but noted that it was difficult to access learning opportunities due to staff shortages. She had applied for clinically relevant courses, but had rarely been able to go. She always put herself forward for courses, but had to wait several years before being sent on the mentorship course, although she was very keen to do it. As a progression from mentorship, the participant stated that she would like to do a PGCE in the future, but cannot afford it, as she would like to go into teaching.

### **9.3.3 Perceptions of role of mentor / mentorship**

#### **Should everyone be a mentor?**

The participant believed that mentors needed to be interviewed for the role, selected on their interest, personality and whether or not they had time to undertake the role. She further felt that mentorship should not be linked to career progression generally, but this was different for her, as she wished to become a lecturer in the long term. She noted that she had worked with students before becoming a qualified mentor: teaching, supervising and supporting students:

*“Well in a sense everybody is mentoring”*

The participant strongly believed that mentors need to be interested in their students and honest with them, even when this was difficult, recognising unprofessional behaviours needed to be challenged, but in a sensitive way.

#### **Qualities of good mentors**

The participant talked about the importance of teaching empathy, kindness and consideration to the students, which she considered was best done through role modelling:

*“You need to set a good example, be a role model. Your behaviour is the most important thing when teaching students.”*

The participant also recognized the importance of teaching students clinical skills, theoretical knowledge about medicines, illnesses, anatomy and research and how to approach patients. She emphasized the importance of body language:

*“your face, your smile”*

The participant felt that the most important role of the mentor involved planning the student's experience and offered the view that students with very little previous experience can work with HCAs, to do basic care. More senior students were given priority to work with the participant as a mentor. She then described some of the other learning techniques used with students:

- Advises them to have pad and paper and to write down anything they are unsure of.
- Looks at the charts with the student and asks them questions about the charts.
- Discusses medication and asks not just what the drug is for, but also how to order it from pharmacy.
- Reviews the patient's paperwork with them and supports the students in checking cannulas, catheters, wound sites etc

#### **9.3.4 Experiences**

##### **Challenging behaviour**

Challenging the students about poor care was an issue for the participant and dealing with this was an area of consideration for mentors. She noted that there had been a few students on the ward who were not doing well; one student in particular, whose attitude was a bit brash and loud required support and advice about her interpersonal skills. The participant confronted the student with her concerns, highlighting,

*“[when] you are here you wear that uniform...and you have to respect it”*

She did say, however, that not all the staff were willing to give such honest feedback.

The participant noted that humour is important, particularly when giving feedback. Her discomfort with “telling people off”, leads her to adopt a different strategy.

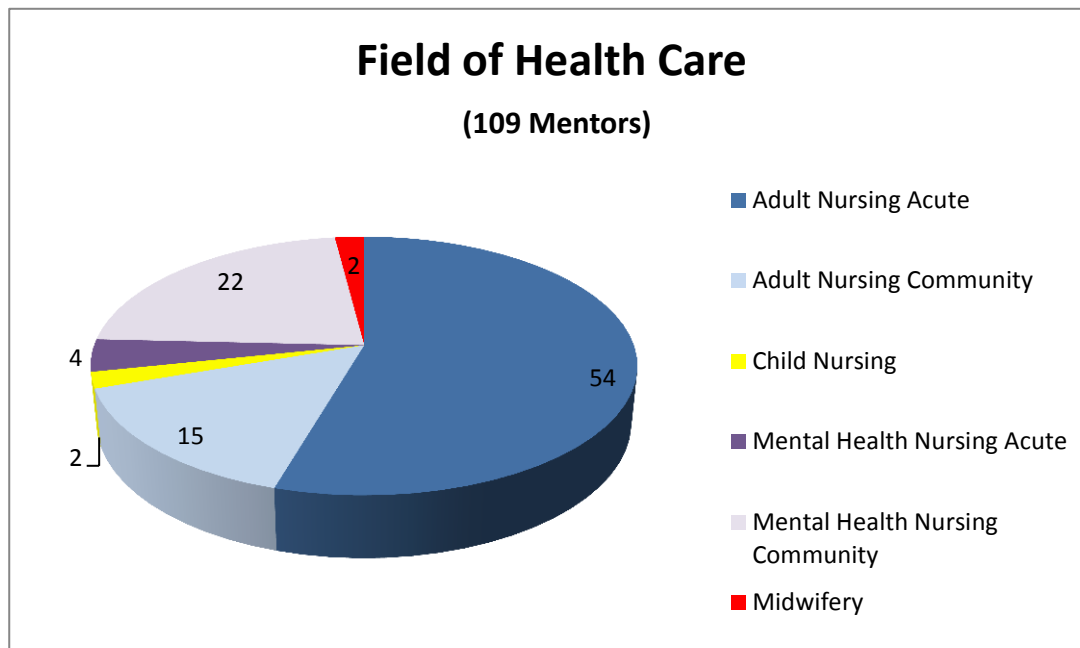
*“I say, what did you do right today? Did you do anything wrong?”*

The participant reported that she then advises the student what she has observed them doing, or not doing, noting the importance of honesty if students are going to learn from feedback. The difficulties of giving good feedback to students were highlighted.

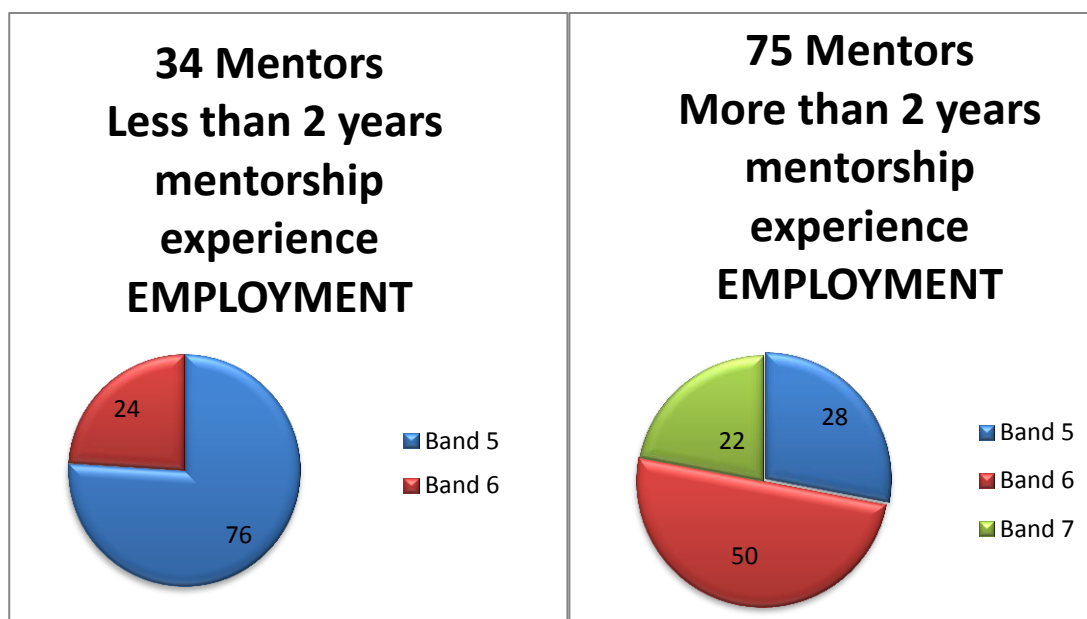
The participant further acknowledged that some students were more motivated than others and she was sympathetic to the difficulties of being a student; academic, financial and emotional.

## 9.4 Survey Questionnaires

### 9.4.1 Demographic data

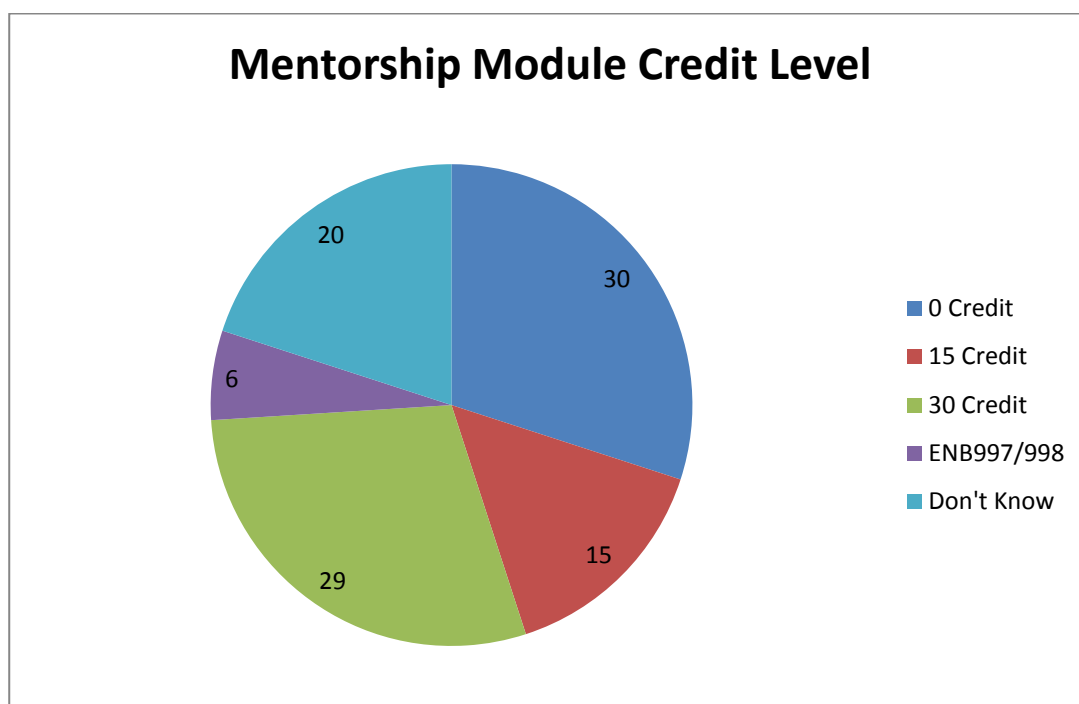


Mentors from a range of professional disciplines and health care settings completed the questionnaire. The majority of these were Adult Nurses working in acute care settings (54%) and a significant number of mentors were Mental Health Nurses working in a community setting (22%).





Of the 34 mentors with less than 2 years mentorship experience, 76% were working at band 5. Those with more than 2 years mentorship experience were mainly employed in band 6 (50%) and band 7 (22%) posts.



0 credit and 30 credit mentorship modules were the most commonly completed by the participants, with 59% undertaking these. Surprisingly, 20% of mentors were unaware of the credit level of their mentorship course.

#### 9.4.2 Support

##### ***Support accessed and received from managers***

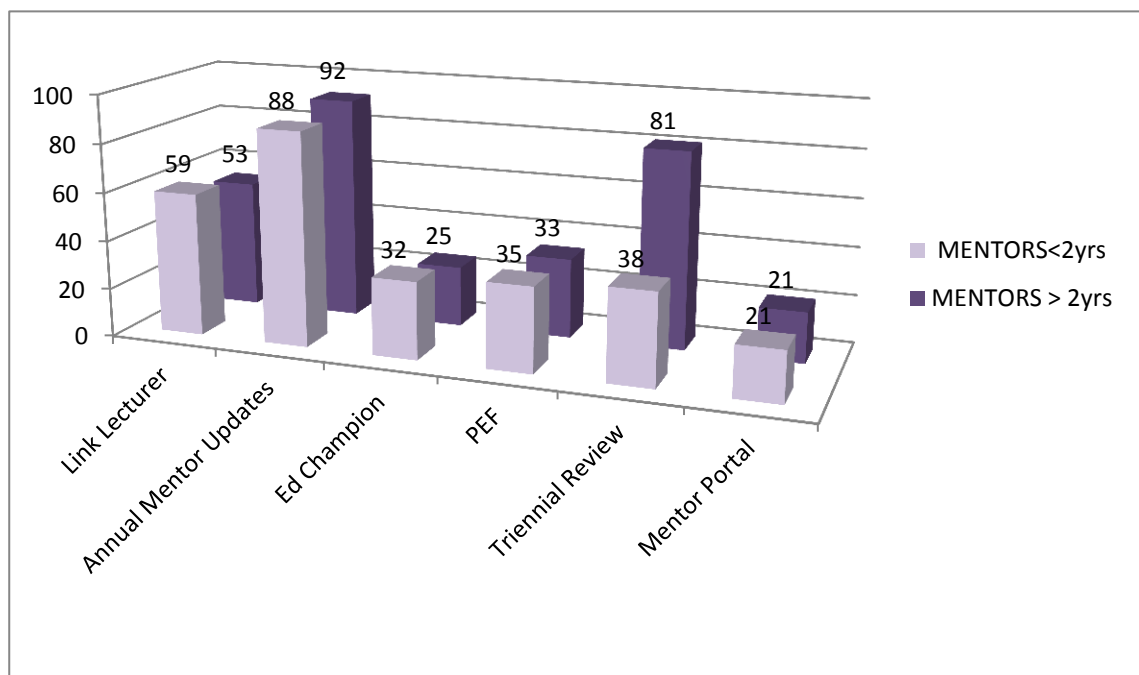
A range of methods were regularly cited by participants to indicate the support they had received from their managers in relation to their mentorship role.

Discussion (informal e.g. advice, formal e.g. triennial review) and time to undertake mentor duties and attend updates, were the most commonly cited support mechanisms.

Supporting mentors to work with students by accommodating this via the staff rota, offering advice with decisions (especially around underachieving students), access to resources, providing informal feedback around mentorship ability and formal feedback at appraisal were also considered useful methods of support provided by managers.

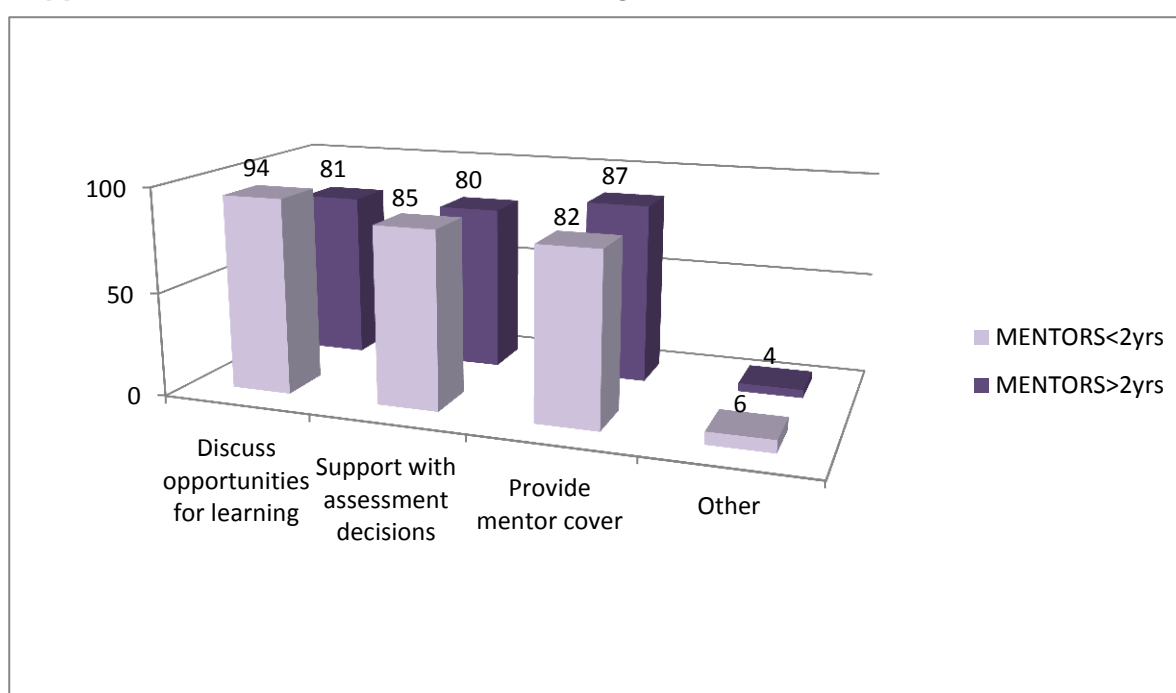
However, this support was not considered readily available to all and some mentors felt isolated in their decision making, believing the correct type of support not to be available from their managers.

### Support accessed and received from universities



Annual mentor updates were considered by both groups of mentors to be the most prominent form of support accessed and received from the universities. Link lecturer support was also acknowledged as regularly sourced. 81% of mentors with more than 2 years mentorship experience considered their triennial review to be amongst the support accessed (though triennial review is undertaken by employers). Interestingly 38% of mentors with less than 2 years mentorship experience also noted triennial review as a form of support accessed from the university. It should be noted that mentors are only eligible for this review from the third year post mentorship qualification. The PEF role was also aligned with support from the university.

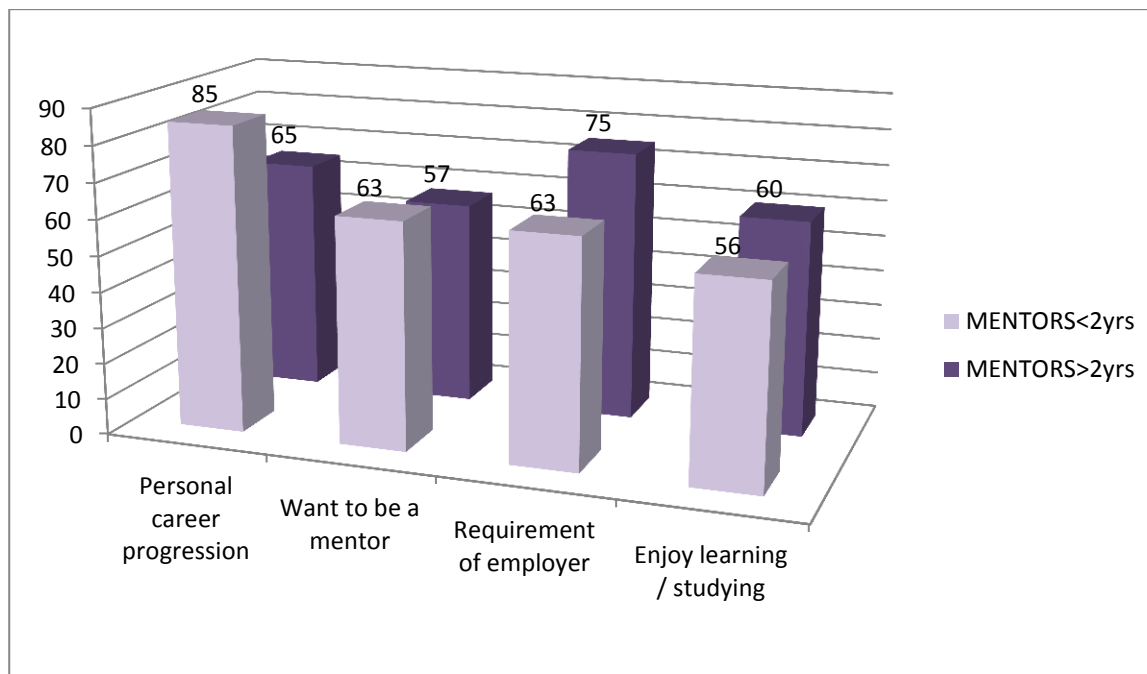
### Support accessed and received from colleagues



Both groups of mentors reported high levels of support from their colleagues and those with less than two years experience of mentorship engaged with their colleagues most often to discuss opportunities for learning.

### 9.4.3 Personal engagement

#### *Reasons for undertaking the mentorship role*



More recently qualified mentors were more likely to undertake the role as a means of progressing their own careers, with 85% indicating this to be a key stimulus. 75% of mentors with more than two years experience, however, considered the requirement of the employer to become a mentor to be a more prominent rationale for engaging with the role.

It is also notable that for both groups, less than two thirds wanted to become mentors or were driven by the opportunity to develop their learning.

#### *Development as a mentor*

Since undertaking the mentorship course, there was an overwhelming view amongst the participants that confidence in their knowledge and skill of mentorship had developed. Being clearer about their role and acquiring the knowledge of educational concepts such as learning styles (including identifying barriers for learning) were identified as supporting this. Mentors also regularly noted that they had developed skills to cope with difficult situations, including how to raise concerns, challenge poor practice and deal with failing students.

Interestingly many mentors acknowledged transferable skills such as leadership, delegation, communication, attention to detail and organisation as skills that they had developed as a result of their experience as a mentor.

Whilst many mentors considered their role provided them with the opportunity to role model and share their knowledge with students, the majority recognised the value of mentoring a learner as a process that contributed to their own development by 'keeping them up to date' with current practice.

### ***Motivation to support learners***

The motivation to support learners was primarily expressed from an intrinsic perspective. The enjoyment experienced in teaching others and sharing their experiences, particularly with enthusiastic students, was cited regularly by mentors in both groups as a key influence in their motivation to support learners. Many discussed the job satisfaction, positive self-esteem, sense of achievement, personal development and career progression as a result of their mentorship role, to be their main stimulus. The prospect of career progression was also regularly cited to be at the heart of the motivation to mentor.

The term 'opportunity' was commonly used and related to role modelling, keeping up to date, and passing on knowledge.

For some, however, their motivation was relatively altruistic and based on their own previous experience of poor mentorship, empathy for the student role, concern for nursing standards (and the belief that they could contribute to raising standards) and their duty to patients, their employer and the profession. 'Gatekeeper' to the profession was cited by some mentors as a key component and motivator of their role, allowing them to influence and monitor standards.

### ***The context of mentorship in CPD***

Mentorship was largely viewed as a compulsory requirement of the Trust, necessary for their ward and the 'gateway' to future development. Many mentors believed they would not have been permitted to undertake other professional development without having completed the mentorship course as their first experience of CPD. Alongside this was the understanding that a mentorship qualification was necessary to support career progression and ultimately linked with their 'pay band'.

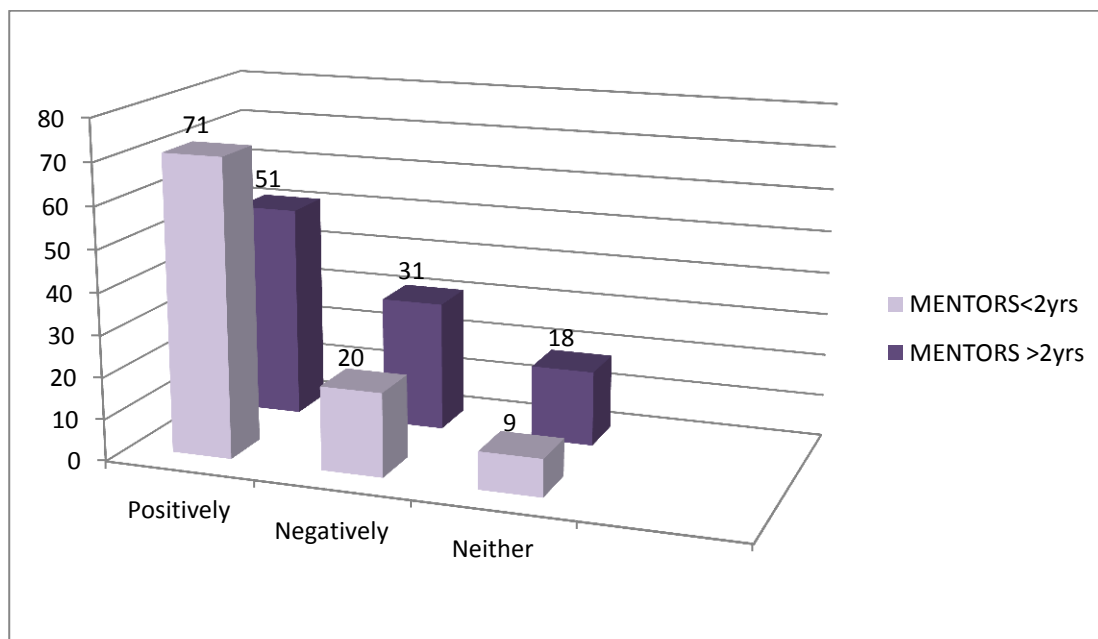
For some, developing clinical skills pertinent to their clinical area was a greater priority than undertaking a mentorship course and felt this to be essential to their performance as an effective mentor. These mentors had been able to negotiate undertaking the mentorship course when they felt ready to do so.

Only 44% had knowingly undertaken credit bearing mentorship modules, with the majority reporting being sent on modules without discussion as to how these may link to any CPD activity. Some mentors did not themselves see a link between the mentorship course and CPD and viewed it as an extension to their nursing role or a requirement of the NMC.

Few mentors cited the mentorship course as part of their degree pathway and had consciously negotiated this as part of this.

#### 9.4.4 Perceptions

##### ***Perceptions of how other staff perceive the role of the mentor***



The vast majority of mentors in both participant groups believed their mentorship role to be viewed positively by other staff.

However, 31% of mentors, with more than two years' experience, cited added workload when supporting students (which impacted on their own clinical responsibilities), time involved in preparing for triennial review and lack of time to undertake the mentorship role positively (often staying behind at the end of a shift to meet with the student and complete documentation) to be aspects that are viewed negatively by other staff.

Almost 20% of this same group believed that other staff perceived both positive and negative elements to the role but neither to be significant enough to label the role as one or the other.

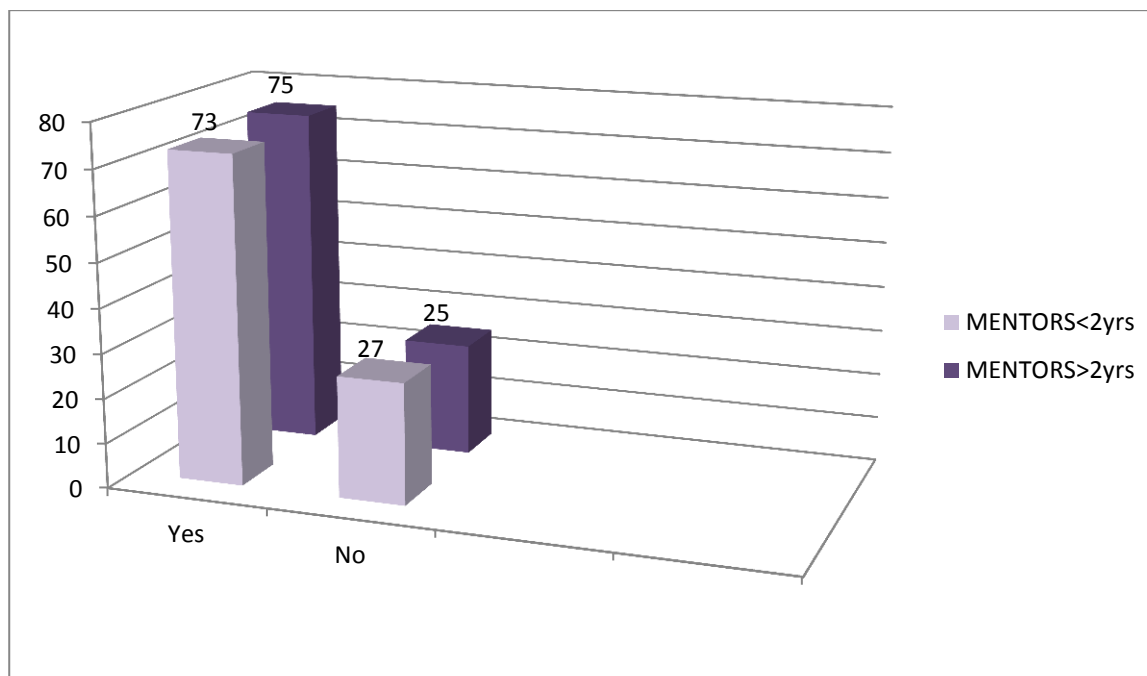
##### ***Personal perceptions of the role of the mentor***

When asked how they currently viewed their own role, the majority of mentors in both groups used positive descriptors including; rewarding, supportive, facilitative, educative, imperative, important, necessary, nurturing, encouraging, appreciated, valuable, inspirational, an opportunity to learn and role model, useful (for personal learning) and a positive challenge.

There was a common belief that mentoring was a core part of nursing and that the development of high quality nurses should be the responsibility of all clinicians. Some mentors appeared to believe that mentorship was a mandatory requirement by the NMC.

Many mentors also described negative perceptions based on their personal experience of the role. The most prominent of these included lack of time, hard work and a requirement of the Trust (not the individual). Other common descriptors indicated that mentors viewed the role as difficult, overwhelming, a ‘juggling act’, challenging, with considerable responsibility.

### ***Should all registered health care professionals be mentors?***



The vast majority of mentors in both groups believed that all registered health care professionals should be mentors. Reasons for this revolved around the belief that mentoring was an integral part of nursing, the workload of mentoring should be shared by all staff and that it was everyone’s responsibility to prepare the future workforce.

Those who did not believe that all health care professionals should be mentors held the view that not everyone had the attitude or capability to mentor and that students who experienced such mentors were being disadvantaged.

## **9.4.5 Experiences**

### ***Personal experience of mentorship***

Positive and negative descriptors were used by all 109 mentors to summarise their personal experience of mentorship.

Rewarding, enjoyable, motivating, interesting, inspiring, refreshing and satisfying were commonly cited as positive aspects to mentorship and it was clear that there is significant gain for those who undertake this role. However, the difficulties associated with mentorship were rehearsed in equal force. Many reported the role to be time consuming, pressured, challenging, burdensome and creating a tension with their everyday workload. Terms such as stressful, demanding and tiring also highlighted the personal impact of this role on the individual mentor. Mentors felt let down by

colleagues who had 'failed to fail' weak students and resentful that they had been left to take responsibility for this, often when students were in the final stages of their course.

### ***Advantages of being mentor***

When asked about the key advantages of their role, many mentors considered this to have personal reward evident in their career progression, confidence, and personal development in areas such as leadership and decision making skills. They also considered mentorship to give them the 'opportunity' to share knowledge, make a difference to someone's development, role model and shape the future workforce. However, the most prominent advantage reported by participants was the impact of mentorship on keeping themselves up to date, with many acknowledging that supporting students has the power to motivate and inform their own clinical practice.

### ***Disadvantages of being mentor***

Lack of time was regularly cited as impacting on the mentorship experience, with the role considered demanding and over and above their 'regular job'. Those working as managers or in part-time posts found this particularly difficult.

Mentors also commented on the personal impact that mentorship had on them, believing it to be tiring, stressful and emotional. Addressing and supporting failing, uninterested, lazy or poor attending students was considered to be particularly emotionally draining and demanding on individual mentors.

The conflict between being a supportive coach and assessor was regularly cited as a source of anxiety:

*'It's difficult, you get to know these students and sometimes we have to fail them. That's an awful feeling'.*

### ***Advice to colleagues***

96% (n=105) of participants would advise their colleagues to undertake the mentorship course and become a mentor to students. Personal development, career progression and the opportunity to influence the profession were frequently cited as key drivers. Many identified the course itself to be enjoyable, worth doing and equipping them with the necessary insight into learning and teaching. For others, the key message was that mentorship is part of everyone's role and that all should take responsibility for this.

A note of caution however, was evident in the responses of some participants, advising that mentorship requires the right attributes (supportive / positive) and that those undertaking this must

be willing to value it and take it seriously. They also advised that time to study should be secured before agreeing to undertake the course.

## 10. Discussion

The findings retrieved from the differing groups of participants (active mentors, student mentors and education leads across the four identified Trusts and varying health care disciplines) indicated similarities in their views and experiences of mentorship. Positive and challenging aspects of mentorship were described by all groups of participants.

### **Mentoring in a changing NHS**

Supporting learners in health care settings is widely recognised as a challenging enterprise in the literature (Myall et al, 2008, Hurley and Snowden, 2008, Murray and Williamson, 2009). Recently these challenges have been further underlined by a number of simultaneous, often competing drivers in healthcare, which in many respects, exemplify the tensions which supporting learners in practice can present those acting in the mentor role.

The ongoing reconfiguration of health care provision in England, precipitated by the Health and Social Care Act (2012) has meant that in many areas, mentoring relationships may often take place amidst a backdrop of upheaval, uncertainty and instability. Whilst this has presented new opportunities for different ways of partnership working, the breaking up and reconstitution of existing partnerships and placement areas may also be compromising the accessibility, availability and consistency of mentorship support for learners and have implications for placement capacity (Robinson et al, 2012).

These changes have been further compounded by the concurrent requirement for the NHS in England to find £20 billion of efficiency savings by 2015, with further budgetary cuts predicted for the future (DOH, 2011, Ramesh, 2013). This has led to a generalised sense of job insecurity for the nursing workforce (Duffin, 2014). Recent statistics suggest that since 2010 there has been a loss of 4000 senior nursing posts and 2000 qualified nursing posts with an increased use of agency and unqualified staff to plug the gaps (RCN, 2014). This has raised concerns around the ability of mentors to effectively undertake the role in an era of 'skill mix austerity' (Glasper, 2012). Willis (2012, p34) further suggests that the 'dilution of skill mix' has resulted in the loss of high quality role models from the pool of mentorship, precisely at a time when they are needed most.

Recognition of the importance of the mentorship role within Nursing and Midwifery remains broadly uncontested. Indeed the necessity for strong positive role models, has over the past three years, been reaffirmed and reinforced by reports outlining organisational failings in care delivery and provision (Francis, 2013, Clwyd and Hart, 2013). This together with the identification of systemic and enduring cultural issues within the NHS (Francis 2013, Dixon-Woods et al, 2013) has



necessitated an ongoing reappraisal of what care is, how it should be delivered and what to do when things go wrong. The ensuing wider scrutiny and debate about the recruitment, preparation and regulation of nurses and midwives is currently situated within the rubric of values based healthcare delivery as adumbrated in the NHS Constitution (DH, 2013) and Compassion in practice (DH, 2012). In practice learning environments, mentors constitute the primary source of professional socialisation of aspirant practitioners (Gray and Smith 2000, Ousey, 2009) and therefore will play a central role in developing not only professional knowledge and skills, but attitudes and beliefs, commensurate with the values agenda and those of the professional body. Greater emphasis on values based health care, necessarily realigns the mentor role toward one with a more overt moral dimension. The findings of this study identified many examples of mentors believing their role to encompass a duty to the public, the profession and the future workforce and considered themselves 'gatekeepers' with a responsibility for maintaining professional standards. These values were seen by many participants to be at the core of their profession and led them to believe that all registered health care professionals had a duty to prepare the future workforce and should be acting in some type of mentorship capacity.

Moral agency within the mentorship role is poorly discussed in the literature, however this study suggests that cognisance of this aspect of the role is both accepted and endorsed by mentors. It also represents a key area of tension, largely because of the difficulties of situating and reconciling personal and professional values in an infrastructure or 'hinterland' (Robinson et al, 2012) which often militates against the facilitation and transmission of these.

### **Time to mentor**

The NMC(2008) require that mentors spend at least 40% of their time with their learner but this is sometimes perceived as a maximum rather than a minimum and some in the study indicated that even this was not always possible in their particular clinical area, which is concerning. Time is a vital commodity in the student –mentor interface and this appears to be the primary casualty of supporting learners in demanding practice placements. Absence of time is a perpetual presence in responses to questions around barriers and challenges to effective mentorship and this has also been well documented elsewhere (Donaldson and Carter 2005, Pearcey, 2008, O'Driscoll et al, 2010.) Mentors and student mentors in this study considered their primary role as practitioner to impact on the time available to them to undertake effective mentorship. The completion of practice assessment documentation was cited as a source of frustration, for which no time was allowed alongside their busy day job.

Undoubtedly mentorship activity is currently taking place in 'straightened circumstances' (Robinson et al 2012). Encouragingly, whilst not dimming commitment to the role, the participants of the study, reported a steadfast, ad hoc 'make do and mend' pragmatism, with many undertaking aspects of the mentor role in their own time (*"I'm meeting up with her (mentor) tomorrow on both our days off to do some of the practice document"*, 4A3). This conduct, whilst laudable, suggests

that the operationalisation of the present model for mentorship for nurses and midwives is, in the current climate, putting individual mentors under increased strain. Arguably this may also make mentorship less attractive for future mentors who may not be prepared, or able, to invest their own time in the role. When elements such as the one hour protected time for sign-off mentors are not costed into organisations' budgets (Robinson et al 2012) and there is no pecuniary reward or recognition for undertaking the role, the value afforded to mentors and mentorship is difficult to discern.

The preeminent value of time in nursing and midwifery can be placed alongside a 'need to look busy' culture within the profession. This has been recognised as a significant feature of professional socialisation (Melia 1989) and is reflected in advice to learners articulated by respondents in the study; *"Even if it's just tidying up or restocking, it was seen as good"* 4C1. This is noteworthy as the inference of this, is that in a 'need to look busy culture' time spent undertaking mentorship activity, for example sitting down to complete practice documents may be regarded as detracting from, or even avoiding, the 'real work' of looking after patients, particularly when this takes place in poorly led or resource depleted areas by reluctant mentors (Phillips et al 2000).

The influence of time on the assessment decision making process by mentors has also been widely discussed in the literature in terms of failing to fail and recent studies suggest that this phenomenon continues to exist (Heaslip and Scammel 2012, Rudowski 2008). The findings of this study however suggest that a further consequence of a lack of time may be affecting the level of support and supervision given to junior learners and potentially placement capacity. Some mentors inferred that whilst the support of third year students is perceived as 'manageable', effective mentorship of first year learners requires a greater investment of time, which although desirable was simply not something that their areas were able to offer. This accords with a body of evidence to suggest that much of the support afforded to pre-registration student nurses continues to be provided by health care assistants (McKenna 2009, O'Driscoll et al 2010, Hasson et al, 2013). This might not arguably be, in itself detrimental, but will not assist the development and promotion of skills and capabilities required of contemporary, autonomous registrants.

Further, the partial abdication of responsibility for supporting junior learners expressed by some mentors in the study, suggests a schism in attitudes towards assessment of nursing students at particular points of the programme. This in part may be a consequence of the incongruous nature of the sign-off mentor role in pre-registration nursing and midwifery programmes. Sign-off mentors are a requirement for all midwives and clear progression points are present throughout their programme. Sign-off mentors are required only for nurses in their last practice placement and this raises concerns about the potential divestment of assessment decisions by mentors- or more colloquially - passing the buck.

## **The NMC Standards- still fit for purpose?**

The current framework for mentorship in Nursing and Midwifery –Standards to Support Learning and Assessment in Practice (SLAiP) were first developed in 2006 and revised in 2008. Robinson et al (2012) have recently outlined the nuances of the interface between theory and practice –what they term the ‘hinterland’ of mentorship in their work. They conclude that a wider conversation needs to take place regarding a number of aspects of the existing infrastructure for mentorship in nursing and midwifery, which include; the selection of mentors, the uncoupling of mentorship from promotion, whether or not all nurses should be mentors and the continued viability of the current NMC standards. These issues are also reflected in this study. A recruitment and selection model that ignores the skills and attributes required for mentorship can only compound the dissatisfaction experienced by those mentors who undertook the mentorship module unwillingly. Whilst we were unable to determine why some health care professionals had chosen not to maintain their live mentor status, it is reasonable to assume that being an unwilling participant on the mentorship course may have been a factor in their decision to allow their live status to lapse. We do acknowledge, however, that many other factors may have been at play. Indeed, with many mentors in the study reporting that attendance of the course was an organisational requirement and a means to promotion, it is safe to infer that a ‘means to an end’ attitude could develop toward the course, which may translate in to relinquishment of the role at the earliest opportunity. Conversely, selecting those with appropriate skills and attributes, at a time when they feel ready to undertake mentorship, may only benefit the mentor, students and ultimately the profession.

There is much to commend the SLAiP Standards (NMC 2008), not least because they imbued mentorship with a relatively robust quality assurance framework which hitherto did not exist. It should be noted however, that these were introduced in a markedly different political landscape and in enviably benign economic times. Concerns have been raised around the standards imperative for the mentor role to include assessment, as well as facilitation of learning, which is seen as a potential role tension (Bray and Nettleton 2007, Webb and Shakespeare 2008). Whilst there is inherent value in the standards requirement that mentors work with students over a period of time to promote continuity and monitor consistency of a student’s performance, many participants in the study referred to mentorship as being stressful and emotional, particularly around failing students with whom they have developed a professional relationship. This is not a new phenomenon. For almost 30 years it has been recognised that “failing a student, particularly on practice grounds, is an unpleasant, messy, emotionally fraught experience” (Milner and O’Byrne 1986, p.21). However the emotional labour involved in the role appears to be an aspect of mentorship that remains underestimated, despite the work of Duffy, (2003) bringing it to the fore in the nursing profession. The nature of the mentor-student relationship self-evidently engenders concerns around validity and reliability of assessment, particularly when this process is taking place in increasingly complex and demanding learning environments (Gidman et al 2011).

Validity and reliability of assessment is also questionable when student mentors are being mentored and assessed by their own work colleagues. This is further compounded in situations

where student mentors are permitted to choose their own mentor for this purpose. To avoid potential bias, an objective view is important.

The current discourse around practice learning affords a natural opportunity to undertake an evaluation of the continued efficacy of the current NMC Standards, which must be conducted through the lens of the current context of healthcare provision and delivery.

### **Valuing teaching and learning in practice**

Some of the student mentors discussed a preference for more exposure to dealing with difficult situations (e.g. the failing student) when undertaking the mentorship course itself. Whilst action planning is already a key feature of the mentorship course, these participants clearly desired other strategies to be in place to support the development of this skill. Since the focus group interviews (In November 2013), role play has been introduced as a complementary strategy to assist student mentors in developing the skills required for dealing with difficult situations in their mentorship role. Identifying the skills that they currently use in their practitioner role when difficult situations arise has also assisted these students in recognising their existing transferable skills.

Several student mentors discussed the fact that they had no choice in the credit rating of the mentorship module they were undertaking and 20% of qualified mentors did not know the credit level of the module they had completed. This indicates that some organisations and staff may not consider mentorship as a potential component of a progressive CPD pathway.

Non-credit bearing modules have their place and may well be the module of choice for many mentors. Graduates in this study however, recognised that they were unable to use the credits from existing mentorship modules in higher level CPD pathways. For some this suited their current needs but others described their desire to progress their learning to a higher level. Recognising that many mentors in the future will be graduates and may consider teaching and learning in practice to be central to their practice and interests, the availability of a masters level module to support this would be appropriate. Lawson (2011) asserts that providing CPD opportunities for mentors can only enhance performance and competence, as well as their motivation, capability and job satisfaction.

Practitioners who are specialists in their field are expected to undertake education of both patients and their colleagues. The RCN (2013) review of specialist nursing in the UK identifies that practitioners in these roles spend 17% of their time educating patients and health care staff. A Masters level module aimed at supporting teaching, learning and assessment in practice may therefore be well placed in such a pathway to prepare specialist nurses for this aspect of their role. Indeed there may be merit in securing a module around teaching and learning in practice within all CPD pathways to raise the profile and value of education within the practice environments.

## **Towards a new framework for supporting learners and mentors in practice**

It is clear from the views of mentors and student mentors that mentorship is an incredibly rewarding role, with a wide range of benefits experienced by those involved. Being able to shape the future workforce, learn from students themselves, keep up to date with clinical practice and the satisfaction experienced when contributing to the development of a learner, were amongst the benefits regularly cited. Participants also acknowledged the complex network of formal support from HEIs and informal support from their colleagues.

The NMC (2008) SLAiP standards which underpin mentorship activity are also now well established and embedded with an effective infrastructure to support them. We therefore see no reason to fundamentally revise these, particularly at a time of ongoing change.

However the findings of this study reflect wider concerns about certain aspects of the standards and their application to the current context of practice learning. This, coupled with the stress, exhaustion and barriers to effective mentorship that participants routinely experienced has prompted the development of a suggested new framework to support NMC mentors and learners in practice settings.

The proposed new framework identifies 3 key roles; coach, sign-off mentor and 'Lead Mentor'.

### **Coach**

75% of participants in this study believed that all registered practitioners should be mentors. This was primarily underpinned by their need for support to share the workload involved in mentoring students. Many participants also considered the tenets of mentorship (including caring, nurturing, empowering, encouraging, committed to quality care, understanding and facilitating) to be integral to the health care role, believing the skills and attributes required replicated those necessary to undertake their practitioner role effectively. This view reflects those of some participants in the recent Robinson et al (2012) study. By implication, those who do not have the qualities to mentor, may not have the qualities to deliver health care appropriately. If this is indeed the case, then interview processes for pre-registration courses are important in identifying future nurses with the inherent qualities of a good health care practitioner and mentor.

However, the recognition that mentors should be selected for their knowledge, skills, attitude and motivation (Willis, 2012) acknowledges that some aspects of the mentorship role may not suit all practitioners. Nonetheless, the NMC Code 2008 (standards 23 and 25) requires every registrant to 'facilitate students and others to develop their competence and share their skills and experience for the benefit of colleagues'. As such, it is reasonable to propose that all registered health care practitioners could be expected to participate in supporting students to meet the required level of competency in specific performance criteria. Formalising this through the development of a coaching role, which is not linked to increased pay or career progression, but an inherent requirement of all nurses and midwives, may encourage the

professions to view education in practice as an intrinsic part of their role and not an added extra.

A coaching model that is outcome focused sits well within the learning contract and action planning system that mentors currently use to guide students in achieving prescribed performance criteria. With the mentor taking responsibility of identifying the specific needs of the student and generating a tailored learning contract and subsequent action plan, a coach (or team of coaches) can contribute to the actual learning experience required to meet the targets documented within these. This approach has parallels with the Robinson et al (2012) study in which participants espoused the value of key workers feeding back information on students' progress to a mentor who made the assessment decisions. To meet the NMC (2008) SLAiP standards, mentors are required to be 'available' to the student for at least 40% of their practice placement time. This 40% may comprise a combination of direct and indirect supervision and therefore supports the facilitation of learning experiences through the coaching system. Separating the responsibilities for teaching and assessment may also assist in addressing the current tensions that mentors report around these aspects of mentorship and dilute the continuous intensity of assessment that students feel when working constantly with their mentor (Bray and Nettleton 2007, Webb and Shakespeare 2008, Robinson et al, 2012).

With all registered health care staff expected to coach or mentor in this framework, student learning will become everyone's responsibility. If, as our participants advised, working with students motivates staff to keep their practice up to date, then a shared coaching/mentorship model may have significant advantages for students, staff and patients.

The model of 'real life learning wards' in the VU Centre in Amsterdam utilises a unique coaching system to support student learning and is currently being explored by Health Education East of England for its suitability as a potential solution to capacity issues in our region. Even if this system is deemed unsuitable for full implementation in its original form, it does indicate that adopting a coaching model alongside mentorship has the potential to support our mentors in sharing their currently perceived untenable workload.

We recognise that workshops would be necessary to prepare registered health care staff who are not currently on the live mentor register for the role of coach. Existing mentors would also require support to adapt the focus of their role. To instil the ethic that teaching and facilitation of students and colleagues is integral to the health care practitioner's role, coaching could be included as a more prominent theme in the content of pre-registration courses, including non-nursing health related professions.



## **Sign-Off Mentor**

Participants in the study reported their concerns around failing a weak student in the final 12 weeks of their course, when a sign-off mentor is required to determine the suitability of a student for entry to the register. Some indicated their belief that they had been used as a

‘safety net’ for those mentors who had failed to fail students at the appropriate stage of their course.

As previously mentioned, the findings of this study recognised the importance of ‘readiness’ for mentorship, with some students reporting they felt they were not ready or had no choice in undertaking the mentorship course. It could be argued that those who do not feel ready to participate in mentorship are possibly not ready to accept the associated responsibilities, such as failing students when necessary. A more robust selection process identifying staff who have the appropriate skills and attributes to deliver effective mentorship is required in the first instance.

The impact of failing a final placement student on both the sign-off mentor and the student is phenomenal (Black, 2011) and our participants discussed the emotional effect they had experienced as a result of failing a student at such a late stage. Implementing a sign-off stage at the end of each year has the potential to support such difficult decisions in a more timely way. However, this would require all mentors to become sign-off mentors.

The midwifery profession and the nursing profession are divergent in their practices around who should become a sign-off mentor and when. Participants from the midwifery profession discussed how they currently complete a mentorship course at the end of their preceptorship period and immediately enter a sign-off mentor workshop to undertake this role. This supports the NMC’s (2008) SLAiP requirements that all midwifery students must be mentored by a sign-off mentor. For nurses, the progression to sign-off mentorship is relatively protracted and dependent on their experience. Black (2011) advises that this experience should relate to dealing with (or exposure to) difficult situations when mentoring students, rather than experience in terms of time spent in the mentoring role. However, the very nature of health care requires practitioners to deal with difficult situations on a regular basis, developing transferable skills that may be applied to mentorship when necessary.

The skills required to mentor effectively and make professional judgements around student competence are no different to those required by sign-off mentors. Indeed the accountability and responsibility associated with the decisions made by mentors and sign-off mentors are also the same. Perceptions may, however, differ, as only sign-off mentors are requested to provide their professional body registration number (PIN) on final documentation.

If a registrant is capable of mentorship and undertaking appropriate assessment of their student, they should also be capable of the sign-off mentor role. As such, it would seem reasonable that all mentors currently on the local register should become sign-off mentors and undertake timely assessment decisions that determine student progression to the following year of the course. This may also provide value to the decisions made by staff involved, as the Robinson et al (2012) report identified how mentors were made to feel that their professional decisions were not supported unless they were sign-off mentors.

### **‘Lead Mentor’**

To negate or minimise the stress and emotional impact associated with mentorship that the participants in this study reported may be considered immoral and indeed at odds with the values espoused in the NHS Constitution. Whilst it is clear that mentors currently have access to a range of support mechanisms, participants indicated this to be insufficient to meet the task of effective mentoring in the workplace. Annual mentor updates were considered to be the most common source of support accessed and received from the universities, with 92% reporting this to be so. 59% of mentors identified the university link lecturer and 35% the Practice Education Facilitator (PEF), as further sources of support that they would readily access. The latter figure may be indicative of the changes to the PEF role over the years, but the accessibility of staff who are not based in the practice setting itself may also be reflected in these results.

In describing mentorship as exhausting and lacking in resource, with some even feeling isolated in their decision making, mentors are crying out for leadership at ground level to help address some of the many challenges associated with supporting learners in practice.

Despite the apparent wealth of support available to mentors in the workplace, the introduction of a ‘Lead Mentor’ who is a practice-based, experienced individual and readily available to mentors and coaches will help to reconcile concerns expressed by participants and recognised in this project. These concerns identified the need for:

- the status of mentorship to be explicitly valued in the practice setting,
- clear and credible role models,
- an accessible point of reference to support assessment decisions around pre-registration and mentorship students,
- the development and identification of suitable professionals for mentorship,
- a practice-based channel for monitoring and communicating issues around mentorship and mentor support to lead managers,
- the promotion of the quality of mentorship in their organisation,
- the culture of practice placements to be overtly educative,
- support and advice to professionals preparing for triennial review
- validity and reliability of practice assessment of trainee mentors.



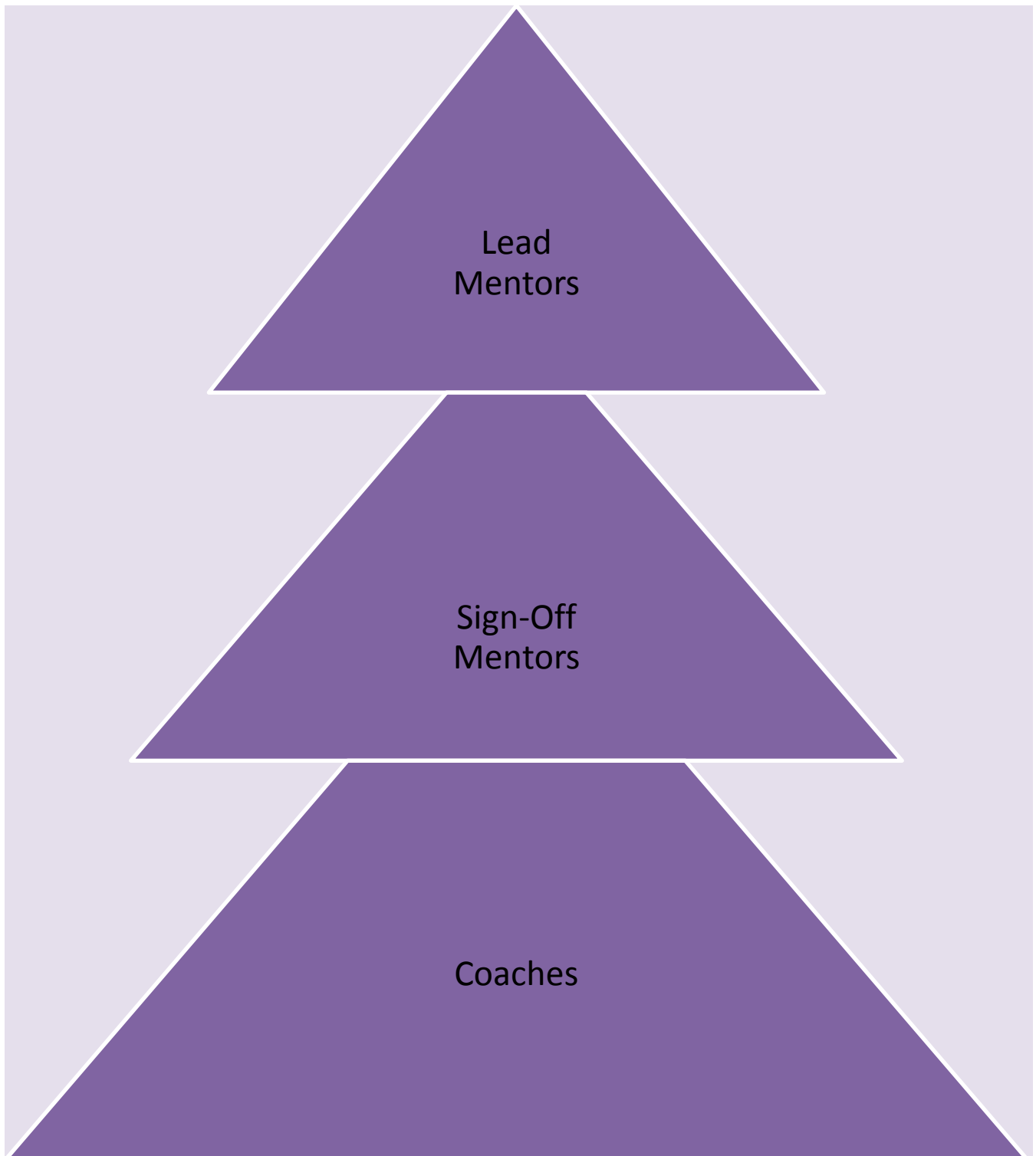
To date these concerns have been continually and consistently reflected in the wider literature, with no solution identified.

Valuing mentors by effectively supporting them is critical. O'Malley et al (2000) assert that in order to fulfil their role, mentors need to receive psychosocial, academic and practical support by their organisation. The introduction of a 'Lead Mentor' role in clinical areas to co-ordinate and facilitate practice learning, support sign-off mentors in decision making, promote an environment conducive to practice education and monitor the quality of mentorship and coaching would promote such value.

We would recommend the 'Lead Mentor' in practice environments to be a sign off mentor, currently in practice, who has demonstrated excellence in the mentorship role and is capable of role modelling the skills necessary for effective mentorship. Initially these individuals may be identified using the Practice Assessment Moderation process employed by HEIs to determine the quality of mentorship. A number of excellent mentors have already been identified through this process.

Role modelling of both effective mentorship practice and positive attitudes to student learning is important if mentors and coaches are to be socialised into viewing the practice setting as a learning environment. Being current practitioners will lend 'Lead Mentors' greater credibility in this regard, enabling them to facilitate knowledge and skills for assessment decisions, fashioned in the local context of practice settings within their organisations. Andrews and Chilton (2000) warn that if mentorship is viewed as a 'task' by some mentors this will impact on the student experience and de-value the role for other mentors. A 'Lead Mentor' would support their practice learning team of coaches and mentors, to develop and sustain a positive and supportive culture in the workplace. It is acknowledged that such a role would require investment and perhaps the introduction of the non-medical tariff for supporting students may be one way of funding this.

**Diagram 1. Framework to support students and mentors in practice**



**Coaches**

- All registered nurses who are not actively functioning as sign-off mentors or “Lead Mentor’s’ should be coaches, supporting learners to meet their goals and to embrace a culture of collective professional responsibility for developing all learners.

- Coaches would be responsible for liaising with sign-off mentors to establish the learning needs of the student and associated opportunities for learning. They would also be required to provide the sign-off mentor with feedback to inform the final assessment of the student, adding to the validity and reliability of the overall assessment.
- Students would be allocated to a team of practice based coaches and a sign-off mentor during each core placement.
- Coaches will have undertaken a workshop to prepare them to understand and employ appropriate teaching and learning strategies in the practice setting. This may be appropriate during the preceptorship period of their career.
- The skill of coaching could be included in the final year of pre-registration nursing courses to support their understanding of the role and the responsibility of all registered nurses for supporting learners in the workplace.

### **Sign-Off Mentors**

- All mentors who are currently on the live-mentor register will be required to become a sign-off mentor and all future mentors will be sign-off mentors.
- Sign off mentors would be available 40% of the pre-registration student placement (as per SLAiP requirement) and responsible for directing / supervising the student learning experience and the assessment of the student.
- Sign-Off Mentors would be responsible for work based teaching and assessment of mentorship students and will discuss final assessment decisions with the 'Lead Mentor'.
- Sign-off mentors will be required to alert the 'Lead Mentor' of any pre-registration student or mentorship student who is at risk of failing the practice element of their course, at the formative stage of their practice assessment.

### **'Lead Mentors'**

- 'Lead Mentors' would be ambassadors for practice learning, promoting an educational environment, role modelling values that reflect the NHS Constitution and monitoring the quality of coaching and mentorship in their area.
- 'Lead Mentors' would be on the live mentor register (with sign-off status), currently in practice and have been deemed to provide quality mentorship. (In the future a Masters level Mentorship Module may also be a pre-requisite).

- ‘Lead Mentors’ would act as advisors to support sign-off mentors in assessment decisions of pre-registration students (where requested).
- ‘Lead Mentors’ would be responsible for confirming the assessment decisions of mentors for students undertaking the mentorship course. This would mitigate against bias in the assessment process where student mentors are being assessed by colleagues.
- ‘Lead Mentors’ would be responsible for liaising with lead education managers in their organisation, alerting them to those students at risk of failing the practice element of the mentorship course.
- ‘Lead Mentors’ would advise sign-off mentors in their preparation for triennial review.
- ‘Lead Mentors’ will identify and support the development of coaches deemed to be suitable candidates for mentorship preparation programmes.

## 11. Limitations

Whilst the strength in this project is the extent of the validation of findings between the different groups of participants, there also some limitations recognised.

Accessing those staff who were no longer active mentors or had been unsuccessful in completing the mentorship course proved to be an insurmountable challenge. With no responses from any of the staff within these groups, it remains unknown why they had chosen to withdraw from mentorship or, for those who were unsuccessful in the mentorship course, the impact of this on their views of mentorship and subsequent career progression.

The survey questionnaire response rate of the original target population was also disappointing at 8%. This may be reflective of the stress and lack of time that participants in the study reported as a feature of mentorship. The same applies to the individual interviews of qualified mentors, where only one of twelve staff invited to participate agreed to do so.

Whilst it did not appear evident at the time of interview, we also acknowledge that student mentors who agreed to participate in the focus group sessions may have tempered their responses as they had not completed their course at that stage, with elements of assessment outstanding. To minimise any concerns that student mentors may have had about reporting their experiences to course leaders, the project leads, neither of whom are responsible for the delivery of any aspect of the mentorship course, undertook the focus group interviews.

## 12. Conclusion

It is evident from this study that mentorship is a rewarding experience for most participants, with numerous benefits for those undertaking this role. Many considered it to be a privilege to mentor students, shape the future workforce, regulate the profession, learn from students and share their knowledge and experience; all of which brought a deep sense of job satisfaction. The appreciative enquiry approach brought many of the positive elements of mentorship to the fore and allowed us to see how fulfilling this responsibility can be. However, so strong was the view that this role requires considerable support, recognition of its value and action around the tensions that have overshadowed the role, that it is clear to see why mentors may consider relinquishing this aspect of their professional practice. Further work is required to engage those mentors who have consciously chosen to abdicate their role and responsibility as a mentor to establish the actual reasons for this.

With many viewing mentorship as a task, consideration of an alternative and robust framework of support is required. The overwhelming view of the participants in this study was that the education of future colleagues is every registered health care professional's responsibility and that the workload must be shared, if it is to be sustained. The proposal of coaching teams, sign-off mentors and 'Lead Mentor's may appear radical, but to ignore the stress and emotional impact that mentors report to be the norm, questions our connection with the values of the NHS Constitution. If the current workforce feels valued, the future workforce will reap the benefits and this sense of value may even impact on their delivery of care to vulnerable patients.

Creating an environment that is considered as important educationally as it is clinically, requires investment of time, finance and effort. It may take some time to achieve the parameters of the proposed framework but this is not insurmountable with effective partnership working, utilisation of the existing infrastructure and perhaps exploring other potential uses of existing finance.

It is clear that making the education of the future workforce an attractive and intrinsic aspect of the role of every nurse and midwife will require action. This will present new and exciting opportunities to rethink current approaches to practice learning. The commitment of mentors in this study to their role is unequivocal. This must be harnessed and further recognised with a concerted effort to make changes which manifest the value of this role and the investment of all towards this end.

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### 13. References

Andrews, M. and Chilton, F., 2000. Student and mentor perceptions of mentoring. *Nurse Education Today*; 20, 555–562.

Black, S., 2011. Being a mentor who fails a pre-registration nursing student in their final placement: understanding failure. PhD thesis, unpublished.

Bray, L. and Nettleton, P., 2007. Assessor or mentor? Role confusion in professional education. *Nurse Education Today*, 27(8) 848-855.

Bushe, G. E., 2007. Appreciative inquiry is not (just) about the positive. *OD Practitioner*, 39, (4) 30 – 35.

Clwyd, A. and Hart, P. 2013. A review of the NHS complaints system: Putting patients back in the picture. [online] Available at:

<[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/255615/NHS\\_complaints\\_accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf)>. [Accessed 11.4.14]

Cooperider, D.L. and Whitney, D., 2005. *Appreciative inquiry: a positive revolution in change*. San Francisco: Berrett-Kohler Publishers Inc.

Department of Health, 2011. Delivering efficiency savings in the NHS. [online] Available at:

<[http://www.nao.org.uk/wpcontent/uploads/2011/12/NAO\\_briefing\\_Delivering\\_efficiency\\_savings\\_NHS.pdf](http://www.nao.org.uk/wpcontent/uploads/2011/12/NAO_briefing_Delivering_efficiency_savings_NHS.pdf)>. [Accessed 11.4.14]

Department of Health, 2013. *The NHS Constitution for England*. [online] Available at:

<[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/170656/NHS\\_Constitution.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf)>. [Accessed 18.4.2014]

Department of Health, 2012. *Compassion in practice. Nursing, midwifery and care staff our vision and strategy*. [online] Available at:< <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>> [Accessed 18.4.2014]

Dixon-Woods, M, Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P. and West, M., 2013. Culture and Behaviour in the English National health Service: Overview of lessons from a large multi method study. *BMJ Qual Saf* 2013;0:1–10. doi:10.1136/bmjqs-2013-001947

Donaldson J. and Carter D., 2005. The value of role modelling: perceptions of undergraduate and diploma nursing (adult) students. *Nurse Education in Practice* 5, 353–359.

Duffin, C., 2014. Only one in seven nurses happy in their job. Nursing Standard. Vol 28,(24 ) 7.

Duffy K , 2003. Failing students: a qualitative study of factors that influence the decisions regarding assessment of students' competence in practice. Caledonian Nursing and Midwifery Research Centre, Midwifery and Community Health, Glasgow Caledonian University.

Francis, C. 2013. The Mid Staffordshire NHS Hospital Trust public enquiry. [online] Available at:< <http://www.midstaffspublicinquiry.com/report> >. [Accessed 18.4. 2014].

Gidman,J., McIntosh A., Melling, K. and Smith, D., 2011.Student Perceptions of support in practice. Nurse education in practice, Vol 11, 351-355.

Glasper, A., 2012. Maintaining nursing mentor skills in a climate of skill mix austerity. British Journal of Nursing, Vol 21, (6), 370-371.

Gray M.A. and Smith L.N., 2000. The professional socialization of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. Journal of Advanced Nursing 29, 639–647.

Hasson,F, McKenna, H. and Keeney,S., 2013.Perceptions of the unregistered Health care workers role in pre-registration Nurses clinical Training. Journal of Advanced Nursing. Vol 69 (7) 1618-1629.

Heaslip, V. and Scammel, J.,2012. Failing underperforming students: The role of grading in practice assessment. Nurse Education in practice 12 95-100

Hurley, C. and Snowden, S.,2008. Mentoring in times of change. Nursing in critical care 13 (5) 269-275.

Lawson, L., 2011. CPD for mentors: creating a portfolio. Nursing Times; 107: 21, 15-18.

MacLaren, J.,2012. Inside mentoring relationships: influences and impacts on mentorship learning for acute care nurses in the NHS. Unpublished PhD thesis, Institute of Education, University of London.

McKenna, H., Thompson, D. and Watson, R., 2007.Healthcare assistants-An Oxymoron? International Journal of Nursing studies. Vol 44(8) 1283-1284



Melia,,K., 1987.Learning and Working. London. Tavistock

- Milner, J. and O'Bryne, P., 1986. The impact of failing students on tutors. Social Work Education. Vol. 6 (1), pp.21-23.
- Moseley, L. & Davies, M., 2008. What do mentors find difficult?, *Journal of Clinical Nursing*, 17, 1627-1634.
- Murray, S. C. and Williamson, G. R., 2009. Managing capacity issues in clinical placements for Pre registration Nurses. *Journal of Clinical Nursing* 18(22)3146-3154.
- Myall, M., Levitt-Jones, T. and Lathlean, J., 2008. Mentorship in Contemporary practice the experiences of nursing students and practice mentors. *Journal of Clinical Nursing* 17(14)1834-1842.
- Nursing and Midwifery Council, 2008. The Code: Standards of conduct, performance and ethics for nurses and midwives. NMC, London. c
- Nursing and Midwifery Council, 2008. Standards to support learning and assessment in practice. .NMC, London.
- O'Driscoll M.F., Allan H.T. and Smith P.A., 2010. Still looking for leadership – who is responsible for student nurses' learning in practice? *Nurse Education Today* 30(3), 212–217.
- O'Malley, C., Cunliffe, E., Hunter, S., & Breeze, J., 2000. Preceptors in practice. *Nursing Standard*, 14(28), 45-49.
- Ousey, K., 2009. The socialization of student Nurses. The role of the Mentor. *Learning in Health and Social Care*. Vol. 8 (3) 175-184.
- Pearcey P., 2008. Shifting Roles in Nursing - Does Role Extension Require Role Abdication? *Journal of Clinical Nursing* 17, 13.
- Phillips T., Schostack J. and Tyler J., 2000. Practice and Assessment in Nursing and Midwifery: Doing it for Real. Researching Professional Education Series no. 16. ENB, London.
- Ramesh, R., 2013. NHS will face 30 billion funding black hole by 2020. [online] Available at: <<http://www.theguardian.com/society/2013/jul/05/nhs-face-funding-gap-2020>> [Accessed 11.4.2014]



- Royal College of Nursing, 2013. Specialist nursing in the UK. [online] Available at: <[http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0018/501921/4.13\\_RCN\\_Factsheet\\_on\\_Specialist\\_nursing\\_in\\_UK\\_-\\_2013.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0018/501921/4.13_RCN_Factsheet_on_Specialist_nursing_in_UK_-_2013.pdf)> [Accessed 15.4.2014]
- Royal College of Nursing, 2014. More than just a number. March 2014, Special report. [online] Available at:<[http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0007/564739/004598.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0007/564739/004598.pdf)>. [Accessed 11.4.14]
- Robison, S., Cornish, J., Driscoll, C., Knutton, S., Corben, V. and Stephenson, T., 2012. Sustaining and managing the delivery of student nurse mentorship: Roles, resources, standards and debates. Report for the NHS London 'readiness for work' programme. National Nursing Research Unit, Kings College London
- Rutkowski, K ,2007. Failure to fail; assessing nursing students' competence during practice placements. Nursing standard 22 13 35-40
- Smith, J., 1995. *Semi-structured interviewing and qualitative analysis* (Ch.2), cited in Smith, J, Harre, R & Van Langenhove, L (Eds) *Rethinking methods in psychology*. London: Sage Publications.
- Teatheredge, J., 2010, Interviewing students and qualified nurses to find out what makes an effective mentor. Nursing Times, 7 (48) 19-21.
- Webb, C., Shakespeare, P., 2008. Judgements about mentoring relationships in Nurse education. Nurse education Today, Vol 28, 563-571.
- Willis Commission, 2012, Quality with Compassion: the future of nursing education. Royal College of Nursing, London.
- Wroten, S. and Waite, R., 2009. A call to action: mentoring within the nursing profession- a wonderful gift to give and share. Association of Black Nursing Faculty Journal, Vol. 20 (4) 106.

# APPENDIX 1: EXAMPLE OF QUESTIONNAIRE FOR ACTIVE 'LIVE' MENTORS

|  |                       |  |   |  |                              |   |   |  |  |  |  |  |
|--|-----------------------|--|---|--|------------------------------|---|---|--|--|--|--|--|
|  <b>Anglia Ruskin University</b><br>Cambridge Chelmsford Peterborough   |                       |  |   |  <b>University of Essex</b> |                              |   |   | <b>Personal Code</b><br><br>Please provide a personal reference number in the blank boxes below. Make a note of this reference number and quote it in correspondence if you later wish to withdraw from the project. |  |  |  |  |
| <h1>Exploration of Mentorship Experience</h1>  |                       |  |   | C  | H                            | U | F | T  |  |  |  |  |
|  |                       |  |   |  |                              |   |   |  |  |  |  |  |
| <p align="center"><b>Please return the completed questionnaire in the SAE provided.</b></p> <p align="center"><b>Completion and return of this questionnaire will be indicative of your consent to participate in this project.</b></p> <p align="center"><b>Confidentiality will be maintained throughout this project and your data will not be identifiable</b></p> |                       |  |   |  |                              |   |   |  |  |  |  |  |
| <b>Please tick a box to indicate the setting in which you are currently employed</b>   | Hospital              |  |   |  | Community                    |   |   |  |  |  |  |  |
|  |                       |  |   |  |                              |   |   |  |  |  |  |  |
| <b>Please tick to indicate the band post that you are employed in</b>  | 5                     |  | 7 |  | Other (Please specify)       |   |   |  |  |  |  |  |
|  | 6                     |  | 8 |  |                              |   |   |  |  |  |  |  |
| <b>Is your employment Full-time or Part-time?</b>  | Full Time             |  |   |  | Part time                    |   |   |  |  |  |  |  |
| <b>Please tick a box to indicate the credit level of the mentorship course undertaken.</b>   | 0 Credit              |  |   |  | 30 Credit                    |   |   |  |  |  |  |  |
|  | 15 Credit             |  |   |  | Don't Know                   |   |   |  |  |  |  |  |
| <b>How long have you been mentoring learners as a qualified mentor?</b>  |                       |  |   |  |                              |   |   |  |  |  |  |  |
| <b>Please tick a box to indicate your Field of health care.</b>  | Adult Nursing         |  |   |  | Midwifery                    |   |   |  |  |  |  |  |
|  | Child Nursing         |  |   |  | Operating Dept. Practitioner |   |   |  |  |  |  |  |
|  | Mental Health Nursing |  |   |  | Other                        |   |   |  |  |  |  |  |
| <b>Please tick a box to indicate the band that represents your age.</b>  | 20-29 years           |  |   |  | 40-49 years                  |   |   |  |  |  |  |  |
|  | 30-39 years           |  |   |  | 50-59 years                  |   |   |  |  |  |  |  |
|  | 60-69 years           |  |   |  |                              |   |   |  |  |  |  |  |

1. Please list 3 support mechanisms that you access and receive from your managers in your role as a mentor.

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

2. Please tick to indicate which methods of support you access and receive from the university when undertaking the mentorship role.

|                       |                          |   |                          |       |
|-----------------------|--------------------------|---|--------------------------|-------|
| Link lecturer         | <input type="checkbox"/> | Education Champion                                | <input type="checkbox"/> | Other |
| Annual mentor updates | <input type="checkbox"/> | Mentor Portal<br>(University website for mentors) | <input type="checkbox"/> |       |

3. Please tick to indicate the type of support you receive from your colleagues when acting as a mentor.

|  |                          |
|--|--------------------------|
| Discuss opportunities for learning           | <input type="checkbox"/> |
| Support with assessment decisions            | <input type="checkbox"/> |
| Provide mentor 'cover' when you are on leave | <input type="checkbox"/> |
| Other (Please describe):                     | <input type="checkbox"/> |

4. Please tick to indicate your reasons for undertaking the mentorship role.

|                             |                          |                           |                          |
|-----------------------------|--------------------------|---------------------------|--------------------------|
| Personal career progression | <input type="checkbox"/> | Want to be a mentor       | <input type="checkbox"/> |
| Requirement of employer     | <input type="checkbox"/> | Enjoy learning / studying | <input type="checkbox"/> |
| Other (Please describe):    |                          |                           |                          |

5. In what ways do you feel that you have developed as a mentor since completing the course?

6. On a personal level, what motivates you to continue to support learners in your role as mentor?

7. Please tick to indicate how you think the role of mentor is viewed by staff in your organisation.

|            |  |                                     |
|------------|--|-------------------------------------|
| Positively |  | Please provide reasons for response |
| Negatively |  |                                     |
| Neither    |  |                                     |

8. How do you currently view the role of the mentor?

9. In your view should all registered health care professionals be mentors? Please tick to indicate your response.

|     |  |   |
|-----|--|---|
| Yes |  | Please provide reasons for your response: |
| No  |  |   |

10. How did the mentorship course fit into your priority for CPD activity and your career progression plans?

11. Please list 5 key words / terms that sum up your personal experience of mentoring students.

\_\_\_\_\_

\_\_\_\_\_

13. In your view, what are the advantages or disadvantages of undertaking the role of mentor?

| Advantages | Disadvantages |
|------------|---------------|
|            |               |

14. If a colleague asked you for advice when considering applying for the mentorship course, you would say.....

.....

.....

.....

15. Is there anything else you would like to tell us about your experience of the mentorship role?

Thank you for taking the time to complete this questionnaire.