

# Standards for Mentoring Programmes & Schemes

## Introduction

Coaching and mentoring are important for personal and professional development [1]. In the UK, a number of mentoring schemes exist within Paediatrics, however there is considerable variation between individual schemes/provision.

The aim of this document is to promote and ensure best mentoring practice within Paediatrics in the UK, using a framework of standards that are consistent in values and principles yet flexible in adapting to local demand, need and resources.

The document also allows mentoring provider organisations to monitor and align themselves with these standards, ensuring benchmarking against best practice and recognition in delivering high quality mentoring.

The standards have been developed based on:

- a literature review identifying evidence for good mentoring practice;
- a survey, with subsequent thematic analysis of comments, on knowledge and experience of mentoring amongst paediatricians in the UK.

## RCPCH Standards

The RCPCH standards for mentoring programmes are a set of 6 principles upon which good practice may be based, and include the following:

- ✓ Mentorship available to all
- ✓ Processes for selection and matching
- ✓ Effective and appropriate training
- ✓ Safety and supervision
- ✓ Evaluation and quality assurance
- ✓ Ongoing training, review and accreditation.

## **Mentorship available to all**

- Participation in mentoring schemes should be accessible to all individuals, at any stage of their career. Mentoring is a key tool for personal and professional development [1] with a range of benefits described for and by mentees, mentors and their organisations. Although mentoring has been shown to have particular benefit at times of difficulty [2], it should not be limited to those who are struggling, but instead be used as a tool to promote fulfilment of potential for all [3].

- Participation in mentoring schemes should be voluntary. Voluntary participation is positively related to rewarding experiences [3] and is likely to lead to greater programme engagement. If participation in the mentor-mentee relationship is not chosen voluntarily, then the mentoring effect can become negative [4].

### **Processes for selection and matching**

- Mentee input into the pairings is strongly encouraged. There is evidence that mentee input into the matching process is associated with greater mentorship quality [5].
- Mentees should be matched to mentors who are independent of their appraisal process so as to avoid risks of mentor bias during assessments, confidentiality breach and role confusion [6].
- There should be a process for recognising mentoring relationships that do not work or do not meet the needs of the mentee, and for reassigning the participants, if they wish.

### **Effective and appropriate training**

- Effective mentorship extends beyond simply sharing one's knowledge or expertise; skills must be taught to enable mentors to work effectively [7]. Therefore all schemes should provide well-designed training for mentors as part of their programme [8, 9].
- All participants and stakeholders should understand the intended objectives, benefits and outcomes of the programme.
- All mentors must understand the concept of mentoring and should ideally receive face-to-face training in knowledge, skills and behaviours they need to apply in their roles as mentors. They must practise within the GMC 'Good Medical Practice' ethical framework [10] and understand the importance of confidentiality and its limits.
- All mentees should understand the concept of mentoring and their role as a mentee.

### **Safety and supervision**

- Participants must be adequately supported throughout the programme.
- Mentors must be regularly supervised (either through 1:1 supervision or peer supervision) to ensure:
  - safe and high quality practice
  - self-reflection on their practice
  - the development of new approaches and learning in order to be more effective with mentees.

- Referral pathways for doctors in need should be clear to all mentors.
- Programme co-ordinators should be readily available for concerns and queries, including confidential advice.

### **Evaluation and quality assurance**

- Mentoring programmes must be evaluated regularly and appropriately to:
  - Identify problems with individual relationships
  - Make timely adjustments to the programme
  - Provide meaningful cost-benefit and impact analyses
  - Ensure RCPCH standards continue to be met.

### **Ongoing mentor training, review and accreditation**

- Learning support for mentors should be available throughout their involvement in the programme.
- Ongoing training should provide opportunities:
  - to identify gaps in skills
  - for structured reflection
  - to build a community of practice, thereby providing an additional layer of peer support
  - for formal individual accreditation.
- Mentoring activities should be included within the mentor's scope of practice for appraisal and revalidation purposes. This will provide an opportunity for them to reflect on their performance in this area and to demonstrate up-to-date knowledge and skills and/or identify the need for additional support.

The RCPCH Mentoring Working Group drew up broad initial themes for development of standards, based on their experience of running mentoring schemes and review of the relevant literature. Having identified paediatricians with relevant interest and experience via a 'scoping email' sent to all paediatric trainees, SAS doctors and consultants in the UK, feedback and comments were sought to enable further development of these themes.

The following is a summary of the thematic analysis of the responses.

## **(A) Broad Principles**

### **Mentoring should be available to all**

The vast majority of respondents felt that participation in mentoring schemes should be voluntary, but with emphasis on accessibility for all. There was a recognition that need for mentoring will vary between individuals and may also vary over time.

*[It should be] entirely optional, but open to all to participate. There are enough compulsory parts of training already. However, in our deanery we found that when offered the chance to be mentored, most ST1s were keen (East Midlands)*

There were examples of schemes where participation was provided by default, and some respondents felt that mentoring should be integrated into existing support structures.

*[It has been] automatic for all ST1s to have a mentor in Wessex for the last 2 years (Wessex)*

### **Mentoring is potentially of benefit to all**

Although it was acknowledged that mentoring would be particularly useful for specific groups of doctors who are vulnerable or in difficulty, the majority of respondents felt it should not be limited to these groups, and would be of benefit to all doctors in ensuring the opportunity to develop their potential and achieve their goals at any stage of their career.

*It is particularly offered to those struggling with exams, eg as a strategy by their educational supervisor/at ARCPs (Wales)*

*For example, offering mentoring to any trainees who make an inter-deanery transfer during their training (East Midlands)*

*I feel it would be best to not associate it with certain 'needs or difficulties' to avoid attaching a certain stigma to mentoring. It should be seen as a positive scheme with benefits to all trainees, not those with specific needs (London)*

## **The mentoring relationship**

When asked to consider the relationship between mentor and mentee in terms of grade and experience, the majority favoured senior to junior mentoring relationships. However, there were positive examples of peer-to-peer mentoring relationships and schemes, and also acknowledgement that inter-disciplinary mentoring may be useful.

*All of my mentors were senior to me. I find their experience valuable, and that they are able to provide guidance in both career & general issues as they arise (region not given)*

*[Our scheme is ...] senior to junior at present - ST1s matched with consultants who have volunteered to take part in the scheme (Wessex)*

*We felt that peer mentoring (ST2-3 mentoring ST1s) was suitable to our trainees' needs ... the mentor scheme has facilitated trainees in supporting each other through exams, eg study teams, resource sharing (East Midlands)*

*Senior to junior and, in a perfect world, inter-disciplinary (Wessex)*

*Age, grade or status is not relevant for (the) mentor-mentee relationship (SAS personal)*

Respondents generally felt that access to mentoring should be through a non-competitive application process. However, it was acknowledged that resource limitations may require a process which limits entry and assures commitment.

*Mentoring should be about support/role-modelling – it should not be 'competitive' (London)*

## **(B) Features of current mentoring schemes**

### **Matching**

Many respondents felt that it was important for the mentee to have some choice of mentor. However, potential advantages of randomly matching mentees and mentors were also highlighted, and this was felt to be a more practical option.

*We gave both mentees and mentors a short questionnaire to complete giving details of their interests in and out of work to aid matching (Scotland)*

*I think it is best for mentees not to 'pick' their mentor as it may become more about certain personalities and may not be a balanced process (Anon)*

When asked to consider whether mentors and mentees should be matched within or outside an organisation and speciality, responses were variable:

*I think for a wider scheme it is not necessary to match within an organisation, but for logistical reasons probably sensible to match within geographical area (St Georges)*

## Appendix 1: Thematic Analysis of 2013 Mentoring Survey Responses

*Needs to be specialty driven. Outside organisation is better allowing for more honesty (region not given)*

*We matched within specialty and within region (East Midlands)*

*From personal experience, true mentoring works better if you don't know the person that well - no pre-conceived ideas (Wessex)*

The majority of respondents favoured matching within region for logistical reasons, although this was not necessarily perceived to be essential for a successful mentoring relationship.

### **Training for mentors**

Not all existing schemes provide or require compulsory training for mentors. However, the importance and value of face-to-face training were strongly acknowledged. Some schemes are currently providing written guidance only.

*Our first training session for mentors will be in face-to-face small group session led by the Deanery (Wales)*

*Mentors are encouraged to attend a face-to-face training workshop (ST1 Scotland scheme)*

*A small number have attended a 4 day structured mentoring course (Wessex)*

*A standard course and then ongoing training. The mentors should have a 'mentor' as well – probably a shared supervisor (Wessex)*

*Ongoing 'face-to-face' sessions once a year. Ongoing training and active learning is essential to catch up with dilemmas posed during sessions (region not given)*

### **Training for mentees**

Preparation of mentees for the mentoring relationship is variable between existing schemes, but was noted to be important to ensure the understanding of the mentees and appropriate expectations of the mentoring process.

*An introductory session (face-to-face, online, e-learning or printed material) must be available for mentees (region not given)*

### **Number of meetings/duration/location**

The majority of mentor/mentee pairings were introduced via email in existing schemes.

Some existing schemes offered little structure/guidance on when or how regularly to meet, though others did offer general guidance. A number of schemes run social events or awaydays to promote relationships within the scheme. In many schemes,

## Appendix 1: Thematic Analysis of 2013 Mentoring Survey Responses

a limited duration is suggested, often with the option to extend if both parties are in agreement.

*Advised to meet about once a fortnight but not enforced and allowed to be quite flexible with this – ie more towards exam time (Wales)*

*We have outlined default that will change mentor after 1 year period, but can opt to keep existing pairings if desired (ST1 Scotland scheme)*

### **Contracting**

A number of respondents highlighted the importance of contracting in a mentoring relationship.

*At the introduction a set of rules must be agreed, including an opt-out clause if things are not moving in the right direction*

### **Safeguarding**

Safeguarding procedures were noted to be crucial for both mentors and mentees.

*Support should be available to the mentors. It should be made clear at the start of the session that everything is confidential; however, should anything arise that is out of the mentor's remit (such as depression) then a referral will be made to the correct person. This referral pathway for doctors in need needs to be clear to the mentors (Wessex)*

*Emphasis was placed on safety/well-being of trainees, who were provided with clear pathways to follow if issues arose. Confidentiality was encouraged, but with the proviso that if mentors became aware of something that risked the safety of their mentee/their patients, they should seek advice from the Training Programme Director (only if the mentee refused to seek formal help themselves). Mentors were to provide informal friendly guidance only, and advised to signpost the mentee to their Educational/Clinical Supervisor/Training Programme Director if any significant issues were raised eg health concerns, bullying, academic issues, clinical incidents. Mentor Scheme Coordinators (ST3 trainees) were made available to contact for confidential advice about any issues, although this was never required in practice (East Midlands)*

The need for supervision of mentors and clear pathways for both mentors and mentees to access support and raise queries and concerns were universally highlighted by respondents.

### **Structured reflection**

Not all existing schemes actively promote or require structured reflection from participants.

*I think if it's too structured you take away the point of it and turn it into a tick box exercise. Reflection would happen naturally in these sessions (Wessex)*

However, the majority felt structured reflection was essential in the mentoring process.

*There should be an element of reflection as part of ongoing training, possibly including feedback from the mentor. I have asked mentees for feedback in the past and found it useful (London)*

*Reflection and review would be vital to improve and allow knowledge gathering for all parties (region not given)*

### **Data collection**

Not all mentoring schemes collected data and feedback. A variety of methods are used, including pre- and post-scheme questionnaires and structured interviews for participants.

### **Sustainability**

Many paediatric mentoring schemes are relatively new, so there was limited information available regarding long-term sustainability. However several strategies for ensuring sustainability were suggested, eg:

- Organise multiple trials and after a set time try to focus on key successes and areas for improvement. What can we all learn from each other?
- Advertising and promotion by college and LETB
- Analysis of data and feedback and presentation at key meetings
- If good evidence of success then confirm its place in curriculum and in revalidation.

*This has not been an issue in our area, it is now a 'tradition' in our local deanery and is popular with mentors and mentees alike (East Midlands)*

### **Accreditation**

Despite the huge enthusiasm for mentoring and large number of successful informal schemes, there is very little formal accreditation currently in place for paediatric mentoring schemes in the UK. Respondents were aware of this and enthusiastic about further training and recognition.

## **(C) Conclusion**

In conclusion, schemes varied considerably in detail depending on local/regional need, infrastructure and demand. Nevertheless, the principal themes emerging were: mentorship available to all; effective and appropriate training; safety and responsible mentoring; and accreditation of skills.

**Note:** A small number of quotes may have been adapted slightly for editorial purposes – the original sense has not been changed.



## Reference List

- 1 Department of Health (2004) 'Mentoring for doctors: signposts to current practice for career grade doctors'.
- 2 Taylor C J, Houlston P, Wilkinson M (2012) 'Mentoring for doctors in difficulty', *Education for Primary Care*, 83, 27-29 (ref type: full journal).
- 3 Parise M R, Forret M L (2008) 'Formal mentoring programs: the relationship of program design and support to mentors' perceptions of benefits and costs', *Journal of Vocational Behaviour*, 72(2), 225-240 (ref type: full journal).
- 4 Mahood S, Rojas R, Andres D et al (1994) 'Educational contracts in family medicine residency training', *Can Fam Physician*, 40, 549-6.
- 5 Allen T D, Eby L T, Lentz E (2006) 'Mentorship behaviours and mentorship quality associated with formal mentoring programs: closing the gap between research and practice', *J Appl Psychol*, 91(3), 567-78.
- 6 Taherian K, Shekarchian M (2008) 'Mentoring for doctors: do its benefits outweigh its disadvantages?', *Med Teach*, 30(4), e95-e99.
- 7 Gagen L, Bowie S (2005) 'Effective mentoring: a case for training mentors for novice teachers', *Journal of Physical Education, Recreation and Dance*, 76(7), 40-45 (ref type: full journal).
- 8 Eisen S, Sukhani S, Brightwell A et al (2014) 'Peer mentoring: evaluation of a novel programme in paediatrics', *Arch Dis Child*, 99(2), 142-6.
- 9 Garr R O, Dewe P (2013) 'A qualitative study of mentoring and career progression among junior medical doctors', *International Journal of Medical Education*, 4, 247-52.
- 10 General Medical Council (2013) 'Good Medical Practice' (ref type: online source).

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