

**Evaluation (and related  
activities) of a NHS supported  
local delivery model for non-  
credit bearing Multi-professional  
Support for Learning and  
Assessment in Practice in  
Greater Manchester**



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**Final Report of the Tender from the University of Salford**

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## Executive Summary

### Background

HEE North West (HEE NW) is currently piloting for 12 months a partnership of Trusts within Greater Manchester to deliver non-credit bearing Multi-Professional Support of Learning and Assessment in Practice (MSLAP) programme in NHS, private, voluntary and independent settings under an agreement with the University of Bolton (UoB). Health Education England North West (HEE NW) have commissioned an evaluation of the model by the University of Salford School of Nursing, Midwifery, Social Work & Social Sciences (NMSWSS) to compare this model to different national HEE mentorship training delivery models and policies.

### Evaluation Objectives

Ethical approval was gained from the University of Salford to explore the following:

1. To examine and synthesise the evidence base regarding the similarities and differences of the mentorship policies and the different mentorship training delivery models in healthcare, on healthcare organisations and on mentors
2. To critically explore the experience of non-credit bearing Multi-Professional Support of Learning and Assessment in Practice (MSLAP) programmes in NHS, private, voluntary and independent settings under an agreement with the UoB from the perspectives of key stakeholders (mentorship students, UoB and in-house programme delivery team, North West Practice Development Network)
3. Provide the evidence for HEE NW of what works well or not so well and what can be transferred to enable a consistent approach to building mentorship capability, capacity and quality across Sustainability and Transformation Plans (STP) within the sub-region Method of delivery: report

### Evaluation Framework

A mixed methodology approach utilising literature review, an online survey questionnaire to mentors on the live register at University Hospital South Manchester, documentary analysis and interviews with key stakeholders provided the opportunity to critically explore the experience of the pilot programme from the perspectives of key stakeholders.

## Findings

The initial literature review undertaken demonstrated how timely the findings of this evaluation are and this is because there is very little robust evidence that informs delivery models for mentor preparation.

An exploration of professional policy for practice learning and assessment demonstrates that the Nursing and Midwifery Council (NMC)(2008) and General Medical Council (GMC)(2012, 2014) both utilise the term mentor whilst the Health and Care Professions Council (HCPC) (2014) favour 'placement educator'. The NMC are the most prescriptive with their mentorship preparation requirements offering a very clear developmental framework, with 8 identified domains as the core components (NMC 2008). Commonalities for mentorship development across the professions could include a programme content that focuses on:

- Facilitation of learning and teaching
- Evaluation of learning/ supporting and monitoring educational progress/ guiding personal and professional development
- Creating and maintaining an environment for learning
- Recognising the context of practice that ensures safe and effective patient care through training

Commonalities for mentor/placement educator development provides the platform for all professional groups to be represented at the Practice Educator workshop which is the update provided for healthcare professionals (excluding doctors and dentists) who mentor/support students. This workshop is currently co- facilitated by PEF and University Link lecturers.

An internet search applying search terms associated with non-credit bearing mentorship identified nine programmes available across the UK (England, Wales and Scotland). Further programmes were identified through use of professional networks. This list was not exhaustive acknowledging that the non-credit bearing model is becoming an increasingly popular and cost effective method of mentorship programme design for many universities.

Adopting purposive sampling techniques (Creswell 2007, Silverman 2010) resulted in the identification of a range of multi-stakeholder groups whose views were instrumental in understanding the realities of the pilot programme and for influencing the future way mentorship programmes are designed and delivered: mentorship students, UoB and in-house programme delivery team, North West Practice Development Network). Thematic content analysis provided the rigorous data analysis framework



whereby links were made between the empirical data and the claims made by the researchers and resulted in the identification of the following three themes: 1. Vision for the Pilot Programme; 2. The MSLAP Programme; 3. Programme Delivery Realities.

### The Pilot Model

UHSM hold a contract with UoB to deliver the in-house non- credit bearing mentorship programme and the programme is managed by University Hospitals South Manchester (UHSM) in-house programme team. The in-house programme team consists of five PEFs, two of these are the programme leaders. The programme is a UoB NMC validated programme. UHSM are contracted to deliver to a set number of students. The Trust can run the programme any number of times and at a time that best fits the Trust requirements.

The pilot model is an extension of the PEF led in -house MSLAP non-credit bearing programme that provides opportunities for Trusts with a smaller numbers of PEFs to offer non- credit bearing mentorship provision. The idea is that PEFs from these Trusts work in partnership as a larger in-house team at UHSM thus producing a programme delivery model that is both viable and sustainable for the multiple organisations that were previously seen as having unsuitable and unsustainable PEF infrastructures. Examples of these Trusts are

- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- Christie NHS Foundation Trust

This variation of the current contract between UHSM and UoB means that other pilot sites across Greater Manchester will consider the viability of the model for other universities and Trusts.

The pilot model is that UHSM become the lead healthcare institution in-house programme delivery team and develop and support the smaller PEF teams from the pilot healthcare organisations to contribute to the UHSM in-house programme. In return these PEFs will identify and send students from their Trusts onto the UHSM programme. There will also be places offered to students from the independent sector organisations, which will build the placement circuit outside the NHS and these students are identified by the North West Practice Development Network (NWPDN).

The pilot module includes the sharing of resources and curriculum validated by the NMC at the UoB. Support would come from the bigger team at UHSM, and UoB lead on the validation, quality assurance and moderation of the programmes.

### The Reality of the Delivery of the Pilot Model

Evidence from interviews with key stakeholders identified a shift from the original pilot programme delivery model. This resulted in two out of the three pilot Trusts changing their delivery model from the larger UHSM delivery model concept to delivering their own in house UoB NMC validated programme. The immediate challenge created for one Trust was delivering their in-house programme with fewer than the four PEFs identified by the UoB as the required number to deliver.

Stakeholders clearly identified the perceived advantages of the pilot programme:

- Notion that non- credit-bearing mentorship would be cost effective and would appeal to the multi-professionals and not just nurses
- Delivery of the in-house programme as opposed to attending a university
- Library resources and PEFs available on site
- Raised awareness of the in-house support and make use of the PEFs much more regularly than some of the more experienced mentors

Perceived advantages of the MSLAP programme and Pilot Programme for the healthcare organisation included:

- People (organisation) really valuing having an in-house programme available
- Organisation could not sustain or maintain the quality and number of mentors that they have without this approach to mentorship development
- Cost, however need to look at the cost of people delivering the programme, there are the unseen costs which are not mitigated for
- Targeted approach to student recruitment, which meet needs of the Trust
- Provide mentorship development for the different kind of nurse who may not access the university programme , i.e. Adaptation nurses

What emerged from the findings of this evaluation are the key processes for successful programme delivery:

- In-house programme delivery team infrastructure in place – at least four PEFs to deliver in-house programme

- Have a good PEF team and a team that has the necessary teaching qualifications along with NMC recorded teaching status (or appropriate evidence of mapping against these standards)
- PEF continuing professional development related to teaching and learning and innovative pedagogies
- Robust quality assurance policies and procedures that are applied and measured
- Funding for sustainability
- Identify the right resources from the outset, i.e. IT infrastructure and adequate rooms
- Workload delivery models to balance MSLAP with the existing PEF outcomes

Importantly, extracted from the evaluation are the challenges identified. Each is summarised together with a proposed improvement and final recommendation

### Challenges, Proposed Improvement and Recommendation

#### **Challenge 1:** *PEFs demonstrating the appropriate teaching qualifications and teaching skills required to deliver a quality programme*

Whilst not seemingly impacting on students (module evaluations are good), PEFs feel that they are not up to date with innovative pedagogies. Some PEFs provided evidence of their worries associated with not holding an appropriate teaching qualification and the impact of the quality of the programme delivery. The 2016-2017 Programme Plan, UHSM does not include any actions that provide the reassurance that PEFs continuing professional development needs will be met in the future. There is a lack of clarity regarding whose responsibility it is to ensure that PEFs have ample opportunity to update and develop their expertise (UoB or UHSM as in-house programme lead). A further challenge is the impact of the role of UHSM as lead team in preparing the smaller PEF teams to deliver the programme if they have not been provided with appropriate continuing professional development to enable them to fulfil the role.

**Proposed Improvement:** Whilst it is arguably the responsibility of individual PEFs to maintain their own professional development (NMC 2015) there is a need to ensure they are best placed to do so. PEF role in the delivery of the programme is synonymous with that of the teachers delivering the core programme at the UoB and it is ultimately the HEI that retains full responsibility in ensuring they have the correct qualifications and remain up-to-date in their teaching practice. Whilst the advertised programme cost per head of student is low, actual costs could be significantly higher if fully costed based on the required input from the validated HEI to ensure that PEFs have the most up to date teaching and learning theories to inform their teaching.

**Recommendation:** Contracting arrangements should clearly set out how on-going development will be addressed and by whom. Programme price should reflect the cost of development needs

**Challenge 2:** *Successful completion by student attending the programme and time spent marking*

The pass rate for the completion of the programme is low. Comparison of pass rates for UHSM for credit bearing and non-credit bearing programmes has not been made available. PEFs report on workload associated with the marking and second marking of the portfolio

**Proposed Improvement:** The 2016/7 Programme Plan for UHSM includes an action point relating to the need to improve the pass rates which have remained static at around 53% across cohorts however improved from September 15 cohort that was 31% ( B4 Enabling student development and achievement).

**Recommendation:** UoB to work with in-house programme team to develop the strategies to increase the pass rate. Re-consider the UoB process for PEFs marking/assessing the portfolio and rationale for second marker (pass/fail marking criteria)

**Challenge 3:** *Dilution of PEF outcomes and potential role conflict, stress and burnout due to the added MSLAP delivery role expectation*

PEFs report that the MSLAP roles takes somewhere in the region of 40% of their time within their existing role. This calls in to question their ability to ensure that they are still able to provide the same level of support to the placement areas within their remit. Further to this it is conceivable that this may cause a degree of stress or frustration on the part of PEFs who are juggling the competing role demands. Direct teaching is not traditionally part of the core PEF role and seems very different to the main focus of their existing job outline.

**Improvement:** Exploring and implementing a workload model that supports PEFs sustain the MSLAP teaching role whilst achieving their wider PEF outcomes could prevent role ambiguity and potential role burnout. UoB recognise that there may need to be a different delivery model whereby the university teach with PEFs in the Trusts but there will be an associated cost attached to this delivery model. The implications and impact on future PEF recruitment who are not comfortable with the delivery and assessment of the programme but have a desire to work within the PEF role requires consideration.

**Recommendations:** Develop the PEF infrastructure and consider the “hidden” PEF role and costs associated with the in-house programme and this should include fully understanding the impact of its facilitation on PEFs achieving the range of PEF outcomes. Consider making the MSLAP role an optional component to the PEF role and this should be recognised within the PEF job outline. Consider models for non-credit bearing preparation which mitigate against PEF role ambiguity and burnout. This is due to potential role dissonance

**Challenge 4:** *Adopting and monitoring UoB quality assurance procedures to ensure the credibility of the in-house programme*

Due to PEF changes there is the perception by one PEF team that the in-house programme has not been running as tight as it could have and the impact of this is providing a course that is less credible than a university equivalent: *It has to be remembered that the pilot is a university programme.*

**Improvement:** Whilst HEIs have clear quality assurance in relation to processes, for example, admission, application of mitigating circumstances, it is important that they are consistently applied to the in-house programme.

**Recommendation:** Adhere to the UoB Quality Assurance Procedures to ensure the ongoing credibility and quality of the programme

#### **Taken from the Final Report of the Tender from the University of Salford**

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## Background to the Requirement

The recently proposed health education funding reforms will increase the number of healthcare learners in training. At the same time there are increasing pressures on the continuing professional development (CPD) budget or Education for Workforce (EWT). Considering innovative and cost effective healthcare training delivery methods is a priority for Health Education England (HEE). They recognise the need to maximise opportunities which align to the Carter Review (2015), whilst maintaining and improving placement capability through mentorship developments. Required is the delivery of sustainable and continuous improvement in placement capability and quality aligned to HEE's Multi Professional Quality Assurance Framework (QAF).

Against this backdrop HEE North West (HEE NW) is currently piloting for 12 months a partnership of Trusts within Greater Manchester to deliver non-credit bearing Multi-Professional Support of Learning and Assessment in Practice (MSLAP) programme in NHS, private, voluntary and independent settings under an agreement with the University of Bolton (UoB). An evaluation of different national HEE mentorship training delivery models and policies compared to the intended outcomes of this pilot model of mentorship training is timely.

HEE NW have commissioned an evaluation of the model by the University of Salford School of Nursing, Midwifery, Social Work & Social Sciences (NMSWSS) to compare this model to different national HEE mentorship training delivery models and policies. This final report presented by NMSWSS establishes the learning of what works well. Recommendations are provided to guide further investment development, strategic planning, research and potentially other delivery models to inform implementation across other Sustainability and Transformation Plans (STP) footprints within Greater Manchester.

## Evaluation Approach

Realist evaluation applied to this study focused on the following key areas:

4. Expected outcomes of an innovation, for example, enhanced mentoring, preparedness for the mentorship role and the 'currency' of the person who is delivering/supporting the learning.
5. Mechanisms and processes by which expected outcomes are achieved and change is realised, such as modes of mentorship delivery, models of mentorship training, and ongoing models of support on completion
6. Influence of context in producing those outcomes

## **Application of the Evaluation**

Ethical approval was gained from the University of Salford to explore the following:

7. To examine and synthesise the evidence base regarding the similarities and differences of the mentorship policies and the different mentorship training delivery models in healthcare, on healthcare organisations and on mentors. Method of Measurement: literature search
8. To critically explore the experience of non-credit bearing Multi-Professional Support of Learning and Assessment in Practice (MSLAP) programmes in NHS, private, voluntary and independent settings under an agreement with the UoB from the perspectives of key stakeholders (mentorship students, programme delivery team): Method of measurement: document analysis, survey questionnaire and semi structured interview
9. Provide the evidence for HEE NW of what works well or not so well and what can be transferred to enable a consistent approach to building mentorship capability, capacity and quality across Sustainability and Transformation Plans (STP) within the sub-region Method of delivery: report

## **Evaluation Methodology**

### **Evaluation Framework**

To address the objectives of the study and to promote the robust evaluation methodology the following framework was applied:

#### **Literature Review**

- Document Analysis
- Focus Group or One to One Interview with key stakeholders
  - Sampling
  - Data Analysis
  - Findings
  - Report writing

## **The Literature Review**

A robust, iterative and multi-staged approach to literature searching was proposed in the tender document. Discussions with HEE NW following post award of the tender resulted in the scaling back of the literature review and instead focus on the exploration of stakeholder perceptions of the model



through conducting focus group, one to one interviews and self-report questionnaire. This would keep the evaluation to the original budget.

### **Approach to the Literature Review**

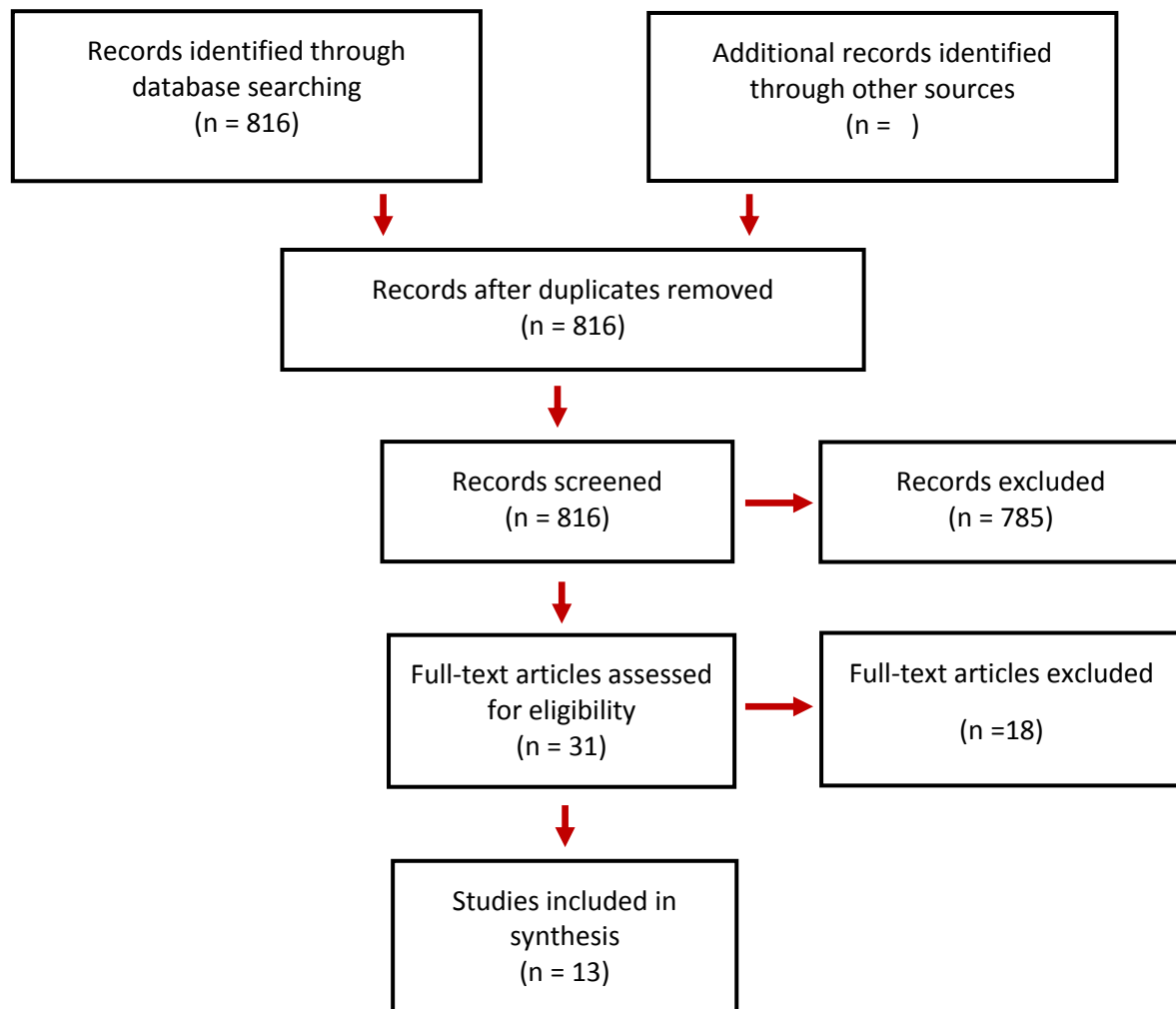
An iterative and multi-staged approach to literature searching was undertaken (Grant and Booth 2009) involving all team members in scoping this topic area and refining both the searches of electronic databases and the inclusion and exclusion criteria. Drawing on our experience of conducting a range of health and social care reviews, clear stages ensured the literature search was undertaken systematically including identifying key terms used by the database (see Table 1), deciding types of evidence to be examined, retrieving the evidence and evaluating it.

Searches identified health and social care perspectives with data also drawn from policies that support mentorship delivery models. The titles and abstracts of 791 records were retrieved for further analysis. The results of the search were reviewed by the whole evaluation team and fed back into the searching process. 31 full text articles were assessed for eligibility, from which 13 articles were included in the thematic analysis of qualitative data.

*Table 1: Search Terms*

- |   |
|---|
| <ul style="list-style-type: none"><li>• Model Mentors</li><li>• Mentoring models</li><li>• Nursing mentorship</li><li>• Evaluation Studies</li><li>• Kirkpatrick Training Evaluation</li><li>• Program Evaluation</li></ul> |
|---|

## Flowchart of Literature Search Process



## Compilation of Findings

*Table 2 - Compilation of Findings*

Author, Title and Journal	Context	Methodology	Key Findings	Themes
Champion C; Bennett S; Carver D; El Tawil K; Fabbro S; Howatt N; Noei F; Rae R; Haggart F; Arnaout A. (2015), Providing mentorship support to general surgery residents: a model for structured group facilitation. [Review] Canadian Journal of Surgery, 58(6):372-3	The University of Ottawa General Surgery Mentorship Program developed as a module-based group facilitation program to support inclusive personal and professional development of junior general surgery residents	Discussion paper	Group format provided an opportunity for both vertical and horizontal mentorship relationships between staff mentors and resident mentees.	Group format
Soklaridis S; Lopez J; Charach N; Broad K; Teshima J; Fefergrad M. (2015) Developing a mentorship program for psychiatry residents, <u>Academic Psychiatry</u> . 39(1):10-5	Evaluate a formal mentorship program for second-year psychiatry residents at the University of Toronto after the program's first year of implementation.	Ten mentees and ten Faculty mentors were interviewed by fellow second-year residents and an independent researcher, respectively, about their experiences in the program. Thematic analysis	3 themes: natural, flexible, and engaging matching process for mentors and mentees; Preference for geographic proximity between mentor and mentee workplaces; informal settings; Clear directions and expectations about the program's goals should be communicated, and That a forum for information sharing among mentors was needed.  Tangible recommendations to improve the process.	Communication programme goals  Matching mentor/mentee  Geographic proximity
Mayer A., Blair J., Ko M., Patel S., & Files J. (2014) Long-term follow-up of a facilitated peer mentoring program Mayo Clinic, USA, ISSN 0142-159X print/ISSN 1466-187X online/14/030260-7 © 2014 Informa UK Ltd.DOI: 10.3109/0142159X.2013.85811	Female medical school Faculty continue to lag behind their male colleagues in academic promotion and leadership positions  Mentoring plays an important role in career success of academic	Female instructors or assistant professors recruited to voluntarily participate in a facilitated peer mentoring program.  Recruitment occurred over 3.8 years between 2005 and 2009.	Participants achieved long-term improvement perceived mastery of academic skills.  Peer-reviewed publications, book chapters, abstracts, posters, and other academic activities increased when activities before the program were compared to those in the five years after program enrollment.	Peer mentoring  Peer groups  Shared academic interests  Increased academic activity

Author, Title and Journal	Context	Methodology	Key Findings	Themes
	<p>medical Faculty. New mentoring models such as peer mentoring have emerged</p> <p>Study aimed to evaluate the long-term impact of a facilitated peer mentoring program on academic achievements</p>	<p>Questionnaire to assess academic skill, career satisfaction, and self-efficacy was administered before program participation and</p> <p>Curriculum vitae reviewed retrospectively to tally peer-reviewed publications, other academic activities, and promotions.</p>	<p>At follow-up, participants reported positive perceptions of the program and 44% continued to work with their original peer mentor groups.</p> <p>Involvement in the facilitated peer mentoring program was associated with increased skills and academic activities for most participants.</p> <p>Future studies are needed to assess its applicability and success among various demographic groups in academic medicine.</p>	Increased academic productivity
<p>Levy AS; Pyke-Grimm KA; Lee DA; Palla SL; Naranjo A; Saulnier Sholler G; Gratias E; Maloney K; Parshankar F; Lee-Scott M; Beierle EA; Gow K; Kim GE; Hunger S; Smith FO; Horton TM. (2013) Mentoring in pediatric oncology: a report from the Children's Oncology Group Young Investigator Committee, Journal of Pediatric Hematology/Oncology. 35(6):456-61</p>	<p>A formal Mentorship Program within the Children's Oncology Group (COG) was established to pair young investigators (mentees) with established COG. NO publications describing and evaluating national mentorship programs in paediatric subspecialties embers (mentors).</p>	<p>Internal program evaluations were performed using surveys of both mentors and mentees. Responses were identified and analysed to determine the utility of the program by both participant satisfaction and self-reported academic productivity</p>	<p>Mentees were generally satisfied with the program. Mentor-mentee pairs that met at least quarterly demonstrated greater academic productivity than pairings that met less frequently. This formal mentorship program appeared to have subjective and objective utility for the development of academic pediatric subspecialists.</p>	Communication-meeting quarterly by mentor/mentee
<p>Jacobson, S. Sherrod, D, (2012) Models for Nurse Educators, <u>Nursing Science Quarterly</u>, 25(3) 279 – 284 [Journal article]</p>	<p>A consistent supply of competent and confident Faculty is essential to meeting the</p>	<p>Discussion paper</p>	<p>Paucity of research demonstrating mentorship frameworks or outcomes in nursing.</p> <p>Absence of articles with a focus on testing mentorship models.</p>	<p>Roles and responsibilities</p> <p>Professional obligation and</p>

Author, Title and Journal	Context	Methodology	Key Findings	Themes
	<p>growing demand for nurses.</p> <p>One way to ensure continuity among nurse educators is through Faculty mentorship.</p> <p>Little literature about nurse educator mentorship models, no research found that tested mentoring frameworks or strategies with nurse educators.</p> <p>The matriculation and retention of nursing Faculty requires diligence in the areas of practice, teaching, and scholarship.</p>		<p>Clear need exists for mentor program outcomes testing to identify what works and does not work in formal mentoring programs for Faculty.</p> <p>Mentor and mentee relationships promote Faculty retention, career development, and quality education.</p> <p>Knowledge, skills, and expertise shared through mentorship experiences are foundational and vital for new and junior Faculty.</p> <p>Universities and other institutions have recognized the value of mentor-mentee relationships and mentorship programs</p> <p>Release time, workload support, and financial resources required to foster development and growth of the mentor-mentee relationship.</p> <p>Nurse researchers need to develop and test models to add to the empirical body of knowledge and explore the impact of mentor-mentee relationships.</p> <p>Successful mentor-mentee relationships and programs help junior Faculty to meet the evolving demands of practice, teaching, and scholarship.</p>	<p>development recognition</p> <p>Interaction between mentor and mentee</p> <p>Positive outcomes for both mentee and mentor - transformational and transcending</p> <p>Congruency of knowledge and skills development for both mentee and mentor</p> <p>Barriers to effective mentoring : time constraints, lack of support, imbalance of expectations</p>
Johnson K., Hastings N., Purser P., Whitson., H. (2011)The Junior Faculty Laboratory: An Innovative Model of Peer Mentoring, <u>Academic Med</u> , December 86 (12): 1577–1582. [Journal article]	<p>Mentoring in academic medicine contributes junior Faculty success</p> <p>Traditional dyadic mentoring, involves one senior Faculty member and one junior protégé</p>		<p>Self-organized flexible dynamic peer mentoring model</p> <p>Advantages: Meets the evolving career development needs of its members; Adaptive curriculum to address challenges of time and competing demands; No consistent input from senior Faculty, facilitates discussion related to shared generational values; Facilitates collaborative research; Supports individual</p>	<p>Increased productivity</p> <p>Career satisfaction and development</p> <p>Opportunities for networking</p>

Author, Title and Journal	Context	Methodology	Key Findings	Themes
	<p>Sharing of knowledge, skills, and experiences among also contributes to the career development of junior Faculty.</p> <p>The Junior Faculty Laboratory, (JFL) has developed a self-organized, flexible, and dynamic peer mentoring model, activities determined by the real-time needs of members.</p> <p>Complements the dyadic mentoring relationship</p> <p>Now in its fifth year, the model has demonstrated success and sustainability.</p>		research projects and career development; Shares strategies for work/life balance	<p>Collegial relationship development</p> <p>Collaborative working</p> <p>Peer mentoring model</p>
Meinel F., Dimitriadis K., Philip Von der Borch P., Störmann S., Niedermaier, Fisch M. (2011), More mentoring needed? A cross-sectional study of mentoring programs for medical students in Germany, <u>BMC Medical Education</u> , 11:68	<p>Despite increasing recognition that mentoring is essential early in medical careers, little is known about the prevalence of mentoring programs for medical students.</p> <p>All medical schools in Germany studied regarding the</p>	<p>Definition of mentoring established, program inclusion criteria determined based on literature review</p> <p>Survey of deans and medical education Faculty in Germany over a 4 month period</p> <p>Qualitative and</p>	<p>20 out of 36 medical schools in Germany offer 22 active mentoring programs</p> <p>All German medical students enrolled as mentees at the time of the survey.</p> <p>63% of programmes established within the last 2 years.</p> <p>27% of programmes offer mentoring in a one-on-one setting.</p>	<p>Demand</p> <p>Publicity and enrolment</p> <p>Recruitment and selection</p> <p>Professional networking</p>

Author, Title and Journal	Context	Methodology	Key Findings	Themes
	prevalence of mentoring programs for medical students as well as the characteristics, goals and effectiveness of these programs.	qualitative questions related to key characteristics of mentoring Programs	<p>82% feature Faculty physicians as mentors.</p> <p>41% involve students as mentors in a peer-mentoring setting.</p> <p>Availability of mentoring is still limited.</p> <p>Mentoring models and goals of the existing programs vary</p> <p>Outcome data from controlled studies are needed to compare the efficiency and effectiveness of different forms of mentoring for medical students.</p>	<p>Enhanced academic performance</p> <p>Pastoral care</p>
Frei E; Stamm M; Buddeberg-Fischer B. (2010) Mentoring programs for medical students--a review of the PubMed literature 2000-2008, <u>BMC Medical Education</u> . 10:32, Journal Article. Research Support, Non-U.S. Gov't. Review] UI: 20433727	Within the framework of planning a mentoring program for medical students at Zurich University, an investigation was carried out into what types of programs exist, what the objectives pursued by such programs are, and what effects are reported.	PubMed literature search was conducted for 2000 - 2008 using the following keywords or their combinations: mentoring, mentoring program, medical student, mentor, mentee, protégé, mentorship. 438 publications were identified. 25 papers met the selection criteria for structured programs and student mentoring surveys.	The mentoring programs reported in 14 papers aim to provide career counselling, develop professionalism, increase students' interest in research, and support them in their personal growth. There are both one-to-one and group mentorships, established in the first two years of medical school and continuing through graduation. The personal student-Faculty relationship is important in that it helps students to feel that they are benefiting from individual advice and encourages them to give more thought to their career choices	<p>Clear aim of mentorship</p> <p>One to one and group mentorship</p> <p>Faculty-student relationship</p>
Gagliardi AR; Wright FC. (2010) Exploratory evaluation of surgical skills mentorship program design and outcomes, <u>Journal of Continuing Education in the Health</u>	Explored outcomes and barriers associated with the design of surgical mentorship programs	Interviews were held with organizers, mentors, and protégés of 2 programs. Data from 23 participant	Participation greater where planning was participatory and mentors visited protégés. Scheduling was a key barrier, and existing relationships enabled mentorship. Most nonparticipants said they were already trained or had no interest in the skill. Mentorship was valued for	<p>Value of mentoring-</p> <p>Tele- mentoring</p>

Author, Title and Journal	Context	Methodology	Key Findings	Themes
<p>Professions, 30(1):51-6, 2010. [Journal Article] UI: 20222034 [Journal Article]</p>		<p>interviews and 23 nonparticipant surveys were analysed thematically.</p>	<p>exchange of tacit knowledge, hands-on learning, and real-time feedback. Mentorship prompted participants to realize gaps in skill; several said they already adopted the new skill, and many were interested in ongoing mentorship.</p>	<p>Train-the-trainer models may promote participation in surgical mentorship. Technical training be integrated within pre- and post-mentorship education and follow-up. Such programs can only be implemented if issues of sponsorship and funding are addressed.</p>
<p>Thomas-Maclean R; Hamoline R; Quinlan E; Ramsden VR; Kuzmich J (2010)Discussing mentorship: An ongoing study for the development of a mentorship program in Saskatchewan, Canadian Family Physician. 56(7):e263-72UI: 20631262</p>	<p>Physician mentorship maybe a feasible and meaningful strategy to address physician shortages and a declining interest in family medicine in Canada Saskatchewan</p> <p>Study explored primary care physicians experiences and their suggestions for programme development</p>	<p>Mixed method study: environmental scan Qualitative, in-depth, semi structured interviews based on an environmental scan or literature review. Transcribed verbatim and analysed thematically.</p>	<p>Positive and negative aspects of mentoring, or having a lack of experience with mentoring. They also outlined key components of a potential mentorship program: matching mentees with mentors: opinions differed regarding methods; random selection by the facilitator, pairing based on profiles; selection via profile list; reception to meet and mingle; create personal profiles; reception with opportunity to meet.</p> <p>Integrating formal and informal mentorship: formal training programme; informal; or the need to integrate the two. This would facilitate the building of relationships, programme growth and evolution.</p> <p>Evaluating the Relationship: feedback on specifics of the relationship; the entire programme or both;</p>	<p>Matching mentors and mentees</p> <p>Integrating formal and informal mentoring</p>



Author, Title and Journal	Context	Methodology	Key Findings	Themes
	<p>25 physicians were purposively sampled based on location, sex, and experience. Fourteen participants practiced in urban areas and 11 in rural settings; 10 were junior physicians and 15 were senior. Junior physicians were defined as those who had graduated from medical school after 1995, and senior physicians were those who had graduated before 1980.</p>		<p>process to evaluate the mentors abilities- knowledgeable, organized, able to establish rapport and accessibility and the evaluation process of the mentorship relationship and program and mentee evaluation</p>	
<p>Silent K. A, Asquith, P, Fleming, M F (2010)</p> <p>A National Survey of Mentoring Programs for KL2 Scholars, <u>Clin Transl Sci</u>, 3(6): 299–304</p>	<p>Provision of research, education, training and career development for the next generation of scientists who work in the area of clinical and translational science , central is the offering of a mentored career development initiative intended to develop new research leaders who can cross the boundaries of their discipline</p>	<p>Semi structured telephone interview to collect baseline data : programme and efforts to support mentoring across 46 CTSA institutions</p> <p>Interview with the Director of the programme at each of the 46 institutions (institutional and programme characteristics, programme structure</p>	<p>Useful information on the programmatic interventions and formalized mechanisms that existed to foster and monitor the effectiveness of the relationship: mechanisms for articulating expectations; how programmes are monitoring the health and effectiveness of the relationship; and mentor development training programmes available</p> <p>Mentor selection: vast majority expect scholars to select mentor, many programmes expressed willingness to assist; programmes. Kathy Kram’s seminal work and framework about mentoring: Initiation, cultivation, separation, redefinition, operating within two primary domains, psychosocial and career development make the match themselves; collaborative process</p>	<p>Mentor selection</p> <p>Communicating expectations</p> <p>Assessing the mentoring relationship</p> <p>Mentor support and training</p>

Author, Title and Journal	Context	Methodology	Key Findings	Themes
		Analysis descriptive analysis	<p>Communicating expectations:</p> <p>These include frequency of the interaction; shared expectations and shared research goal (communicated at the orientation session)</p> <p>Written agreement or contract between the scholar and mentor. Some institutions have introduced ground rules for discussion; such as confidentiality. This provides the forum to negotiate working and communication styles, expectations negotiated between the mentoring team</p> <p>Assessing the mentoring relationship: Traditional means is measuring the success of the mentor-evaluate the scholars interest annual basis, formal evaluation; developing an instrument, how to proceed with unsatisfactory mentoring</p> <p>Mentor support and Training incentives for the mentors to take on the role: salary support, travel allowance; culture that publically expresses gratitude; annual award , letters of appreciation</p> <p>Barriers: budget cuts to programmes, experience of senior Faculty who succeeded in spite of not having mentors</p>	
Myall M; Levitt Jones T; Lathlean J, (2008) Mentorship in contemporary practice: the experiences of nursing students and practice mentors, <u>Journal of Clinical Nursing</u> 17 , 1834 – 194, 2008	<p>Explores the role of the mentor in contemporary nursing practice in the UK.</p> <p>Investigates the impact of a locality-based nursing education initiative on students,</p>	<p>A two-phased design with data on mentorship being focused on the second phase.</p> <p>Phase 1 included semi-structured interviews with key academic, clinical and wider</p>	<p>Student experiences</p> <p>Allocation of named/designated mentor is important before starting in a practice area.</p> <p>Quality of the relationship between the mentor and the mentee important, mutual trust and respect</p>	<p>Designated mentor integral to the quality of the student experience</p> <p>Development of a student /mentor relationship</p>

Author, Title and Journal	Context	Methodology	Key Findings	Themes
	<p>practice mentors and academic staff and draws on another study, conducted in the same setting and two Australian sites, to examine the perceptions of nursing students and mentors</p> <p>Despite a plethora of studies focussing on mentoring and its nature and application within the practice setting, limited attention has been paid to the extent to which guidelines provided by regulatory bodies for nursing inform and influence the practice of mentoring in contemporary health-care settings.</p>	<p>stakeholders and a survey of prequalifying students, via a self-administered questionnaire.</p> <p>Phase 2 involved a survey of academics, practice mentors and prequalifying students. This paper reports on selected findings from Phase 2 of the study</p>	<p>Qualities required by mentor   supportive, helpful, knowledgeable, experienced, and enthusiastic about their role and committed to their students.</p> <p>Good quality placement experience linked to mentor assisted planning of learning opportunities, feedback about progress,</p> <p>Amount of time students spent with their mentor was seen as essential in influencing the quality of their placement experience.</p> <p>Mentor experiences</p> <p>Important to prepare for student arrival</p> <p>Mentor support facilities students   skill development, linking theory to practice</p> <p>Benefits (mentor) Providing clinical support to students facilitated updating of their own clinical skills and knowledge and ensuring evidence based practice</p> <p>Rewarding, job satisfaction.</p> <p>Constraints - Lack of time working together due to workload and staff shortages impacts on student experience</p> <p>Insufficient numbers of live mentors and time contains means unable to attend mentor updates impacted on mentor experience</p> <p>Support from HEI important</p>	<p>Role and responsibilities of the mentor to facilitate learning</p> <p>Adequate preparation of mentors to prevent negative student experiences</p>

## Findings

The papers generated from the literature review were predominantly medical (doctor) focused and tended to operationalise mentorship to develop research and career prospects. There is a paucity of primary research; most of the papers found were opinion based article. Findings demonstrate how the term associated with healthcare “mentorship” holds different meanings to different professions. Proving useful to have explored these papers, what emerged were key areas to consider that promote effective mentorship within this healthcare context.

***Communication within the mentorship programme:*** Need to communicate clear programme goals and role expectations to facilitate learning; communication

***The mentorship relationship:*** Matching of the mentor/mentee and mentor selection; Interaction between the mentor/mentee and their relationship (collegial relationship development and collaborative working)

***Barriers to effective mentoring:*** time, lack of support, imbalance of expectations and funding

***Mentorship models:*** These include peer mentoring, peer groups, one to one and group, tele-mentoring, train the trainer models, formal and informal mentoring

***Education within the mentoring programme:*** (pre and post programme and follow-up); congruence of knowledge and skill for both the mentor and mentee; mentor support and training; adequate preparation to prevent negative mentee experience

***Evaluation of the mentoring programme/mentorship:*** The focus on the evaluation of the mentorship: increased academic productivity; quality of the mentee experience

Understanding the literature available raised questions by the evaluation team and this prompted an exploration of guidance on mentorship provided by the following professional bodies: Nursing and Midwifery Council (NMC); Health and Care Professions Council (HCPC); and General Medical Council (GMC). Model, education, length of programme, qualifications of the educator and other information is summarised for each professional body in table 3.

## Nursing and Midwifery Council (NMC) Perspectives of Mentorship

The NMC is the regulator for 2 professions, nursing and midwifery and has defined a structured preparation programme to enable the preparation of mentors to enable them to assess and supervise students in practice. It is a mandatory requirement for each part of the register

- Nursing

- Midwifery
- Specialist Community Public Health (SCPHN)

The NMC requires all students undertaking a programme leading to registration as a specialist community public health nurse (SCPHN) to have a named practice teacher. Practice teachers must have met NMC requirements defined in this standard, or be supervised by a practice teacher who has met them.

All students must have been qualified for one year and be recorded as live on the NMC register. Mentor preparation programmes must be at a minimum academic level of HE Intermediate level (previously known as level 2) or SCQF Level 8, and include learning in both academic and practice settings. The programmes must include relevant work-based learning, e.g. experience in mentoring a student under the supervision of a qualified mentor, and have the opportunity to critically reflect on such an experience. Student mentors can accredit Prior learning and experience AP(E)L to up to 100% of the programme, which recognises previous preparation of an equivalent nature and standard.

The NMC do not stipulate the credit worthiness of mentor preparation modules. It does state the level at which the programme has to be delivered (and therefore assessed). Mentor programmes either afford credit or no credit. Both can be taught either in a HE institution or in house. Both are required to be validated by a NMC approved HEI.

All mentor preparation programmes must include a minimum of 10 days, of which at least five days are protected learning time, and normally be completed within three months.

The practice assessment element of the programme requires the supervision of a qualified mentor on the same part of the register as the student, and the assessment verified by an HE provider. Theoretical assessment for credit bearing modules requires a teacher with a recognised teaching qualification. Student mentors require access to students / learners throughout the module

Even when a non-credit bearing approach is taken this requirement should still be met. The verification/assessment of the portfolio should be undertaken by someone with a 'teacher status'.

"The NMC teacher standard is mandatory for those nurses and midwives based in higher education who support learning and assessment in practice settings for students on NMC approved programmes"(NMC 2008).

The NMC state that teachers are responsible for:

- Setting and monitoring achievement of realistic learning objectives in theory and practice.

- Assessing performance and providing evidence as required of student achievement.

The NMC require evidence of ongoing development within the teaching role:

- *‘Their teaching role will be supported by appropriate professional and academic qualifications and ongoing research, education and/or practice development activity to provide an evidence base for their teaching’ (NMC 2008).*

A developmental framework to support teaching and assessment in practice sets out 8 domains that have to be achieved by the mentee. The following competencies and behaviours are recognised as being best practice for mentorship in nursing and healthcare practice (NMC 2008)

#### **Establishing effective working relationships**

- Understanding of factors that influence how students integrate into practice settings.
- Providing ongoing and constructive support to facilitate transition from one learning environment to another.
- Having effective professional and inter-professional working relationships to support learning for entry to the register.

#### **Facilitation of learning**

- Use knowledge of the student’s stage of learning to select appropriate learning opportunities to meet individual needs
- Facilitate the selection of appropriate learning strategies to integrate learning from practice and academic experiences
- Support students in critically reflecting upon their learning experiences in order to enhance future learning.

#### **Assessment and accountability**

- Foster professional growth, personal development and accountability through support of students in practice.
- Demonstrate a breadth of understanding of assessment strategies and the ability to contribute to the total assessment process as part of the teaching team.
- Provide constructive feedback to students and assist them in identifying future learning needs and actions.

- Manage failing students so that they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future.
- Be accountable for confirming that students have met, or not met, the NMC competencies in practice.

### **Evaluation of learning**

- Contribute to evaluation of student learning and assessment experiences – proposing aspects for change resulting from such evaluation.
- Participate in self and peer evaluation to facilitate personal development, and contribute to the development of others.
- Creating an environment for learning
- Support students to identify both learning needs and experiences that are appropriate to their level of learning.
- Use a range of learning experiences, involving patients, clients, carers and the professional team, to meet learning needs.
- Identify aspects of the learning environment which could be enhanced – negotiating with others to make appropriate changes.
- Act as a resource to facilitate personal and professional development of others.

### **Context of practice**

- Contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated.
- Set and maintain professional boundaries that are sufficiently flexible for providing Inter-professional care.
- Initiate and respond to practice developments to ensure safe and effective care is achieved and an effective learning environment is maintained.

### **Evidence-based practice**

- Identify and apply research and evidence-based practice to their area of practice.
- Contribute to strategies to increase or review the evidence-base used to support practice.
- Support students in applying an evidence base to their own practice.

## Leadership

- Plan a series of learning experiences that will meet students defined learning needs.
- Be an advocate for students to support them accessing learning opportunities that
- Meet their individual needs – involving a range of other professionals, patients, clients and carers.
- Prioritise work to accommodate support of students within their practice roles.
- Provide feedback about the effectiveness of learning and assessment in practice.

### **The Health and Care Professions Council (HCPC) Perspectives of Mentorship (Practice Educator)**

In contrast to the NMC and GMC The HCPC (2014) do not use the word ‘mentor’ they favour ‘placement educator’ and they have no specific requirements or expectations, instead they state that the education provider should ensure that placement educators are suitably qualified and prepared for the role . The HCPC do not set specific requirements for the length or content of this training, instead leaving the level of detail to be decided by individual education providers.

Suggestions of what training and preparation might include have a similar focus to the NMC however as identified the NMC takes a structured approach to the preparation of qualified nurses who wish to mentor student nurses, having their developmental framework to support teaching and assessment:

- Demonstrate knowledge, skills and experience to support students and that they provide a safe environment for effective learning
- Feel fully prepared to support student in placement in terms of learning outcomes to be achieved;
- Timings and the duration of any placement experience and associated records to be maintained;
- Expectations of professional conduct;
- Assessment procedures including the implications of, and any action to be taken in the case of, failure to progress;
- Communication and lines of responsibility.
- Ability to apply a range of learning and teaching methods that respect the rights and needs of service users and colleagues



## General Medical Council (GMC) Perspectives of Mentorship

The term mentor within medical education is defined as is the practice of facilitating development of trainee and junior doctors in practice. Mentors provide support, direction and an objective view on how the mentee can develop and progress in their working environment.

The GMC's view of mentor as demonstrated here is very much that shared by non-healthcare industries, in that mentors are seen as a guide and source of support and information. This view is clearly visible from the literature review conducted as part of this evaluation (UK and international evidence base).

The GMC does not currently have statutory powers to approve trainers other than GPs who are providing training for GP registrars. However, it has powers to promote and establish standards, to secure effective instruction for medical students, to recognise programmes for training provisionally registered doctors and to approve programme and programmes for postgraduate training.

A regulatory structure for safe, effective medical education includes standards for medical trainers, called Recognising and Approving Trainers: The Implementation Plan (GMC 2012). Postgraduate deans and medical schools are responsible for setting up arrangements to develop and validate their trainers

The Academy of Medical Educators "Professional Standards for medical, dental and veterinary educators" (2014), acts as the framework for the criteria which all trainers in recognised roles will be expected to provide evidence of their ongoing professional development against. Contrasting to the NMC there is no live register to demonstrate currency of professional development with mentorship. These standards are

- Ensuring safe and effective patient care through training
- Establishing and maintaining an environment for learning
- Teaching and facilitating learning
- Supporting and monitoring educational progress
- Guiding personal and professional development
- Continuing professional development as an educator

Training is carried out in-house within individual Trusts and offered to qualified licenced doctors of all specialties and grades who are interested in taking on a training role in their workplace, or who already have training responsibilities and would like to improve their practice. Trainers keep supporting information about their training and job plans consistent with their responsibilities which can be used both to support annual appraisal and to obtain recognition as a trainer. Beyond meeting the minimum

standards, trainers are expected to develop their skills and competence, and to consider opportunities for career progression as trainers, supported by the processes involved in trainer recognition.

In summary, the concurring themes that emerge from the three professional bodies relate to:

- Facilitation of learning/ teaching and facilitating learning
- Evaluation of learning/ supporting and monitoring educational progress/ guiding personal and professional development
- Creating and maintaining an environment for learning
- Recognising the context of practice ensures safe and effective patient care through training

*Table 3 - Professional bodies guidance on mentorship*

Professional Body	Model	Preparation Education	Length of Programme	Qualifications of Teachers	Other useful Information
Nursing and Midwifery Council	<p>Structured preparation programme to enable the assessment and supervision of mentees in practice</p> <p>Mandatory requirements for each part of the register</p> <ul style="list-style-type: none"> <li>• Nursing</li> <li>• Midwifery</li> <li>• Specialist Community Public Health (SCPHN)</li> </ul> <p>A developmental framework to support teaching and assessment in practice sets out 8 domains that have to be achieved by the mentor</p>	<p>Prerequisites - Students qualified for one year and be recorded as live on the NMC register</p> <p>Mentor preparation can be accredited on non-accredited</p> <p>Both can be taught in an HE institution or in house</p> <p>Both require HE/NMC approval</p> <p>Work-based learning, to enable practicing mentoring a student under the supervision of a qualified mentor</p> <p>Required to have access to students / learners throughout the module</p> <p>Reflection on practice</p> <p>AP(E)L up to 100% of the programme</p>	<p>A minimum of 10 days, of which at least five days are protected learning time</p> <p>Normally, be completed within three months</p>	<p>Practice element requires the supervision of a qualified mentor</p> <p>Practice assessment by qualified mentor on same part of the register – verified by the HE provider</p> <p>Theoretical assessment for credit bearing modules requires a teacher with an approved teaching qualification</p>	

Professional Body	Model	Preparation Education	Length of Programme	Qualifications of Teachers	Other useful Information
<b>The Health and Care Professions Council (HCPC)</b>	<p>Stipulates that education providers (HEIs) should ensure that they have placements with suitably prepared placement educators.</p> <p>No universal standards are provided for this and it is recommended that local providers find an approach that is more suitable for them.</p> <p>Some professional bodies by provide further guidance but at present there is none for Physiotherapy or Occupational Health</p>	<p>No minimum requirement for either the commencement of preparation programme or the content or level of study of such a programme.</p> <p>Placement providers can be deemed as suitable through peer to peer support if that approach is favoured by the local HEI</p>	None specified	None required	
<b>General Medical Council</b>	<p>No current statutory powers to approve trainers other than GPs who are providing training for GP registrars.</p> <p>Powers to promote and establish standards, to secure effective instruction for medical students, to</p>	In-house training within individual Trusts	Ranges from 1-2 days with ongoing development of supportive information about the ongoing training	<p>Qualified licensed doctors of all specialties and grades interested in training or are trainers wishing to improve their practice.</p> <p>Supporting information about the training is used</p>	Locally the North West deanery strongly recommends that registrars and consultants involved in the training and assessment of junior doctors complete a

Professional Body	Model	Preparation Education	Length of Programme	Qualifications of Teachers	Other useful Information
	<p>recognise programmes for training provisionally registered doctors and to approve programmes and programmes for postgraduate training.</p> <p>Regulatory structure - Recognising and Approving Trainers: The Implementation Plan</p> <p>Individual medical schools devise arrangements to develop and validate trainers</p> <p>The framework provides evidence of ongoing professional development against the prescribed standards</p>			<p>both to support appraisal and to obtain recognition as a trainer.</p> <p>Annual review of agreed job plans consistent with responsibilities</p> <p>Trainer recognition is not a 'tick-box' exercise.</p> <p>Develop skills and competence, relevant to career progression opportunities as trainers, supported by the processes involved in trainer recognition.</p>	<p>suitable post-graduate qualification. They provide funding for a Post-Graduate Certificate of Higher Education in Medical Education</p> <p>Within the medical profession a mentor is often used to refer to an individual who provides career support and guidance, the term educator is used for role similar to that of mentor within nursing and midwifery.</p>

## Models of Nursing Mentorship

This next section focuses on Models of Nursing Mentorship, traditionally NMC acceptable/recognised mentorship programmes have been delivered in the hospital and university setting across a range of levels

*Table 4 - Typical models of Nursing Mentorship*

Mentorship Model	Key Features	Length/ Duration of Programme NMC Requirements	Educators/Qualifications delivering	Place of Study
ENB 998	No longer available			
City and Guilds 7307 Level 3 Teaching Adult Learners	<p>Since September In England 2007 new teaching and training qualifications have been introduced</p> <p>New overarching professional standards for teachers, tutors and trainers.</p>	<p>4 Day programme</p> <p>No NMC accreditation</p>	<p>All new teachers in the learning and skills sector must now complete the City and Guilds PTLLS 6302 Award</p> <ul style="list-style-type: none"> <li>• Understanding roles, responsibilities and relationships in education and training</li> <li>• Understanding and using inclusive teaching and learning approaches in education</li> <li>• Understanding assessment in education and training</li> </ul> <p>A tariff for legacy ( pre Sept 2007) qualifications has been established to rate existing teaching</p>	<p>National Centres</p> <p>Classroom based plus self-study</p>

Mentorship Model	Key Features	Length/ Duration of Programme  NMC Requirements	Educators/Qualifications delivering	Place of Study
			<p>qualifications within the new framework and enable accreditation of prior achievement (APA) in relation to:</p> <ul style="list-style-type: none"> <li>• Preparing to Teach in the Lifelong Learning Sector (PTLLS)</li> <li>• Certificate in Teaching in the Lifelong Learning Sector (CTLLS)</li> <li>• Diploma in Teaching in the Lifelong Learning Sector (DTLLS).</li> </ul> <p>These form part of the Qualified Teacher - Learning and Skills (QTLS) framework</p>	
University Taught Academic credit-Bearing	<p>Can be studied as a single module for continuing professional development</p> <p>Can be studied as part of a first or higher degree</p> <p>Enables students with Diploma level qualifications to top up to degree level</p> <p>Levels 6 &amp; 7 available</p>	<p>NMC validation required</p> <p>A minimum of 10 days equivalent blended learning of which at least five days are protected learning time.</p> <p>Normally, be completed within three months</p> <p>NMC validation</p>	<p>Recorded teacher status with NMC</p> <p>Recognised teaching qualification – equivalent to PGCE</p>	<p>HE institutions with live NMC approval to deliver the programme</p>

Mentorship Model	Key Features	Length/ Duration of Programme  NMC Requirements	Educators/Qualifications delivering	Place of Study
	<p>Develops skills and knowledge to prepare student to become a successful mentor and fulfil the requirements of the professional body</p> <p>Partly or fully prepares for the sign-off mentor role</p>	<p>Some programme require compulsory day 1 attendance</p>		
University Taught Academic Non Credit Bearing	<p>Most suited to applicants who have already completed a degree/PgDip and do not wish to gain credits for further academic progression</p> <p>Or those who don't have recent experience of level 6 study</p> <p>The modules meet the NMC (2008) Standards to Support Learning and Assessment in Practice.</p> <p>Develops skills and knowledge to prepare student to become a successful mentor and fulfil the requirements of the professional body</p> <p>Partly or fully prepares for the sign-off mentor role</p> <p>The module suited also to practitioners from other</p>	<p>NMC validation required</p> <p>A minimum of 10 days equivalent blended learning of which at least five days are protected learning time.</p> <p>Normally, be completed within three months</p> <p>NMC validation</p> <p>Some programmes require compulsory day 1 attendance</p>	<p>Recorded teacher status with NMC</p> <p>Recognised teaching qualification – equivalent to PGCE</p>	<p>HE institutions with live NMC approval to deliver the programme</p>



Mentorship Model	Key Features	Length/ Duration of Programme  NMC Requirements	Educators/Qualifications delivering	Place of Study
	professional groups who support nursing and midwifery learners in practice.			
In-house Credit-Bearing	<p>Student - Time saving , travel and money</p> <p>Organisation - training budgets spent on site</p> <p>Develops skills and knowledge to prepare student to become a successful mentor and fulfil the requirements of the professional body</p> <p>Partly or fully prepares for the sign-off mentor role</p>	<p>A minimum of 10 days equivalent on-line learning of which at least five days are protected learning time.</p> <p>Normally, be completed within three months</p> <p>NMC validation required</p>	<p>Recorded teacher status with NMC</p> <p>Professional Development and Education Team</p> <p>Recognised teaching qualification – equivalent to PGCE</p>	
In-house Non Credit Baring	<p>Student - Time saving , travel and money</p> <p>Organisation - training budgets spent in-house</p> <p>Develops skills and knowledge to prepare student to become a successful mentor and fulfil the requirements of the professional body</p>	<p>A minimum of 10 days equivalent on-line learning of which at least five days are protected learning time.</p> <p>Normally, be completed within three months</p> <p>NMC validated HEI required</p>	<p>Recorded teacher status with NMC</p> <p>Professional Development and Education Team</p> <p>Recognised teaching qualification – equivalent to PGCE</p>	

Mentorship Model	Key Features	Length/ Duration of Programme  NMC Requirements	Educators/Qualifications delivering	Place of Study
	Partly or fully prepares for the sign-off mentor role			
E- learning Credit Bearing and Non Credit Bearing	<p>Enables remote learning</p> <p>Reduced travel</p> <p>Negotiated study time with managers rather than 'fixed ' study days</p> <p>Interactive learning package will be utilised to enable progress through the learning outcomes.</p> <p>Planned communication through a range digital technologies with peers and academic staff</p> <p>Level 6 and 7 options available</p> <p>Develops skills and knowledge to prepare student to become a successful mentor and fulfil the requirements of the professional body</p> <p>Partly or fully prepares for the sign-off mentor role</p>	<p>A minimum of 10 days equivalent on-line learning of which at least five days are protected learning time.</p> <p>Normally, be completed within three months</p> <p>NMC validation required</p>	<p>Recorded teacher status with NMC</p> <p>Recognised teaching qualification – equivalent to PGCE</p>	
Multi professional Support for	Suitable for qualified nurses, midwives or another health	A minimum of 10 days equivalent blended learning	Recorded teacher status with NMC	

Mentorship Model	Key Features	Length/ Duration of Programme  NMC Requirements	Educators/Qualifications delivering	Place of Study
Learning and Assessment in Practice	<p>professional, such as a speech and language therapist, who supports students or others to learn in practice.</p> <p>Develops skills and knowledge to prepare student to become a successful mentor and fulfil the requirements of the professional body</p> <p>Meets key standards identified by the NMC, Health and Care Professions Council, and Higher Education Academy for continuing professional development</p> <p>Profession-specific learner requirements embedded in the programme where appropriate.</p> <p>For nurses and midwives - Partly or fully prepares for the sign-off mentor role</p> <p>Credit and non-credit bearing options</p> <p>Level 6 &amp; 7 options available</p>	<p>of which at least five days are protected learning time.</p> <p>Normally, be completed within three months</p> <p>NMC validation</p> <p>Some programmes require compulsory day 1 attendance</p>	Recognised teaching qualification – equivalent to PGCE	

### **Non- Credit Bearing Mentorship**

An internet search applying search terms associated with non-credit bearing mentorship identified 9 programmes available across the UK (England, Wales and Scotland). A further programme was identified through use of professional networks. The quality and quantity of information available from each university site differs and has been captured in table 2.

This list is not exhaustive as the non-credit bearing model is becoming the norm. What is not clear from the information provided is whether the programmes are delivered by university academics or in-house by the PEF type role, combination of the two or a different delivery model is adopted.

*Table 5 - Non-Credit Bearing Mentorship, January 2017*

University	Aims	Cost	Duration	Assessment
Kings College London	Prepare nurses and midwives to become mentors of pre-registration students in clinical settings	£575	Taught over 3 days with an e-learning component. Attendance for the first day is compulsory	Portfolio comprising of a written component (NMC Standards x8) and Practice Based Assessment (PBA)
Anglia Ruskin University	Develop knowledge and skills to support and assess learners in practice. If you're a registered healthcare professional, the course will enable you to meet your professional body requirements for mentorship/practice educator and to enter the local register of mentors.	Not known	Three taught days and two days of online study.	Not known
University of West London	Equip healthcare professionals with an appropriate level of knowledge and understanding to facilitate learning and assess competency and proficiency of pre-registration healthcare professionals.  This includes professional responsibility and accountability when making judgements of assessment in achievement of competency in clinical practice.	Not known	6 protected study days, 3 face-to-face contact days and 3 online learning days (36 hours in total). In addition 164 hours of independent study	Not known
Kingston and St Georges University London	Enables health and social care practitioners to develop their skills, knowledge and attitudes as mentors to meet the relevant professional body's standards for mentorship e.g. The Nursing & Midwifery Council, Health Care Professional Council.	£400	Minimum of 10 days of which at least five days are protected learning time and demonstrate learning in both the academic and practice setting.  Module length: 5 days (seems to contradict the above)	Complete a practice assessment document. There is no academic assignment.
Sheffield Hallam University	Meet the Nursing and Midwifery Standards for Mentors (including HCPC requirements) or (midwives only) to meet all the requirements for sign-off proficiency.	£460	Distance learning. Structured and interactive virtual learning package will support a range and variety of eLearning sources as well as opportunity for regular	Portfolio

University	Aims	Cost	Duration	Assessment
			online discussion with other students and teachers.	
Central Manchester Foundation Trust	Not known from the information presented on the internet but this is a UoB validated programme. Delivered by the trust.	Not known	Not known	Portfolio
University of Stirling	Utilise robust evidence base to enable learner centred approach to facilitating and creating an effective learning environment; enable development in relation to facilitating learning  and professional growth, acting as a resource and directly managing learning in practice to ensure public protection; assess learner performance in practice and recognise their accountability for their decision to pass, refer or fail a learner; experience can be satisfactorily mapped to the NMC Mentor Standards (NMC 2008); demonstrates, clear evidence, linking knowledge and mentoring practice.	Normally, the Department makes no charge for the non-accredited module??	10 days in length.  The 5 days protected learning time is made up of 3 days of face-to-face learning and teaching, and 2 self-study days. The remaining 5 days learning time will be time spent in practice. This will require 37½ hours to be logged in practice over a 3 month period	Verified by the log of practice hours and academic attendance  Self-assessed with the Portfolio of Evidence by the Student Mentor  Verified by an experienced mentor (the supervisor)  Quality assured by the module tutor also reviewing the Portfolio of Evidence.
Canterbury Christchurch University	Prepare learners (students engaged on this module, as opposed to the “students” they are mentoring) for their role in supporting, facilitating, assessing and evaluating, workplace learning.	Not known	3 days over a 4-5 month period.	Successfully complete and pass workplace competencies
Swansea University	Enable registered practitioners to meet the professionally relevant standards in order to support learning and assessment in practice	Not known	Equivalent to five days of taught study and five days learning time in clinical practice, and the module should be completed within 3 months of commencement	Not known

University	Aims	Cost	Duration	Assessment
University of Huddersfield	To facilitate the preparation of healthcare practitioners who wish to be mentors to students studying on NMC/HCPC approved programmes, therefore on successful completion you may be eligible to apply for 'mentor' or 'sign off mentor status' on your local mentor register	£500	Online - weekly directed study based on the NMC Standards and discussion groups on social media	E-Portfolio  3 learning contracts one with mentor and 2 with student.  Practice assessment demonstrating evidence of achievement of the NMC standards
Manchester Metropolitan University	<ul style="list-style-type: none"> <li>• Level 6 – 20 credits, NMC approved</li> <li>• Level 7 – 20 credits, NMC approved</li> <li>• Non-credit bearing, NMC approved</li> </ul> <p>Plus – we have attendance only for AHPs only who do not wish to be assessed</p>		We do not currently have any of these options delivered by Trust based staff, but this is being requested by some organisations. Currently, Manchester Met staff deliver all the teaching and assessment of the unit and this is frequently delivered at Trust premises.	

## **Critical Exploration of the Experience of MSLAP: Key Stakeholder Perspectives**

This next section of the report critically explores the pilot model in order to establish the learning of what works well or not so well from the and provides recommendations to guide further investment development, strategic planning and research and potentially other delivery models. The evaluation methodology utilises document analysis, interview and survey questionnaire.

### **Document Analysis**

The following documents have been made available from the UoB and UHSM programme team. The documents provide the quality assurance details of the programme and content was used to inform the content of the semi structured interview schedule. It is not the purpose of this report to analyse these documents and instead they may be referred to throughout this report. The following reports are available from the Professional Education Lead UHSM or Dr Jacqueline Leigh, Evaluation Lead:

Student Staff/Liaison Committee (SSLC) for NMC Approved Preparation for mentorship (Non Credit Bearing) UHSM NHS Trust, November 2016

- Module Evaluation Report 2015/6, Semester 3, MSLAP, UHSM, May 2016
- Module Evaluation Report 2015/6, Semester 2, MSLAP, UHSM, January 2016
- 2016/7 Programme Plan UHSM
- Student /Staff Liaison Committee (SSLC) NMC Approved Preparation for Mentorship (Non Credit Bearing) UHSM NHS Trust Module Statistics Report, November 2016

An analysis of the reports demonstrates that the non-credit bearing sites meet at the staff student liaison committee.

### **Focus Group or One to One Interviews with key stakeholders**

Adopting purposive sampling techniques (Creswell 2007, Silverman 2010) resulted in the identification of a range of multi-stakeholder groups who had knowledge and understanding of the pilot non- credit bearing programme and whose views would be instrumental for the future way mentorship programmes are designed and delivered:

The Focus group interviews were conducted with the following:

- Practice Education Facilitators UHSM (n=4)
- Practice Education Facilitators Comparison Healthcare Organisation (n=2)



- UoB programme team (n=2)

The face to face one to one interview was conducted with:

- Professional Education Lead (n=1)
- Practice Education Facilitator Stockport NHS Trust (n=1)
- Practice Education Facilitator Christie NHS Trust (n=1)
- North West Practice Development Network (n=1)

Due to sickness and absence in the Tameside Practice Education Team it was not possible to interview the Practice Education Facilitators

## **Data Collection**

Data was collected through the use of semi-structured interviews (Silverman 2010). This approach was operationalised within the context of focus groups and one to one interviews and comprised of questions that would explore participant's perspectives of the pilot MSLAP programme. The themes identified from the literature review informed the content of the interview schedule and the interviewees were also free to raise additional issues

## **Data Analysis**

Thematic content analysis provided the rigorous data analysis framework whereby links were made between the empirical data and the claims made by the researchers. All the interviews lasted for approximately 60-90 minutes 40-50 minutes and were recorded and transcribed with coding schemes generated from the line-by-line analysis of the interview schedules (Graneheim & Lundman 2004). Typical and atypical recurring areas were identified and drawn together into themes to gain an understanding of the emergent key areas around higher apprenticeship design and delivery. Interviews, were recorded with permission, and were mainly conducted in each individual's place of work. An interview with PEFs at a different site who deliver MSLAP also took place to provide the comparison. Interview with NWPDN senior manager also took place.

## **Findings**

The following themes and subthemes emerged:

## Theme 1 Vision for the Pilot Programme

1. Background to Non-Credit Bearing at UHSM and UoB and the Pilot Model
2. Role of the University of Bolton for MSLAP Non Credit Bearing Provision
3. The Pilot Model
4. Introduction to PEFs involved in this Evaluation
5. Reality of the Pilot Delivery Model
6. Stakeholder Perspectives of the Perceived advantages of the MSLAP programme and Pilot Programme for students
7. Stakeholder Perspectives of the Perceived advantages of the MSLAP programme and Pilot Programme for Healthcare Organisation
8. The Model Mentor

## Theme 2 The MSLAP Programme

1. Overview of the UoB Non-Credit Bearing programme
2. Background
3. Philosophy influencing the programme
4. Programme Structure & Learning Outcomes
5. The Assessment Brief
6. Assessment Pass Rate
7. Marking of the Portfolio
8. Preparing to deliver the in-House MSLAP Programme by PEFs involved in the Pilot
9. Key Processes for Successful programme Delivery

## Theme 3 Programme Delivery Realities

1. Professional Development of PEFs
2. Processes Required and Credibility of the Programme
3. Percentage of Time spent on the Pilot Programme by PEFs
4. Impact of Pilot Programme Delivery on the other Components of the PEF role
5. Sustainability of the Pilot Model
6. The Future

Coding: To maintain anonymity of PEFs who participated in the interviews, participants from the pilot are identified as F 1-6. The PEF Programme team from the Comparison Healthcare Organisation are coded as PEFs Comparison Healthcare Organisation. Findings are triangulated with documentary

analysis (Moodle site, programme handbook, module evaluations and 2016/7 Programme Plan UHSM) and confidential survey to mentors on the live register at UHSM. 16 mentors completed the survey questionnaire.

## **Theme 1 Vision for the Pilot Programme**

### **Background to Non-Credit Bearing at UHSM and UoB and the Pilot Model**

Documentary analysis (i.e. Moodle site, programme handbook) and interviews with key stakeholders at UoB and UHSM provided evidence about the background to the partnership model for MSLAP non-credit bearing mentorship development programme and the associated pilot model.

The Pilot is defined as the MSLAP Model whereby smaller trusts: Stockport NHS Foundation Trust; Christie NHS Foundation Trust; and Tameside Hospital NHS Foundation Trust are collaborating with a larger trust (UHSM) to deliver the programme.

UoB have been delivering non-credit bearing Multi-Professional Support of Learning and Assessment in Practice (MSLAP) programmes in NHS, private and voluntary sector for over six years. This NMC validated mentorship programme emerged as a result of healthcare organisations (Trusts) identifying a need to increase the numbers of mentors but at a reduced cost from the current credit-bearing mentorship preparation options. At that time Trusts were keen to utilise their service level agreements provided for continuing professional development (CPD) via Health Education North West in a better way, for example, to upskill staffing practice, rather than on mentorship preparation. Concurrently, Trusts also recognised that qualified professionals were predominantly graduate practitioners therefore did not require the mentorship development with an academic qualification attached.

Historically, Practice Education Facilitators (PEFs) were being paid on an hourly basis to assist the UoB to deliver its established credit bearing mentorship programme. The idea to develop the non-credit bearing programme delivered by PEFs from within their healthcare organisation was an extension of the use of this existing expertise. This PEF delivery model was already available and operationalised by the University of Stirling for Salford Royal NHS Foundation Trust.

The NMC requires that mentorship preparation for nurses is delivered by NMC teachers with a recognised NMC approved teaching qualification. The majority of PEFs who would be delivering the in-house non-credit bearing mentorship programme held the NMC teacher qualification and this enabled the delivery of the model. The in-house non-credit bearing programme commenced with

those partners who had PEFs with this qualification (and associated Post Graduate Certificate in Education (PGCE)). The minimum number of PEFs per Trust required to sustain the in-house model was identified by the UoB as four. The order of the trusts adopting the programme was:

- Bolton NHS Foundation Trust and Pennine Acute Hospitals NHS Trust
- Greater Manchester West Mental Health NHS Foundation
- CMFT Central Manchester NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Trust
- University Hospitals South Manchester (UHSM)

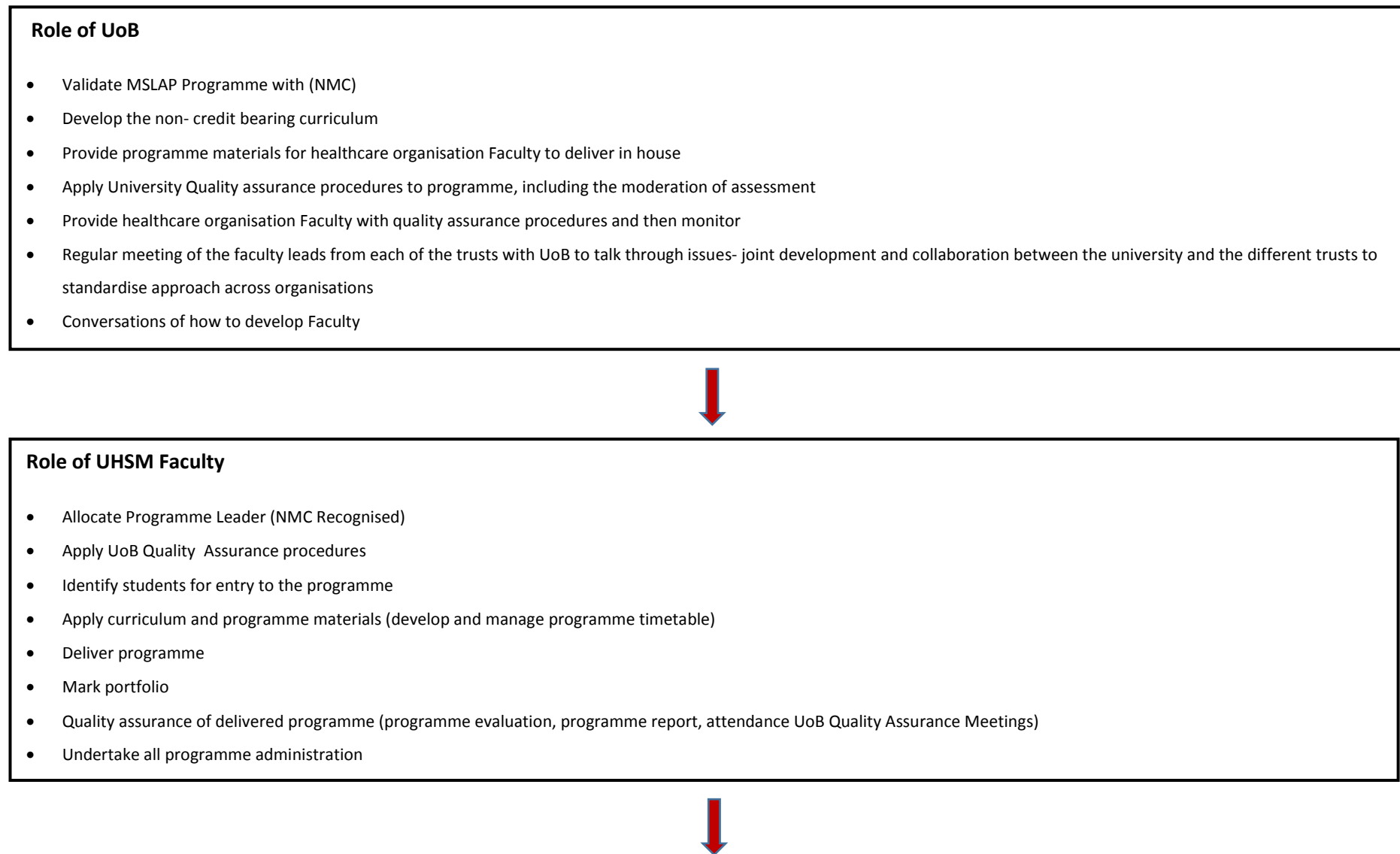
Currently, one designated Lead at the UoB manages the non- credit bearing programme and also delivers the teaching on the credit bearing programme. This one designated lead approach is seen to provide the consistency to delivery and quality assure across the multiple healthcare organisations and has the potential to identify the development needs of its PEF programme team.

#### Role of the UoB for MSLAP Non Credit Bearing Provision

- The role of the UoB as identified from the Professional Education Lead and UoB is summarised in figure 1 but in essence is to:
- Validate MSLAP Programme with NMC
- Provide programme materials for healthcare organisation PEFs to deliver the programme in-house (Power Points, lesson plans). PowerPoints can be changed as long as the main principles are being taught
- Provide healthcare organisation PEFs with quality assurance procedures and then monitor the application
- Regular meetings of the PEF programme leads from each of the Trusts with UoB to talk through issues related to the joint development and collaboration between the university and the different trusts to standardise approaches across organisations
- Chair Staff- Student Liaison committee to identify and address areas of concern
- Regular assessment standardisation updates run by PEFs with support from the UoB
- Provide annual peer observation
- If PEF does not have NMC teacher status, the university needs to ensure a close working relationship to enable observation of all the sessions (Lancashire Teaching Hospital as an example). UoB encourage PEFs to observe delivery methods on the programme from within the different organisations. This provides the supporting network and “cross-pollination”.

The university lead for non- credit bearing mentorship also encourages PEFs to observe her credit bearing mentorship teaching and is planning an annual conference for mentoring. There is no evidence of the development of this.

**Figure 1 - Principles of the MSLAP Pilot Model**



## **UoB and UHSM MSLAP *Original Thinking* around Pilot Model**

### **Role of UHSM Faculty**

Invite smaller Faculty from Trusts who has not offered non- credit bearing MSLAP to join the larger Faculty at UHSM (Stockport, Tameside, Christie) – promotes a sustainability model for MSLAP. Students from these Trusts would attend programme at UHSM. Pilot philosophy fitted at the time with the south sector hospital partnership model whereby Trusts would collaborate. The philosophy changed with the single hospital focus for the future. Pilot to also offer programme places to primary care and private and independent sector organisations.

Contract: for the GM pilot, this is a variation of the current contract between UHSM and UoB. Other pilot sites across GM will consider the viability of the model for other universities and Trusts.

### ***Role of UHSM Faculty with smaller Faculty***

- Provide support and guidance for Faculty
- Provide shadowing opportunities for Faculty (on the job training to observe programme delivery)
- Discussion programme content to supplement shadowing
- Support with admission of students to the programme
- Marking and standardisation exercise (in conjunction with UoB)

***Reality:*** concerns by Trusts of students travelling to UHSM to attend programme. Pilot amended so that Stockport & Tameside will deliver their own in-house programme using same UoB validated programme (consistency of resources, curriculum) supported by UHSM Faculty. Applicants from the Christie will join the UHSM programme.

### **Role of UHSM Faculty:**

- Provide the support as above with the difference that smaller Faculty (Tameside & Stockport) will deliver their in-house programme commencing January 2017 with 10 students per Trust programme cohort
- Support with admission of students to the programme and application University quality assurance procedures (Professional Educational Lead UHSM)
- Marking and standardisation exercise (in conjunction with UoB)



**Tameside Hospital NHS Foundation Trust:**

Trust deliver own programme  
January 2017



**Stockport NHS Foundation Trust:**

Trust deliver own programme  
January 2017



**Christie NHS Foundation Trust:**

Attend UHSM with Faculty providing  
some of teaching in exchange for  
students attending January 2017



**NWPDN:**

Allocate third sector and PVI to  
programme



## The Pilot Model

UHSM hold a contract with UoB to deliver the in-house non- credit bearing mentorship programme and the programme is managed by UHSM in-house programme team. The in-house programme team consists of five PEFs, two of these are the programme leaders. The programme is a UoB NMC validated programme. UHSM are contracted to deliver to a set number of students. The trust can run the programme any number of times and at a time that best fits the trust requirements.

The pilot model is an extension of the PEF led in -house MSLAP non-credit bearing programme that provides opportunities for trusts with a smaller numbers of PEFs to offer non- credit bearing mentorship provision. The idea is that PEFs from these trusts work in partnership as a larger in-house team at UHSM thus producing a programme delivery model that is both viable and sustainable for the multiple organisations that were previously seen as having unsuitable and unsustainable PEF infrastructures. Examples of these trusts are

- Stockport NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- Christie NHS Foundation Trust

This variation of the current contract between UHSM and UoB means that other pilot sites across Greater Manchester will consider the viability of the model for other universities and trusts.

The pilot model is that UHSM become the lead healthcare institution in-house programme delivery team and develop and support the smaller PEF teams from the pilot healthcare organisations to contribute to the UHSM in-house programme. In return these PEFs will identify and send students from their Trusts onto the UHSM programme. There will also be places offered to students from the independent sector organisations, which will build the placement circuit outside the NHS and these students are identified by the North West Practice Development Network (NWPDN).

The pilot module includes the sharing of resources and curriculum validated by the NMC at the UoB. Support comes from the bigger team at UHSM, and UoB lead on the validation, quality assurance and moderation of the programmes.

UoB recognise that there may need to be a different delivery model whereby the university go and teach with the smaller PEF teams in the trusts but there will be an associated cost attached to this delivery model.

## Introduction to In-House PEF Programme Teams involved in this Evaluation

**The PEFs at UHSM NHS Foundation Trust:** There are five PEFs involved in delivering the MSLAP programme. Their experience and teaching qualifications vary. Out of the four PEFs who attended for interview, one Faculty holds a teaching qualification (PGCE). One PEF has 3 years -experience of working on the programme. The 3 years comprises of working at UHSM since November 2016 and previously teaching on the same programme delivered in a different trust. One PEF has worked on the programme since its inception (approximately 3.5 years ago). The identified programme leaders do not hold a teaching qualification.

Two further PEFs have been in post since September 2017 so are relatively new to MSLAP and are therefore undertaking induction and observations of the teaching on the programme. PEFs demonstrate a range of professions: nurse, social worker and physiotherapist.

**The PEFs at Stockport NHS Foundation Trust:** There are two full time and one part time PEF members. The part time PEF member works for two days per week and is due to retire. The programme leader holds a mentorship qualification (ENB 998) and a Certificate in Education. One PEF member holds a mentorship qualification (ENB 998) and a PGCE.

One Faculty member holds mentorship qualification (ENB 998) and Level 7 Mentorship Module. The experience of these PEF members extends multiple specialities such as ICU, blood transfusion nurse, paediatric ED, theatres and we have got ourselves as well, and we have got somebody from community.

**The PEFs at the Christie NHS Foundation Trust:** There is one PEF for the trust who is an Operating Department Practitioner, holds a PGCE and Level Six Mentorship qualification and is a former university lecturer. The NMC recognises that some academic nurses or midwives but instead will have specialist knowledge and expertise. In such instances the NMC require quality assurance that teaching qualifications meet stage for of the developmental framework. Discussions have taken place with Professional Education Lead around ensuring that this is clearly documented,

**The PEF at the Comparison Healthcare Organisation:** There are two that focus on the mentorship programme, both are full time PEFs and refer to themselves as “part time educators”. One PEF holds a Masters in Professional Health Education with the NMC Practice Educator, ENB 998 and the City and Guilds 7307. One PEF holds a mentorship qualification (ENB 998, MSLAP Level 7), PGCE and the NMC Recordable Practice Educator qualification

### Reality of the Pilot Delivery Model

UoB and UHSM stakeholders (Professional Education Lead) have provided the evidence to the reality of the delivery model for the MSLAP non-credit bearing mentorship development pilot model.

The reality was that some of the pilot trusts raised concerns about whether their staff would travel to UHSM to attend the programme. The pilot therefore changed whereby Tameside and Stockport agreed to run their own UoB in-house non-credit bearing programme (commencing January 2017) and Christie Hospital chose to keep to the original pilot delivery plan. The Christie PEF is not aware of any issues of staff from the Christie attending UHSM for the programme apart from the cost of parking for the day (£10) and the potential extra travel term to get there.

The pilot model includes a preparation period for the smaller PEF teams comprising of the shadowing of UHSM PEFs who deliver MSLAP and who would become part of the team for a cohort. The current programme lead at UHSM is also planning a marking standardisation exercise with UoB and this is open to all PEFs irrespective of where and how the programme is being delivered. The Professional Education Lead is also helping to co-ordinate PEF develop towards the PGCE at UoB. This will help to ensure that they meet the NMC Standard requirements (NMC 2008).

### Stakeholder Perspectives of the Perceived advantages of the MSLAP programme and Pilot Programme for students:

- Notion that non-credit-bearing mentorship would be cost effective and would appeal to the multi-professionals and not just nurses
- Delivering the in-house programme as opposed to attending a university- easy access in-house and staff feel more comfortable attending
- Added support, links and relationships with PEFs (Faculty) in-house
- Library resources and PEF available in-house
- Raised awareness of the in-house support and make use of the PEF much more regularly than some of the more experienced mentors
- PEF understanding of students who have submitted work and manage submissions in a timely manner
- PEF have practical knowledge and clinical credibility
- Students easily released to attend the programme

- PEF accessible for student support
- PEF educationally sound who have real life exposure and experience of practice as well
- Need to train at least 52 mentors identified through the age of staff and natural staff movement
- PEF get to know the students and have relationships with the new mentors. Fact that they train mentors to do things properly
- Do not have to travel outside the Trust

Triangulation of data from the online survey questionnaire to students demonstrates how 4 students who attended the in-house programme report that the programme was well taught, good feedback throughout, and they enjoyed the variety of teaching methods and teachers. Data from the 2016-17 Programme Plan UHSM identifies a need for UHSM programme lead to increase the levels of student satisfaction with the module with an action plan to work with allied health professional's educators to engage AHP MSLAP students. Data from the 2016-17 Programme Plan UHSM identifies how the module literature is nursing specific and that new resources have been put in place for the January 2016 cohort.

#### Stakeholder Perspectives of the Perceived advantages of the MSLAP programme and Pilot Programme for Healthcare Organisation:

- People in the organisation value the in-house programme
- Organisation could not sustain or maintain the number of mentors that they have without this approach to mentorship development
- Sustained the number of mentors in the Trust
- Cost (£40 per student (F5) however need to analyse the cost of people delivering the programme..."there is the unseen cost not mitigated for"
- Targeted approach to student recruitment to meet needs of the Trust
- Support placement capacity and capability
- Provide mentorship development for the different kind of nurse who may not access the university programme, i.e. Adaptation nurses
- Link programme to Trust objectives and mission
- Cost effective as PEFs are delivering the programme
- Lack of transparency by the Trust executive team in supporting the programme. However there is an education award for staff who have completed accredited programmes and this

includes staff who has successfully completed the mentorship programme within a 12 month period

- Increased and then sustained over 1200-1300 mentors within the Trust
- The contract with the UoB and Trusts is to deliver the programme to a set number of students, with flexible coot start dates

The 4 mentors who completed the online survey questionnaire identify how the in-house programme referred to trust practice and policies and the no travel was seen as an advantage. Travel.

Before introducing the MSLAP non- credit bearing programme the model mentor is explored

### The Model Mentor

Stakeholders explore their perceptions of the model mentor and these are summarised in table 4

*Table 6 - The Model Mentor*

Qualities	Knowledge		Behaviours
Approachable	Competent and can probe the student's knowledge base		Talent that they have as a nurse with a patient
Good listener	Ability to match the learners learning needs to the way that they learn		Able to facilitate and identify learning opportunities
Ability to positively impact the learning environment	Aware of the students position in the programme		Collaborative and work with others
Student advocate	Understanding of the learning processes		Someone who wants to be a mentor
Committed to being a mentor , wanting to support someone to improve	Knowledge of the bigger picture		Super keen
Professional role model , friendly and professional	NMC standards forms the core of the curriculum		Model how we expect mentors to work, what the role of the registrant is, what the role of other professionals is in supporting students
Having the right values	Clear to people what everyone's role is in terms of students and how they work together to create that support and assessment for the student.		Good and honest feedback

Ability to provide compassionate care			
Support the student who has had a bad experience			
Honest...if they are failing, they are failing			
Trustworthy			

Whilst PEFs do not know the students prior to commencing the programme, they are able to spot talented students who are attending the programme:

*“Once they are on the course we can spot those that are going to be really good. And then you can see them in their clinical areas afterwards” (F3)*

## Theme 2 The MSLAP programme

Documentary analysis (The 2016 Programme handbook) and UoB stakeholders (focus group interview) has generated the information about the programme. This is the programme that the pilot is following.

**Overview and background to the UoB Non -Credit Bearing programme Module: Provided by the 2016 Programme Handbook and Stakeholder Interviews)**

The (MSLAP) programme is appropriate for all healthcare practitioners who support, supervise and assess learning in the practice setting and who do not wish to gain academic credits on completion.

The programme has been designed to comply with the NMC Standards to support learning and assessment in practice (NMC 2008). It has also been mapped against the learning outcomes for the Chartered Society of Physiotherapy (CSP) - Accreditation of Clinical Educators scheme (ACE) and the College of Occupational Therapists (COT) – Accreditation of Practice Placement Educators’ (APPLE) scheme.

It is envisaged that in the near future the programme will be considered and approved by the CSP & COT. Furthermore, this programme will help practitioners to provide evidence that they have met the requirements for appropriately qualified and experienced staff in practice placements (5.6, 5.7 & 5.8) as part of the ‘Standards for Education & Training Guidance’ by the Health Professional Council.

## Philosophy influencing the Programme

Recognised is that students are adult practitioners from a range of disciplines, who bring with them a wealth of life experience, skills and values and prior learning. The team believe that it is important to build upon these attributes and, using a variety of teaching and learning approaches, utilise them as a basis for the students' preparation for mentorship and personal development during the programme. It is intended, therefore, that the approaches used to deliver this programme will recognise these valuable attributes and experiences whilst also encouraging learning, the further development of communication skills and the creation of supportive peer relationships.

The programme team believe that mentorship is an important role and that in order to fully prepare students as mentors, health professionals must be equipped with the necessary knowledge, skills and attitude (as identified by the Department of Education (1998) – Dearing Report) to work in partnership with others, not only within their own profession, but also with other disciplines who can make a valuable contribution to the student learning process. The Trust and University of Bolton recognise that it is important that the programme content is current, research and evidence based and related to practice.

The programme team believe that affiliation with the University of Bolton for quality monitoring systems will ensure that the module remains updated and, most importantly, focussed upon the development of students in their role as mentors. The programme team believe that many students value the importance of achieving the outcomes for learning and assessment in practice. However, some staff may not require the academic credits or wish to complete the various assessments required for the Credited Preparation for Mentorship, therefore have not applied to complete the Preparation for Mentorship programme previously. The programme team believe the non-credit bearing programme will provide an alternative route to achieving the Standards to become a mentor which was previously unavailable.

## Programme Structure and Learning Outcomes

- These intended learning outcomes have been developed to ensure that those undertaking the programme meet the NMC standards (NMC, 2008). When students have successfully completed this programme they will:
- Demonstrate the ability to develop and maintain a supportive relationship with the learner that promotes socialisation and integration in the workplace and incorporates plans for ongoing support.

- Demonstrate the ability to diagnose individual learning need(s), mobilise resources to meet learning need(s) and promote patient centred critical reflection on the learning experience
- Utilise an analytical approach in demonstrating the role and professional responsibilities of the mentee as part of the teaching team in the effective deployment of assessment strategies and processes to ensure safe and effective practice
- Show a critical understanding of key factors that contribute to the development and maintenance of the practice placement as an environment for inter professional learning in which safe and effective evidence-based care is delivered.
- Contribute to the evaluation of the student learning and assessment experience through self/peer/student evaluation and proposes a plan of action to meet shortcomings
- Demonstrate commitment to accommodate student support and advocacy through prioritising workloads; collaborating with other professionals, patients, clients and carers; acting as a resource for others and promoting feedback on the quality of the practice and learning and assessment. Programme plan

The programme will be delivered over 15 weeks using a range of teaching and learning strategies. It states it should 'normally be completed within 3 months'. There will be 5 protected (4 days for AHPs / HCS) study days spread evenly across the 15 weeks. In addition 5 unprotected study days should be negotiated with managers by programme members to complete any directed study, work with the student and supervising mentor, and complete portfolio work for submission in week 15.

A range of teaching and learning materials is available on the Trust intranet, held on the Learning Hub within the MSLAP Folder, within Personal development. The programme does not receive academic credits. However, on successful completion of the programme, production of a work based portfolio with evidence mapped against the NMC/ APPLE/ACE / HCPC Standards to support learning and assessment in practice and countersigned by the supervising mentor/ educator, the programme member will be awarded a certificate<sup>1</sup> from the Trust and UoB and assigned onto the Trusts' local mentor/ educator register

UoB require the student to attend at least 80% of the programme. Students are required to demonstrate how they have made up any study time that they have missed.

The programme is supported with the Moodle (Virtual Learning environment) platform and this is available for the pilot sites.



## The Assessment Brief

The assessment requires the submission of a portfolio of evidence demonstrating specific learning experiences and supporting evidence to cover all the eight NMC standards. This part of the assessment carries no academic weighting but is essential to demonstrate the professional achievement of the eight standards. Students are required to put together a folder of evidence that demonstrates that they have achieved the 8 NMC standards. This will then be assessed by the programme team and externally moderated by the UoB. The programme team verifies the portfolio of evidence by stating whether the student has provided relevant and sufficient exemplars of evidence.

Stakeholders provide mixed views on the efficacy of the assessment:

*“It deals with the concepts, the ideas that we discuss and work around and we talk about what makes a good mentor, what would be the bad mentor, what makes a good learning environment (PEF R4)*

*“Really gives you an insight as to whether somebody is going to be a good mentor or not. Because you can read somebody’s reflection and it is very personal and it’s very...often they are quite personal “(Faculty R3)*

PEFs whom are embarking on their first in-house programme or are joining with the UHSM identify strategies for students to develop their portfolio:

*“We have stressed with them [Mentees] that if they do the work on the day that they come in, this adds to their portfolio of work and gives them the base to move on from” (PEF 5).*

*“Set work on the first session to submit before the second session and then second session again submit something for the third and so on, that might make it a lot easier” (PEF 6).*

Alternative approaches to portfolio development include

- Simulation, but would need a bigger PEF team
- Pilot around coaching
- Sit in on the mentor/mentee interview and provide feedback (*Comparison Healthcare Organisation*)

Below provides an example of the realities for trying something new:

“We would like to have a change and try different ways of doing things... it comes down to time and resources...we are not full time teachers... we have got to fit it in with everything else... we have got a lot of issues going on with students and placements that can take priority”  
(Comparison Trust)

The Professional Education Lead reports on the need to balance the assessment with available resources:

*“If we did anything where we would want to do more practical observation on assessment of the mentors in practice that would add to the commitment of the PEF. The primary thing is making sure it's a worthwhile assessment, but also not increasing the workload” (Professional Education Lead)*

One PEF just embarking on their first marking of the portfolio reflects on its fitness for purpose to effectively demonstrate the competence of a mentor:

*“In total honesty I don't think that it does. I don't necessarily agree that, being able to write an assignment delivers competency. What you want is someone super keen to work with students and that students want to work with... effectively you get people who just work to the marking criteria or work to whatever the criteria is for passing the course” (PEF 6).*

## The Assessment Pass Rate

The pass rate for the portfolio at UHSM is identified below. The pass rate is not available for the pilot Trusts as their first programmes have not yet completed. Comparison of pass rates for UHSM for credit bearing and non-credit bearing has not been made available.

**Table 7 – UHSM Portfolio Pass Rates**

Group	Total Enrolment	Pass (all) 1 <sup>st</sup> attempt	Refer Re-submission	Defer Non submission Mitigation Withdrawn	Pass 2 <sup>nd</sup> /3 <sup>rd</sup> attempt	Fail 2 <sup>nd</sup> / 3 <sup>rd</sup> attempt	Mitigation 2 <sup>nd</sup> attempt
Sep 15	23	13 / 7 (76%) 41%)	1	6	5/1	1	1
Jan 16	22	12/8 (63%/42%)  1 provisional pass awaiting additional evidence awaiting result	2	3	4/1	3	
May 16	24	11/48	9	1/3	Awaiting	Awaiting	Awaiting

The 2016/7 Programme Plan for UHSM includes an action point relating to the need to improve the pass rates which have remained static at around 53% across cohorts however improved from September 15 cohort that was 31% ( B4 Enabling student development and achievement).

The course profile 2015-6 provides further information around the pass and attrition rates (information taken from the 2016-17 Programme Plan UHSM):

*“The number of students enrolled onto the programme was 75 , Of these there were 37 passes , 14 refers waiting to submit (9 due 23/11/16), 8 non submissions, 5 fail and finish (after 3 attempts) , 5 left the course, 1 left the Trust. Therefore of the 69 submissions received the pass rate is between 87 -53% for this academic year.*

*The pass rate for each cohort varies quite widely, however has decreased from 83- 64% in 2014-2015. The number of defers/ mitigation and withdrawal seems fairly static for each cohort at around 21-30%.*

*Nurses remain the highest numbers of professional group accessing the course remain at 63, followed however there is a wide representation from different professions – 7 from midwifery, 4 from physio, 1 application received from ODP but did not start.*

*For this academic year there was a decreased number from the previous year passing on first time 47 - 53%. Difficult to know why this was the case as support, content and requirements for the portfolio have not changed. A number of students have commented on high work load of the portfolio, and difficulties in balancing work and family life The support offered to the students is :-*

- *All resources held on the learning hub which can be accessed from work and home*
- *The resources indicate to which parts of the portfolio they are aligned*
- *The portfolio is explained on Day 1 of the course, the students are informed of the submission date and a tutorial session is offered on Day 4*
- *All students are allocated a PEF tutor with whom they can liaise and they are encouraged to email their work to.*
- *Follow up emails are sent to the cohort after each taught day with guidance, links to the learning hub and additional resources”(2016-17 Programme Plan UHSM)*

The Professional Education Lead feels that the pass rate is on a par with the other Trusts that deliver the same programme. The UoB feel that completion rate is probably higher than the credit bearing mentorship (not necessarily passing at first or second attempt).

PEFs from the comparison healthcare organisation discuss the pass rate of the programme and submission of the portfolio. They report multiple incidences where students do not attend the study days or submit their portfolio:

*“ I am talking about our first time pass rates, it feels like it’s about 50%. But I think obviously they get three attempts to do it. So probably our pass rate is probably higher over the three attempts” (Comparison Healthcare Organisation)*

### **Marking of the Portfolio**

At the inception of the non- credit bearing programme six years ago the UoB worked with the six partner Trusts to develop PEFs marking skills and to facilitate their learning. The majority of PEFs at that time had completed the PGCE but had not marked before. As with any new academic staff the UoB moderated all portfolios. Now that PEFs are established and UoB are confident that they are

marking adequately and within the requirements, they now moderate as per UoB quality assurance procedures.

UHSM PEFs provides evidence of the time spent marking the portfolios and anxieties related to this. A PEF programme team approach supports the process:

*“The team are extremely supportive and take responsibility for each other around making sure that we are able to get through the challenge of marking MSLAP (PEF R2).*

The PEFs from the Comparison Healthcare Organisation are an established team and have experience of marking the portfolios. Their method of learning to mark consisted of the following:

- Initially sit in the room with all the portfolios and two PEFs mark the portfolios, applying UoB marking criteria
- Learned overtime
- Currently double mark every portfolio
- UoB moderate (Comparison Healthcare Organisation)

In terms of confidence to mark the portfolios one member of the pilot PEF demonstrates a proactive approach to ensuring marking parity:

*“I am confident of marking the portfolios as I have taught at University of Manchester and marked portfolios and assignments at levels five, six and seven.... we are going to meet as a group so that we are singing from the same song sheet, that we are marking at the same level” (PEF 5).*

The need for more support from UoB has been identified by PEFs:

*“In hindsight, it might have been good if Bolton had of come over and gone through the marking criteria with us and just told us what they expected, or at least provided us with a couple of portfolios so that we had something to gauge our marking against, ...if one of them had come out and said what Bolton’s expectations were, would have been useful as a team” (PEF5)*

In terms of marking, a different pilot PEF member is marking for the first time

*“I’ve been sent the marking criteria... I’ve got to the point with certainly this portfolio which I need now to go back and verify one or two points to make sure that I’m on the right lines” (PEF 6).*

Evidence from the module evaluations dated January and May 2016 includes the external examiner and moderator praising the quality of marking feedback provided by PEFs to students.

### Preparing to deliver the in-House MSLAP Programme by PEFs involved in the Pilot

UoB identify PEF involvement in preparing to deliver their first in-house MSLAP Programme:

- Advertising the programme internally
- Recruiting students from areas in the Trust (hotspots)
- Negotiating credit bearing or non- credit bearing mentorship (dependent on student's needs)

From the perspective of the pilot Trust delivering their own in house programme the preparation/support from the UoB comprised:

- PEF confirms that adequate resources available for example rooms (achieved via PEF providing information as opposed to dedicated site visit)
- PEF recruit students from the Trust and send the completed student application/admission forms to UoB

PEFs feel that further support was required with this process:

*“Could have done with somebody coming out and sitting with us and just saying, from a Bolton perspective, this is what we expect (PEF 5).*

The role of UHSM PEF programme team is to prepare the smaller PEF teams involved in the pilot to deliver the MSLAP programme:

- Provide support and guidance for PEFs
- Provide shadowing opportunities for PEF (on the job training to observe programme delivery)
- Discussion of programme content to supplement shadowing
- Support with admission of students to the programme
- Undertake marking of the portfolio
- Marking and standardisation exercise (in conjunction with UoB)

The smaller PEF team provided evidence of their preparation to deliver their own in-house programme and this consisted of:

- Spoke to the programme leader at UHSM
- Sat in on the programme deliver days at UHSM (days one and three )

- Adapted UHSM Power points that originated from UoB: kept them the same but added Trust slant
- Went through the non-observed days with the UHSM programme lead (PEF 5)

Shadowing and observing the teaching seems to be the method of choice for PEF development:

*“I’ve sat in on four of the five days to get a gist of the programme, spent a morning or so marking already and just looking over the material” (PEF 6).*

There seemed to be some confusion from UHSM PEF programme team in terms of their role in preparing the pilot organisations:

*“It hasn’t really started to be honest. They have sat in on our days to see the content and structure to give the basis of how they might like to run it. What’s not been clear really whether we’re supposed to be mirroring it, whether they are mirroring ours” (PEF).*

Data from the 2016-17 Programme Plan UHSM does not identify an action related to the continuing professional development of PEFs.

### Key Processes for Successful programme Delivery

The following key processes are identified by UoB and Professional Education Lead that are required to support a successful programme delivery:

- Healthcare organisation PEF infrastructure in place – at least four PEFs to deliver own in-house programme and PEF hold the required teaching qualification
- Quality assurance processes in place
- Funding
- Student tracking process and reporting back to their manager
- Admissions procedure
- Assessment processes, including regular standardisation exercises

## Theme 3 Programme Delivery Realities

### Professional Development of PEFs

The Professional Education Lead recognises the need for the development of its PEF programme delivery team:

- Support PEF with NMC Teacher status and PGCE
- Multi-professional role and multi-professional students, so identify PEF with diverse professional backgrounds and support with educational development (PGCE)
- Expectation that the programme leader will have an NMC recognised teaching qualification (NMC requirement)
- More development around learning theories

For one PEF there is recognition of their need for further professional development and role of the university:

*“I am personally beginning to reflect that we need to be, I don’t know if it is like we previously sort of wanted to run with it. I probably think we should access the expertise of Bolton more often. And it isn’t about being dependent on Bolton, it is about developing us” (PEF 4)*

From the UoB perspective, there is no formal agreement for the development of PEFs and this is due to this group of professionals not being UoB employees. The UoB seems reliant on their established relationship with PEF programme team (UHSM and pilot smaller PEF team) for identifying learning needs. There seems to be an expectation for PEFs to contact them if there is an issue or learning need. In terms of development around teaching and learning and pedagogies, the UoB Lead for non- credit bearing mentorship states how she uses time after moderation to identify PEF learning needs. An example provided includes putting on an assessment workshop. The university leads seems to support PEFs with the assessment process as well as moderate. PEFs are also invited to attend UoB staff development study days and teaching and learning conference every -year. It is not clear if PEFs have attended and the impact of this.

Compared to UHSM and the pilot model organisations, PEFs from the Comparison Healthcare Organisation manage their own development through attending a master’s programme and linking in with their Trusts Learning and Development Team. There is no specific development provided by the UoB and it is felt that there is development offered by HEE NW for PEFs.

Whilst PEFs report on a really good relationship with UoB, would welcome more support in terms of discussing and applying innovative teaching and learning techniques to the MSLAP programme. Where collaboration and discussions take place this is welcomed by PEFs and an example is provided:

*“Day two is a really dry day...[name UoB staff] was explaining how she did it.... it was quite enlightening ...(PEF 4)*



In a different pilot healthcare organisation, PEFs are not sure if they are applying the most up to date teaching and learning theories to the programme and their teaching:

*“We can only go on our experience. It would be useful for Bolton to provide us with a short course on the most up to date teaching practices and assessment methods.... it is only from reading and looking at the internet and things like that, where we have caught up with bits and pieces. We might be way off” (PEF 4).*

For a different PEF member, professional development would be nice:

*“I was just asked could I deliver on the programme in exchange for numbers if you like and I’ve taught before and the fact that you’re teaching from set slides, with I guess limited deviation so it’s fairly simple. I’m confident enough to do that... that would be nice...” (PEF6).*

The support that PEFs would like from the UoB:

- Recognition that when programme leader left, more support was required
- Support with a marking standardisation workshop
- Support but without the reciprocal arrangement

PEFs explored their worries associated with not holding a formal teaching qualification and impact on the quality of the non- credit bearing programme delivery:

*“I feel that I might not give the candidates what they need, because I don’t have that piece of paper that I have got the qualification” (PEF 1).*

*“I feel nervous because I am going to be doing my first teaching here and also because my background is non clinical [non-nursing]. Although there are lots of similarities because my background is practice learning, so there are anxieties about having the knowledge base” (PEF 2)*

*“I think it depends on the level of qualification and expertise and maybe past experiences (PEF 6).*

From a different perspective worries are related to the credibility of the programme being delivered. Whilst one PEF feels confident with the content of the programme and has experience and background to practice learning she questions outsider perceptions of the credibility of the teaching delivery team:

*“If somebody came to review and they are saying well actually you’ve got all these people teaching on this course and none of them have got a teaching qualification, how is that a credible course? Does that make the standard any worse than it would be somewhere else? Obviously not that I think our teaching standard is any different or is any worse for it, but it is a formality, that sets a standard” (PEF 3)*

An experienced PEF member notes a decrease in PEFs with formal teaching qualifications from when the programme first commenced over 3 years ago and this is attributed to changes in the team. This has caused some anxieties in relation to the quality of the programme. However, she recognises how holding a PGCE does not make her the expert:

*“My anxieties would be around, whether I knew what I was teaching” (PEF 4)*

There is also recognition by one PEF the skills required of new PEFs joining the team, and recognition of how the MSLAP teaching role was not previously associated with the PEF role:

*“For somebody new coming in, I understand and I empathise...it is a lot to take on, if you’ve not done teaching before and if you’ve not got a qualification. And the kinds of things we’re expecting people to do, we’re expecting people to teach, we’re expecting people to mark people’s work. We’re expecting people to have understanding of an academic process that was actually never previously in our job before and has been kind of we’ve taken it on board, but it was never something we were ever trained for as well”(PEF 2)*

Experience of the MSLAP teaching role goes some way to alleviate anxieties:

*“In the early days we were very nervous about teaching on the programme....as we have gone through getting over the anxiety of teaching, the subject matter, apart from learning theories which we struggled with in the early days....the teaching matter is our bread and butter anyway” (Comparison Healthcare Organisation).*

Evidence from the module evaluation (January and May 2016) reported that the way that the course was structured had given them confidence and that the balance of teaching and learning was right (100% satisfied with the relevance, up to date materials). Data from the 2016-17 Programme Plan UHSM does not identify an action related to the continuing professional development of PEF and provision of education around teaching and learning (innovative pedagogies). One action relates to the monitoring of systems that have been put in place around the standardisation of marking (B3 learning and teaching).

There is recognition and further debate around academic qualification versus clinical practice:

*"When we are teaching on MSLAP we have the insight to have seen the students.... We talk a lot about what we have seen with students and how that's impacted a student" (PEF 3)*

In two other Trusts the notion of credibility for their PEFs is not an emergent theme. Credibility comes from their expertise in practice education:

*"We're always on the shop floor troubleshooting, being a resource, and offering advice. That links into our credibility of the teaching of the mentorship programme."*

Exploring whether the students feel that the in house programme is as credible as a university programme:

*"I don't think the students even know. I think the students just see all they want is a mentor who is live on the live register. I don't think they care whether it's a Level Zero, Level Five, Six or Seven" (PEF 6)*

### Processes Required and Credibility of the Programme

Due to PEF changes there is the perception by one PEF team that the programme has not been running as tight as it could have and the impact of this is providing a course that is less credible than a university equivalent: It has to be remembered that the pilot is a university programme.

*"In the future is to tighten everything up and get in tune with Bolton a little bit more that actually this is a formal course. It is not just something that we have put on in the hospital, people can turn up if they want and they don't have to turn up and they don't give it in ([portfolio]...I don't feel when I am teaching in a room that people don't feel I am credible (PEF 3)*

*"I think we have come to the conclusion by the way the students have both acted and communicated around particular issues that probably wouldn't be as tolerated in an academic course. And I think we're still in a learning curve about that....." (PEF 4)*

*"We need to be doing things much more formally and much more structure" (PEF 4).*

*"It's about the contracts that the staff at the moment are only employed on a 12 month contract and that has an implication for MSLAP because this time next year you might be in the same boat again having to train up people" (PEF 3)*

The Professional Education Lead acknowledges the impact of change from within the PEF Team and report on perceptions of credibility:

*"I think we feel vulnerable. PEFs [PEF] know the subject, they know the day to day practicalities..... they perhaps need to do a bit more on their underlying theory. I think for a lot of university staff, it can be very hard for them to have the clinical, the practical credibility as opposed to the theory, and so people relate to them differently, it's a different issue to try and manage."*

Stakeholders identified the systems that need to be put in place to deliver an MSLAP programme

**Table 8 - Systems that support the delivery of an effective MSLAP Programme**

Apply UoB Admissions policy	Apply UoB Personal mitigating circumstances procedures
Managing non-submission of assessment of portfolio	Clear programme aims
Clear programme expectations: PEF and students	How to manage the non-submissions: 15 non submissions out of a cohort of 30
How to manage non-attendance: processes for passing students who have not attended the programme	Facilities/equipment to mark at home
Identifying the right resources from the outset, i.e. DVD clips did not work unless we had chrome, adequate rooms.	Planning for the right human resources: recruit to PEF team: right qualifications; ability to deliver at the level; ability to nurture the students; mark at the right level; observe other people deliver (for new programmes and PEF). <i>"It's about the contracts that the staff at the moment are only employed on a 12 month contract and that has an implication for MSLAP because this time next year you might be in the same boat again having to train up people"</i> (PEF 2).
Allocating students to specific multi-professional groups from the outset: builds the relationships	Ensuring multi-professional approach to delivery and slide content
Managing roles (time management and activities, especially if there are two programme leaders.	Administration (all organisations manage own administration
Forward planning such as booking rooms and securing resources	Liaise with managers to consider last year's new graduates were recruited to start next September because they are still hopefully super keen, want to progress, maybe even want to do a Level 7 for a Masters.

A great system is the team itself and this is recognised by PEF in three different healthcare organisations:

*“One thing I have noticed is, how supportive the team are in terms of looking after each other as best as they can around MSLAP. There is a mountain of other work to do, outside of that {MSLAP} (PEF 2).*

#### Percentage of Time spent on the Pilot Programme by PEF Programme Team

UHSM has identified the number of mentors that need training each year and the capacity to deliver five study days per programme, mark and provide student support. The decision at UHSM is for PEFs to deliver 3 cohorts per year with an intake of 20-25 health professionals. The UHSM Professional Education Lead does not feel that the specific percentage of time to be spent by PEFs was stated in the initial contract with UoB and is not explicit to what this time may equate to.

Similarly, the UoB are not prescriptive on the time that each PEF should spend on the programme and this is because each team have got different numbers of PEFs who facilitate and lead on the mentorship.

PEFs from three different healthcare organisations articulate the time spent on facilitating the programme. For example, two from the same organisation provide the same percentage:

*“I would say about 40% of our time” (PEF 3)*

*“I would agree with at least 40%” (PEF 4)*

This next PEF member is setting up their first in-house programme and provides a timeframe for activities completed and this healthcare organisation is hoping to run three cohorts per year and with larger numbers than the current pilot programme of ten:

*“Probably at least a day or two a week... to get everything up and running smoothly and to make sure that we are delivering a quality programme to the students, because we want it to be the best it can be for the students. And to make sure that we are not setting them up to fail” (PEF 5).*

This final example provides evidence of the time factor when preparing to become part of the UHSM PEF team. This PEF member has identified:

*“I’ve sat in on four of the five days to get a gist of the programme, spent a morning or so marking already and just looking over the materials... there’s been a fair amount of time liaising between the departments to try and get people on the course” (PEF 6).*

**Table 9 - Role Activities Undertaken by PEFs when Facilitating the MSLAP Programme:**

Facilitate tutor groups as part of study days and supplementary groups	Deliver the programmes (teaching) 5 days
Marking the assessment (portfolio)	Dealing with the non-submission of the portfolio
Marking at a time when the portfolio is not due for submission	Second marking because somebody is not confident
Workload associated with what the students generate	Prepping for the next course
Continuous activity throughout the year, never a break from it	Providing student review and feedback
Update of Moodle site	Preparation of reports demonstrating Quality assurance (programme leaders report, report staff student liaison)

### Impact of Pilot Programme Delivery on the other Components of the PEF role

PEFs teaching on MSLAP, but also undertaking the traditional PEF duties means that they see the mentor in placement and have the ability to support the student. They also have real and current stories that support the concept of the model mentor:

*“When we’re teaching on MSLAP we often relay lots of experiences we have had with students... if you’re not in a clinical environment, if you might just be in an academic environment you might just be talking to the mentors about what they need to do and this is what you need to do, and this is how you do a good assessment (PEF 3)*

PEFs provide their feelings around the impact of MSLAP on other components of their PEF role:

*“It feels all-consuming because you no sooner finish marking a programme and then the other programme has started. So in terms of the three cohorts a year, that has a huge impact on*

*the workload..... It has to impact because you have to block out time in your diary devoted to these activities and sometimes that's negotiable with your workload and sometimes, it isn't. Generally we make MSLAP priorities in diaries" (PEF 4)*

For the smaller PEF team who are planning to deliver three larger cohorts per year the impact on the traditional PEF role is explored and that being responsive to emergent issues could be impacted:

*"It does have a big impact on my other work...I look after all the educators, supervisors and mentors across the Trust in all of the different allied health professionals, as well as nursing... that is a big chunk of the workforce....that takes a lot of my time and energy. So my diary, at the moment, does not have many spaces in it (PEF 5)*

Whilst MSLAP is perceived as all-consuming one PEF reports of her enjoyment with the role:

*"I really enjoy MSLAP... it does impact on us and it is hard work it is part of the job that actually gives me one of the best job satisfactions and I do really enjoy it. it gives me that job satisfaction, that sometimes I don't get from the other parts of the job.. a really good adjunct to our job" (PEF 3).*

### Sustainability of the Pilot Model

PEFs from the smaller team who are delivering their in-house programme provides their experiences of the initial set up of the programme in terms of securing to teach on the programme:

*"It has been hard work, because we have had to look through the Trust for people who have a relevant qualification, to bring them into, like, a little PEF team to teach on the programme, because there is no way our team could have taught the whole programme" (PEF 5)*

Moving from a pilot to a sustainable model with an increase of cohorts per year and number of students in the cohorts is a requirement by one Trust. PEFs provide ideas of how to sustain the model:

- Despite NHS constraints and hard hitting frontline reconfigurations make sure that we can keep PEFs on board and even recruit some more
- Review the contract with UHSM to allow for larger numbers of students
- Management team in the Trust to support the programme: give time and space to deliver the programme

For one PEF:

*"It's almost like a quick fix type thing that maybe if it doesn't continue that every couple of years when numbers drop, you throw a bit of funding and you do it in one place and you get as many people in and you do a quick fix" (PEF 5).*

Sustaining MSLAP activity with the traditional role of PEF, the PEF provides their viewpoint:

*"I think it would depend on the number of people we get on the course and how much marking I'm required to do... in the long term if they stopped doing university MSLAP courses and it was all in house then potentially I don't think it would be sustainable" (PEF 6).*

The number of PEFs within the organisation and balancing the traditional role of the PEF is challenging:

*"Like a hidden role, I want to do it because it means we get more mentors in areas so I can increase the student capacity or keep the student capacity status quo even in some cases. It's not exactly in the job description I don't think (PEF 6).*

PEFs spending time delivering MSLAP seems to have impacted on the other components of the PEF role:

*"Because it is fully PEF run, there does appear from the outside looking in, to be areas that are not being concentrated on because this extra workload is going on. We're not sure how sustainable it is in the service delivery element from the PEFs" (NWPD).*

*"We're having problems with the current mentors and the support and capacity in areas that perhaps needed more PEF input to ensure the mentor numbers stayed on the live register and they stayed at a decent and acceptable level. And areas have lost capacity because of reduction in mentor numbers. This may have happened anyway, but I think with extra PEF input that could have been prevented" (NWPDN).*

Whilst new members of staff shadow PEFs and observe teaching sessions they are conscious of the expectations of the role:

*"With new people... it is such a heavy workload and the PEF role is so busy, they come in and they have a massive amount to take on board quite quickly of which one is MSLAP... we're then expecting these people to teach learning theories which they have only learned either from watching us or from doing their own research in a book.... I sometimes think not how credible is that, but how right is that... we have had no teaching background, how does that work?....And then we give them a portfolio and say can you mark that,.... we do give*



*them support but maybe there is something we need to look into for the support, and give more support for that. (UHSM)*

Current PEFs provide top tips for PEF's embarking on MSLAP delivery:

- Practice effective time management.
- Adopt forward planning approach
- Block out time for marking.
- Know who is teaching on what day, and that there is a back up
- Pre-planning and flexibility
- Infrastructures in place
- Administration as well as the management of day to day programme requirements

## The Future

Stakeholders provide future opportunities and these include widening PEF to include the wider multi professional team, including medical staff, developing recognised supervision processes and coaching models. Data from the 2016-17 Programme Plan UHSM identifies a plan for the future. This includes:

- Review the outcomes of the stakeholder consultation by the NMC and Health Education England in relation to mentorship provision within nurse education. To analyse the proposed changes / potential new standards for mentorship
- Advantageous to ensure that the requirements and the provision also meets the other AHP requirements and establish ways in which the provision will be endorsed by these other professional bodies
- Ensure a more multi-professional uptake of the provision is established. There has been issues raised by students in the last cohort
- Use the new standardized and streamlined NCB e portfolio with the January 17 cohort and monitoring the results closely (2016-17 Programme Plan UHSM)

Future plans do not include any plans for PEF development.

## Discussion

The framework adopted for this evaluation has provided the evidence to HEE NW of the challenges and opportunities for professional support for learning and assessment in practice in Greater Manchester.

The initial literature review undertaken demonstrates how timely the findings of this evaluation are. This is because there is very little robust evidence that informs delivery models for mentor preparation. The findings should also be applied to the outcomes of the review of the pre-registration standards and associated practice learning requirements.

Findings identify how the term associated with healthcare “mentorship” holds different meanings to different professions and what emerged are key areas programme to consider that promote effective mentorship within this healthcare context. These include:

- Communication within the mentorship programme
- Getting the mentorship relationship between mentor and mentee right
- Addressing the barriers to effective mentoring and these time, lack of support, imbalance of expectations and funding
- Application of mentorship models
- Education within the mentoring programme for both PEF and learners
- Evaluation of the mentoring programme/mentorship

An exploration of professional policy for practice learning and assessment demonstrates that the NMC (2008) and GMC (2012, 2014) both utilise the term mentor whilst the HCPC (2014) favour ‘placement educator’. The NMC are the most prescriptive with their mentorship preparation requirements offering a very clear developmental framework, with 8 identified domains as the core components (NMC 2008). The NMC are also very clear that teachers of an NMC approved programme, of which mentorship is one, should have an NMC recognised teacher qualification or appropriate evidence of mapping against these standards. This also seems to be an implied requirement for the mentorship programme leader role. In one of the healthcare organisations, the programme leaders do not hold this teaching requirement. An exploration of the range of typical models of mentorship preparation found universities and health care organisations all using the NMC standards framework to underpin mentor preparation.

Currently doctors who support the practice based learning for medical students do not attend the in-house mentorship programme. Providing opportunities for this professional group to participate

whilst at the same time expanding the education team to include medical educators provides the vehicle for a truly joined up approach to practice learning. This would also promote the learning organisation (Senge 2006). This would also provide the opportunity for this professional group to be represented at the Practice Educator workshop which is the update provided for healthcare professionals who mentor students. This workshop is co- facilitated by PEF and university Link lecturers.

Commonalities for mentorship development across the professions could include a programme content that focuses on:

- Facilitation of learning and teaching
- Evaluation of learning/ supporting and monitoring educational progress/ guiding personal and professional development
- Creating and maintaining an environment for learning
- Recognising the context of practice that ensures safe and effective patient care through training

An internet search applying search terms associated with non-credit bearing mentorship identified 9 programmes available across the UK (England, Wales and Scotland). Further programmes were identified through use of professional networks. This list was not exhaustive as the non-credit bearing model is becoming the norm. The quality and quantity of information available from each university site differed and what was not clear from the information provided is whether the programmes are delivered by university academics or in-house by the PEF type role, combination of the two or a different delivery model is adopted.

A mixed methodology approach utilising an online survey questionnaire to mentors on the live register at UHSM, documentary analysis and interviews with key stakeholders provided the opportunity to critically explore the experience of the pilot programme from the perspectives of key stakeholders (mentorship students, programme delivery team, North West Practice Development Network and Comparison Healthcare Organisation). Adopting purposive sampling techniques (Creswell 2007, Silverman 2010) resulted in the identification of a range of multi-stakeholder groups whose views were instrumental for the future way mentorship programmes are designed and delivered. Thematic content analysis provided the rigorous data analysis framework whereby links were made between the empirical data and the claims made by the researchers

Stakeholders clearly identified the perceived advantages of the pilot programme:

- Notion that non- credit-bearing mentorship would be cost effective and would appeal to the multi-professionals and not just nurses
- Delivery of the in-house programme as opposed to attending a university
- Library resources and PEF available on site
- Raised awareness of the in-house support and make use of the PEF much more regularly than some of the more experienced mentors

Perceived advantages of the MSLAP programme and Pilot Programme for the healthcare organisation included:

- People (organisation) really valuing having an in-house programme available
- Organisation could not sustain or maintain the quality and number of mentors that they have without this approach to mentorship development
- Cost, however need to look at the cost of people delivering the programme, there are the unseen costs which are not mitigated for
- Targeted approach to student recruitment, which meet needs of the trust
- Provide mentorship development for the different kind of nurse who may not access the university programme , i.e. Adaptation nurses

Students clearly value the teaching by PEFs and academics who are immersed in the practice role and can provide real examples of the challenges faced by mentors. What emerged from the findings of this evaluation are the key processes for successful programme delivery. Further information around processes is included in table 8:

- In-house programme delivery team infrastructure in place – at least four PEFs to deliver in-house programme
- Have a good PEF team and a team that has the necessary teaching qualifications along with NMC recorded teaching status or appropriate evidence of mapping against these standards
- PEF continuing professional development related to teaching and learning and innovative pedagogies
- Robust quality assurance policies and procedures that are applied and measured
- Funding for sustainability
- Identify the right resources from the outset, i.e. IT infrastructure and adequate rooms
- Workload delivery models to balance MSLAP with the PEF outcomes

Importantly, extracted from the evaluation are the challenges identified:

- PEFs demonstrating the appropriate teaching qualifications and teaching skills required to deliver a quality programme Successful completion by student attending the programme
- Whilst the advertised cost per head of student is lower, actual costs could be significantly higher if fully costed based on: PEF time and the required input from the validated HEI to ensure that PEFs have the most up to date teaching and learning theories to inform their teaching
- Lack of clarity regarding whose responsibility it is to ensure that PEFs have ample opportunity to update and develop their expertise (UoB or UHSM as in-house programme lead)
- Dilution of PEF outcomes and potential role conflict, stress and burnout due to the added MSLAP delivery expectation; and recognition that MSLAP delivery was not necessarily a clear part of their role upon recruitment –PEF report not forming part of their job description (not validated by evaluation team)
- The role of UHSM programme team in preparing the smaller pilot teams to deliver the programme if they have not been provided with appropriate continuing professional development to enable them to fulfil the role
- Shadowing of the larger programme team by the smaller could be compromised if the larger PEF team are not up to date
- Some PEFs provided evidence of their worries associated with not holding an appropriate teaching qualification and the impact of the quality and credibility of the programme delivery
- Whilst the HEIs have clear quality assurance in relation to processes, for example, admission, it is important that PEFs apply them
- Impact of PEFs delivering the mentor preparation programme on PEF outcomes and the support of existing students and mentors in practice

Evidence from interviews with key stakeholders identified a shift from the original pilot programme delivery model. This resulted in two out of the three pilot Trusts changing their delivery model from the larger UHSM delivery model concept to delivering their own in house UoB NMC validated programme. The immediate challenge created for one Trust was delivering their in-house programme with fewer than the four PEFs identified by the UoB as the required number to deliver. The impact of this infrastructure on PEFs delivering the programme and on student outcomes requires close monitoring and strategies put in place to manage any emergent issues.

The delivery of the in-house programme is reliant on the trust-based PEF programme led team to deliver the content and assess the work. Individual PEFs have differing views on how they feel about their role of teaching on the programme in relation to how it fits with their existing role. They all work within PEF roles and undertake content delivery and assessment as part of that role. On the whole the PEFs reported that this took somewhere in the region of 40% of their time within their existing role. This calls in to question their ability to ensure that they are still able to provide the same level of support to the placement areas within their remit. Further to this it is conceivable that this may cause a degree of stress or frustration on the part of PEFs who are juggling the competing demands. This is further noted in the comments by some of the PEFs when they state that whilst the programme is enjoyable that the process felt relentless at times as the end of one cohort runs into the end of another. Exploring and implementing a workload model that supports PEFs to sustain the MSLAP teaching role whilst achieving their wider PEF outcomes could prevent role ambiguity and potential role burnout. PEF perceptions of the “hidden” role associated with the delivery of the programme makes it timely to fully understand the impact of its facilitation on achieving the range of PEF outcomes.

UoB recognise that there may need to be a different delivery model whereby the university teach with the smaller PEF in the Trusts but there will be an associated cost attached to this delivery model.

Whilst not impacting on students (module evaluations are good), in interviews, PEFs feel that they are not up to date with innovative pedagogies Whilst there is evidence how the Professional Education Lead at UHSM is supporting PEFs with the Post Graduate Certificate in Education, the 2016-2017 Programme Plan UHSM does not include any actions that provide the reassurance that PEFs continuing professional development needs will be met in the future. The need to maintain academic currency and credibility though continuing professional development is very clearly set out within the NMC standards and there is a need to ensure this is adhered to. This is a significant challenge for the PEF because direct teaching is not traditionally part of their core role and seems very different to the main focus of their existing job description. The implications and impact on future PEF recruitment who are not comfortable with the delivery and assessment of the programme but have a desire to work within the PEF role requires consideration.

Whilst it is arguably the responsibility of individual PEFs to maintain their own professional development (NMC 2015) there is a need to ensure they are best placed to do so. PEF role in the delivery of the programme is synonymous with that of the teachers delivering the core programme at the UoB and it is ultimately the HEI that retains full responsibility in ensuring they have the correct

qualifications and remain up-to-date in their teaching practice. Contracting arrangements should clearly reflect this and set out how on-going development will be addressed and by whom.

## **Conclusion and Recommendations**

This report has illuminated implications and clear recommendations are provided to inform further investment development, strategic planning, research and potentially other delivery models to inform implementation across other STP footprints within the sub region:

1. Recognise and celebrate the experience that an in-house team bring to the mentorship programme, and this is because they are immersed in the day to day activities associated with the mentor role
2. Develop the PEF infrastructure and consider the “hidden” PEF role and costs associated with the in-house programme and this should include fully understanding the impact of its facilitation on PEFs achieving the range of PEF outcomes (UoB state at least four PEFs to deliver)
3. Consider models for non-credit bearing preparation which mitigate against PEF role ambiguity and burnout. This is due to potential role dissonance
4. Provide a framework for the ongoing continuing professional development of PEF. Contracting arrangements should clearly reflect this and set out how on-going development will be addressed and by whom
5. Consider making the MSLAP role an optional component to the PEF role and this should be recognised within the PEF job outline
6. Adhere to the UoB Quality Assurance Procedures to ensure the credibility and quality of the programme
7. Review range of assessment opportunities to include simulation
8. Consider the process for PEFs marking/assessing the portfolio and rationale for second marker

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