

Evaluating the role of mentor for advanced practitioners: an example from community matrons in England

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Abstract

This study evaluates the role of mentor for the new community matron role in England and identifies the implications for others in advanced practice roles. With the introduction of 3000 community matrons in England by March 2008, a national pilot education programme was introduced to prepare them for their role. Given the recent requirement by the UK Nursing and Midwifery Council to introduce support at the advanced level of nursing practice, a purposely developed mentorship module was introduced for those supporting the new community matrons.

A mixed-method approach to data collection was used. This involved documentary analysis of a range of sources and, during July 2006, a self-administered postal questionnaire was sent to all community matrons undertaking the pilot education programme ($n = 70$) with a response rate of 67% ($n = 47$). Individual telephone interviews were conducted with 17 students, and 6 mentors on the purposely developed mentor module. A focus group interview was undertaken with the education programme development team ($n = 5$). Quantitative data were analysed using SPSS and qualitative data analysed using content and thematic analyses.

Despite some initial problems, 96% ($n = 45$) students had access to a mentor during the programme. Overall, the findings reinforce the value placed on individual support for the role and identify the problems associated when support was absent or unsuccessful. For those who had support, there were different expectations of the mentoring role, variation in the quality of their relationship and the perceived value of education to support the mentors in their role.

The study concludes that supporting pioneers to develop new roles when neither party is clear about its strategic direction, nor fully aware of its impact on service, requires risk taking by both parties, and a genuineness, openness and commitment by both in forging the new pathway.

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Introduction

Within the UK, the concept of mentorship is well established to support those undertaking programmes of study leading to a professional qualification. More recently, the role has begun to permeate more widely across health and social care organizations especially at the postqualifying level of activity (Foster-Turner 2006; Hafford-Letchfield *et al.* 2008). Indeed, from September 2008, specialist and advanced nurses undertaking a programme of study leading to a registerable qualification must be supported and assessed by a qualified mentor/practice teacher (Nursing and Midwifery Council 2006, p. 3). This comes at a time of continued radical change within the UK health and social care sectors where it is anticipated that by 2010, role redesign will be commonplace to bring the services into the 21st century and permit the system to be organized around the patient. For example, in England, the National Health Service Improvement Plan (Department of Health 2004) announced the introduction of 3000 community matrons, advanced practitioners, into every primary care trust (PCT) by 2008. As with the introduction of any new role, personal support for the new community matron seems crucial on several counts and relates to their leadership role, their advanced skills development, their underpinning knowledge to support their competence achievement and their confidence in building relationships across the health and social care services. This study aims to evaluate the role of mentor for those completing the national pilot education programme to prepare community matrons to perform their role.

Background

Despite a wealth of literature globally on the subject of mentorship (Hayes 1998; McKinley 2004; Henderson & Malko-Nyhan 2006), there remains some confusion as to the interpretation and expectations of the role (Yonge *et al.* 2007; Andrews & Wallis 1999). There are also various perceptions as to what constitutes the best preparation for mentors, particularly at the advanced practice level. Within the USA, there is an emerging body of

literature advocating the need for support at this level, confirming the value of the mentor as being 'an authority in the field, an educator, a counsellor, a sponsor and having personal commitment' (Barker 2006a, p. 57). Additionally, McKinley (2004) recognizes the importance of mentorship in work-force development. It supports the strategic direction of the individual and by focusing on values and culture, provides a 'human connection' as a way of transferring knowledge, going beyond skills and processes to foster leadership development (p. 3).

Nevertheless, there is a need to differentiate between mentoring and other forms of support, for example, coaching, training, etc. with Hafford-Letchfield *et al.* (2008, p. 169) in social work offering some clarity, advocating the use of coach-mentoring. Here they suggest that mentoring aims to foster 'strategic business goals and personal, spiritual or life growth' while coaching focuses on improving 'performance in a specific area and is often more practice than theory driven'. With the focus on their professional life, Hafford-Letchfield *et al.* (2008) confirm the 'synergistic and complementary' aspect of the two roles and their combined value to the individual.

As to who should take up the mentor role, Barker (2006b) and previously Hayes (1998) advocate that if the strategic mentor is about increasing the individual's leadership skills, then the mentor should themselves be in a leadership role and act as a role model. However, within the UK, Read *et al.* (2001) acknowledged the difficulty advanced practitioners have in finding suitable support especially when the roles they are performing are unique within their trusts. The community matron is one such role, with different interpretation of the role across the country (Rosser & Rickaby 2007).

Effective mentor relationship

Not surprisingly, effective mentorship is dependent on a 'bi-directional' relationship between the mentor and mentee where both parties share the responsibility for its success (Barker 2006a, p. 57). Although Anderson *et al.* (2002) acknowledge the inclusion of organizational resources, especially

time, as one of the benefits of formal mentorship, it is the informal arrangements which Barker (2006b, p. 48) confirms as being of value. She suggests these tend to work better, with the likelihood of both parties wanting to work together sharing mutual respect and admiration. A number of papers reinforce the value of the voluntary nature of the mentor relationship and the mutual benefits to be achieved for its success (Hayes 1998; Barker 2006a; Lloyd & Bristol 2006; Hafford-Letchfield *et al.* 2008). However, it is well recognized that not everyone can successfully engage in a mentor relationship (Hayes 1998; McKinley 2004; Barker 2006a). Barker (2006a, p. 58) refers to different categories of 'toxic mentors' who 'derive energy from oppressive relationships' as identified by Darling (1985) with an acknowledgement that some mentees can be equally destructive in their relationships. Additionally, Henderson & Malko-Nyhan (2006) recognize that the best practitioners are not always the best support, as they cannot necessarily communicate at the appropriate level with their tutee.

Preparation for the role of mentor

There is an emerging body of literature supporting the value of education preparation for the role of mentor (Jinks & Williams 1994; Wilson-Barnett *et al.* 1995; Foster-Turner 2006). Within the UK in nursing, such preparation has been mandatory since 1999, to support practitioners undertaking programmes leading to initial registration (Nursing and Midwifery Council 2006) and developed and updated in 2006 for preparation of practitioners at four developmental stages. Preparation for mentors to support those at the advanced practice level has now been endorsed at the highest level (Nursing and Midwifery Council 2006) and becomes mandatory from September 2008 for those supporting practitioners undertaking a programme of study leading to a registerable advanced nurse practitioner (ANP) qualification. Although such programmes have not yet been identified, the infrastructure to support these practitioners has now been set.

The positive outcomes from a skilled mentor relationship are well known. Eraut (1994) recognizes

the problems of having untrained mentors who are likely to show rather than explain and may even have difficulty explaining as they have become so immersed in the taken-for-granted work of their daily practice, thus potentially disadvantaging their mentee's progress. Until now, the skills of the mentor at the specialist and advanced level of practice have always been assumed. However, new role development is having considerable impact on the whole healthcare work-force with Read *et al.* (2001) acknowledging the importance of management, as well as individual, support if new roles are to be sustained. The need for mentor preparation has never been so evident.

The mentoring role in the context of the national pilot education programme

In May 2005, 85 students from five English Health Communities commenced a 1-year bespoke Postgraduate Certificate in Long-Term Conditions developed and delivered by Sheffield Hallam University in the north of England. Alongside this programme, a 15-credit Masters level module commenced for those mentors supporting the new community matrons. The complexity of the context within which the community matrons and their mentors were expected to function was considerable, including a major re-organization of the PCTs across England (July 2005). The financial impact as well as the threat to job security directly affected their motivation to strive for success. However, from the developers' perspective, the intention was to introduce a whole system redesign through the introduction of the new role, and it was recognized early on that support in practice was crucial to the project success, not only to support the community matrons in navigating their way through their organization but also to facilitate the work-based and distance learning aspects of the programme.

The study

The overall aim of the study was to evaluate the development of the national pilot education programme to prepare community matrons to fulfil

their role and is reported elsewhere (Rosser & Rickaby 2007; Girot & Rickaby 2008). The purpose of this paper is to report the findings related to the mentoring role for the new community matron through the following question:

How successful are the mentors at facilitating the community matron development?

Methodology

A mixed-method approach to data collection was used. This permits triangulation of data to check, compare and confirm views and experiences of the effectiveness of the mentors in facilitating the community matrons to fulfil their role. The following methods of data collection were adopted:

Documentary evidence:

- National steering group minutes
- Two of the three progress reports (progress report 1, progress report 2)
- Four of the five published bulletins (bulletin 2, bulletin 3, bulletin 4, bulletin 5)
- Update report
- Local pilot site evaluations (local evaluation 1,-5)

Self-administered postal questionnaires

The views of community matron students on the national pilot education programme were collected using a purposely developed, 24-item semistructured postal questionnaire during June/July 2006. In addition to data relating to student satisfaction with the programme, questions were grouped around their views on the success of their mentorship relationship and organizational support for their work-based learning. Quantitative questions using a Likert response scale and qualitative questions requiring a discursive response were used. For example, students were asked 'how well do you feel your mentor has facilitated your development during the programme?' and invited to respond 'Very well ... not at all', with the opportunity to explain. Approximately, 2 weeks after the initial mailing, reminders were sent to non-responders. Of the 70 students enrolled on the

programme at the time of the study, 47 responded (67.1% response).

Telephone interviews

Individual semistructured telephone interviews were conducted with 17 students (24%), and designed to elaborate more fully on areas identified in the postal questionnaires and six mentors (from a total of 10 mentors remaining active on the specially developed mentor module). An interview framework was developed for each group of participants and indicative questions were structured around three main areas: the programme(s), the success of their mentor relationship and their organization's support in meeting their needs (Tables 1 and 2). Both sets of interviews took place during July 2006. With the exception of two students and one mentor who failed to provide a valid contact number, all those who responded positively to the invitation to participate were selected. Interviews were recorded and transcribed and interviewees were sent copies of the transcripts for review and confirmation. Reminders were sent to non-responders along with questionnaires 2 weeks after the initial mailing.

Focus group interview

A focus group interview was conducted in July 2006 with the education programme development team comprising five members (the project sponsor, project lead, the education consultant, programme lead and research associate). The interview framework encompassed three main areas: the context of the new role development, their expectations of student need and their views on student support. The interview was transcribed and participants were sent a copy of the transcript for review and confirmation.

Ethics

Ethical approval was gained from the ethics committees of both the faculty undertaking the study and the faculty hosting the education programme. All potential participants were sent an information sheet which provided further details

Table 1 Student interviews: indicative questions

National Pilot Education Programme

Views on how well the programme has met your needs?

Views on whether the programme aims are realistic and achievable?

What aspect of the programme would you change if you had the chance and why?

Views on how well the programme has enabled you to take the lead in coordinating services across the range of provider services?

Mentors

Views on how well your mentor relationship has supported you in the community matron role?

Organizational support

Views on how supportive your organization has been in relation to enabling your work-based learning in practice and how has this been achieved?

End

Any other comments about the community matron role?

Table 2 Mentor interview: indicative questions

Mentor module:

Views on how well the mentor module has met your needs?

Views on the need/achievement of protected time in practice to undertake the role?

Mentoring relationship:

Views on the success of your mentoring relationship with your community matron?

National pilot education programme for community matrons

Views on the success of the pilot education programme in facilitating the community matron role?

Views on the support required to facilitate the community matron in feeling confident in managing the coordination of services and other professionals in his/her case management role?

Organizational readiness:

Views on your understanding of how well your colleagues within the organization understand and support the role of the mentoring relationship with the community matron?

Views on the state of readiness of the/your organization to support this role of community matron?

End

Any other comments?

about the study. Participants were informed of the right to withdraw at any point without consequence. Return of a questionnaire was deemed to indicate willingness to participate. Interviewees and focus group participants were asked to sign a consent form before the interview took place. To ensure confidentiality, introductory letters, information sheets and consent forms were distributed through the host institution and not directly by the researchers.

Data analysis

Qualitative data from the individual interviews and self-administered student questionnaire were transcribed verbatim and content analysed. The responses were read and re-read and using a system of hand sorting, they were categorized by theme by one researcher and checked and confirmed independently by the other. Finally, a process of cross-referencing across themes and to the original

source took place in an attempt to remain close to the context of the original data (Fielding 1993). The focus group interview and documentary data were analysed using a thematic analysis. Both researchers became thoroughly familiar with the data, with one researcher organizing the data into themes and coding them into categories before being checked by the other and final categorization agreed. Manual categorization was possible for all data sets because of the relatively short duration of the telephone interviews and limited volume of the qualitative responses to the questionnaires. The quantitative data from the self-administered student questionnaire were analysed using SPSS for Windows version 11.0, primarily using descriptive statistics.

Validity and reliability/rigour

The semistructured postal questionnaire was assessed for face validity by an expert panel (the development team) as reasonably representing the desired qualities. Content validity was assessed by piloting the tool with six community matrons external to the main study before being finalized (Streiner & Norman 2006). Similarly, individual telephone interview schedules were validated by the expert panel and participants were sent a copy of their interview transcript for validation and confirmation. As a result, a few minor amendments were made for accuracy. To establish trustworthiness and ensure credibility, each researcher listened to each other's tapes and analysed the data independently and then compared coding before final categorization was agreed (Bowling 1997).

Findings

The findings presented in this paper focus on the success of the mentor role and draw on all data sets. It is important to recognize at the outset that although all students worked in a community setting at commencement of the programme, just over half were working as community matrons ($n = 27$, 57.4%) with eight employed as district nurses and six as case managers. The remaining six were employed as either clinical managers or senior

clinicians. Only one of these practitioners did not have a purely clinical role. Of those interviewed, just over half were community matrons ($n = 10$) and the remaining seven were not. Where appropriate, the findings will be reported identifying the students as either community matrons or not.

Expectations of the mentor role

During the development phase of the project, the development team discussed at length their expectations of the mentoring role, where the mentors might be drawn from and what skills they would require. Of greatest concern was the availability of appropriate mentors in practice and this was reinforced by the community matrons themselves when a number of them found difficulty in identifying someone suitable, especially as each was expected to have a named mentor for the duration of the programme. This was reported by four of the five local evaluations with medical input proving particularly problematic:

Finding mentors is difficult as there are a limited number of enthusiastic GPs. (Local evaluation 5)

One student was emphatic about her problem in finding someone suitable:

I had big problems with mentorship, major problems. (Student 48, questionnaire, non-community matron)

Despite these initial problems, questionnaire results reveal that most students ($n = 45$, 95.7%) had access to a mentor(s) during the programme. General practitioners (GPs) were the most commonly cited mentor ($n = 13$), followed by 'matrix of mentors' ($n = 7$) and nurse consultant ($n = 6$).

Initially planned using a '*traditional view that mentors would be clinicians, doctors because it was the clinical skills we thought that people needed, it was the diagnostics, it was the examinations and those sorts of things*' (development team member 2), the development team quickly came to the decision that the mentor role would be more concerned with bringing together the leadership aspects of the community matron role rather than focusing on the individual skills achievement. The confusion around mentor expectations was reinforced by the

students who each had their own expectations of the role. In particular, five students were adamant that the lead mentor could only be undertaken by someone in a senior nursing role, with some critical of the fact that many of the Strategic Health Authorities (SHAs) were encouraging GPs to take on the role:

... whilst for clinical skills it might help ... I think it gives the wrong message because GPs don't understand advanced nursing practice ... I think it gives the impression that we're somehow still their handmaidens rather than forging a path of our own ... and it's somehow doctors once again signing off nursing competences. I genuinely believe they are not in a position to do that as far as advanced nursing goes. (Student 27, interview, community matron)

Some students reinforced the value of a system of matrix mentorship, as recommended by the development team, where students draw on a number of clinical coaches to support their work-based learning with one lead mentor supporting the direction of the new role:

Someone who has been at the forefront of change and knows what it's like to be challenged all the time ... (Student 65, interview, community matron)

One of the mentors reinforced this:

They need somebody with some high level clinical skills but also a strategic and organizational overview to act as that conduit really between the ... project and the organization of making long-term conditions and case management successful, as well as the practicalities of... developing relationships with ... other professionals, GPs and hospitals and other staff/colleagues (Mentor 1).

Overall local evaluation 1 participants perceived mentorship to be crucial to programme success:

Mentorship, a key and must be available. (Local Evaluation 1)

with students commenting in their interview that the absence of a suitable mentor or peer support served to emphasize the difficulties:

I think actually, because it was a new job for me and I was the only one in post, I had nobody to relate to, I had nobody to run ideas off, I had nobody to talk to about what to do best or next, because nobody had ever done it before, so they didn't know either anyway. (Student 61, interview, community matron)

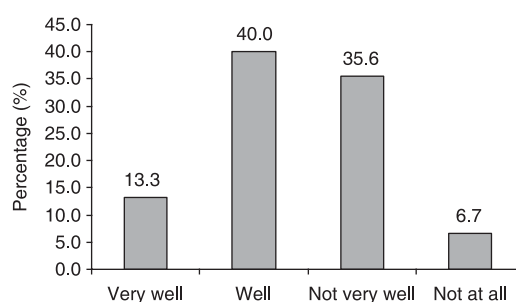


Fig. 1 Responses to question 20: How well do you think your mentor has facilitated your development during the programme?

Success of mentor relationships

Findings illustrate considerable variation as to the success of the students' mentor relationships. A matrix mentorship system was secured by seven practitioners, of whom five found this a positive experience. Of those with only one mentor, 18 found them exceptionally supportive with interview data reinforcing this:

For me, it's been enormously successful. (Student 27, interview, community matron)

It was excellent. (Student 37, interview, community matron)

while 10 found their relationship very unhelpful:

Unable to talk to him even when appointments made, etc. (Student 47, questionnaire, community matron)

When asked 'How well do you think your mentor has facilitated your development during the programme?' Fig. 1 illustrates that just over half of questionnaire respondents ($n = 24$) were positive. Forty students chose to comment further on this issue and again the results present a mixed view (33 negative to 31 positive responses). Negative responses referred to the mentor's lack of availability and time to fulfil the role, as well as a lack of what might be expected from them as mentor. Some also lacked any clear understanding of the community matron role. Positive comments referred to the mentor being 'brilliant for expanding clinical skills and discussing case studies' (Student 9, questionnaire, non-community matron),

giving full support throughout the programme, good facilitation, support and supervision and being responsive to the student's needs.

Documentary evidence is similarly varied. In local evaluation 4, the use of a matrix mentoring approach resulted in '*mixed experiences*' for each student and in local evaluation 5 '*... support from hospital doctors [was] valued more than [that from] GPs*'. Many of the community matrons from local evaluation 2 were mentored by their line managers, and as a result, they reported feeling unable to discuss their frustrations regarding the level of organizational preparedness for the role. Two students commented on this issue during interviews:

... Now because it was a line manager I don't think that was successful at all and that was of very little benefit. (Student 9, interview, non-community matron)

When asked, '*What aspects of the mentor relationship did you find most helpful?*' the majority of respondents commented on the support and facilitation as the aspects valued most by students ($n = 24$). Reflection, supervision and assessment ($n = 15$) along with the mentor's availability ($n = 9$) were also positively evaluated. Those who commented negatively ($n = 4$), pointed to the mentor's lack of availability ($n = 3$), structure ($n = 1$) or poor relationship ($n = 1$).

From the mentors' point of view, all six interviewees felt that they had developed good relationships with their student(s), with one commenting on the success of the matrix mentorship approach:

My role, I feel, is a leadership mentor and you know, overcoming organizational difficulties ... I certainly have had a big input on ... how we're overcoming those difficulties (Mentor 4).

As most students had considerable distances to travel to the workshops which supported the distance learning approach, they acknowledged the value of peer support, which, for some, was as good as or better than the support provided by mentors. In particular, local evaluation 5 and student interviews confirmed the value of learning sets as the most effective source of support for their new role. And this was reinforced by one of the mentor interviewees:

They've probably mentored one another to a degree almost like clinical supervision ... and they've done a lot

of action learning sets within community matrons locally ... (Mentor 6)

The mentor module

Almost all ($n = 5$) of the mentors were positive in their assessment of the mentor module and felt that overall, it had met their needs. Those mentors interviewed hoped to gain considerably from the module, including greater understanding of the community matron role/preparation ($n = 2$) and of the mentoring role/their own mentoring skills ($n = 4$). Four mentors indicated that they had found the learning materials which accompanied the module, particularly helpful:

... I think the literature that they gave [us] was really, really good. I thought the folders and the information was very good (Mentor 1).

From the student perspective, questionnaire data reveal that very few of their mentors ($n = 8$) completed the specially developed mentor module. Of the few who chose to comment on this during interviews, five students recognized its value as giving their mentor a good understanding of the community matron role, and two of these practitioners were adamant that it was necessary for the mentors to complete. Four generally considered it unnecessary as long as they had the skills to support them and time available to meet.

The development team also recognized the difficulty of: '*how [do] you mentor somebody you don't know what the role is?*' (development team member 2) reinforcing the need for some preparation of the mentor role and also '*the benefit of putting this module together was to actually get the mentors to really think about this as a different type of mentoring, this was mentoring to support role development rather than assuring competence which I think ... they are two very different approaches.... so it was not just about mentor preparation it was about mentee preparation*' (Development team member 3).

Discussion

The findings of this study reinforce the value placed on individual support for this new role and the

problems associated when support was absent or unsuccessful. Nevertheless, for the majority who did have support, there were different expectations across the participants as to what was expected of the role, the qualities of a positive mentoring relationship and the value of education to support them in their role. Each of these will be considered individually.

Different expectations of mentorship

Against the complex context within which the community matron role was being introduced, it is not surprising the findings reinforce existing literature on the varied interpretation and expectations of the role (Andrews & Wallis 1999; Hafford-Letchfield *et al.* 2008). Given that just under half of students interviewed were not yet employed as community matrons, many organizations were not yet ready to understand the role or the impact it would have across the workforce (Rosser & Rickaby 2007). This made it difficult for mentors to engage in promoting the development of self-efficacy (Hayes 1998) and realize their developmental potential (Hafford-Letchfield *et al.* 2008), especially at the advanced level of practice.

Despite their initial focus on skills acquisition, the development team acknowledged the work already undertaken in the USA and Australia, as well as across therapist and social work roles with regard to building the practitioners' leadership capability rather than merely develop the processes or skills for the new role. Students in the present study reinforced the value of coach-mentor skills choosing either a matrix mentorship approach or one mentor with both leadership and practice skills to support the 'synergistic and complementary' aspects of the mentor role to support them in practice (Hafford-Letchfield *et al.* 2008). Indeed, in nursing and allied health professions, Read *et al.* (2001) acknowledge the need to build support from a variety of sources into the new role from the outset.

Within the present study, students and organizations set up a range of support mechanisms other than mentors, such as the development of

'communities of practice' as identified by Wenger (1998). Already well established in non-healthcare organizations, 'communities of practice' encouraged students to come together both locally and nationally using online and face-to-face meetings to support themselves in their new role. Communities of practice helped them to articulate their tacit knowledge about their day-to-day problems, share their informal learning and their own interpretation of the role and helped them shape their new direction (Sanders & Heller 2006). As evidenced in the literature (McGill & Beaty 1995; Palloff & Pratt 1999), students valued the series of master classes set up nationally to support a small group of them, as well as action learning sets, organized by some local primary care trusts to enable community matrons to deal with conflict, manage challenging situations, take risks and cope with uncertainty (Hafford-Letchfield *et al.* 2008). Although some acknowledged their difficulties accessing peer support electronically, others gained considerably from the experience.

There were mixed views in the present study as to who would be equipped to give the personal support at the strategic level. Four of the five pilot sites reported the access to appropriate mentors problematic, reinforcing Read *et al.*'s findings (2001). Despite a number of pilot sites targeting GPs as the most appropriate mentor for the community matron, a minority of students were firm in their resolve that key mentors should be senior nurses, with the same professional identity as the community matrons and who understand the context within which the new role is being implemented. This is reinforced by others (Stuart 2003; Nursing and Midwifery Council 2006; Gopee 2008) who advocate mentors as requiring to be on the same part of the professional register to effectively act as role models, develop their confidence and help meet their learning needs. Although the value of mentorship is not being questioned, some creative thinking is required as to who should take up this role. If both parties can agree clear boundaries around the relationship, varied interpretations need not be problematic as long as both parties feel empowered to achieve their common goal.

Success of mentor relationship

The findings present a mixed picture as to the success of the mentor relationship reinforcing the value of a 'bi-directional' relationship, with each party sharing responsibility for its success (Anderson *et al.* 2002; Barker 2006a). Although the development team recognized the need to formalize the role to legitimize the relationship, many students acknowledged the importance of informal support and the mentor's availability and commitment as the most valuable (Barker 2006b; Hafford-Letchfield *et al.* 2008). Indeed, the present study reinforces the value of peer support which was well organized and considered as good as, or better than that provided by their mentor. In contrast, for several students who were linked with their line manager, this informality in the relationship was lacking and their inability to share in the mutual respect and admiration as suggested by Barker (2006b) emphasized their vulnerability to express their weaknesses for fear of influencing their progress within the organization (Clutterbuck 1985; Hayes 1998; Barker 2006b; Hafford-Letchfield *et al.* 2008).

Although all six mentors interviewed enjoyed good relationships with their mentees, this was not reciprocated across all the student participants. This suggests that not everyone can successfully engage in a successful mentor or mentee relationship (McKinley 2004; Henderson & Malko-Nyhan 2006; Barker 2006a), at least not without some preparation and understanding of the role, and a willingness to engage. Indeed, the voluntary nature of the relationships seems crucial to its success where both parties gain from the partnership. If mentorship is about providing a 'human connection' (McKinley 2004), then compatibility in the human characteristics of both parties will influence how well the mentors perform their role. This reinforces Henderson & Malko-Nyhan's (2006) suggestion that the best practitioners are not always the best support. Rather, it is their ability to engage in 'positive mentoring, infuse socialization processes, ascertain graduates' learning styles, and give appropriate feedback' (Henderson & Malko-Nyhan 2006, p. 131) which characterizes a positive

mentor relationship, no matter what level of practitioner development.

Preparation for the mentor role

The findings of this present study demonstrate that very few of the students' mentors completed the purposely developed mentor module with only 10 completing of the 32 who commenced. Given their senior role within the organization and their specific support role, either at the coaching level of skills development or strategic mentor role, there were mixed views from the students as to whether an accredited module was necessary to support this level of practice development. The few mentors who participated in the telephone interviews confirmed how much they had gained from the module, supporting current literature illustrating the value placed on education preparation for the role (Jinks & Williams 1994; Wilson-Barnett *et al.* 1995; Foster-Turner 2006). Examples from other professional groups further endorse mentor preparation schemes such as those which bring together coach-mentors from across a number of health and social care organizations. This can be a liberating and empowering experience for both parties as recognized by Hafford-Letchfield *et al.* (2008). With the advent of new role development for all health and social care professionals, the need to invest in the mentor relationship and its value in giving these pioneers confidence to carve out their new direction has never been so important.

Study limitations

We acknowledge the limitations of our study, constrained by its time limited contract of 4 months over a peak holiday period. Therefore, it was not possible to gain access to a larger sample of mentors. To satisfy ethical requirements and respect the confidentiality of the participants, all initial communication with students and mentors was made through the university hosting the programme and not directly by the researchers. However, we were satisfied that the wide-ranging approach to data collection permitted us to consider the views of individual pilot sites in addition

to the participants. Despite only 57.4% of those undertaking the programme being employed in the new role, there was no key difference between the views of those employed and not employed in the role. Additionally, all were employed in a community setting at the start of the programme and so were able to maximize the learning opportunities offered by the programme.

Conclusion

In conclusion, with the example from community matrons, this study reinforces existing literature across a range of health and social care profession, of the need to support new role development for advanced practitioners. It recognizes the dual aspect of coach-mentor in maximizing both leadership and practice development confirming that even at the advanced practice level, both are essential for success. In addition to the value of formal structured preparation for the mentor role, this study reinforces the importance of investing in a range of mechanisms to support the new practitioner in their role. Supporting pioneers to develop new roles when neither party is clear about its strategic direction, nor fully aware of the impact on service, requires risk taking by both parties and a genuineness, openness and commitment by both in forging the new pathway.

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