Peer Mentoring in South London

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Mentoring is identified as an important aspect in supporting and developing good medical practice by the GMC[1,2]. "Improved access to mentoring" has also been recognised as a key factor that would improve the working lives of doctors[3], and benefits are achieved by both mentors and mentees. There are different models of mentoring and there is currently an increased interest in developing Peer Mentoring schemes in postgraduate medical training in various specialties.

What is mentoring?

Mentoring is a relationship-based process whereby an experienced individual (Mentor) guides another individual (Mentee) in taking charge of their own development, releasing their potential and achieving results which they value[4].

What is the difference between Mentoring and Coaching?

There is often confusion about whether these two terms are the same or refer to different processes. Although there are a few differentiators, there is a great deal of overlap in their underlying principles and the skills required to deliver them. In fact, often the two terms are used together or interchangeably especially in the health care settings. The main differentiators include:

- Coaching is task oriented and focuses on a particular issue whereas mentoring is relationship oriented and seeks to provide an environment where the mentees can explore several issues that are affecting them.
- Coaching is short-term and mentoring is longer-term.
- Coaching is performance-driven and mentoring is development driven.

How does Peer Mentoring differ from classical mentoring?

In Peer Mentoring, the mentor and mentee are closer in terms of age, experience and rank; whereas in classical mentoring, the mentor tends to be older, more experienced and higher in seniority.

Peer Mentoring has several potential benefits over classical mentoring. As the mentor is closer in personal and professional circumstances as the mentee, it allows empathy to develop more readily and enable mutual support and collaboration. It also has the potential for social interaction within the mentoring relationship which may increase the sense of community. This may be particularly important at this time when the European Working Time Regulations have resulted in reduced and more fragmented working hours, making it more difficult for trainees to develop sustained relationships with supportive colleagues. Currently there is no evidence to support whether there is any difference in outcome between Peer Mentoring and more traditional form of mentoring.

Is Peer Mentoring the same as Buddying?

Not really, but there is a potential degree of useful overlap. Buddy systems tend to be used by organisations to help new employees/students adjust to the jobs/environment during their first few months of starting. It is used to provide a one-point access to essential information about the organisation. Therefore, an individual's development is not an expected output. Buddies usually have no specialised training in their role. Mentoring is a more complex relationship and focuses on an individual's development. However, as peer-mentors/mentees are closer in circumstances, this process does encourage some sharing of ideas and experiences, and for mentors to provide guidance in a collaborative manner which is similar to buddying and valuable.

What is the evidence base for Peer Mentoring provision for postgraduate trainees?

Currently there are few published studies in Peer Mentoring provision for postgraduate trainees in the UK. Most of the studies available are from North America and tend to focus on academic medicine instead of clinical medicine, and more classical mentorship instead of Peer Mentoring. There are no studies which compare the outcome of classical mentoring with Peer Mentoring available.

The few recent papers in the UK looked at local pilot Peer Mentoring schemes which were developed in various specialty training programmes including obstetrics & gynaecology, paediatrics, surgery and psychiatry[5-8]. These studies have shown general benefits for both mentees and mentors with high satisfaction, enabling acquisition of new and transferrable skills, and has a positive impact on professional behaviour and outlook. However, these studies all have small number of participants and the results are based on self-reported change. So currently the evidence for Peer Mentoring for postgraduate trainees in the UK is limited but they have shown general interests for its existence suggesting it to be a worthwhile development tool. This correlates with the wider evidence available for (classical) mentoring in medicine or health care professionals.

A literature review in mentoring in medicine by Ramani and colleagues[9] reported that benefits for mentees include socialisation into the profession; help with choice and fulfilment of career path; meaningful involvement in academic activities; and the development of close collaborative relationships. Self-reported benefits for mentors include pride in developing the next generation, building a network of professional collaborators within an institution and being able to disseminate their expertise and skills to a group of mentees. From a mentoring program perspective faculty retention has been reported as a positive outcome. This review is mainly based on studies on classical mentoring in North America so it may not apply fully to our current subject.

A recent study[10] looking at Mentorship in Surgical Training in the UK recommends surgical trainees in all regions should have access to a mentor and be encouraged to develop a mentoring relationship. Interestingly, the study found that current perceptions of an ideal mentor appear to be based on seniority and the directive advice that they can give based purely on personal experiences. The idea of goal-orientated coaching is not widely practiced or well understood. This may suggest that a Peer Mentoring programme may not appeal to trainees due to its peer nature. The study also highlights the lack of formal mentoring/coaching training available which hinders the development of mentoring frameworks and relationships, which may also partly explain why trainees would prefer to have more senior mentors compared to peer mentors.

However, there is some evidence to support the use of Peer Mentoring as a professional development and training tool[11]. Participants identified their peers as collaborators while seeking shared insights, experiences, ideas, guidance, problem-solving and support from them. It allows a non-hierarchical process in contrast to more classical senior-junior mentoring relationships where characteristics such as power, dominance, dependency and transference have been noted. It has been shown that participants may be more willing to share their difficult problems with peer mentors than with senior mentors.

The main difference between Peer Coaching and Peer Mentoring is that the former relies on coaching techniques to encourage increased utilisation of a person's current skills and resources without guiding or advising, but this would ideally be a component of Peer Mentoring if mentors are equipped with coaching. A review study on Peer Coaching for health care professionals also supports its use as a staff development tool and although the process takes considerable time and commitment, it is a worthwhile investment[12]. This review study also made suggestions for the key criteria for successful Peer Coaching: the

peer partnership should be voluntary, mutually beneficial and non-evaluative; the coaching should be focused on strengths the individual already has, goal directed and involve feedback and self-reflection; the coaching relationship must be co-operative in nature; and the coach can be either a more experienced individual or a peer.

Where are we at now?

We don't really know. We know there is increasing interest and recognition that mentoring is a key component in good medical practice. However, it is not clear whether its provision is available to all trainees across specialties and training schemes.

What do we need to think about to move forward?

1. What is the current provision of Peer Mentoring in South London?
2. Who should take part in being mentored? Should it be compulsory/non-compulsory? Should it be opt-in/opt-out?
3. How do mentors best prepare for and develop their role? Do they need training?
4. Do mentors need support in their role?
5. How formal should the role of mentors be?
6. Should every organisation have a Peer Mentoring scheme?
7. How to evaluate the success of a scheme?
8. What is the cost implication of running a scheme for the organisation and the individual?

SURVEY ON PEER MENTORING PROVISION IN SOUTH LONDON

In order to find out about the current provision of peer mentoring available for trainees across South London and attempt to answer some of questions elicited in the briefing document, an electronic survey was sent to all DMEs and MEMs of the 10 Local Education Providers (LEPs) in November 2014. They were asked to provide details of their peer mentoring scheme if it is available. Questions in the survey can be made available on request.

Results

Availability of Peer Mentoring Scheme

8 out of 10 LEPs reported having a peer mentoring scheme available. However, the mentoring scheme provided by Croydon recruits consultants and Staff and Associate Specialists as mentors, which would not fit the "Peer Mentoring" model, and therefore it is not included in the main analysis of this study. GSTT and KCH both use STs as well as consultants as their mentors. GSTT scheme also uses other health care professionals as mentors. As their schemes include the use of STs as mentors as well, they are included in this analysis. However it will be further discussed in the Discussion section how this model might influence the mentoring scheme. The two LEPs (Lewisham and Greenwich, and Epsom and St Helier) which do not have a peer mentoring scheme reported that they would be interested in setting up one in their Trust.

Who are the mentees?

5 of the 7 schemes are available for all trainees across all specialties within the Trust. The Oxleas scheme is only for core trainees. Kingston has only one scheme which is for CT1s in Paediatrics.

Who are the mentors?

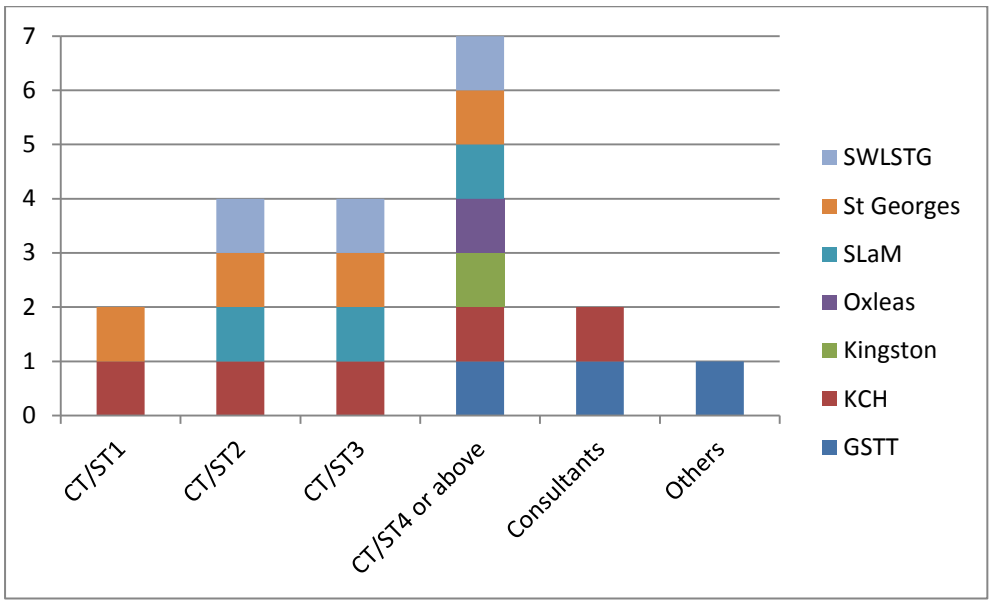


Figure 1. Who are the mentors?

As illustrated in Figure 1, most of the schemes use trainees with at least 1 year of experience as mentors. In GSTT, mentors include other health care professionals.

Opt-In or Opt-Out?

3 schemes (St George's, GSTT, SLaM) use the Opt-In system, i.e. only trainees who sign-up are provided a mentor. 1 scheme (Kingston) uses the Opt-Out system, i.e. all trainees are provided a mentor and they can opt-out if they wish. It is not clear if the 3 others schemes use either system.

When does recruitment of mentees take place?

All schemes recruit mentees at the time when new trainees join the rotation. Both GSTT and KCH also provide mentoring at any time during the rotation when a trainee makes the request to join as well as when a specific trainee is referred (such as due to difficulties).

Average estimated uptake of the scheme

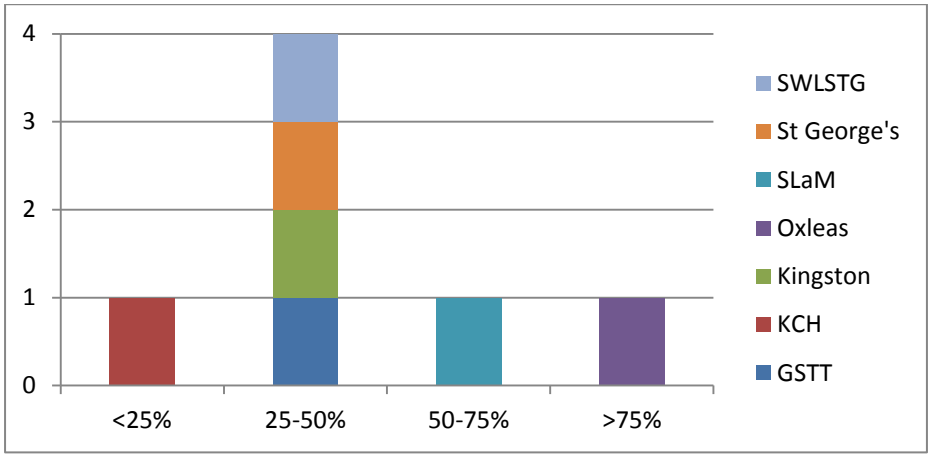


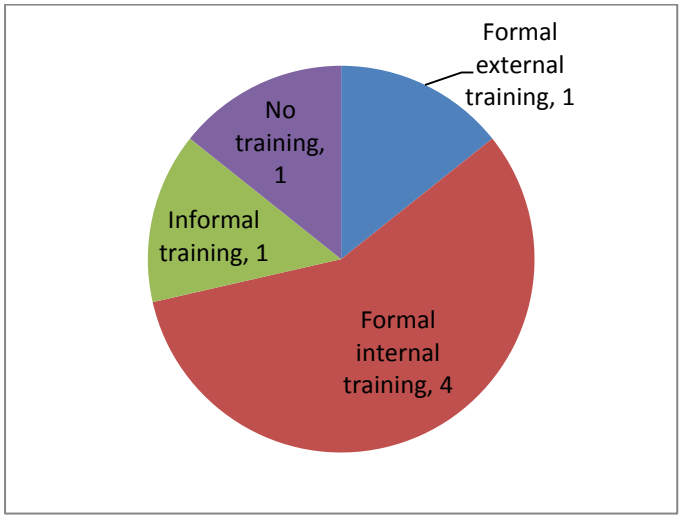
Figure 2. Average uptake of the scheme

Figure 2 illustrates the average estimated uptake of scheme by trainees as mentees. It appears that on average only 25-50% of the trainees are estimated to have taken up the mentoring scheme as mentees.

How often do the mentoring pairs meet?

The frequency of the mentoring meeting varies amongst the schemes as well as amongst each mentoring pair within a scheme. On average the pairs meet monthly to 2-monthly.

Training for mentors



Most of the schemes provide some form of training which ranges from formal external training through to informal training. The Kingston scheme is an informal trainee-led scheme and the mentors do not receive any training.

Figure 3. Training for mentors.

Support for mentors

Both GSTT and SLaM provide mentors with 1:1 supervision. Group supervision is provided for 3 of the schemes (GSTT, KCH, St Georges). Oxleas mentors are provided support by the DME. Support is only provided when required for SWLSG mentors. No support is provided for mentors at Kingston.

Who run the schemes?

Two of the schemes (SLaM and Kingston) are trainees-led. The SWLSG scheme is run by both trainees and consultants. Postgraduate centre of KCH and Oxleas administrate their peer mentoring scheme. St George's scheme is run by Workforce Development Team, and GSTT's scheme is run by the Training and Development Service.

Allocated resources for the scheme

Trainees-led schemes tend to have no allocated resources from the organisation to run their schemes, except that in the SLaM scheme, the trainee organisers received financial resources for training. Administrative resources are available for all the other schemes. Financial resources for training and supervision are also available for the schemes in GSTT, KCH and St George's.

Outcome Data

Only 3 of the schemes have collected data for the outcome of the mentorship. SWLSG and KCH reported positive outcome, however no objective outcomes were provided by these schemes in the survey.

Difficulties in running the scheme

The main reported difficulties in running the peer mentoring scheme are trainee sign-up, lack of time for staff in participating, and mentors not attending supervision.

Discussion

1. What is the current provision of peer mentoring in South London?

7 out of 10 LEPs provide peer mentoring, however 2 of these schemes (GSTT and KCH) do not follow the peer mentoring model strictly as they include the use of consultants and other health care professionals as mentors. It is interesting to note that these 2 schemes are also the only schemes which provide mentoring when a specific trainee is referred (such as due to difficulties). It is not clear from the survey whether more senior mentors are used in these relatively more complicated cases and whether these schemes might have a more supervisory role.

The estimated uptake of these schemes varies from less than 25% to over 75%. There is also large variation in terms of who the mentors are, the use of opt-in or opt-out model, provision of training and support for mentors, administrative organisation and allocated resources for the schemes. Unfortunately due to the lack of objective outcome data from the schemes, it is not possible to analyse whether any of these variables contribute to outcome.

KCH has the lowest uptake amongst all schemes. The main differentiator between this scheme and the other schemes is that it has mentors who are consultants as well as STs. This might highlight the importance of the "Peer" nature of mentoring schemes to encourage uptake. As some trainees are referred specifically to the scheme due to their difficulties, the scheme might be perceived as having a supervisory or monitoring role which affects their uptake. GSTT also includes consultants as mentors but has a higher estimated uptake of 25-50%. It may be possible to speculate that as GSTT scheme is run by Training and Development Team instead of Postgraduate Centre, and its inclusion of other health care professionals mediate the supervisory/monitoring effect.

2. Who should take part in being mentored? Should it be compulsory/non-compulsory? Should it be opt-in/opt-out?

Only 4 schemes provided information about their opt-in/opt-out model. The 3 schemes which use the opt-in model have estimated uptakes of <25%, 25-50% and 50-75%; the only scheme which uses the opt-out model has an uptake of about 25%-50%. Opt-in/opt-out therefore does not seem to affect uptake. As there is no usable outcome data provided by the schemes, it is not possible to analyse whether these 2 models affect outcome.

A recent study looking at mentorship in surgical training in the UK found that they tend to prefer having senior staff as mentors and for the relationship to be more directive[10]. However, it is not clear whether this might be influenced by the lack of understanding in the collaborative nature of the mentoring process by the trainees. Some participants of a pilot Peer Mentoring scheme in CST in the UK[7] also felt that it would be more appropriate to target such a scheme to trainees in difficulty or those who express a need for mentorship. The authors argued that an opt-out scheme is an appropriate means of involving all trainees who could benefit from Peer Mentoring, while avoiding any obligation to participate among those who see little benefit. Voluntary nature of the mentoring relationship is recommended for the Peer Mentoring to work, and restricting it to trainees in difficulties might lead to stigmatisation of the scheme.

3. **How do mentors best prepare for and develop their role? Do they need training?**

   Most of the schemes provide some sort of training. The most popular form of training is formal internal training. However, internal training likely lies on a spectrum from being very formal to slightly formal and informal. Again, it is not possible to draw conclusion from this survey whether the form of training affects uptake or outcome. It is commented by the Kingston scheme that the mentors would benefit from receiving training to better prepare their role in supporting mentees.

   There is a general consensus from literature that training for mentors is a key component for the mentorship to be effective. Mentors need to have clear expectations of their roles and attain mentoring skills, including active listening skills, skills for both positive and negative feedback, skills to balance support and challenge, strategies to recognise problems in a relationship. etc.

4. **Do mentors need support in their role?**

   4 of the schemes provide 1:1 or group supervision. Ad hoc support is provided for 2 other schemes. It is not clear if availability of support for mentors affect the uptake or outcome of the schemes. It is commented by the Kingston scheme that mentors would benefit from having support, however the SLaM scheme commented that mentors do not attend supervision when offered.

   Support can be helpful for mentors where they can discuss problems in their mentoring relationship and get advice. This can be in the form of peer-support forum where mentors can interact with colleagues where they may discover solutions to each other's challenges. Periodic meetings with senior mentors or external consultants could be helpful in building knowledge and techniques in mentoring. Mentors would also benefit from mentoring themselves to reflect and further develop their skills.

5. **How formal should the role of mentors be?**

   This is not explored in this survey. As discussed above, voluntary partnership is highlighted from literature as an important component. Trainees expressed that they prefer to have informal and confidential meetings, and ideally they would like to choose their own mentors[2]. However, allowing mentees to choose their own mentors might be difficult to administrate on a practical level.

6. **Should every organisation have a peer mentoring scheme?**

   Unfortunately, there is no objective data available from the survey response regarding the outcome of peer mentorship. However, there appears to be a generally positive attitude towards peer mentoring. The 2 LEPs which do not have a mentoring programme available currently are interested in developing one.

7. **How to evaluate the success of a scheme?**

   No objective data on outcome has been provided by any of the schemes. This may suggest an uncertainty of how to evaluate the success of a scheme.

   For mentoring programmes to succeed, evaluation is important to allow reporting of current problems and suggesting new approaches to mentoring, or changes to the

existing programme. Grainger[13] suggested evaluation of mentoring should look at process, content and outcomes as noted below:

- Process
  - Clear objectives
  - Regular, purposeful meetings
- Content
  - Feedback
  - Mentee could raise issues and challenge mentor
- Outcome
  - Progress and career development
  - Networking

8. **What is the cost implication of running a scheme for the organisation and the individual?**

   Cost varies amongst the schemes and we do not have enough evidence from this survey to conclude whether availability of resources affect uptake or outcome. The trainees-led schemes receive no administrative and little financial resources and therefore rely on enthusiastic trainees to maintain the schemes. Their uptake does not seem to vary from schemes that do have such resources, however it may pose challenges in sustaining long-term when enthusiastic trainees leave the rotation. According to literature on mentoring, to run a Peer Mentoring scheme successfully, it would require both time and financial budget for administration, participation, training and supervision/support.

Conclusion

There is general interest in Peer Mentoring for postgraduate trainees in the UK at present and there is some evidence to support its use as a professional training and development tool. Currently, there is large variation amongst LEPs in their Peer Mentoring provision and its uptake by trainees, and not all trainees across South London have access to Peer Mentoring. Training and support, and programme evaluation are highlighted as important components to successful mentorship in literature.

Strategies in taking Peer Mentoring forward in South London could include areas as listed below:

- Improving access to Peer Mentoring
- Raising the culture of Peer Mentoring
- Training for both mentors and mentees
- Operational infrastructure of Peer Mentoring programmes
- Evaluation and outcome measurement

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