

NHS Expert Patient Mentoring Project

Evaluation Report on behalf of



by:

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August 2006

INTRODUCTION

Foreword

It is a great privilege to write a few words of introduction to this evaluation report. The following pages describe an innovation in the field of mentoring, describing a unique partnership between people from the NHS Expert Patients Programme becoming mentors to healthcare staff from Primary Care Trusts (PCTs). This document is really their story of a small scale experiment to bring a human face to changing the culture of the NHS.

In 2005 two patient-mentor projects were funded by NHSU's Learning Support team. They represented an important work stream amongst a total of nine national initiatives which were designed to bring mentoring as a form of learning support to those people working in and for the NHS who had little opportunity to experience this approach to learning and personal development.

The report documents an approach to learning through mentoring which honors' the principles of self-managed patient learning which is at the heart of the Expert Patients programme.

Our understanding of, and professional commitment to self-managed learning both for patients and NHS staff provided a framework in which we began to explore the themes which appear in this report.

One of project's implicit themes was to use mentoring as a tool, or more precisely a set of human skills and competencies which could re-shape the nature of the emotional relationship between patients, in this instance people with long-term health conditions, and those who support and care for them.

As you read the pages in this report you are reading both a proper evaluation of two valuable but modest initiatives to bring mentoring into a new perspective, but you are also reading a new story of how things might be in the future. Furthermore, the report invites you to reflect on the potential

contribution patient - mentors could have in shaping the new learning culture in which patients and healthcare practitioners collaborate in local healthcare organizations. To underestimate or undervalue the potential of patients as mentors, facilitators or teachers in building a new learning culture for the NHS would be an error of judgment, a great mistake.

The two patient mentor projects were designed to offer graduates from the Expert Patients Programmes, especially volunteer tutors with expertise in self-managed learning opportunities to be trained as mentors by experts from the Mentoring and Coaching Research Unit at Sheffield Hallam University.

Volunteer mentees were recruited from amongst NHS and other professional staff who support patients with long-term health conditions.

Volunteers were drawn from multi-disciplinary backgrounds which in itself, is an important dimension of the project. Practice nurses, healthcare assistants, dieticians, community matrons along with other health and social care staff participated in the two schemes in the East Midlands and Sussex. It is worth recalling that the projects began at a time of great uncertainty amongst Primary Care Trusts, an unsettling situation which formed a permanent backcloth to the mentoring projects. Without the personal engagement of individual Patient and Public Involvement leads it is unlikely that little would have been achieved over the past year. Several PCT's provided on-going support and encouragement for the mentoring projects for which we are truly thankful.

The recently published White paper 'Our Health, Our Care, Our Say' describes the future direction of travel for the health service, in which patients are considered as active co-managers of service design and delivery. We would say that the patient mentor projects have been delivered in the spirit of developing a learning culture which underpins a future patient-led NHS. In the words of the White paper "We want change to be driven...by the people who

use services and by the professionals who provide them”. This report describes this kind of cultural change in action.

I would like to use this opportunity to publicly thank my two ex-NHSU colleagues who despite all the imaginable difficulties that life after the NHSU could throw at them continued to support patients and NHS staff who were participating in the projects. Kevin Blanks supported activity across the East Midlands, whilst Tris Benedict-Taylor supported similar work in Sussex. Without their professional and personal commitment to mentors and mentees there would in all likelihood be no project to report on.

I would also wish to acknowledge Dr Patrick Hill’s personal help in finding resources for the project at a critical moment during its inception.

Thanks are also due to all participants in the projects without whom our sense of the future would be further diminished. Once again I would wish to pay homage to all colleagues in the Mentoring and Coaching Research Unit for their invaluable contribution to designing mentor training for patients and healthcare staff who support them.

Ed Rosen
Formerly Head of Learning Support
NHSU
2002--2005

Executive Summary

This unique innovative project between people from the NHS Expert Patients Programme becoming mentors to healthcare staff from Primary Care Trusts (PCTs) was conducted with the aim of:

- Releasing the potential of expert patients' knowledge and skills for the benefit of staff so they can help to deliver even better quality healthcare
- Offering mentoring and development opportunities to patients who had completed the Expert Patients Programme
- Offering mentoring and development opportunities to health and social care staff working in patient self-management
- Promoting a wider understanding amongst PCT staff of the Expert Patients Programme as it works toward mainstreaming in 2006 onwards.
- Promoting a wider understanding and take-up of the emerging strategy for patient self-management as it builds on successful pilot projects
- Supporting the patient engagement process as a whole by modelling staff and patients as equal partners in the planning and delivery of healthcare
- Supporting multidisciplinary team working in the NHS

The innovative projects in the East Midlands and South East of England were conducted over five months from February to June 2006.

An evaluation was undertaken by the Mentoring and Coaching Research Unit at Sheffield Hallam University which explored the perceived experience of the programme of both mentors and mentees. The areas of exploration focused on the initial two-day training, the overall programme process and the mentoring relationship; in terms of what worked, what could have worked better and recommendations for future programmes.

The evaluation was carried out in two phases - in the form of post-programme questionnaire and a focus group session.

Questionnaire response rates are often an issue in this type of evaluative research. Estimates of what is a 'reasonable' response rate vary but many studies cite 30% as being typical. Overall the response rate of this study was

over 50% which can be seen as gratifying. However, it should be pointed out that the response rate from mentees was not as great as from the mentors, which may link to the recommendation for future programmes in terms of the need to raise the profile of this type of programme within all-levels and across divisions of the NHS. The size of the pilot means that the number of responses was modest; nonetheless conclusion can be drawn about the positive impact such programmes can make in the future.

Benefits of continuing the Expert Patient Mentoring Programme within the NHS

Responses from both mentors and mentees via the questionnaires, focus group and emails to the programme organisers were enthusiastic about the potential of such mentoring schemes in terms of the beneficial impact on patient care. Some examples of feedback that support this are:

- *'Find all the means you can to keep this programme going, as getting volunteer mentors' (with long-term conditions) 'is such an untapped resource, and as our early experiences of mentoring are so positive in promoting knowledge that helps improve people's lives, this surely must have a place in the NHS's future'.*
- *'The mentees have said that they have learned so much, they understand more, and they have put some of the new skills into practice and they have worked' - from mentor respondent #22*
- *'You have given me a great insight into how a patient is able to take back control of their illness, without being dependant on the nursing/medical profession'. - excerpt from a mentee's email to programme organisers*
- *'Your expertise as both an expert patient and tutor allowed me to see a broader picture. You have given me the knowledge to be able to empower the patients to make informed decisions regarding their management options. Initially it was quite difficult to put into operation, patients always think it's easy for a health professional to give advice when they have no experience of the illness'. - excerpt from a mentee's email to programme organisers*

- *'I think I have also become more empathetic to the frustrations that patients with long term conditions endure on a daily basis'*. - excerpt from a mentee's email to programme organisers

Effectiveness of two-day training

There was an overall positive response to the initial two-day training by the respondents. This is highlighted in a response by one staff member of the Expert Patient Programme who said *'all mentors felt that the training they had received was done well'*. A participant, in their questionnaire response to question 34 'any other comments' said *'thank you for the training which I found most informative and enjoyable'*.

- 95% of the mentor respondents either strongly (24%), mostly (47%) or mildly agreed that after the training they were confident about practicing their mentoring skills while 80% of mentee respondents either mostly (40%) or mildly (40%) agreed
- 89% of mentor respondents either strongly (18%), mostly (47%) or mildly (24%) agreed that the *training* event was *relevant to their role within EPP*.

Key success factors for future programmes

One of the purposes of this report is to highlight some key success factors for implementing future mentoring schemes. In reviewing the feedback from participants in this study the following factors have been identified:

1. **Actively and effectively promoting the benefits of such programmes within the wider NHS** context (all levels, and cross-divisional) which would assist in
2. Getting **active buy-in from all levels and divisions (organisational settings) within the NHS**. This was seen as *crucial to the success of future programmes*. In the first instance this may mean *increasing commitment from senior managers in PCTs* and those *NHS staff with responsibility for extending patient involvement and engagement*. Getting this active buy-in would enable and support

- a. The **degree of desire that potential mentees have in being actively involved in such schemes** in the first place. The desire to be involved is pivotal not only to the success of recruiting engaged mentees to the mentoring scheme but also to the fundamental rationale of the scheme (that is, having a positive impact on patient care)
 - b. Additionally, this support would be demonstrated, at a strategic level, by having the **appropriate resource** to ensure the effectiveness of such programmes. This resource would be in the form of both financial as well as having full-time **scheme facilitation/administrative support** thereby ensuring the smooth running and ultimate success of the scheme.
 - c. This type of concentrated focus/support (scheme facilitation) would also support **ongoing/effective communications streams**, which the participants saw as a key success factor for future schemes
 - d. Aligned with the above participants highlighted the need to have an individual(s) who would act as **scheme champions within the relevant levels and divisions (organisational settings) within the NHS**
3. Another key success factor seen by the participants was the issue of matching criterion; one of the most important factors they stressed was the need to **match each mentor's long-term condition experience with the mentee's speciality area**. While another mentor urged for the 'careful evaluation of voluntary mentors' in terms of their suitability.
 4. The need for **pre-programme training** (both mentor and mentee) which helps participants manage their expectations and sharpen their mentoring skills
 5. **Participant commitment to the programme and the effort to give priority to the mentoring relationship** is key (this commitment was evidenced in

these innovative projects in spite of the infrastructural demise of the NHSU). Garvey (1995)ⁱ and Clutterbuck & Megginson (1999)ⁱⁱ have emphasised the importance of voluntarism within mentoring relationships

6. **Future programme organisers to be aware of the potential tension created from historic power relationships between health care professionals (mentees) and Expert Patient Mentors** - the mentor that discussed this issue in the previous section reiterated it here. They talk about '*working longer*' on getting their mentee to '*answer their own questions*' rather than relying solely on the mentor's experience. Additionally, another mentor, spoke about '*talking in indirect terms, so that the mentees own their answers, as they have been teased into working them out, with a little persuasion from me!*'
7. **Establishing specific programme goals, outcomes and key success factors** with all relevant stakeholders at the outset of each scheme

The above key success factors are not listed in any prioritized order but were given equal weight and importance within the feedback from the project participants. The key success factors will contribute to building a culture of learning in a patient-led NHS.

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1.0 Purpose of this report

Building on the recognition of the importance of mentoring to the nurturing of a new learning culture in the NHS, Ed Rosen (NHSU) commissioned this report.

The purpose of this report is two-fold. Firstly, it aims to present the findings from the evaluative study of the pilot Expert Patient Mentoring Programme (EPMP). The second objective is the identification of possible best proactive criteria/critical success factors for future mentoring schemes which arose from participant feedback in the form of questionnaire and focus group.

2.0 Background

2.1 Background information on Patient Self-Management and the Expert Patients Programme (EPP)

Evidence, from the United States, shows that the care of people with chronic conditions account for about 78% of all healthcare spending. Chronic conditions are those that can at present only be controlled, not cured – for example, dementia, arthritis, heart failure and a range of disabling neurological conditions. In Great Britain, around 17.5 million people are estimated to have one or more chronic conditions. Around 80% of GP consultations relate to chronic conditions. Patients with a chronic disease or complications use over 60% of hospital bed days, and two-thirds of patients admitted as medical emergencies have exacerbation of chronic conditions or have chronic conditions. 10% of inpatients account for 55% of inpatient days. Therefore, chronic disease is not just a primary care agenda. However, many interventions aimed at managing and preventing chronic conditions are delivered in primary and community care settings, and improvements will have a beneficial effect not only on secondary and emergency care but also on social care: many people with chronic conditions receive support from social services such as community equipment, housing adaptations and personal careⁱⁱⁱ.

The Expert Patients Programme, which was set up in April 2002 across the UK has seen over 10,000 people with chronic conditions develop their capacity for 'self management', that is, life skills to cope with a chronic condition. There is increasing evidence that patients, with proper support, can take a lead in 'self-managing' their conditions.

A review of the available UK and US research on self-management conducted for the Expert Patients Task Force by Professor Julie Barlow and Dr. David Ellard (2004)^{iv} of Coventry University UK showed that the benefits include reduced severity of symptoms, significant decrease in pain, improved life control and activity, resourcefulness and life satisfaction.

Patient self-management or 'Expert Patient' Programmes are not simply about educating patients about their condition or giving them relevant information – they are based on developing patients' confidence and motivation to use their own skills, information and professional services to take effective control over life with a chronic condition. The programmes recognise that people with all kinds of long-term conditions are dealing with similar issues on a daily basis: for example, pain management, stress, low self-image and the development of coping skills

The Expert Patients Programme course is run over six consecutive weekly sessions of 2½ hours each week. Each week, two volunteer tutors lead 8-16 participants through structured course material delivered from a scripted manual covering topics such as relaxation, diet, exercise, fatigue, breaking the symptom cycle, managing pain and medication, and communication with health care professionals. The course is based on the **Chronic Disease Self-Management Program** (CDSMP) developed and researched over the past twenty years by a team at Stanford University, California^v.

2.2 Current position - Patient Self-Management

A new Patient Self-Management strategy is emerging, signalled by documents such as Improving Patient Self-Management (2004)^{vi} and recent events held

by NATPACT (the National Primary and Care Trust Development Programme), and based on successful UK pilot projects which have seen reductions in hospital admissions and length of stays, more appropriate referrals and faster response times for social services assessments. *There are strong indications that this strategy will see multi-disciplinary Patient Self-Management Teams recruited in local areas.*

2.3 A brief description of the Expert Patient Mentoring Pilot (EPMP) proposal

The Patient and Community Engagement Unit, NHSU regions and the Expert Patients Programme worked together to recruit teams of health and social care staff engaged in patient self-management in ten locations in England. Depending on the progress of the Patient Self-Management strategy, these teams may or may not already have been formally constituted as Patient Self-Management Teams.

In the original proposal each Patient Self-Management team would be mentored by a pair of EPP volunteer tutors. These twenty mentors were to be given a short course in Mentoring. At least one individual from each of each pair of mentors was to complete this course. The pilot hoped to recruit 20% (i.e. 4) of the mentors to the City & Guilds qualification in Mentoring, a six to twelve month programme for active mentors.

Each mentoring relationship (between a pair of expert patients and a patient self-management team) was to be supported for one calendar year. The exact nature of each relationship was to be negotiated by its participants, with support, active involvement and guidance on how to achieve the most productive relationship from the project partners. It was envisaged that EPP mentor pairs would also have the opportunity to share with their peers; this could be constituted as a self-supervising action learning set or similar, either face to face or by telephone or email. There was also a preference for providing some form of external supervision for mentors.

At the end of the year, the mentoring relationship was to be celebrated and closed unless teams wished to make their own arrangements to continue.

A number of NHSU Regional Offices were approached informally including the North East, North West and East Midlands and indicated their interest in participating should the original proposal win funding. Ultimately the East Midlands and the South East regions participated in the mentoring pilot scheme. Both patient self-management teams as well as individuals were mentored by EPP mentors.

The need for the mentoring project

- Releasing the potential of expert patients' knowledge and skills for the benefit of staff so they can help to deliver even better quality healthcare
- Offering learning and development opportunities to patients who had completed the Expert Patients Programme
- Offering learning and development opportunities to health and social care staff working in patient self-management
- Promoting a wider understanding of the Expert Patients Programme as it works toward mainstreaming in 2005-2006
- Promoting a wider understanding and take-up of the emerging strategy for Patient Self-Management as it builds on successful pilot projects
- Supporting the modernisation process as a whole by modelling staff and patients as equal partners in the planning and delivery of healthcare
- Supporting multidisciplinary team working in the NHS

2.4 The initial proposed significance of the mentoring pilot

It was felt that for NHSU regions, the mentoring pilot would deliver an innovative programme, that would contribute to a patient-led NHS in which patients and health and social care staff would learn together. For the Patient and Community Engagement Unit, it would meet an established target to deliver learning and development opportunities for Self Management alumni.

In broader terms, it would promote both the work and participants of the Expert Patients Programme in specific local health communities and support the process of embedding self management and chronic disease strategy across health and social care.

2.5 How the project was to be managed

Overall responsibility for the project was to lie with the Learning Support in collaboration with designated NHSU staff from the Trent and South East Regions Patient & Community Engagement Units. A member of this unit was to be designated as project lead to ensure that timescales and budgets were met. The project lead would seek advice from a Steering Group which would include representation from the involved NHSU regions, NHSU Learning Support, the Expert Patients Programme and others as appropriate.

3.0 Profile of scheme evaluation respondents

3.1 Overview

In all there were twenty-four mentor questionnaires sent out of which fifteen were returned. There were sixteen individual and two sets of group mentee questionnaires sent out of which four individual questionnaires were returned.

What follows is the profile of the individuals who responded to the questionnaire, which includes age, gender, geographical location, ethnicity, status of employment and nature of mentors' condition(s) as well as mentees' specialist areas. This is necessitated by the fact that this evaluation can only report on the individuals responding to the questionnaire.

Despite the fact that the matching of mentors to mentees seems to have had an impact on the number of questionnaires returned - more so with the mentees - approximately 70% of the mentors gave feedback via the questionnaire. Of the fifteen mentors that returned their questionnaires nine had not been matched, while one of the four mentees that gave feedback via the questionnaire was not matched. On first glance this may appear to hinder

the strength of the feedback in terms of any recommendations that come from it however, there are two things to consider here:

1. the quality of the feedback will greatly assist in the design and implementation of future programmes
2. participants were so passionate about the value of such a programme that they took the time to fill out the thirty-five questions asked.

Additionally, it should be remembered that this programme was implemented in a time of major upheaval within the NHS (upheavals within Strategic Health Authorities and Primary Care Trusts) as well as the abolition of NHSU.

3.2 Breakdown by age

All percentages cited in this section are of the total number of respondents in each of the categories presented.

82% of the mentors were fifty years of age or over, while only 20% of the mentees were in this age bracket. The remaining mentors ranged in age from thirty-six to forty-nine and the remaining mentees ranged in age from twenty-two to forty-two.

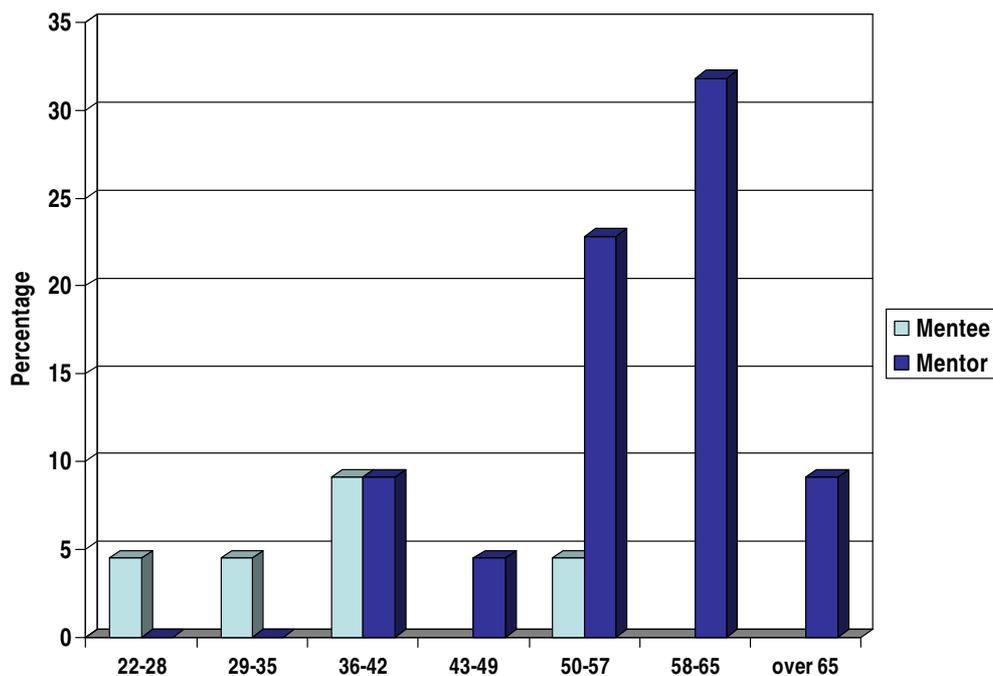


Figure 1 - Age of questionnaire respondents

3.3 Breakdown by gender of questionnaire respondents

Gender	Mentees	% of total	Mentors	% of total	Total
Female	5	100%	14	82%	86%
Male	0	0%	3	18%	14%
Total	5	100%	17	100%	100%

Figure 2 - Gender of respondents

Breakdown by gender - total number of questionnaires sent out

Gender	Individual mentees	% of total	Mentors	% of total	Total
Female	16	100%	19	79%	87%
Male	0	0%	5	21%	13%
Total	16	100%	24	100%	100%

Figure 3 - Gender - total number of questionnaires sent out

Of the respondents that returned feedback via questionnaire women represented 86% of the population and males 14%. The gender response rate is comparable to the gender breakdown of the questionnaires originally sent out - women 87% and males 13%.

3.4 Breakdown by geographical location

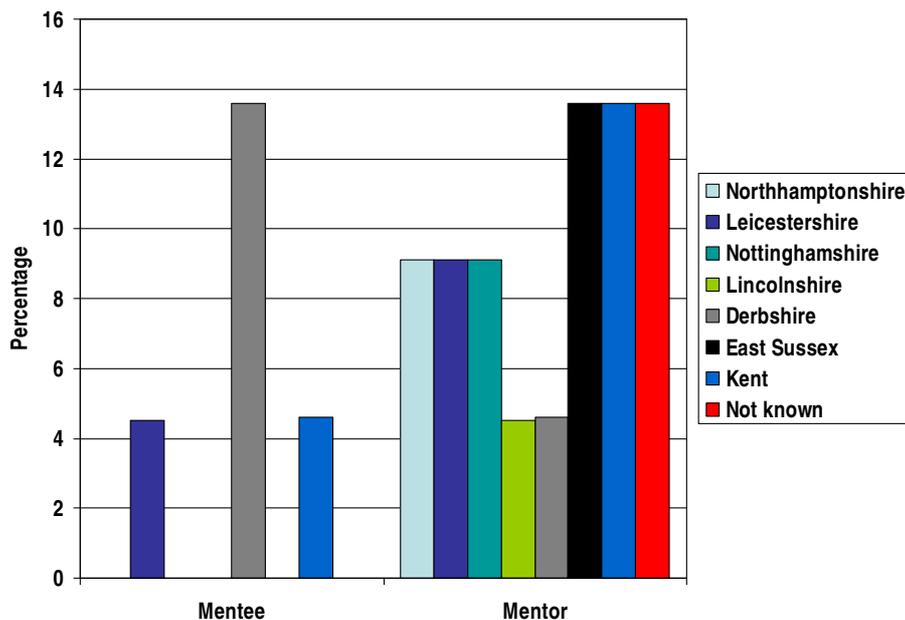


Figure 4 - Geographical location of respondents

Four mentees came from the East Midlands region and one mentee came from the South East region. Eight of the mentors came from the East Midlands region, six came from the South East region while three mentors did not report their geographical location.

3.5 Breakdown by ethnicity

All the respondents reported that they were of white ethnic origins.

3.6 Breakdown by employment

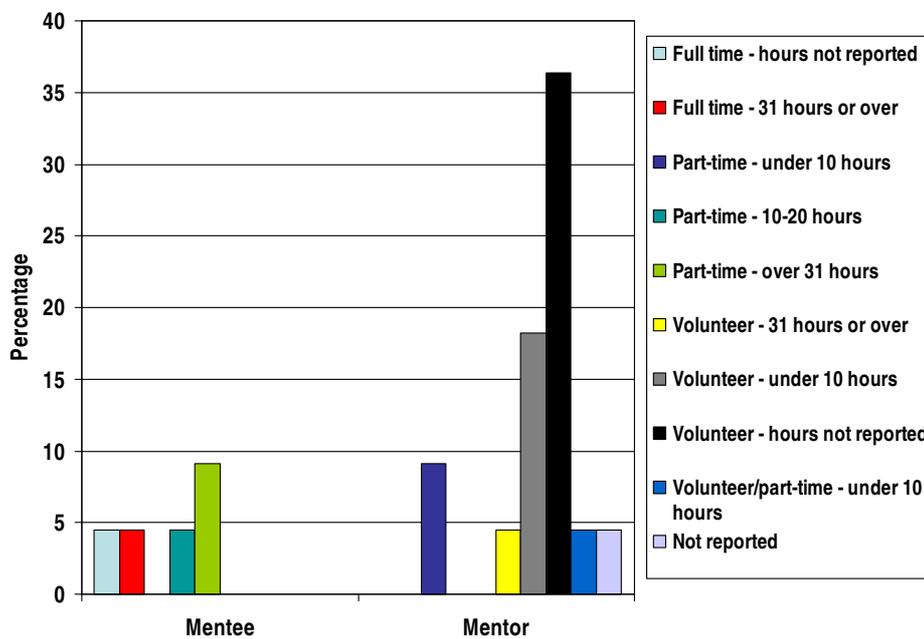


Figure 5 - Employment status of respondents

3.7 Length of time involved with Expert Patient Programme

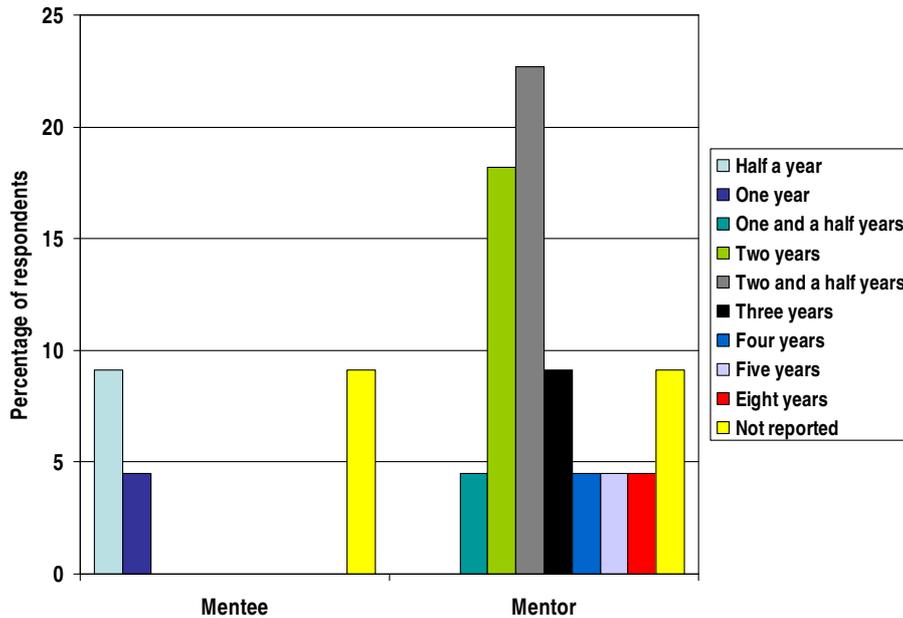


Figure 6 - Length of time involved with Expert Patient Programme

While 18% of the respondents (9% -mentors and 9% - mentees) did not report the length of time they had been associated with the EPP, nearly 64% (all mentors but one) reported being associated with the programme for two years or more.

3.8 Mentor's long-term conditions

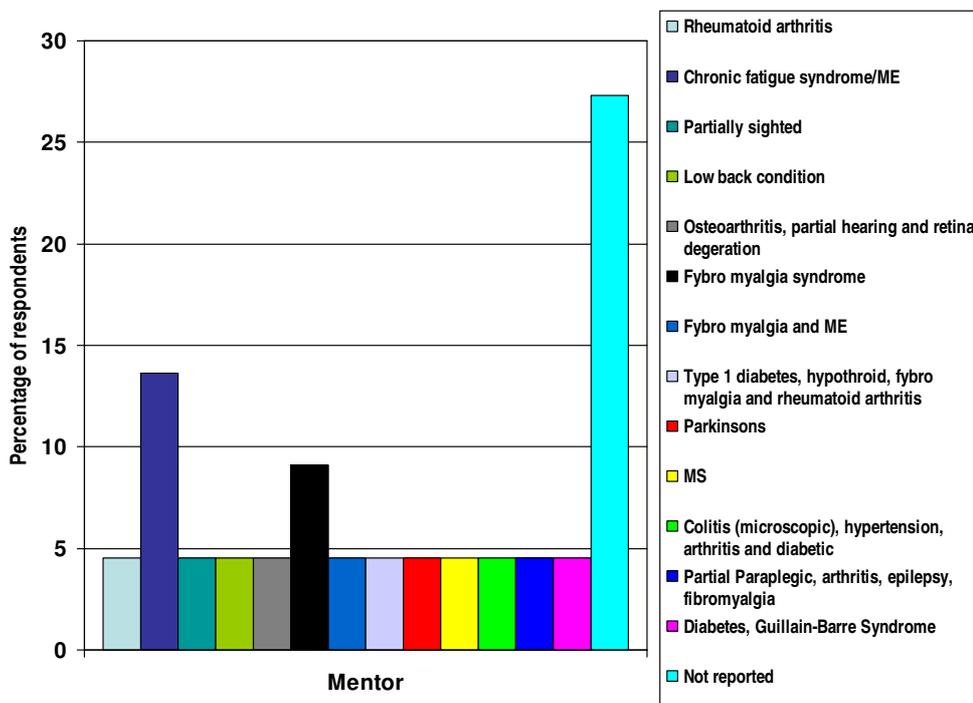


Figure 7 - Mentors' long term conditions

While 27% of mentors did not report the types of long-term conditions they were self-managing, 41% reported multiple conditions. 40% of the mentees' specialisms concentrated in the area of elderly care and rehabilitation while another 40% focussed in the area of, what they termed as, long-term or complex long-term conditions. 20% of the mentees specialised in the area of heart failure.

4.0 Intended project outcomes

Mentors

1. A certificate of attendance for attending the initial training session
2. Experience of honing mentoring skills for the expert patients
3. Personal development
4. A greater awareness of the principles of self-management in relation to Patient Self-Management
5. Improved confidence and ability to personally contribute to the Patient Self-Management agenda
6. Increased awareness and confidence in relationships between patients with a chronic disease and staff involved in Patient Self-Management
7. Development of knowledge and transferable skills in mentoring theory and practice
8. Opportunity to directly relate to and negotiate the patient experience/staff experience of Patient Self-Management

Mentees (NHS staff)

There were three areas of intended outcomes:

Personal development

1. A greater awareness of the principles of self-management in relation to Patient Self-Management.
2. Improved confidence and ability to personally contribute to the Patient Self-Management agenda.

3. Increased awareness and confidence in relationships between patients with a chronic disease and staff involved in Patient Self-Management.
4. Development of knowledge and transferable skills in mentoring theory and practice.
5. Opportunity to directly relate to and negotiate the patient experience/staff experience of Patient Self-Management.

Team working

1. Improved multidisciplinary team working.
2. Clarity in definition and process required for Patient Self-Management and the role of the team within this.
3. Acknowledgement and respect of individuals' roles in their contribution to Patient Self-Management.
4. Shared decision making.

Organisational development

1. Sustainable organisational developments implemented around Patient Self-Management (including increased provision and uptake of the Expert Patients Programme).
2. Meaningful contribution to the statutory obligations of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) around Patient and Public Involvement.
3. Promotion of behaviours required by the Choice agenda.

Making a distinction between outcomes and report findings

It is important to make some distinction between these outcomes and the findings in this report. Whilst it is possible to gain some insights into the added value that similar future programmes may bring in relationship to the above, it should be recognised that this report draws solely on participants' feedback immediately at the end of the programme. Evaluation of some of the desired outcomes listed above might be more appropriate after a longer

period of time has elapsed and draw on additional data (i.e. establishing key performance indicators aligned with each outcome). Nevertheless, it should be noted that participants reflected the importance of continuing this type of mentoring programme within the NHS.

The evaluation methodology was directed to exploring what worked, what could have worked better and recommendations for future programmes.

5.0 Programme Structure

5.1 Recruitment

Mentors were sought as volunteers from the existing pool of trained tutors emerging from the EPP in the Trent and the Leicestershire, Northamptonshire and Rutland (LNR) divisions of the **East Midlands** as well as the Kent/Medway and Surrey/Sussex divisions of the **South East** of England. This meant that they were accredited in self management, which is a key part of the emerging Patient Self-Management strategy. The principles of self management formed the focus of the mentor relationship, supporting staff in the acknowledgement of their potential to contribute to Patient Self-Management. The Mentors were also interested in mentoring and prepared to learn more about it as part of their own personal development.

Mentees were sought as volunteers from teams of health and social care staff in local health communities who came into frequent contact with people with long-term conditions (or staff who manage, train and significantly support them in their work). An obvious starting point was seen to be the nursing staff who were likely to take on case management under the emerging Patient Self-Management strategy. However, other main providers of care include GPs, practice nurses, health care assistants, pharmacists, dieticians, opticians, podiatrists and physiotherapists. It seems sensible to encourage diverse groups of learners extending to social care and accident and emergency professionals if appropriate. It was thought that Trusts in local areas would have ideas about how individual teams of mentees might be constituted and their full collaboration was sought in establishing the project. Additionally, because of the volunteer aspect of mentee involvement in the project it was expected that they would be ready for and embrace personal change. It was anticipated that this

willingness to change would be discussed and agreed on as part of the mentoring contract in each group.

5.2 Training and support

Following the recruitment of the mentors, a two-day residential programme of training was provided by *The Mentoring and Coaching Research Unit* (Faculty of Organisation and Management) and *The Centre for Professional and Organisational Development* (Faculty of Health and Wellbeing) at Sheffield Hallam University. There was also a half-day development session for the mentees.

It was recognised that the mentors had needs deriving from their condition(s) and those were taken into account. As well as training for the mentors, supervision and support was to be provided for them. This support would cover both their role in the project and their continuing personal health and well-being. It was thought that quarterly away-days would enable mentors and mentees to gather together to share experiences and provide mutual support. It was thought that such days might also be helpful for capturing information for evaluation purposes. However, it was recognised that this type of involvement would require considerable time away from practice and an offer of some money to pay for 'backfill' to mentees was to be a consideration in the project proposal. It was envisioned that a commitment to releasing staff for a total of six days (three full days and six half days) over the period of six months would be the maximum requirement.

6.0 Evaluation

6.1 Evaluation methodology

This evaluation was carried out in two phases - in the form of post-programme questionnaire and a focus group session. The questionnaire was based on collecting data on three levels. One, to ascertain the effectiveness of the initial two day training and secondly to gain insights, in programme process terms and lastly to look at the effectiveness of the mentoring relationships. All aspects look at what had worked, what could have worked better and recommendations for future programmes.

The questionnaires were analysed using the industry standard computer package for analysing data called SPSS. The evaluation was then augmented by focus group feedback.

All percentages cited in this document are of the total number of respondents in each of the relevant categories.

6.2 Evaluation of initial two-day mentoring skills workshop - *questionnaire responses*

The evaluation of the two-day workshop was in the form of eleven-item section of the questionnaire, which was created by members of the Mentoring & Coaching Research Unit at Sheffield Hallam University. The questions, in the main, covered issues relating to the content and delivery of the workshop (see Appendix 1 for a list of the questions asked).

6.2.1 Mentors' evaluation of initial training

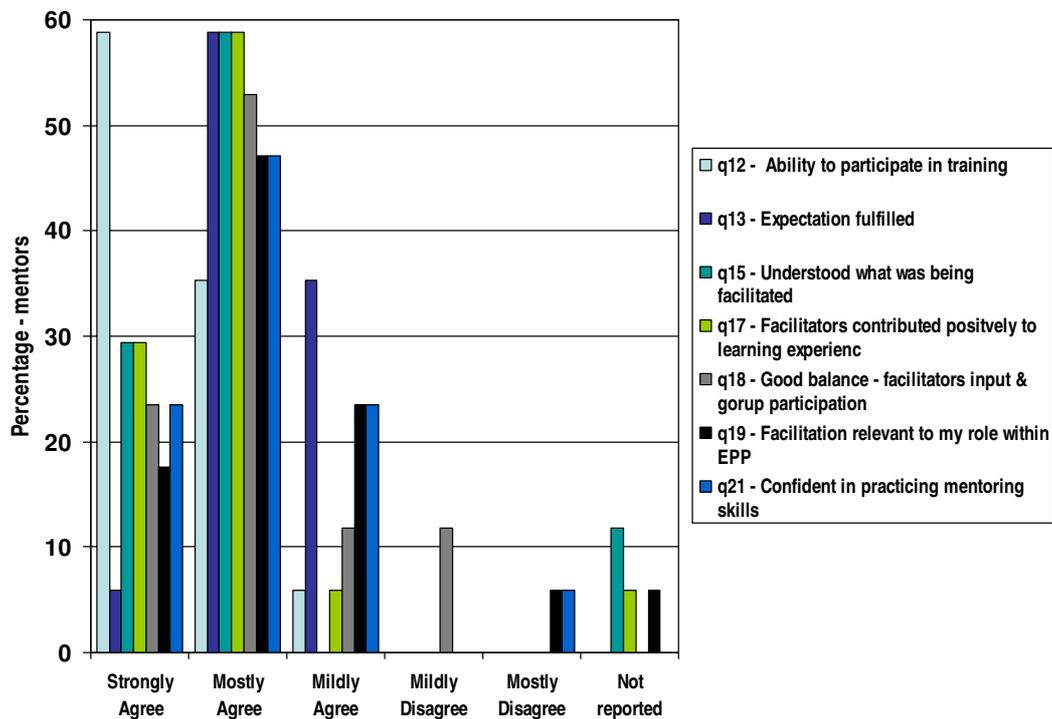


Figure 8 - Mentors' evaluation of initial training (questions 12,13,15,17,18,19 and 21)

As is illustrated in the above graph there was an overall positive response to the initial two-day training by the seventeen respondents that were programme mentors.

Increased confidence in practicing of mentoring skills:

- 71% of the mentor respondents either strongly (24%) or mostly (47%) agreed that after the training they were confident about practicing their mentoring skills, while a further 23% mildly agreed. This compares to 6% who mostly disagreed that they had increased confidence about practicing their mentoring skills.

Relevance of training to mentors' role in EPP

- 65% of mentor respondents either strongly (18%) or mostly (47%) agreed that the *training event was relevant to their role within EPP* while 24% mildly agreed. This compared to 6% who mostly disagreed that the training had relevance to their EPP role.

Mentors expectations met

- 65% felt that their *expectations were fulfilled* (6% strongly agreed and 59% mostly agreed), while a further 35% mildly agreed.

Course content and material

- 88% either strongly (29%) or mostly (59%) agreed that they had *understood the nature of what was being facilitated*. The other 12% did not record a response.

Effectiveness of facilitation style

- 94% either strongly agreed (59%) or mostly agreed (35%) when asked if they felt *able to participate in the training*, while 6% mildly agreed.

- 88% of the mentors responding felt that the *facilitators had contributed positively to their learning experience* (29% strongly and 59% mostly agreed) while 6% mildly agreed. 6% of the respondents did not respond to this category.
- 76% reported that there was a *good balance between the facilitators' input and group participation* (24% strongly and 53% mostly agreed) while 12% mildly agreed. A further 12% mildly disagreed that this balance had been present during the two-day initial training.

6.2.2 Mentees' evaluation of initial training

Overview

Before looking at the details of the mentee respondents' evaluation of the initial two-day training it is prudent to note that this feedback is from four individuals, as the fifth mentee who responded to the questionnaire did not attend the initial training.

It is also important to note that mentees were only required to be present for one day of this initial two-day training. Therefore, they did not receive the benefit of the complete training content. The rationale for this decision, by the programme organisers, was two-fold; one that the mentees would/could only be absent from the immediacy of their functions for a day and two that the focus of the training should be on the mentors.

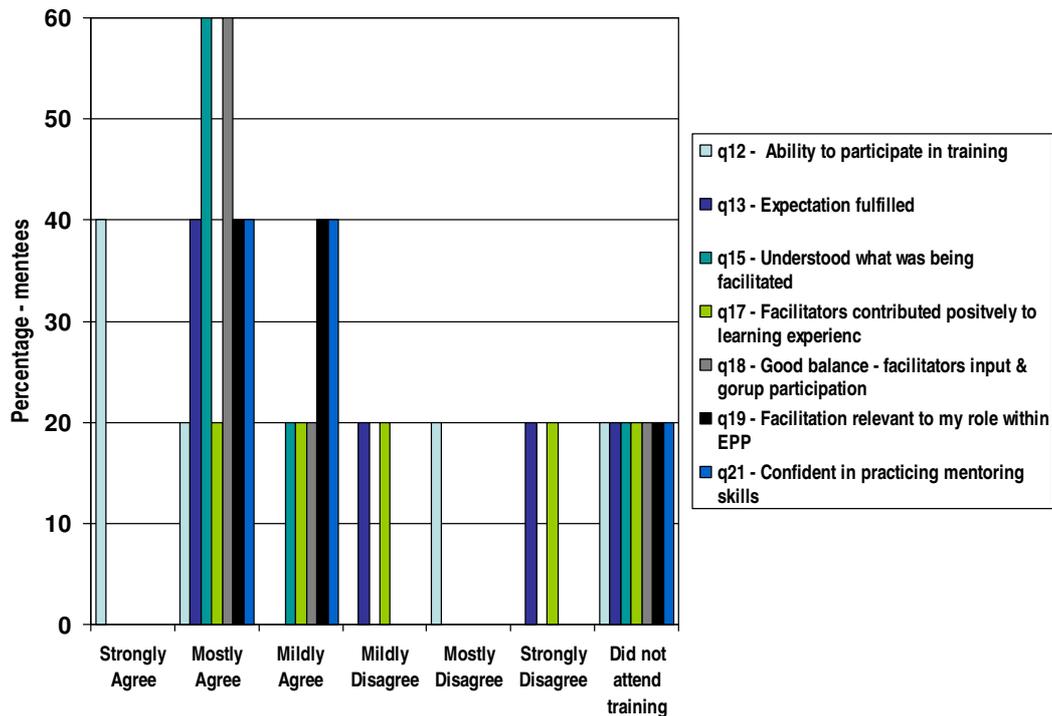


Figure 9 - Mentees evaluation of initial training (questions 12,13,15,17,18,19 and 21)

Increased confidence in practicing of mentoring skills:

- 80% of the mentees either mostly (40%) or mildly (40%) agreed that after the training they were confident about practicing their mentoring skills, while the remaining 20% did not attend the training.

Relevance of training to mentees' role in EPP

- 80% of the mentee respondents either mostly (40%) or mildly (40%) agreed that the *training event was relevant to their role within EPP* while the remaining 20% did not attend the training.

Mentees expectations met

- 40% mostly agreed that their *expectations had been fulfilled during the two-day training* while 40% either mildly (20%) or strongly (20%) disagreed. The remaining 20% did not attend the training.

Course content and material

- 80% mostly (60%) or mildly (20%) agreed that they had *understood the nature of what was being facilitated*. The remaining 20% did not attend the training.

Effectiveness of facilitation style

- 60% either strongly agreed (40%) or mostly agreed (20%) when asked if they felt *able to participate in the training*, compared with the 20% that mostly disagreed. The remaining 20% did not attend the training.
- 40% of the mentees responding mostly (20%) or mildly (20%) agreed that the *facilitators had contributed positively to their learning experience*. This compared with 40% who felt mildly (20%) and strongly (20%) that this had not been the case. The remaining 20% did not attend the training.
- 80% reported that there was a *good balance between the facilitators' input and group participation* (60% mostly and 20% mildly agreed). The remaining 20% did not attend the training

An understanding of what mentoring is

- 94% of the mentors and 80% of the mentees gave some form of response when asked their understanding of the term 'mentoring'.

6.2.3 Further mentee/mentor evaluation of initial two-day training session

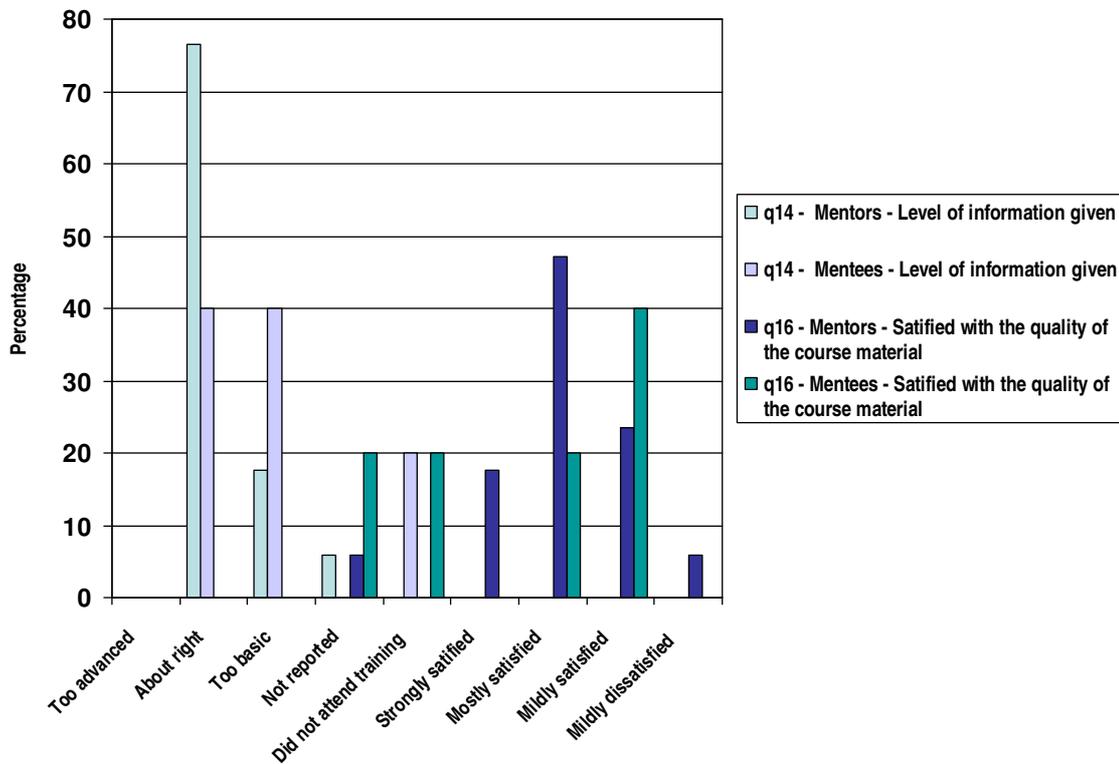


Figure 10 - Further Mentee/Mentor evaluation of initial training (questions 14 and 16)

Satisfaction with level of information given and quality of course material

- 77% of the mentors and 40% of the mentees thought that the *level of information given* during the two-day training was about right, while 18% of the mentors and 40% of the mentees thought it too basic. 6% of the mentors did not respond to this question while 20% of mentees did not attend the training session.
- 89% of the mentors were either strongly (18%), mostly (47%) or mildly (24%) satisfied with the quality of the course material while 6% were mildly dissatisfied and 6% did not respond to this question.
- 60% of the mentees either mostly (20%) or mildly (40%) were satisfied with course material quality; the other 40% of the mentees either did not attend the training (20%) or respond to the question (20%).

6.2.4 Further feedback on initial two-day training - *focus group*

What worked - participant interaction

- A vehicle which allowed the reciprocal positivity for the programme - from the perspective of both mentees and mentors - to be demonstrated
- Allowed the participants to meet potential mentoring partners
- Mentees gaining initial insight into the benefits that could/would be presented by being mentored by mentor/patients
- Mentors appreciated being able to interact with NHS staff (potential mentees)

What worked - facilitators' input

- Once again the quality of input and enthusiasm of the facilitators was cited as one of the elements that participants valued

6.2.5 Recommendations for future training

Ten of the twenty-two respondents made recommendations for future training sessions. The main recommendations are as follows:

Continuation of content, process and facilitation style

- The content, process and facilitation style of the training session appears to have been highly successful in terms of participant involvement, learning and confidence to go out and practice mentoring within the NHS.

Continuation and extending opportunities of promoting participants' informal interaction

- Continuing the concept of participants staying overnight throughout the course duration
- Additional opportunity for participant contact following the initial training
- Limiting number of participants on any one course to around 36

Course content

- A greater degree of hands-on mentoring practice (which could include a demonstration of mentoring skills by facilitators)
- Possibly might be useful to have more specific examples/practice relevant to health care
- More training on 'listening' skills - one mentor illustrated the need for listening as an underpinning element of their relationship to their mentee by saying *'my role has tended to be passive, often listening and then providing experiences and discussion to cover the topic, whereas my mentee has tended to set the pace and the agenda and appears satisfied with the progress'*.
- More course content around 'group' mentoring skills
- Shorter sessions (maybe over 4 days instead of 2 full days)- due to participant fatigue and/or attention span

Venue facilities

- Better amenities for mentors related to their condition (e.g. if you are inviting people with ME to training session you need to provide somewhere comfortable to rest; better food - need non-wheat/non-dairy foods and herb teas)

Follow-up training sessions

- It was felt by some of the focus group participants that follow-up training/sharing sessions would evolve their mentoring practice which would subsequently make their mentoring relationships more effective.

6.3 Evaluation of overall programme process

6.3.1 Overview

This part of the evaluation focuses on the overall programme process with respect to what worked, what could have worked better and recommendations for future programmes.

In the main the feedback for this section will come from the focus group findings, which will be augmented by information from responses to questions 23 to 25 of the questionnaire returned from individuals not taking part in the focus group.

Before this report looks at aspects of the expert patient mentoring programme process, the wider context in which this project was instigated and implemented should be reflected upon.

This programme was implemented in a time of major upheaval within the NHS (within Strategic Health Authorities and Primary Care Trusts) as well as the abolition of NHSU. Therefore, it may be felt that these two substantial issues could and in all probability would have some impact on the programme being evaluated. However, the lessons learned in such a fluctuating context will be powerful pointers to the success of future such programmes.

6.3.2 Overall programme process - *what worked*

***What worked* - building positive relationships**

The participants of the focus group felt that the idea of partnership (between mentor/patients and NHS staff) had worked.

Evidence to support this was the apparent enthusiasm for and congruence with the underpinning notion that being mentored by expert patients could/would have a beneficial impact on patient care which was illustrated by some Primary Care Trusts. This '*enthusiasm*' was evident from the inception of the programme which also included the feeling of and interaction on the initial two-day training event.

***What worked* - beginning to see long-term care as an issue of 'we' rather than 'them and us'**

Another aspect that came from the building of relationships and '*bonding*' that the programme afforded was that it provided the context in which participants

could begin to see other peoples' *'contributions'* to and perspectives on (*'views'*) the issue of long-term care. For the participants this happened on both an intra (within each of the mentee and mentor groups) and inter (between mentees and mentors) creating a *'group atmosphere'*.

Within the focus group feedback there was quite a few comments about the positive nature of both the concept and the created context of the programme.

What worked - evolving participants' view of and confidence in their knowledge of long-term care

Additionally the recognition of *'contribution'* enabled or enhanced some participants' sense of confidence. While for others, it enhanced their *'development'* and *'improved'* their *'understanding'*.

What worked - enhanced communication

For some the *'group atmosphere'* enhanced communication on both the intra and inter (mentee/mentor) level.

6.3.3 Overall programme process - *what could have worked better*

What could have worked better - more substantive buy-in from Primary Care Trusts

Focus group participants believed that a higher degree of demonstrable recognition of the value of such a programme, from within the NHS (specifically cited were Primary Care Trusts), would have enhanced the implementation and success of the programme.

They felt that this support would be in the form of both resources (e.g. financial as well as time allocated for mentees to engage more fully with such programmes) and representation of and input into the programme by Primary Care Trusts staff. Additionally, the participants believed such programmes require a higher profile in terms of *'advertising'* both its philosophical base and, just as, or more importantly, the practical advantages which would, they

argue, have garnered interest from a cross-section of NHS professionals (including Doctors).

What could have worked better - the matching process

The focus group participants strongly highlighted the need for streamlining the matching process (mentee to mentor) in terms of timing in relation to the initial two-day training. This imperative was heightened by comments like *'the day (training) set us goals that have not happened'* and *'enthusiasm wavered because of not putting into practice (immediately) what we learnt'*. The lesson to be learnt here is that the cadre of mentors of mentees match in terms of number and desire to participate.

What could have worked better - enhanced pre-programme planning

The need to enhance the matching process is reflective of the broader issue of programme planning raised by the focus group participants. They urged a need for a more comprehensive pre-programme plan that would look at issues of matching as well as raising the profile of such a programme and its benefits within the NHS.

What could have worked better - programme communication

It was unilaterally felt that communication with and among the programme participants could have been enhanced. Ongoing and timely communication would have informed participants about the stages in the practical implementation of the programme and alleviated any concerns and frustration that were felt by some of the schemes participants.

6.3.4 Recommendations for future programmes - overall programme process

Overview

There was unilateral agreement from respondents that the core concept underpinning the Expert Patient Mentoring Programme was sound and a powerful and beneficial way forward within the NHS.

Focus group participants stated that the already established baseline of the programme was an excellent foundation for evolving the future schemes.

6.3.4.1 Strategic issues

Getting buy-in for future schemes from all levels and divisions within the NHS

In the first instance this 'active buy-in' may be *increasing the commitment from senior managers in PCTs and those NHS staff with responsibility for extending patient involvement and engagement*. This 'active buy-in' from all levels and divisions within the NHS was raised, by respondents/participants, as being *crucial to the success of future programmes*.

From the perspective of the participants a benefit of this active buy-in would be a higher concentration of multi-level, cross-divisional matching of mentors to mentees. The participants felt that a *'better spread of mentees'* would include *'Consultants, General Practitioners, Managers, Physiotherapists and Practice Nurses'*.

Appropriate level of resource allocation

Additionally, this buy-in would be demonstrated, at a strategic level, by having the appropriate resources to ensure the effectiveness of such programmes. This resource would be in the form of both financial as well as having a full-time facilitation/administration support underpinning the smooth running and ultimate success of the scheme.

The need for scheme champions

Aligned with the above recommendations focus group participants highlighted the need to have an individual or individuals who would act as *scheme champions* within the relevant levels and divisions within the NHS (e.g. PCTs).

6.3.4.2 Enhancing communication stream

Aligned with the above recommendations the participants envisioned enhanced communication being built in from the inception of any new scheme.

Raising awareness of benefits of future schemes

Raising awareness of the benefits of the expert patient mentoring scheme featured very strongly in the focus group session. The participants felt that this was crucial to properly resourced future schemes but to the ongoing success of subsequent programmes.

Some of the suggestions coming out of the session were to use mentors to inform professionals within the NHS about the Expert Patient Mentoring programme and its benefits; using representatives from successful schemes to encourage others within the NHS to set up similar schemes; or the creation of promotional video material.

One suggestion was to have a *'passionate enthusiast'* to outline the benefits of such programmes to all stakeholders, which would include potential scheme champions and mentees from all levels and divisions within the NHS.

Dedicated resource for facilitation/administration of future schemes

Participants recommended that future programmes have the capacity of dedicated facilitation/administration, which would provide and ensure an on-going and relevant two-way (including feedback) communication loop. Another benefit of having this dedicated resource would be ongoing

communication with all stakeholders (which would include scheme champions within PCTs).

Additionally, the participants saw that part of this enhanced communication within future schemes would be the provision, to both mentors and mentees, of their counterparts' expertise and areas of speciality before engaging in a mentoring relationship.

This leads to us to the next area of recommendation - the issue of matching mentees and mentors.

6.3.4.3 Matching process

Expedite matching process

As we have seen in 6.3.2 focus group participants strongly highlighted the need for streamlining the matching process in terms of timing in relation to the initial two-day training. In the 'any other comments' question (34) a participant argued that *'training should not take place without first ensuring that mentees have been recruited.'*

Criterion for matching

Additionally, a recommendation for future programmes is the need to take into consideration: mentor long-term conditions with mentee specialisms, geographical location (in terms of mentor ability to travel) and to some degree personality compatibility. Another point raised was the need for *'careful evaluation of voluntary mentors'* in terms of their suitability for the mentoring role e.g. the ability to *'listen'*. A recommendation coming from another mentor was to choose mentors not just through a *'written application only'* but also through a *'face-to-face interview'*. This they argue would help *'to select mentors with appropriate skills'*.

Consideration taken in respect to long-term conditions of volunteer mentors

Another issue that seemed to dovetail with the above is the need for NHS stakeholders to remember and respect that mentors engage in the programme in a voluntary capacity and that consideration of their individual long-term conditions needs to be taken into consideration with any programme arrangements are made.

6.4 Evaluation of mentoring relationships

6.4.1 Overview

In the section **6.3.4.3 Matching process** a future recommendation was to make sure that the matching process was expedited in a more effective and timely fashion. This is reflected below in the fact that eight of the mentors (out of the 17 responding) and one mentee (out of the 5 responding) that responded to the questionnaire, had not, at the time the questionnaire was issued been matched. This does seem to point to the need for more streamline programme processes in future schemes. However, this report can not speculate on the number of individuals matched after the questionnaire was filled out and returned. Finally, though it must be recognised that the administration and implementation of this innovative project ran concurrently and post the demise of the NHSU.

6.4.2 Profile of mentoring relationships

6.4.2.1 Type of mentoring relationship

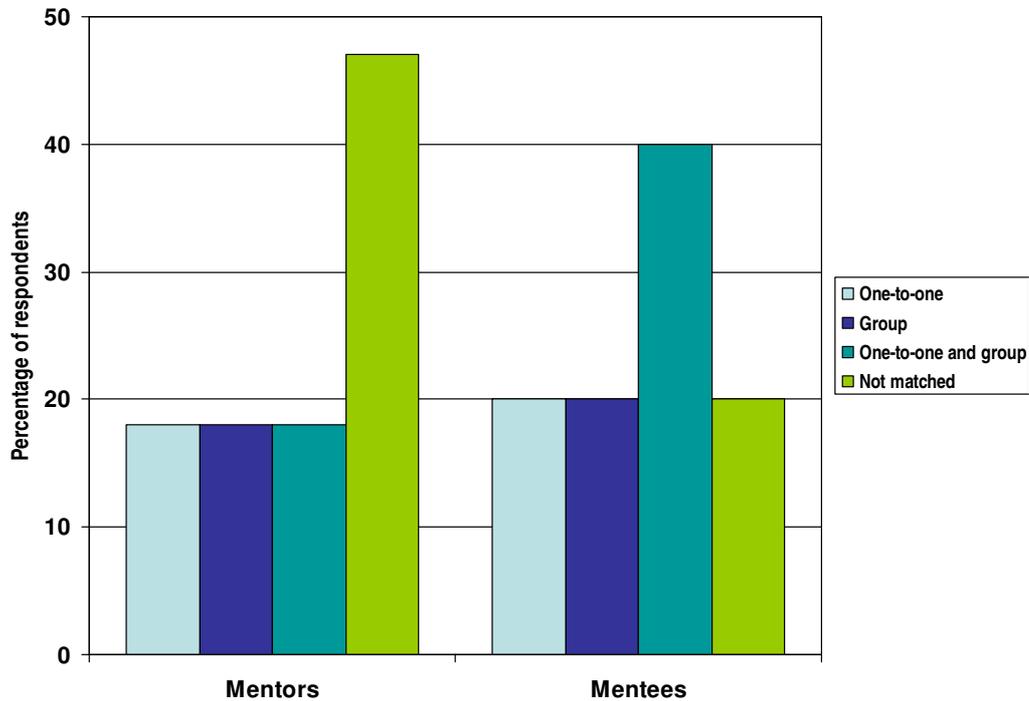


Figure 11 -Type of mentoring relationship (question 26)

Mentors

There was an even distribution for the mentors that had been matched in terms of having either one-to-one, group or both one-to-one and group mentoring relationships.

Mentees

There seemed to be more mentee respondents that had both one-to-one and group mentoring relationships.

6.4.2.2 Number, duration and frequency of mentoring sessions

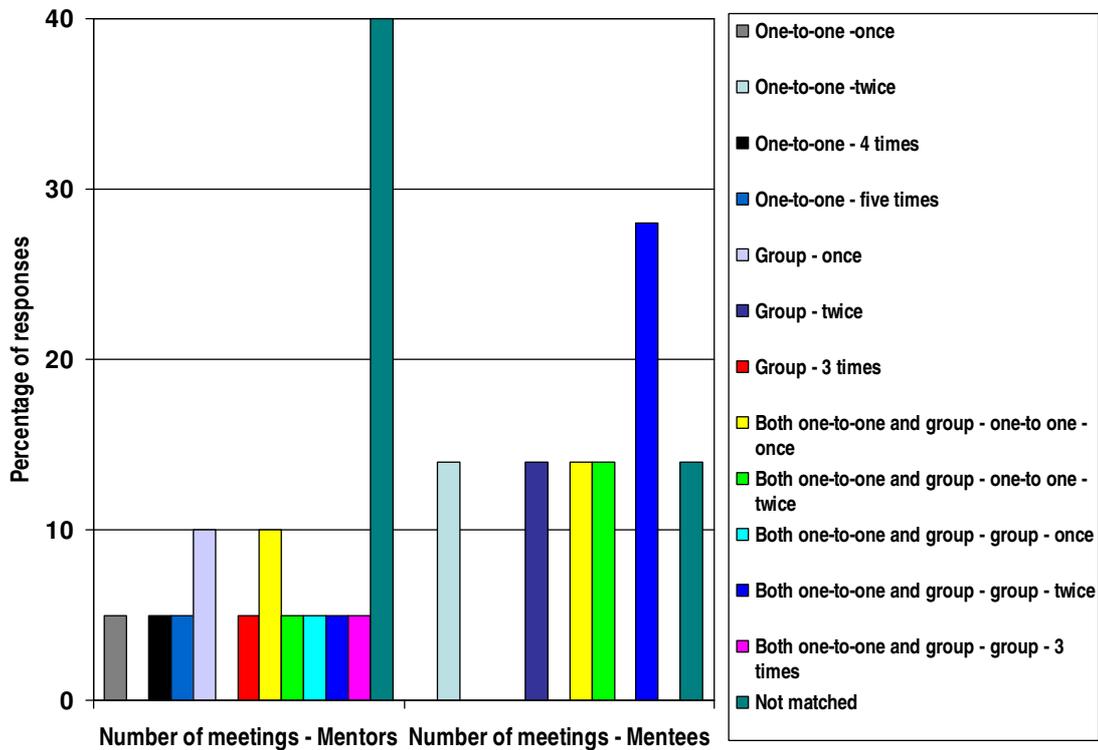


Figure 12 - Number of mentoring sessions (question 27)

Mentors

All mentors had had at least one mentoring session with their *one-to-one* mentees while three mentors had met with their mentees two, four and five times respectively. Five of the nine matched mentors reported these sessions lasting anywhere from half-an-hour to two hours. The three mentors that responded to question 29 asking about frequency of meetings reported that the meetings had occurred monthly.

Mentors involved in *group mentoring* had met the groups at least once with three mentors meeting their groups two and three times. Five of the nine matched mentors reported these sessions running between one to three hours. The three mentors that responded to question 29 asking about frequency of meetings reported that the meetings had occurred monthly.

Mentees

Mentees reported having met with their mentors (*one-to-one relationships*) at least once with two reporting have met twice. Three of the four matched mentees experienced these sessions lasting anywhere between one and three hours. Of the three mentees that responded to question 29 asking about frequency of meetings two reported their meetings occurring every two months while the other reported that the meetings had occurred monthly.

Mentees experiencing *group mentoring* reported meeting with their mentors twice. Three of the four matched mentees experienced these sessions lasting anywhere between one and two hours. The three mentees that responded to question 29 asking about frequency of meetings reported that the meetings had occurred monthly.

6.4.2.3 Did the participants find the mentoring role different from the Expert Patient tutor role?

Four of the nine matched mentors (either in a one-to-one, group or both mentoring relationship) that responded to this question said they had found their mentoring role a *'totally different experience'* from their role as an Expert Patient Tutor.

Some of the differences commented on revolved around the *'much more prescriptive'*, *'scripted'* or *'dictated to'* nature of the EPP tutor role in terms of delivery. Whereas in the mentoring relationship is *'more about getting to know each other'* coupled with the need to *'think of open questions'* that facilitates discussion and exploration. While another talked about the mentoring relationship as being *'on a more personal level'*. Two of the four mentors that responded to this question talked about these differences impacted on their sense of contribution to the relationship, however, as one suggested that *'this will become better'* as the relationship matured and evolved.

6.4.3 Mentoring relationship - what worked

Six of the nine matched *mentors* responded to this question. Some of the points that were raised were:

1. **Positive impact on patients through new understanding** - Both an individual mentee and a group of mentees had indicated that they had been able to pass insights learned through mentoring relationship to peer group and patients alike. The mentee felt *'very strongly that the patients were more empowered'* while members of the group of mentees had indicated to the mentor that *'they feel happier know that they are doing their job better'*
2. *'Good turnout'* of group mentees - which lead to a *'good insight'* into *'main concerns and further conversation'*
3. Mentee *'satisfied with what has been achieved'* through mentoring relationship
4. One mentor felt it was too early in the programme to comment

The only mentee to contribute to this question talked about:

5. **Cross-fertilisation of ideas through diversity of mentee groups** - having different disciplines present in a group mentoring session was a positive experience in that it brings different ideas to the fore. Additionally they talked about the impact of being part of small mentoring groups was that it assisted *'quieter members of the group'* to *'build their confidence'*.

6.4.4 Mentoring relationship - what could have worked better

Six of the nine matched mentors contributed to this section of the questionnaire. The following came up as issues:

1. **Future programme organisers to be aware of the potential tension created from historic power relationships between health care professionals (mentees) and Expert Patient Mentors** - this seemed to be apparent in a mentor's response when they talked about their

mentee's preference to *'asking questions about my experience'*. This may be an indication of the way that the mentee (health professional) has in the past related to their patients and to some extent still see the mentors as just that - a patient. Alternatively, this might mean that for this individual asking questions was the most effective way of fulfilling their own agenda as a mentee. Interestingly, but not specific to this question, another mentor talked about *'developing trust'* between mentors and mentees as well as getting the mentees to *'open up'* would be indicated by mentees *'stepping out of their professional roles and communicating as equals'* with their mentors.

2. **Mentee commitment to the programme** -three mentors talked about the need for mentees to be firmly committed to future programmes - which is captured in this report as a key success factor for future programmes. This commitment was discussed in terms of both one-to-one and group mentoring relationships.
3. **Linking mentors long-term conditions with mentees' area of specialisms** - one mentor felt that this would be beneficial to the mentees in future programmes.
4. **The issue of co-mentoring groups of mentees**- one mentor talked about their preference to mentor groups on their own (not their experience in the programme). Their rationale for this was their awareness of *'very different personalities and styles'*.
5. **Establishing mentors' preference for one-to-one and/or group mentoring** - one mentor talked about their preference in terms of being in a one-to-one mentoring relationship rather than the large group mentoring relationship that they had been in.

Two mentees contributed to this section.

6. **Smother transition (no long lapse of time) from training to matching to first mentoring session** - one mentee stressed the need for the mentoring relationships to begin *'closer'* in terms of timing to the

training as *'by the time we all met again we had to remind ourselves of the aims etc.'*

7. **Making sure that matching occurs** - the other mentee (who had not been successfully matched) talked about, not surprisingly the need to be matched with a mentor.

6.4.5 Mentoring relationship - recommendations for future programmes

Five of the nine matched mentors contributed to this section. The following came up as the main issues:

1. **Future programme organisers to be aware of the potential tension created from historic power relationships between health care professionals (mentees) and Expert Patient Mentors** - the mentor that discussed this issue in the previous section reiterated it here. They talk about *'working longer'* on getting their mentee to *'answer their own questions'* rather than relying solely on the mentor's experience. Additionally, another mentor, spoke about *'talking in indirect terms, so that the mentees own their answers, as they have been teased into working them out, with a little persuasion from me!'*
2. **Mentee commitment to the programme** - again this notion of mentees being commitment to be involved in the programme came up. There was the suggestion that part of ensuring this commitment was that mentees self-selected to be involved in future programmes. This might negate some of the *'drop-in arrangements'* which *'unsettled'* the group dynamic in group mentoring sessions that one mentor alluded to. Another mentor, talked about one of *'the challenges'* for future programmes *'will probably be getting enough health care professional to see the benefits of the exercise'*.
3. **Smoother transition (no long lapse of time) from training to matching to first mentoring session** - in the last section a mentee had raised this issue. Under this section it was a mentor that stressed the need for the

mentoring relationships to *'start mentoring relationships soon after the training'*.

4. **The necessity of mentee training** - in terms of managing their expectations about the mentoring relationship
5. **Utilising the gained expertise of mentors' from pilot scheme in East Midlands and South East for future programmes** - one mentor suggested getting the *'best Return on Investment'* of the initial training by utilising the original mentors either as mentors in future programmes or supporting new mentors in future schemes. Another comment from a mentor was that it *'would be a shame if we were not able to build on the experiences that we have gained as mentors'*.
6. **The need to set the boundaries of the mentoring relationship at its outset** - one mentor felt it was important to *'negotiate the mentoring relationship at the beginning and review it'*.

One mentee contributed to this section. Their contribution is as follows:

7. **Establishing mentees' preference for one-to-one and/or group mentoring** - in the last section we saw that this seemed to be important for one mentor and now we are seeing that at least one mentee also feels that they should have a choice in the type of mentoring relationship they are involved in

6.5 Summary, key success factors and main recommendation for future programmes

6.5.1 Overview

The purpose of this section of the report is to bring its various elements together and to spell out the key messages that emerged.

There are a number of general points to make. Whilst there was a 'reasonable' return rate (over 50%) of evaluation questionnaires, compared with a typical response rate of 30%, it should nevertheless be pointed out that a significant number of scheme participants have not returned their evaluation

forms. It is difficult to tell what this none-response means in terms of the views of the scheme as this set of participants have not articulate their views, but this must temper any general conclusion that can be drawn about this project.

Also one of the strengths of using questionnaire research is that it enables trends to be identified in participants' responses and lessons for future schemes to be learnt. On the other hand, it does place some constraints on understanding 'why' certain individuals have given certain answers. Although, it must be pointed out that the participants, in this evaluation, were given the opportunity to voice their underlying thoughts and beliefs throughout the questionnaire (this type of feedback equated to about a third of the questions asked).

Positive orientation by both mentors and mentees as to the benefits of continuing the Expert Patient Mentoring Programme within the NHS

Despite the above qualifications, there was sufficient robustness in the data collected to enable some conclusions to be drawn with some confidence. Firstly, there was a generally positive view of the scheme on the part of both mentor and mentee respondents.

Responses from both mentors and mentees via the questionnaires, focus group and emails to the programme organisers were enthusiastic about the potential of such mentoring schemes in terms of the beneficial impact on patient care. Some examples of feedback that support this are:

- *'Find all the means you can to keep this programme going, as getting volunteer mentors' (with long-term conditions) 'is such an untapped resource, and as our early experiences of mentoring are so positive in promoting knowledge that helps improve people's lives, this surely must have a place in the NHS's future'.*
- *'The mentees have said that they have learned so much, they understand more, and they have put some of the new skills into practice and they have worked' - from mentor respondent #22*

- *'You have given me a great insight into how a patient is able to take back control of their illness, without being dependant on the nursing/medical profession'. - excerpt from a mentee's email to programme organisers*
- *'Your expertise as both an expert patient and tutor allowed me to see a broader picture. You have given me the knowledge to be able to empower the patients to make informed decisions regarding their management options. Initially it was quite difficult to put into operation, patients always think it's easy for a health professional to give advice when they have no experience of the illness'. - excerpt from a mentee's email to programme organisers*
- *'I think I have also become more empathetic to the frustrations that patients with long term conditions endure on a daily basis'. - excerpt from a mentee's email to programme organisers*

Effectiveness of two-day training

There was an overall positive response to the initial two-day training by the respondents. This is highlighted in a response by one staff member of the Expert Patient Programme who said *'all mentors felt that the training they had received was done well'*. A participant, in their questionnaire response to question 34 'any other comments', said *'thank you for the training which I found most informative and enjoyable'*.

- 95% of the mentor respondents either strongly (24%), mostly (47%) or 24% mildly agreed that after the training they were confident about practicing their mentoring skills while 80% of mentee respondents either mostly (40%) or mildly (40%) agreed
- 89% of mentor respondents either strongly (18%), mostly (47%) or mildly (24%) agreed that the *training* event was *relevant to their role within EPP*.

6.5.2 Key success factors for future programmes

One of the purposes of this report is to highlight some key success factors for implementing future mentoring schemes. In reviewing the feedback from participants in this study the following factors have been identified:

1. **Actively and effectively promoting the benefits of such programmes within the wider NHS** context (all levels, and cross-divisional) which would assist in
2. Getting **active buy-in from all levels and divisions (organisational settings) within the NHS**. This was seen as *crucial to the success of future programmes*. In the first instance this may mean *increasing commitment from senior managers in PCTs* and those *NHS staff with responsibility for extending patient involvement and engagement*. Getting this active buy-in would enable and support
 - a. The **degree of desire that potential mentees have in being actively involved in such schemes** in the first place. The desire to be involved is pivotal not only to the success of recruiting engaged mentees to the mentoring scheme but also to the fundamental rationale of the scheme (that is, having a positive impact on patient care)
 - b. Additionally, this support would be demonstrated, at a strategic level, by having the **appropriate resource** to ensure the effectiveness of such programmes. This resource would be in the form of both financial as well as having full-time **scheme facilitation/administrative support** thereby ensuring the smooth running and ultimate success of the scheme.
 - c. This type of concentrated focus/support (scheme facilitation) would also support **ongoing/effective communications streams**, which the participants saw as a key success factor for future schemes

- d. Aligned with the above participants highlighted the need to have an individual(s) who would act as **scheme champions within the relevant levels and divisions within the NHS**
3. Another key success factor seen by the participants was the issue of matching criterion; one of the most important factors they stressed was the need to **match each mentor's long-term condition experience with the mentee's speciality area**. While another mentor urged for the *'careful evaluation of voluntary mentors'* in terms of their suitability.
4. The need for **pre-programme training** (both mentor and mentee) which helps participants manage their expectations and sharpen their mentoring skills
5. **Participant commitment to the programme and the effort to give priority to the mentoring relationship** is key (this commitment was evidenced in these projects in spite of the infrastructural demise of the NHSU). Garvey (1995) and Clutterbuck & Megginson (1999) have emphasised the importance of voluntarism within mentoring relationships
6. **Establishing specific programme goals, outcomes and key success factors** with all relevant stakeholders at the outset of each scheme

The above key success factors are not listed in any prioritized order but were given equal weight and importance within the feedback from the scheme participants. The key success factors will contribute to building a culture of learning in a patient-led NHS.

6.5.3 Recommendations for future programmes

6.5.3.1 Overall programme process (see section 6.3.4 for details)

Overview

There was unilateral agreement from respondents that the core concept underpinning the Expert Patient Mentoring Programme was sound and a powerful and beneficial way forward within the NHS.

Focus group participants stated that the already established baseline of the programme was an excellent foundation for evolving the future schemes.

1. Strategic issues

- Getting buy-in for future schemes from all levels and divisions within the NHS
- Appropriate level of resource allocation
- The need for scheme champions

2. Enhancing communication stream

3. Raising awareness of benefits of future schemes

4. Dedicated resource for facilitation/administration of future schemes

5. Matching process

- Expedite matching process
- Establish criterion for selection of mentors
- Establish criterion of selection of mentees
- Establish a criterion for matching

6. Consideration taken in respect to long-terms conditions of volunteer mentors

6.5.3.2 Initial two-day training (see section 6.2.5 for details)

Ten of the twenty-two respondents made recommendations for future training sessions. The main recommendations are as follows:

1. **Continuation of content, process and facilitation style**
2. **Continuation and extending opportunities of promoting participants' informal interaction**
3. **Course content**
 - A greater degree of hands-on mentoring practice
 - More specific examples/practice relevant to health care
 - More training on 'listening' skills
 - More course content around 'group' mentoring skills
 - Shorter sessions
4. **Venue facilities** - Better amenities for mentors related to their condition
5. **Follow-up training sessions**

6.5.3.3 Mentoring relationships (see section 6.4.5 for details)

Five of the nine matched mentors contributed to this section. The following came up as the main issues:

1. **Future programme organisers to be aware of the potential tension created from historic power relationships between health care professionals (mentees) and Expert Patient Mentors**
2. **Mentees being fully committed to the programme**
3. **Smoother transition (no long lapse of time) from training to matching to first mentoring session**
4. **The necessity of mentee training**
5. **Utilising the gained expertise of mentors' from pilot scheme in East Midland and South East for future programmes**
6. **The need to set the boundaries of the mentoring relationship at its outset**

One mentee contributed to this section. Their contribution is as follows:

7. **Establishing mentees' preference for one-to-one and/or group mentoring**

The above recommendations are not listed in any prioritized order but were given equal weight and importance within the feedback from the scheme

participants. However, as with the key success factors they will contribute to building a culture of learning in a patient-led NHS

References

- ⁱ Garvey B. (1995), *Let the actions match the words: Engineering UK*, pp.111-113, in Megginson D. and Clutterbuck D. (1995), *Mentoring in Action*, Kogan Page London
- ⁱⁱ Megginson D. and Clutterbuck D. (1999), *Mentoring Executives and Directors*, Butterworth-Heinemann, Oxford
- ⁱⁱⁱ Adapted from Improving Patient Self-Management, Department of Health, March 2004
- ^{iv} <http://www.nhspartners.org.uk/IWL%20final%20rep%20Nov%202004.pdf> (accessed 23.05.06)
- ^v Adapted from www.expertpatients.nhs.uk
- ^{vi} http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4075214&chk=YxS1Yj (accessed 23.05.06)