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Using interviews and focus groups to investigate the effectiveness of mentoring in a UK Healthcare Trust.

Mentoring is increasingly being used in a healthcare setting as it is seen to hugely benefit both individuals and organisations. This research is aimed at investigating WHAT is being learnt, WHAT are the moderating factors and HOW do both these factors change over time, within mentoring relationships. 38 semi-structured interviews and two focus groups were used to find out more from six mentoring dyads about their lived experience of being both mentors and mentees.

Key findings were that both parties learnt in all four learning domains, learning fluctuated over time and that common factors were both facilitating and hindering for both parties. Methods are reflected upon and recommendations for future similar studies shared. The six NHS values are discussed in harmony with mentoring values, together with the impact on supporting managers as mentors and mentees for the future. In short, it is concluded that using mentoring to develop more skilled managers and leaders in healthcare, will ultimately mean more supported and nurtured teams, which will in turn will mean happier employees and ultimately better supported and nurtured patients.

Introduction

The background to the study

Mentoring in the workplace is becoming more popular than traditional training interventions as it is more personal and tailored to the individual and ultimately is proving to be a cost-effective way of embedding long-term movement and change in an organisation's culture and operations. Essentially mentoring is a unique interpersonal relationship between two people (Eby, Rhodes & Allen, 2010; Janasz, Behson, Jonsen & Lankau, 2013). The key purpose of mentoring relationships is to

support and challenge both parties towards their learning and development (Garvey, 2014; Parsloe & Wray, 2016).

Professional nursing has suffered from educational, recruitment and retention challenges over the last decade and it has since been recognised that role socialisation and career development are a useful ongoing development process (to both the employer and the employee) that can lead to greater job satisfaction and commitment within the workplace. Using a more experienced person as a 'supervisor of practice' to guide and to support the less experienced nurses within a 'mentorship' scheme has been the cornerstone of this initiative both in the UK and beyond (Papastravrou, Lambrinou, Tsangari, Saarikoski & Leino-Kilpi, 2010.) Mentoring is also being offered in a healthcare setting for other groups; high potential staff, those new to management and those in transition (NHS Leadership Academy, 2021).

Based on the understanding that mentoring is increasingly used in a healthcare setting and is seen to benefit both individuals and organisations, this research was aimed at investigating WHAT is being learnt within mentoring relationships, within the 4 established domains of learning (Wanberg et al, 2003; Hezlett, 2005) of cognitive learning, skills-based learning, affective-related (inner) learning and social networks for both parties, WHAT are the moderating factors that help and hinder the mentoring relationship, and HOW do both these factors change over time?

Three case study organisations were researched originally but for the purposes of this chapter, the focus will be on the healthcare study. This case study organisation was a UK Healthcare Trust which involved two large hospitals covering over 500,000 patients and approximately 6000 employees. To further support their managers, the Learning and Development Department decided to launch a pilot formal mentoring programme to support both clinical and non-clinical members of staff in their part-time study for a postgraduate management qualification.

The research questions

The key research questions were;

1. What do mentees and mentors perceive they are learning during their formal mentoring relationships?
2. How does the learning change over time for both parties?
3. What are the factors that moderate (help and hinder) the mentoring relationship for both parties?
4. How do these moderating factors change over time?

The research approach and methods used

Semi-structured interviews and focus groups were used for this study.

The aim of this study was to understand the subjective world of the human experience (Cohen et al., 2017) by uncovering and appreciating the many different realities and meanings that mentees and mentors have created based on their mentoring interactions, whilst taking into account the influence of the organisational context (Bryman & Bell, 2015; Cohen et al., 2017; Easterby-Smith et al., 2018.)

Recognising that this research was aimed at better understanding the perceptions of people, in an attempt to offer 'explanation, clarification and demystification' of formal mentoring, it was decided that a qualitative approach would be best fit for this research. All qualitative and case study methods of data collection were considered for this study including observations, documentation including diaries, archival records, physical artefacts, interviews and focus groups and it was decided to use both interviews and focus groups; recognising that it was important to hold face to face conversations with the people involved to get a deeper sense of their reality.

Interviews

An interview is a 'conversation with a purpose' (Maykut & Morehouse, 2005, p. 75), not unlike mentoring. Yin (2018) suggests that interviews are an essential source of case study evidence and should be 'guided conversations' rather than being too formal and structured. There are a variety of interviews: structured, unstructured and semi-structured (Gillham, 2001). Structured interviews use a predetermined set of questions, they can be administered relatively quickly and the interviewee's response can be easily coded. Unstructured interviews tend to be more informal whereby the interviewer sets the topic but the interviewee sets the agenda. For this type of interview, the researcher goes in with a more open mind than structured interviewers might. Semi-structured interviews, used in this study, are a combination of the two aforementioned interviews, whereby the interviewer presents a semi-structured list of themes or questions and has freedom to probe and follow up throughout. There is still a clear sense of the topics to explore and a sense of order in which to explore them but there is less chance of 'pigeon-holing' the respondents at the outset (as may occur with structured interviews).

According to Gillham (2001), semi-structured interviews are the most important type of interview in case study research. Semi-structured interviews allow consistent themes and questions to be explored. Not having a completely fixed framework to follow allows the researcher not to get too 'tied up' (Easterby-Smith et al., 2018) in the formal structure and so allows some flexibility between interviews for further probing and discussion, depending on the attitudes and opinions expressed in the conversational flow (Bryman & Bell, 2015). It was felt that busy people within

Healthcare may prefer to meet and reflect on events face to face, away from their daily work practices. Meeting people individually gave an opportunity for both the researcher and the mentees/mentors to build a rapport and an element of trust between each other, reiterate and share any questions and concerns about confidentiality, share feedback and be reassured by others. This was also the preference of the sponsoring organisations.

Table 1 – the semi-structured interview questions used

Semi-structured interview questions used for both mentees and mentors
• How would you describe your mentoring relationship so far? • What have been your most effective/least effective mentoring experiences? • What do you think you are learning, from being involved in mentoring? • What do you think your mentee/mentor is learning from being involved? • How do you think you and your mentee/mentor is learning this? • What do you and your mentee/mentor do that helps/hinders your learning? • What other factors enable or inhibit your learning whilst mentoring? • What do you feel has changed since you started being involved in mentoring? i.e. for you, your mentee/mentor, within the relationship, your job?

ACTIVITY 1: Think of at least one follow up question for each of the 8 questions above. Remember these are questions used as part of a semi-structured interview process, so there is room to be flexible within them with additional, probing questions to dig deeper.

Focus groups

Focus groups, like interviews, are about a ‘free flowing’, but focused, discussion on a particular topic (Fisher, 2010) and have become an important technique because they offer a way for researchers ‘to listen to the plural voices of others’ (Denzin & Lincoln, 2003, p. 384). It was hoped that those involved in mentoring would be willing to engage in a number of focus group discussions with colleagues, as they may see this as a chance to meet likeminded colleagues and to share similar challenges. It is also a professional requirement for mentors to attend regular ‘supervision’ type sessions (EMCC Guidelines on Supervision 2016) to share their ideas, get support and ultimately aid their personal development.

In contrast to interviews, the researcher takes a more marginal role within focus groups, acting as facilitator or discussion stimulator but not as a director or guide. The ‘unstructured nature’ of the interaction between focus group members helps to take the emphasis off the researcher, as facilitator, and so helps to reduce the influence of their views on the group, thus adding to the objectivity and limiting any bias and subjectivity (Denzin & Lincoln, 2003.) However, it is recognised that the focus group environment is still in some part contrived and involves ‘steered conversations’ (Easterby-Smith et al., 2018) giving less opportunity for personal responses and issues to be explored in greater depth. There is also concern about the joint production of meaning, as there may be some social or status pressure or dominance from others that may constrain or influence contributions.

Due to the flexible and free-flowing nature of both interviews and focus groups, they were deemed to be the most appropriate data collection methods for this study. The advantage of using two qualitative methods, interviews and focus groups, is that they both provided insights into how the research participants viewed the world. Being present at both, the researcher had some control over the data collection whereby they can follow up areas of interest and probe for further information or clarification to provide more complete, rich data.

Outline of the research study

Sample and recruitment

The cohort studying the postgraduate qualification were invited to be part of the mentoring programme. As such, this mentoring pilot started with six mentors and six mentees; six dyads but one pair did not carry on their mentoring relationship after a short period of time (and so their results were not included in this study) so only five dyads stayed actively involved in the research throughout. Dyads were made up of three female pairs, one male pair and one female mentee and one male mentor pair. All mentors and mentees who offered to be involved with mentoring and this research were volunteers. Mentors were all experienced managers and most were or had been previous students doing the same qualification. Some mentors had mentored or been mentored before. The mentors were trained by an external training company, and once the training was completed, mentors had a group discussion with the Trust Learning and Development team to discuss their expectations, and myself as the researcher, before starting their mentoring relationships. The researcher was not involved in the mentor training nor the mentee matching but was invited to evaluate the programme from the beginning to the end.

In short, 10 employees from 5 pairs volunteered to be part of the study, from either a clinical and/or non-clinical background, across two Hospitals. Once the mentoring

had started, semi-structured interviews were carried out with each mentor and mentee (except one mentor was working abroad so was not available for the last two interviews) making an overall total of 38 interviews. These 30 minute semi-structured interviews were carried out over a 12-month period at four points to coincide roughly with the four phases of the mentoring lifecycle (Kram, 1988). For instance, interview 1; at the end of the initiation phase (3 month point), interview 2; at the end of the cultivation phase (6 month point), interview 3; at the end of the separation phase (9 month point), and interview 4; at the end of the redefinition phase (12 month point).

Meeting this homogeneous group at regular intervals allowed the researcher to build a deeper relationship with the mentors and mentees over time and so gain a richer picture of their experiences (Silverman, 2020). The researcher was given the contact details of all mentors and mentees and made her own appointments to meet both parties. There was no Mentoring Co-ordinator involved in setting up the interviews, so the researcher was in control of co-ordinating who to meet and when

Two focus groups were also carried out with mentors only (at the 3 month point and 6 month point) to share challenges and best practice, to discuss the results so far and to gather any additional information. These were organised by the Mentoring Co-ordinator. These were offered as ‘supervision’ CPD ‘giving back’ group sessions to support the mentors, so they were not offered to mentees.

Each set of interviews and focus group sessions were recorded and transcribed, and then coded through NVIVO software to search for patterns and themes. An overview report was sent back to the management team of the sponsoring organisation. This was also sent to the mentors and mentees to verify the summary and for additional comments.

Key findings

Table 2 shows a very brief summary of the key findings coming from both the interviews and the focus groups combined.

Table 2 – the key learning from the NHS mentoring case study overall, covering all 4 research questions

SUMMARY OF THE KEY FINDINGS
• Both parties learn in all four learning domains. • Mentoring develops confidence. • Mentoring develops wider knowledge. • Mentoring develops different skills. • Social networks generally created the least amount of learning.

- Affective-related learning increases over time.
- Confidence increases over time for both parties.
- Cognitive and skill-based learning fluctuates over time.
- Additional (facilitating) moderating factors included other (supportive) relationships, similarity and difference.
- Managers can be facilitating or hindering in mentoring.
- Time is a hindering factor in mentoring.
- The pattern of some responses over time was similar for mentees and mentors.
- Mentoring seemed to endure and learning occurred despite some significant hindering factors.

ACTIVITY 2: It is often hard to quantify the impact of activities that involve people developing personal insights, like mentoring, coaching, training etc. Considering that both mentors and mentees developed an increased confidence over time through their mentoring relationships (linked to the affective-related domain), how do you think you could measure the application of this back in the workplace?

These findings, when compared to the other two case study organisations, provided valuable insights towards a better understanding how to create and nurture formal mentoring as a development tool in the Healthcare workplace.

> *'Mentoring perhaps is an 'unsung hero' in the field of development. Its potential is huge, and with careful planning and a lot of support, can be impressively effective. Innovative mentoring programmes, properly resourced and supported, should be on every HR and Organizational Development team's agenda' (Western, 2012, p. 53).*

Reflections and evaluation of the research study

Hindering factors

The key practical issues and challenges centred on availability, workload, location and bird flu.

All mentors and mentees were initially keen to get involved and were aware of the purpose of the research and their part to play within it. Informed consent was obtained (Bryman & Bell, 2015). However, when it came down to putting a date in the diary for the first face to face meeting, this was difficult to do with unpredictable shift patterns and changing rotas. As the research took a longitudinal approach, it was imperative to keep talking to the same pairings at the same intervals throughout

the study, so as the researcher I needed to be very flexible with when/where I met the mentees/mentors. I was also conscious of adding to the workload of already busy Healthcare practitioners, especially as they were both working and also studying postgraduate degree alongside. As a result, I chose their coffee/lunch break to meet them and always bought them a coffee as a small token of thanks. It was not an option to arrange video call type meetings as the technology was not available for individual use at the Hospitals.

The dual location of the hospitals was also a factor to be navigated when agreeing the days/times to meet, as I needed to schedule this around my own working day commitments and location of where I was working.

Bird-flu was both a positive and negative factor. On one hand it meant that those who I was interviewing were now extra busy dealing with the effects of bird flu, and so were potentially less available for meeting up. It also meant that they were in the workplace more. This made getting a date in their diary a little easier, albeit needing to meet the participants at sometimes unsociable hours in their longer working days.

The fact that the focus groups were already planned in and considered a mandatory part of the mentoring programme, helped to ensure that the mentors protected this time in the diary and were all able to come long.

Facilitating factors

When the mentoring offer was made to the participants, I was there to answer any questions about mentoring but also to explain my role as the researcher. This helped them to see my role was directly connected with the programme and helped me to connect myself with the group very quickly. So, recruiting the sample was easy enough to do but as it was only a small sample it was crucial to keep the relationship and momentum going with both parties. One pairing did drop off over a short period of time but once the first interviews were carried out and the first focus group too, a rapport was established with the mentees and mentors which meant that it was easier to keep in touch and build the trust from then on in.

Doing a longitudinal study helped to develop a greater sense of what was going on and a better understanding of the organisational culture. In addition, sharing coffees and sitting (most often) in the canteen area, created a more relaxed, informal atmosphere in their own surroundings. This not only helped the flow of conversation in the interview but also gave a greater sense of the context and culture of their workplace.

Facilitating the focus groups was also helpful as it created a dynamic within the mentor group, that helped to develop a 'community' of mentors who were keen to hear about each other's experiences which again, was helpful information for the ongoing research. It also gave me an opportunity to give back to the group, by sharing some additional insights to support their mentor training and their CPD.

Ethical issues

There were no ethical issues in relation to this research project.

Sound ethics are the essence and underpinning of good mentoring (Passmore, 2021). Throughout this research, it was extremely important to remain sensitive to the impact of the researcher and this research on those who are approached for help, those who provide access and cooperation, and those affected by the results. Maylor and Blackmon (2005) suggest that an overriding ethical principle when researching should be that we treat others as we wish to be treated ourselves and as a result, provide benefits to the individuals and organisations that are involved.

Formal ethical approval was given by the case study organisation through the Mentor Co-ordinator. Once this was attained, ethical approval was sought and given by the University's Research Ethics Committee. Formal ethical approval was not needed through the NHS Trusts (Medical) Ethics Committee as it was clear through the methods chosen, that no patients were directly involved, there was no intrusion on their privacy and they were not affected by the research. Information about participant rights was fully discussed with all mentors and mentees and consent forms were signed by all parties before the research commenced.

All participants were informed through an initial meeting about the aims, purpose and likely publication of findings involved in the research, the potential uses to which the data might be put, and any potential risks or consequences for participants. All participants had the right to participate or not, and those that did were clear about the parameters and the purpose. All participants freely gave their informed consent based on a full and fair explanation of the study (Cohen et al., 2017).

Having face to face interviews and focus groups gave the researcher the opportunity to reiterate aspects of informed consent and also to reassure that any personal information concerning research participants was being kept confidentially and anonymised throughout. Any references to names, initials and jobs were removed in the notes that were typed up and shared, to ensure no-one could be identified by a third party. Also, permission was sought from all involved to share an anonymised summary of the information with senior organisational stakeholders and later through external publications.

The researcher is a professional member of The European Mentoring and Coaching Council (EMCC), and as such abides by the EMCC Global Code of Ethics (2018) in terms of working with clients, professional conduct and excellent practice. Sensitivity, integrity and confidentiality were maintained throughout.

Reflections on the methods used

Table 3 – the key advantages and disadvantages of the two methods used

Methods	**Advantages**	**Disadvantages**
Semi-structured Interviews	• Can reiterate ethics • Personal account • Rich/deeper information • Could buy a ‘thank you’ coffee • Flexibility with diary • Freedom to probe beyond set questions • Room to develop rapport and trust	• Time consuming • Participants availability • Participants accessibility • Dual location of Hospital • Potential interviewee bias • Potential interviewer bias
Focus groups	• Can reiterate ethics • Quick way of getting a sense of what is going on • Helps to see key themes/patterns • Perceived as a mandatory part of the programme by mentors, so mentors protected time in their diaries to do this	• Still a ‘steered conversation’ – potential interviewer bias • Can limit personal responses/less detail • Potential ‘group think’ – go with the majority • Social/status pressure from group • Unable to access mentees too

Application/relevance to practice

The key values of the NHS constitution (2021) are focused on involving everyone, improving lives and working together. This is essentially and directly the same for mentoring. Table 4 shows how the six NHS values can be directly translated into mentoring.

Table 4 – The six NHS values and mentoring.

NHS constitution (2021)	NHS constitution (2021) translated into mentoring
1. **Working together for patients**. 2. **Respect and dignity**. 3. **Commitment to quality of care**.	1. Working together in partnership 2. Respect and dignity 3. Commitment to quality relationships

4. **Compassion**. 5. **Improving lives**. 6. **Everyone counts**.	4. Compassion 5. Improving lives 6. Everyone counts

These six values can also be translated into the research process too;

1. Working together in partnership; the research was set up with the researcher in partnership with the NHS Trust Learning and Development department, the mentors and the mentees.
2. Respect and dignity; ethical approval was sought and agreed to ensure that everyone who was part of the research was treated rightly and fairly. Mentors were trained so that they could treat their mentees with respect and dignity too.
3. Commitment to quality relationships; the researcher developed quality relationships over time, through the regular interviews. Mentor training and the support given through the focus groups/supervision type sessions helped to secure the quality of the mentoring relationships too.
4. Compassion; this was shown by the researcher in relation to the flexibility and commitment to meeting up regularly. This was also shown by both the mentors and mentees, and evidenced through the feedback shared over time.
5. Improving lives; the results have been shared and this type of mentoring support expanded within and beyond this NHS Trust, which has ultimately touched many lives. The support offered to the mentees was aimed at improving their chances of success with their postgraduate management qualification and ultimately in their management role. The mentor also benefits from this two-way relationship in relation to their learning gained and further skills developed.
6. Everyone counts; everyone who was within this sample group was invited to take part and all their views were equally recorded and taken into account though the interviews and the focus groups.

In addition, mentoring builds in time for reflection on practice for both parties, which in turn enhances knowledge, competence and skills in the role and confidence to make changes. It encourages people to work and learn together and to feel empowered to make changes back in the workplace, which will have a positive impact on all service users. This sits well with the notion of reflective practitioners within the healthcare context too.

In addition, all those involved were either established managers (mentors) or those new to management (mentees), so encouraging managers/leaders to role model (NHS Leadership Model, 2021), share their experience with others, and develop mentoring skills as part of their management skills toolkit, will have a snowballing effect towards developing more nurturing managers/leaders into the future.

Dissemination

From a research point of view, this research has been disseminated as a report on the NHS Trust involved, through the researchers PhD, through 2 published articles (Jones, 2012; Jones, 2013) and also contributed to a chapter in a more recent book (Hatton, 2019). More details below;

Hatton, K. (2019). Developing Coaching Skills to Support OD Skills for Leaders In Hamlin, R. G., Ellinger, A. D & Jones, J (eds) Evidence-based Initiatives for Organizational Change and Development, Chapter 21, Volume II. US: IGI Global.

Jones, J. (2013). Factors influencing mentees' and mentors' learning throughout formal mentoring relationships, *Human Resource Development International,* 16 (4) pp. 390-408 https://doi.org/10.1080/13678868.2013.810478

Jones, J. (2012). An analysis of learning outcomes within formal mentoring relationships, *The International Journal of Evidence Based Coaching and Mentoring,* 10 (1) pp.57-73 http://ijebcm.brookes.ac.uk/documents/vol10issue1-paper-05.pdf

Impact on social care/nursing/public health practice, policy or education

From a practical point of view, this research has informed practice about the benefits of mentoring and how best to implement and sustain an effective programme within this NHS Trust and beyond. The learning has been shared and others have come forward to support the initiative. As a result, it has since been adapted into a more formalised coaching programme offered to all employees, rolled out across these two Hospitals and also led to a 'coaching skills for leaders' course to enhance all managers skills set. The impact of these interventions, over a five year period, has since been measured and discussed in a follow up chapter (Hatton, 2019) which points out that through a survey of the 300+ employees who had been involved, 90% felt it had developed helpful skills for their management and leadership role and 100% of those involved would recommend a mentoring or coaching programme to others. Over 1000 employees have now accessed some form of coaching or mentoring, representing approximately one fifth of this NHS Trust. As mentioned before, more skilled managers and leaders, will mean more supported and nurtured teams, which will in turn will mean happier employees and ultimately better supported and nurtured patients..

Suggested further reading

McGrath, C., Palmgren, P. J. & Liljedahl, M. (2019) Twelve tips for conducting qualitative research interviews, *Medical Teacher,* 41(9) pp. 1002-1006. https://www.tandfonline.com/doi/full/10.1080/0142159X.2018.1497149

NHS (2016) Running Focus Groups for Patient and Public Engagement https://www.england.nhs.uk/wp-content/uploads/2016/07/bitesize-guide-focus-groups.pdf

NHS (2020) Leadership Academy on Coaching and Mentoring in the NHS https://www.leadershipacademy.nhs.uk/resources/coaching-register/

Saunders, M., Lewis, P., & Thornhill, A. (2018). *Research Methods for Business Students* (8th ed.). London: Pearson. [Some helpful chapters on doing interviews and focus groups.]

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