My Care Academy

Learning when you need it.

In partnership with Middlesex University London

NHS

REPORT OF THE ‘MY CARE ACADEMY’ STAKEHOLDER AUDIT

August 2018

Introduction

I was asked by members of the My Care Academy (MCA) governance board in June 2018 to carry out a rapid audit of MCA from the perspectives of its stakeholders. We agreed on a number of key questions (see Appendix 3) and I was supplied with details of several stakeholders and asked to contact them. First, ethics approval was applied for, and this was granted on 11th July 2018 by the Social Work & Mental Health Research Ethics Committee, Middlesex University (*see Appendices 1 and 2*). (This approval was necessary in case future publications are to be produced). Interviews were then arranged to suit stakeholders and these were held by telephone with each of them during July and August 2018. Quotes given in the report are anonymous, to ensure confidentiality as far as possible.

Many thanks to all the stakeholders who participated in this audit.

Dr Linda Bell
Associate Professor (retired)
Visiting Academic/Research Fellow
Dept of Mental Health, Social Work & Integrative Medicine
School of Health & Education
Middlesex University
The Burroughs, Hendon
London NW4 4BT
l.bell@mdx.ac.uk

EXECUTIVE SUMMARY

- I was asked by members of the My Care Academy (MCA) governance board in July 2018 to carry out a rapid audit of MCA from the perspectives of its stakeholders.
- Ethics approval was granted in July 2018 by the Social Work & Mental Health Research Ethics Committee, Middlesex University (*see Appendi*ces *1 and 2)*.
- Sixteen MCA stakeholders representing all three partners (Middlesex University, Camden & Islington NHS Foundation Trust, and Barnet, Enfield & Haringey Mental Health Trust, as well as representatives of the Expert Reference Group of service users) were approached by e mail and invited to give a telephone interview; **15 stakeholders** agreed to be interviewed.
- The available timescale did not allow for interviews to be fully transcribed. I analysed interview recordings briefly, as far as possible looking for consensus and possible differences across stakeholders' accounts; this makes for an impressionistic rather than a fully systematic report of the audit.
- **Stakeholders** were asked to describe their 'role' in relation to My Care Academy: most were working in the health service or in the university (Middlesex) and had part-time involvement with MCA. Service user representatives were included. Some people were employed in very senior positions in their organisations. Many had become involved with MCA quite recently.
- **What is the overall purpose of MCA?** Stakeholders talked about developing 'a community', a 'community of practice', or about partnership. Some mentioned the digital learning element, although a few felt there was still a place for face to face learning. Another key element was ensuring effectiveness of

the learning environment and materials. I considered that different stakeholders were constructing slightly different views of the purpose(s) of MCA, though superficially they might be using similar language.

- **Who is MCA mainly intended for?** There were different responses ranging from 'newly qualified nurses' to multi-disciplinary staff groups.
- **The overall model of MCA.** A few people were able to explain all the linked elements and the ways in which the overall system ought to work as an 'all encompassing model'. MCA was also said to involve 'changing the culture'. For others, 'MCA' was more likely to involve one or more key elements (below). Time (or lack of it) was mentioned by several people as a barrier to accessing and using the various MCA elements.
- **Key elements: Virtual classroom/ online learning.** A key issue was the need for high quality content 'that can be translated from concepts to actual usefulness' for staff. This would ensure MCA's commercial viability. Service users were enthusiastic about contributing to this content. Making more links to well produced external training materials was also suggested.
- **Key elements: SLACK and the knowledge bank.**

  SLACK in particular came across as one aspect of MCA that many stakeholders found problematic. Several reasons emerged, including (initial) technological limitations / lack of availability; time factors; having to learn another means of digital communication (staff 'all use Twitter'); and staff views about 'social media' seeming unsuitable for serious learning /CPD. One person said 'staff '*don't like SLACK*' but are '*fully committed to the other aspects of the project'.*

The knowledge bank. This content was considered by most people to be useful, although its scope seemed to overlap with the virtual classroom for some stakeholders.

- **Key elements: the Website** When asked, most people said it was useful and it had been *professionally set up,* although few people seemed to be using it very much.

What is going well?

- Service users and stakeholders from both trusts said they valued their links with the university, enabled through MCA.
- Service users found a sense of empowerment through making their contributions and having regular meetings at the university.
- There were positive reactions to the knowledge bank and to the provision of both e-learning and also (in one trust) face to face learning, via the university.

Challenges: what is not going well, or needs to be changed?

- For some stakeholders, the main issues were structural, or concerned fundamental issues of communication. The governance board, it was suggested, ought to include service user representation.
- Some people felt that there were other issues affecting the relationship between the existing MCA partners. These included changes of personnel, communication issues and each trust having different CPD needs, previous experiences and infrastructure.
- There were different views about whether or not SLACK ought to be replaced and if so, with what.

The future of MCA

- Some stakeholders thought it would perhaps be beneficial to **widen out MCA's scope** e.g. to include other partners, including prisons or the private sector ; or to change the overall focus from being solely on mental health.

- Other stakeholders thought that perhaps MCA had attempted to take on too much initially and should now **consolidate around what was going well**. For example additional specialists could be brought in to deliver relevant content.
- It was suggested that the board and the university in particular should provide a clearer picture of 'what MCA was for', saying that it was more difficult to engage staff with it, if this key point was not clear.

Conclusions and suggestions

Key areas seem to be:

- Clarifying what MCA is for
- Use of the overall model and use of the different elements
- How could MCA be organised in future?
- Learning from what *hasn't* worked as well as from what *has* worked

Audit: methods and background

Sixteen MCA stakeholders representing all three partners (Middlesex University, Camden & Islington NHS Foundation Trust, and Barnet, Enfield & Haringey Mental Health Trust, as well as representatives of the Expert Reference Group of service users) were approached by e mail and invited to give a telephone interview, on the basis that they were stakeholders in, or had contributed to, My Care Academy. Stakeholders were e mailed a copy of the Participant Information Sheet that was approved by the Ethics Committee (*see Appendix 2*). This information sheet informed them that ethics approval was in place for the audit, and so their participation would be voluntary. Those who were interested in participating would be sent a consent form when we confirmed the date and time for interview.

I was impressed by the willingness of most stakeholders to quickly confirm that they would take part in the audit, especially as this was during the summer holiday period. We therefore obtained 15 interviews with a range of stakeholders and so there is good potential for differing views to be expressed. I did several of the interviews within a short time, which also helped to give me a quick 'impressionistic' view of the organisation of MCA and stakeholders' experiences, allowing a developing picture to emerge as the interviews continued.

From my ethnographic experience as an anthropologist I have become familiar with seeing and experiencing immersion in a particular social context, the only difference here being that this was entirely an auditory experience via telephone interviews (you might say I was 'wading into a sea of individual voices'), rather than being immersed in a participatory, ethnographic setting (both visual and verbal).

Although I also looked briefly at the MCA website and the SLACK tool prior to starting work, I wanted to rely mainly on the stakeholders' own experiences and to explore what they were able to tell me about MCA in their accounts, rather than going into the audit with too many preconceived ideas.

It was important to maintain confidentiality by not naming any stakeholders or identifying them too closely during the interviews, so I subsequently identified their audio recordings by number (Stakeholder 1, Stakeholder 2 etc); I have tried not to link stakeholders too closely to their own trust or to the university; since more than one ERG service user was interviewed it is also possible to indicate where relevant comments or ideas do come from a service user perspective, which I felt would be helpful.

Following each interview, I took notes and was able to analyse interview recordings briefly, looking as far as possible for consensus and possible differences across stakeholders' accounts; as mentioned above this makes for an impressionistic, rather than a fully systematic report. This is a limitation that needs to be borne in mind when reading this report. As I had already explained at the outset to members of the governance board, given the overall timescale I was given, there would be insufficient time at this stage to have all the interviews fully transcribed, although by making the audio recordings and getting ethics approval this allows for the possibility of interview transcriptions in the future if required.

RESULTS

Fifteen stakeholders agreed to be interviewed and they were sent consent forms to be returned by e mail; this consent also specified that telephone interviews would be audio recorded. All interviews were carried out by Dr Linda Bell beginning on 25th July and finishing towards the end of August; interviews lasted for an average of 30 minutes.

STAKEHOLDERS

Stakeholders interviewed represented both the Trust partners (BEH and C&I), Middlesex University and the Expert Reference Group of service users.

In each interview I first asked stakeholders to describe their 'role' in relation to My Care Academy, and found that nearly all were doing other work either in the health service or in the university (Middlesex) and had part-time involvement with MCA. Some were employed in very senior positions in their organisations; some were new in their current post and I was surprised by how many of them had become involved with MCA quite recently. I was told by various people that only 4 of the original stakeholders were still involved with MCA; it was suggested that a core group was necessary for a project like this, but this might need to expand if (as I queried) MCA itself was going to expand, so as to cover all the necessary future work.

STAKEHOLDERS' OVERALL IMPRESSIONS OF MCA

I first asked stakeholders :

What is the overall purpose of MCA?

Gradually a picture of MCA emerged which I found was consistent to some degree across the interviews, as it was initially described by all the stakeholders when

answering this question. In response, stakeholders often talked about developing 'a community', a 'community of practice', as expressed in these verbatim examples:

> *'it's about establishing a community of practice, which is really around, ….well I would say, a knowledge building community which is drawing on the expertise and talents of the three partners'*

> *'ultimately it's looking to create a learning community or a knowledge building community, particularly between the three partners [in the trusts?] Barnet and Haringey, Camden & Islington and Middlesex University'*

> *'I think the main objectives are probably to link our staff and hopefully in the future other staff from different trusts up in order to be able to share good practice and information'*

Other related ideas also emerged from these examples, particularly the notion of 'partnership'. Another element that was focused on more specifically by some of the stakeholders was the digital element, although a few felt there was still a place for face to face learning:

> [*The overall objective was] 'to prove the concept of having a digital option for CPD, so for it to be more than just kind of e-learning, so the whole idea behind it was that you kind of build and connect up individuals and in doing so you create a kind of knowledge learning community…..'*

' to change the culture of learning within the partnership, and to use the talents and skills of the organisation of the staff, to create and disseminate learning but in partnership of the digital age, so using digital technology, websites and so on but to be smarter, and give staff a different way of learning…'

' I think the main aim is to create a virtual classroom across three organisations, in which we would be able to share best practice and skills and knowledge, and so there's not this 'we're all doing it in isolation' and so to share the work, but to have a resource that staff at any level and qualification could access for information…'

'it's a collaboration between academic establishments and clinical provider trusts to bring academia and clinical practice together in a forum that can be face to face, but also might be an e-forum, developing e learning packages, making education accessible more widely than it currently is…'

'..it's really as a way of sharing good practice, knowledge and experience with NHS workers and other people in other roles across the trusts, across north London, and it's really important because there are so many people doing actually similar jobs, but they do not get to share their knowledge and make use of multi-media and use learning and training in a very bite-size and quick way…'

A third area which was highlighted by some stakeholders and links to this final quote (above) concerns effectiveness:

'I think its main objectives are to create a learning environment.. whereby the three current organisations can collaboratively share learning in a way that's efficient and effective…'

'a knowledge building community which is drawing on the expertise and talents of the three partners…… it is getting value for money through that partnership by everybody sharing their expertise… it is addressing what we know to be current, and not going to get any better, the shortfall in continuing professional development or CPD and development for staff, and (?) development of the workforce'

'a knowledge-building community, […..] built on knowledge building principles and enabling [us] to unlock the talent of staff within organisations, so that they could share that best practice, and [?doesn't go off] and we recruit and retain that talent'

As I pursued this first question through all the interviews it became clearer that different stakeholders were constructing slightly different views of the purpose(s) of MCA even though superficially they might be using similar language. This was confirmed by one stakeholder who said:

'I think the project has [had] various changes as it's evolved over the past couple of years, so there's been some confusion about what it *is* about…'

This perspective also came through from another stakeholder, employed in one of the trusts, who asked that the board and the university in particular should provide a clearer picture of 'what MCA was for', saying that it was more difficult to engage staff with it, if this key point was not clear. Someone also suggested that MCA had started

with big ideas, but now needs to consolidate; had it taken on too much? Another stakeholder suggested that there were remaining issues about the 'commercial viability of the project'.

One stakeholder suggested that in targeting **who MCA was intended for**, a clearer focus on 'newly qualified nurses' would be helpful; another pointed out that MCA was meant to be multi-disciplinary and felt there had been too much focus on nurses, who seemed to them to predominate in any meetings or other forms of engagement with MCA.

THE OVERALL MODEL AND DIFFERENT ELEMENTS OF MCA:

Virtual Classroom and on-line learning ; Knowledge Bank and SLACK; the Website.

Overall model

Next in each interview I asked all stakeholders about **MCA overall** and the **different elements of MCA**. I became slightly confused about the potential overlaps between these various elements, again because stakeholders were, from their different perspectives, explaining them to me in different terms. For some, the main focus of their involvement with MCA turned out to involve one key element, and so this what they considered to 'be MCA', as with the stakeholder above who had said:

'the main aim is to create a virtual classroom across three organisations'

A few people were able to explain all these linked elements and the ways in which the overall system ought to work as an 'all encompassing model', which then made more sense to me in terms of it constituting the aforementioned 'learning community', for example:

one of the selling points I think of My Care Academy is that it's not just about it being an e learning platform where you can find relevant and appropriate materials that have been developed by your own staff in your own Trust, that you have the ability in addition to that, within the model, to connect via social media with your colleagues online and have debates and discussion about relevant and important practice issues. And on top of that you have a website, which is a kind of 'one stop shop' where you can go and read blogs in terms of what people are doing, but you can also look at the events page and see what else is happening, that might be happening across London, that will be posted there, that's relevant. So it's really a sort of ***all encompassing model*** *where you're not just talking about doing an online course, you're actually engaged in a learning community together, where you can influence.'*

Whilst 'the penny dropped' for me about the overall scope of MCA when hearing these kinds of explanations, it was clear from talking to several stakeholders that they felt some staff still 'didn't get it'. Clearly this 'all encompassing model' is an interesting one and potentially exciting, but its usefulness does depend on:

- having smooth technological linkages between all the different elements.
- staff needing to fully understand something about the potential directions of travel between those elements and why they would need to access all of them.

One person suggested that staff simply do not have time to search through the 'various levels' in MCA to reach something, and said that if they cannot find what they need quickly 'they just give up'. But a useful suggestion made by more than one person

was to place a “Q&A” section or forum, perhaps on the website, which could address some of these issues concerning the use of various digital elements.

Much was made of the potential for MCA to deliver ‘quick’ and ‘bite-size’ learning to staff, and the overall question of **time** therefore looms large in the background within all these interviews. This is both in terms of staff ‘lacking time’ (it was said) to undertake CPD or other learning, and on the other hand that various elements of MCA seemed to require sufficient time to be learnt and appreciated fully. These comments about time may seem quite obvious in busy NHS settings, and so it was interesting to hear from one stakeholder that whilst they had started out with a negative view of SLACK (see also below), the person could now say this was something to be recommended to other staff, especially newly qualified nurses. This was because the stakeholder had spent a lot of time really trying to understand this form of social media, and now felt it would benefit others after all, if staff were also prepared to make an effort to understand it. A contrary view was expressed by another stakeholder who said that

‘*you shouldn’t have to explain [SLACK] to people if this is not obvious’*

A different stakeholder also expressed the view that it was not really a matter of ‘time’, but thought that people were simply fearful of using digital media *per se.* (But this did not seem to be corroborated by others’ accounts.) It was also pointed out by a stakeholder in one of the trusts that since they already had existing staff platform(s) in place which could accommodate digital materials, this questioned the need for additional digital platform(s).

Virtual classroom and online learning

This particular aspect of MCA was regarded positively in general terms, and some stakeholders also talked about making contributions to these materials, related to specific content and online modules ; however there had clearly been delays not only in developing this aspect of MCA but also technologically in disseminating to staff whatever material was available in the 'virtual classroom'. This aspect of MCA was important according to a few people partly because if beginning with CPD, '*should staff wish they could then develop that into [formally] accredited systems',* for enhancing their professional portfolios and the like.

One person made the fairly obvious point that the usefulness of the virtual classroom 'depends on its content'. Someone suggested that what was needed was '*more content that can be translated from concepts to actual usefulness'* for staff i.e. in practice. For some interviewees there seemed to be a focus on university staff providing this content, whilst other stakeholders including members of the Expert Reference Group (service users) were enthusiastic about making contributions to the virtual classroom and to other digital platforms and were actively engaged in this work. Most people I spoke to seemed to think that now the MCA virtual learning materials were becoming accessible on trust digital platforms, rather than only on the university systems, things would get easier for staff to use; there had previously been issues for example about the issuing of licences by the university (an issue also applicable to SLACK and the knowledge bank). Another suggestion was that more links to external training materials could be included in the virtual classroom as *'there is already a lot of content out there which could be accessed'.* The point about having good quality, relevant content (emphasised by several stakeholders), though ideally produced by partners, still applied. Some interviewees wished to thank university staff for 'keeping

everything going' with MCA. However, there were also questions raised by some stakeholders about the quality of some of the MCA e-learning content; the suggestion might be that external material was perhaps more professionally produced, which could add to the commercial viability of MCA in the longer term.

Emerging from all these discussions about virtual learning I began to see how, (despite the emphasis nearly all stakeholders gave to the concept of 'partnership' at the beginning of their interviews) for most people 'partnership' tended to mean links between the university and their own trust.

> *'…it's really handy for us to have a relationship with Middlesex, I know that we do… I think it would be useful to think about how they could support maybe the transition for the newly qualified nurses…[..] I think there are a few gaps in terms of this transition period, and how we could work together to do that..'*

Service users also particularly valued their links with the university, whilst they also had links to the trusts in many other contexts. As I learnt more about the changes that had come about in MCA over the past two years, it seemed that the trust partners were developing MCA in somewhat different ways, including the development of different modules and also specific face to face teaching and seminars.

(see also section below on **Challenges**, below).

SLACK and the knowledge bank

SLACK in particular came across as the one aspect of MCA that many stakeholders found problematic. One person described trying to get staff to use SLACK as 'flogging a dead horse'. However, there were various reasons for this. In addition to the stakeholder who, as mentioned earlier, felt the need to spend a lot of time investigating its usefulness before being able to recommend it, there were both technological and

what might be termed ‘social’ issues to overcome, as well as the time factors already mentioned. In terms of technology, several people talked about the (un)availability of materials on digital platforms and said that these problems of accessibility arose for example from factors such as staff in one trust initially not having work smartphones available. However, I was also told that staff were not allowed to use their own phones on the wards and so they had to rely on other technology such as the ward computer. This seemed to potentially stifle possibilities for ‘bite size learning’ in spare moments during work time.

Furthermore, issues with the availability of licences for staff to enable their access to SLACK had delayed their involvement with the platform. I found it difficult to accept the suggestion that staff were simply ‘scared’ of using SLACK, particularly when I asked interviewees if, and how, staff communicated with each other digitally: several people replied ‘they all use Twitter’. One result of this situation was that people seemed to be asking ‘why should staff learn to use *another* digital / social media system?’ They found this to be potentially time consuming and unnecessary and also queried why SLACK was not used in the university as well, for consistency across the partnership (this however had related to issues with licences as noted above). The idea of having one digital social media platform to be used across the partnership did seem to be one reason for disenchantment with SLACK; some interviewees did suggest using Twitter as a replacement, whilst also acknowledging that this would potentially break into the enclosed nature of the partnership and might cause issues with being able to vet materials that were being uploaded to the knowledge bank. There were other notes of caution. One person talked about having to be ‘very confident’ about the value of moving to a new platform and dropping SLACK, before this was attempted.

However, I also learnt that staff in the trusts seemed to have problems with the whole idea of linking 'social media' with the serious business of learning and CPD: this is in addition to the issue of not wanting to overload staff by expecting them to study / work in their own time. Is SLACK (and indeed Twitter) therefore to be used 'personally', or 'professionally'? If 'personally', can this form of 'social media' then be taken seriously as a mechanism to deliver CPD? This line of argument may challenge the idea of 'changing the culture' which some stakeholders also talked about, or perhaps it shows up how necessary this change in fact is, so that staff would be able make full use of the 'all encompassing model' of MCA and thus take more responsibility for their own learning. Time pressures surely remain, however.

The Website

There was a generally positive response to the website when I asked about it, which several stakeholders said had been *professionally set up,* although few people seemed to be using it very much. During the interviews not many stakeholders mentioned the website at all. One comment was that people *may not have time to use it effectively.*

WHAT IS GOING WELL AND WHAT ARE THE CHALLENGES?

What is going well?

After trying to get an idea about stakeholders' understandings of MCA, and the various elements it contained, I noted various positive reactions expressed through stakeholders' experiences. There were for example many positive comments about links that had been forged between each of the trusts and the university which were facilitated by having MCA in place, including the involvement of service users:

'I think MCA is to help staff from the two NHS trusts to benefit from [and]… to learn using the expertise of the academics who work with us to bring in the service user perspective…'

In addition, another trust stakeholder also suggested that:

'*I would be really interested in reading service user blogs .. if we could get service users to do that, that would be brilliant'*

Generally, service users and stakeholders from both trusts said they valued their links with the university, enabled through MCA, as noted earlier:

it's really handy for us to have a relationship with Middlesex.

In addition service users found a sense of empowerment through making their contributions and having regular meetings at the university.

As already noted, there were positive reactions to the knowledge bank and to the provision of both e-learning and also (in one trust) face to face learning facilitated by Middlesex staff.

Challenges: what is not going well, or needs to be changed?

For some stakeholders, the main issues were structural, or concerned fundamental issues of communication:

'the structure needs to be much more coherent, transparent and formalised'

'my instinct is to say, consolidate [possibly pause this?] and have a proper chat with the partners..'

'…what hasn't helped, and it's not anyone's fault, …..there has been a massive change in personnel at board level etc….[ ] …and that has had an effect, because very much it's about individuals driving forward, especially individuals on the clinicians side, senior staff, [who] have very much helped in driving forward the project'

Despite attempts to develop better communication between staff, one stakeholder suggested that more information needed to be shared about projects taking place in different parts of the partnership. Some people felt that there were other issues affecting the relationship between the existing partners, that could perhaps be addressed by widening out MCA's scope:

'*I think [MCA] could be really successful with other trusts…'*

It was suggested to me that the two NHS trusts may have reacted to MCA in different ways, based on their existing CPD experiences. So for C&I, which already had some CPD in place when they took part in the MCA 'pilot', there may have been less incentive subsequently to 'share' these experiences with other trusts. I was also told that C&I had good existing platforms for disseminating e-learning materials and that this had rendered some parts of MCA less useful. The trust was also, I understood, making continuing use of some face to face teaching in conjunction with the university. For BEH however, coming into the MCA partnership enabled the take up of more CPD for their staff than had previously been available. This has also led onto development of some specific module(s) specifically for BEH, using the MCA online platform(s).

For other stakeholders there were issues about specific elements of MCA and as already discussed, many people were negative about the use of SLACK. But as one person said, for example, staff '*don't like SLACK*' but are '*fully committed to the other aspects of the project'.*

THE FUTURE OF MCA – what would you like to see happening?

There were several suggestions concerning the future development of MCA when I asked about this: for example, some suggested that in terms of its scope, MCA could develop by making additional links with the voluntary or private sector(s). It was felt by some that having clearly identified stakeholders to organise MCA is important:

> *…..we are getting there because things are stabilising with the newer groups that are around… secondly we have to stop this reactive sort of ad hoc jumping around – what we need is consistent membership …we need key, identified stakeholders who are accountable.*

> '*I think we should have service users sitting on the board'*

In terms of its key links to mental health, there were suggestions that MCA could link up to forensic services, including work in prisons; but some thought there could also be potential in linking to acute trusts and generally in widening out to move beyond mental health.

> *'The knowledge bank and the virtual classroom could be used still , but the content could be different … the content could be for general nursing…'*

However, for current service user stakeholders, the link to mental health services was key:

> *'if everything was in place [future funding etc] I would be more than happy to continue because it is so empowering, and informative, and there is the opportunity to network as well…'*

Whilst acknowledging that digital materials were 'a huge part' of MCA, one stakeholder suggested that the bit that had worked best for their trust was the face to face learning.

Communication, as always, was a key issue, especially in terms of 'selling' MCA to senior / executive staff and to other staff groups:

> *It would be really sad if it [MCA] stopped .. I think we're just getting over the hump with all our IT issues.. I think I could possibly persuade the chief exec and whatnot that this would be a really good* ***communication route*** *for the organisation……the worry is that we are running out of time, because this would take time..'*

> *'….we need a consistent communications strategy which is systemic and strategic across both the trusts for all partners, so everybody in the partnership understands this project'*

For some stakeholders, it was important to reflect, consolidate, and perhaps to scale back on current activities. Some said it was important to ensure that learning materials being produced were of good quality and of commercial relevance.

There remained a key issue about who exactly MCA was aimed at and so there seemed to be a need to focus on staff engagement:

> *'We need to look at our engagement strategy to the 'shop floor'*

> *'I think the biggest thing would be to just have a really clear message out to everybody about what it is, how we can use it best and how it benefits us, in terms of the whole workforce'*

In terms of what MCA is offering, some stakeholders had specific suggestions which could enhance the available materials :

> *'How do we get people into the team who can turn expert clinical materials into expert educational materials?'*

'It would be good to have an educational technologist on the MCA team, or someone with that skill set'

'…we need to be very, very confident that it will actually deliver to clinicians good training that they will need, and that's got to be the benchmark…..so… as I said I think some of the applications haven't delivered that … there's been a lot of investment in the technology and we've learnt, but… you know going forward the benchmark has to be that, developing good training that is picked up and used '

Conclusions and suggestions

This rapid audit of the views of different stakeholders has, I hope, raised several issues which I summarise below, and that I hope can be taken forward when developing MCA.

Clarifying what MCA is for

The over-riding need from stakeholders' perspectives seems to be for better communication to ensure a consistent picture of what (and for whom) MCA is primarily intended. This is despite the positive reactions for example to the website, said to be professionally set up, but which few people seem to be using. There is also the question of whether overall *expansion* or *consolidation* is preferable.

Some stakeholders thought it would perhaps be beneficial to **widen out MCA's scope** e.g. to include other partners, including prisons or the private sector; or to change the overall focus from being solely on mental health.

Other stakeholders thought that perhaps MCA had attempted to take on too much initially and should now **consolidate around what was going well**. For example additional specialists could be brought in to develop and deliver content.

Use of the overall model and the different elements

There are clearly a number of different possibilities for staff to engage with their 'learning community', but perhaps it is unrealistic to expect them to always be aware of working within an 'all encompassing model'. However, if trying to implement such a model with staff, this engagement could happen using the different elements of MCA in different ways. Stakeholders suggested more guidance on these possibilities; for example they could:

use the website to find out about an event, attend the event, connect with colleagues about their experience via social media, perhaps write a blog…..

How could MCA be organised in future?

In relation to its organisation through the governance board and operational groups, some people suggested that membership should not only be consistent but that it would also be particularly beneficial to include service user representatives.

Learning from what *hasn't worked* as well as from what *has worked*

Although I feel that everyone had useful points to make, it was noticeable that some stakeholders from all partners told me they felt they were not being listened to and that situations had been allowed to drift. Some people said that it should not be a problem to learn from mistakes, from inappropriate actions and organisational or workforce issues as well as from celebrating successes.

Middlesex University London

Social Work & Mental Health Sub-Committee

The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 0208 411 5000

11/07/2018

APPLICATION NUMBER: 4475

Dear Linda Bell

Re your application title: MyCareAcademy Stakeholder Audit

Supervisor:

Co-investigators/collaborators: Carmel Clancy

Thank you for submitting your application. I can confirm that your application has been given approval from the date of this letter by the Social Work & Mental Health Research Ethics Committee.

Although your application has been approved, the reviewers of your application may have made some useful comments on your application. Please look at your online application again to check whether the reviewers have added any comments for you to look at.

Also, please note the following:

1. Please ensure that you contact your research ethics committee (REC) if any changes are made to the research project which could affect your ethics approval. There is an Amendment sub-form on MORE that can be completed and submitted to your REC for further review.

2. You must notify your REC if there is a breach in data protection management or any issues that arise that may lead to a health and safety concern or conflict of interests.

3. If you require more time to complete your research, i.e., beyond the date specified in your application, please complete the Extension sub-form on MORE and submit it your REC for review.

4. Please quote the application number in any correspondence.

5. It is important that you retain this document as evidence of research ethics approval, as it may be required for submission to external bodies (e.g., NHS, grant awarding bodies) or as part of your research report, dissemination (e.g., journal articles) and data management plan.

6. Also, please forward any other information that would be helpful in enhancing our application form and procedures - please contact MOREsupport@mdx.ac.uk to provide feedback.

All the best for your research.

Yours sincerely

Dr Margaret A. Volante

Chair: Social Work & Mental Health Research Ethics Committee

APPENDIX 2 PARTICIPANT INFORMATION SHEET & CONSENT FORM

Version Number 2

MIDDLESEX UNIVERSITY
SCHOOL OF HEALTH AND EDUCATION
Health & Social Care Research Ethics Committee

.

1. Study title

MY CARE ACADEMY AUDIT OF STAKEHOLDERS

2. Invitation paragraph

You are being invited to take part in an audit. Before you decide it is important for you to understand why this is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.
Thank you for reading this.

3. What is the purpose of the study?
We are conducting an audit of stakeholders involved in My Care Academy. The interviewer is an independent researcher (a retired academic from Middlesex University) who has not been involved in the My Care Academy project.

4. Why have I been chosen?
We are choosing to interview various informants, such as yourself, who all have relevant experience and knowledge of the work of My Care Academy.

5. Do I have to take part?
It is up to you to decide whether or not to take part in these interviews. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason, until the report is produced in August 2018. In order to withdraw your data from the audit you can contact the Principal Investigator (Dr Linda Bell) by email, who will explain what will happen to your interview data.

6. What will happen to me if I take part?
The researcher will arrange to interview you once by telephone. Interviews may last for up to 30 minutes.
In order to ensure quality assurance and equity this project may be selected for audit by a designated member of the Ethics committee. This means that the designated

member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. What do I have to do?

The interview will be semi-structured and we will ask you about your involvement with My Care Academy and what your experience of the initiative has been.

8. What are the possible disadvantages and risks of taking part?

There is no known risk in participating in this project.

9. What are the possible benefits of taking part?

We hope you will find taking part in these interviews interesting and that your views will also be of interest to other professionals.

10. Will my taking part in this study be kept confidential?

All information that is collected about you personally during the course of the research will be kept strictly confidential. Any information about you which is used will have your name removed so that you cannot be recognised from it.
All data will be stored, analysed and reported in compliance with the Data Protection Legislation of the relevant country where the study is being conducted and other privacy regulations.

11. What will happen to the results of the audit?

Initially it is intended that the information you provide will be used to provide an audit report to My Care Academy in September 2018. Later on the material may be used in research publications.

12. Who has reviewed the study?

The Middlesex University School of Health and Education, Health & Social Care Ethics Committee.

15. Contacts for further information

You can contact the researcher via the University where she is currently a Visiting Academic/Research Fellow as follows:

Dr Linda Bell
Associate Professor (retired), Visiting Academic
Dept of Mental Health, Social Work & Integrative Medicine, School of Health & Education
Middlesex University, The Burroughs, Hendon, London NW4 4BT
l.bell@mdx.ac.uk

My Care Academy Lead:
Professor Carmel Clancy
Dept of Mental Health, Social Work & Integrative Medicine, School of Health & Education
Middlesex University, The Burroughs, Hendon, London NW4 4BT
c.clancy@mdx.ac.uk

Version Number: 1 6th July 2018

Participant Identification Number:

CONSENT FORM

Title of Project: My Care Academy Stakeholder Audit

Name of Researcher: Dr Linda Bell

Please initial box

1.	I confirm that I have read and understand the information sheet dated 6th July 2018 for the above study and have had the opportunity to ask questions.	1
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason UNTIL AUGUST 2018	2
3.	I agree that this form that bears my name and signature may be seen by a designated auditor.	3
4.	I agree that my non-identifiable research data may be stored in National Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers.	4
5.	I understand that my interview may be taped and subsequently transcribed.	6
6.	I agree to take part in the above study.	7

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

APPENDIX 3

Interview Questions

1) What is your role in relation to MY CARE ACADEMY? (prompt – some information about when you joined in this role/have been active. Your key responsibilities)
2) What do you think are its objectives OVERALL and in relation to:
    - Virtual classroom and development of online learning materials (prompt - have you added anything?)
    - Knowledge bank - SLACK
    - Website – (prompt - have you actively engaged with this and if so in what way?)
3) WHAT HAS WORKED WELL? – about project itself, and from their partner organisation's perspective (prompt – generally, and in relation to the above 3 aspects).
4) WHAT HAS NOT WORKED WELL/COULD BE CHANGED?/ barriers – (prompt – generally, and in relation to the above 3 aspects).
5) OTHER CHALLENGES/BENEFITS e.g. in relation to: BOARD STRUCTURE, OPERATIONAL GROUPS
6) THE FUTURE: what would you like to see? – stop/ continue / start in MCA?. (PROMPT: Future vision of what MCA would look like to benefit their organisation). PLUS ANY OTHER GENERAL COMMENTS