NORTH OF SCOTLAND

PUBLIC HEALTH NETWORK
1st February 2007
Item 5.8

Evaluation of Public Health/Health Improvement Networks by peer review of self-assessment

REPORT FOR THE NORTH OF SCOTLAND PUBLIC HEALTH NETWORK

2006

Evaluation of the North of Scotland Public Health Network: Self assessment and Peer Review carried out during October 2006

Background to the evaluation in brief:

The North of Scotland Public Health Network (NoSPHN) was set up in the 1990s but formalised in 2002. As part of it's sustainability in terms of funding, the management group of the network decided that it should be evaluated. It was also recommended and agreed by the management group that there should be at least two methodologies employed in the evaluation: survey and self-assessment with peer review. The former was completed earlier in 2006 and reported on (Evaluation of the North of Scotland Public Health Network: Telephone and e-mail Survey, Final Report, February 2006). This report relates the Peer Reviewers findings and recommendations from the self-assessment and peer review evaluation carried out in the Autumn of 2006.

Next Steps

The findings and recommendations laid out in this report to be considered in the future direction and work of the network. This evaluation may be used as the baseline for assessment of the network at a future time.

Contents

1. Evaluation process

1.1 Steps involved in the evaluation process

The individual steps involved in the self-assessment and the peer review evaluation were:

- Adoption and agreement of the six core standard statements
- Pilot using the designed assessment tools
- Finalisation of the assessment tool and identification of potential interviewees
- Submission of completed self-assessment framework with associated evidence
- Pre-review day assessment of position
- Review day
- Reporting process

Adoption and agreement of the six core standard statements
The six core standards were adapted from but not identical to the seven attributes on which the survey evaluation was based. A set of criteria appropriate to each of the six standard statements were identified. A peer reviewers framework (PRF) and a self-assessment framework (SAF) were designed to map against the criteria appropriate to each of the six core standard statements. The peer reviewers framework accommodated comments and scores against each criteria with an overall grading system to provide a grade against each of the six standards. The self-assessment framework was designed to map submitted written or other evidence to each of the criteria with an option for the submission to be commented on by the submitter on behalf of the NoSPHN. For all of the above stages and prior to the evaluation process, the NoSPHN steering group was informed at each of it's meetings regarding the methodology, the standards and criteria, and the completed SAF.

Pilot using the designed assessment tools
The provisional assessment tools were piloted using provisional evidence for two of the six core standards. Changes were made on the basis of the pilot in respect of criteria but the grading system remained unchanged, see appendix 2 for the final PRF.

Finalisation of assessment tool and identification of the possible interviewees
A list of potential questions/areas for validation was drawn up based on the six standards. These were used to identify appropriate persons or organisations that could reasonably be expected to provide answers to, or to inform on, these questions/areas. Invitations to potential interviewees were sent out with the option of either being interviewed in person or remotely (telephone or video-linkage). The responders were then allocated to one of four interview groups according to their appropriateness to common areas of relevance to the NoSPHN. In practice, this was compromised by their stated availability during the course of the review day. As a result, all of the standards were potentially relevant for validation or further investigation by question and discussion in all the groups.

Submission of completed self-assessment framework with associated evidence
Prior to the review day (two weeks), the Peer Reviewers received the completed self-assessment framework with copies of the written evidence. They were asked to

make a provisional assessment against the criteria and to elicit any questions or points in need of clarification before the pre-review day session.

Pre-review assessment of position
During the evening prior to the review day, the Peer Reviewers completed the PRF as much as possible. A list of questions and issues for validation or further inquiry were compiled for instances where the following occurred:

- a consensus was not reached amongst the Peer Reviewers
- an assessment could not be made on the available evidence
- instances where the criteria were thought not to have been met by the Reviewers but indicated to have been met by the network

The questions and issues were then allocated to the appropriate group(s) of interviewees for use during the following review day.

Review day
The review day was scheduled to allow four interview slots, consultation times for the Peer Reviewers and a preliminary feedback session to the network-see appendix 3 for the actual schedule.

Reporting process
The reporting schedule included a draft report of the evaluation to be sent to the network for consultation. Any suggested amendments were considered by the Reviewers and the report finalised when signed off by the chair of the Peer Reviewers panel see section 1.4.

1.2 The people involved

The Peer Reviewers represented Public Health in their following roles: Health Boards Director of Public Health, Professional Support Manager for NHS Health Scotland and the Lead Consultant of the Scottish Public Health Network who also chaired the Peer Reviewer group.

The evaluation was facilitated and supported by the lead and other members of the Epidemiology and Health Science Team based in a Health Boards Public Health department.

The interviewees (17) in terms of the roles they represent are listed in appendix 5

1.3 Standards, criteria and assessment tools

Six standard statements were developed to cover the seven areas that the network management considered the NoSPHN should succeed in:

1. Delivers a workplan
2. Network influences processes (local, regional, national)
3. Network has added value
4. Supports increases in public health capacity
5. Network is quality assured
6. Partnerships are established which are conducive to effective networking

Criteria that would need to be met for each of these six areas were identified and the PRF designed on the basis of these (see appendix 2). The following grading system for each of the criteria was used:

(1) Met = confident of it having been achieved

(2) Partially Met = evidence and belief that it's not been fully met and there is some way to go in achieving it to a satisfactory degree

(3) Not met = when there is no evidence of progress either due to there being no evidence submitted, or the evidence submitted being irrelevant or on the basis of the commentary provided indicating that it is not met

(4) Not Applicable = Criteria or sub-criteria that have been denoted as Not applicable (N/A) **by the self-assessor**. The Peer Reviewer should not append this grade to any criteria and it should not be used in the overall grading of the standard unless it is the opinion of the peer reviewer that it should apply and therefore the grading of the criteria should be "Not met"

In order to award an overall grade to each of the six standards, a hierarchical set of rules was developed, see appendix 4 for the grading system used.

1.4 Schedules and Review arrangements

The following time-scales applied:

April 2005:	Scoping paper outlining the dual approach to the evaluation of the NoSPHN
August/September 2005:	Telephone and e-mail survey undertaken
December 2005:	Process for self-assessment by Peer Review and nominations for Peer Reviewers discussed by the NoSPHN steering group
January 2006:	Three Peer Reviewers accepted invitation by NoSPHN Lead Clinician
July 2006:	Pilot of two standards
October 11th 2006:	Completed SAF with supporting evidence sent to Peer Reviewers
October 26th/27th 2006:	Pre-Peer Review session and Peer Review day
December 8th 2006:	Collation of all review findings in Facilitators outline draft report sent to Peer Reviewers
January 8th 2007:	Draft report sent to NoSPHN for steering group meeting
February 1st 2007:	Comments on the draft report sent from NoSPHN to Peer Reviewers
February 2007:	Final Report issued

The pilot and review were both based in NHS Highland, hosted by the Department of Public Health. Video/telephone linkage was used for two of the Peer Reviewers during the pilot and for 12 of the interviewees during the Review day. The NoSPHN Lead Clinician and the Network Co-ordinator were available to be present on request throughout the review day including all of the interview sessions.

2. Overview of the North of Scotland Public Health Network

2.1 History of the NoSPHN

The network was set up formally in Autumn 2002 as a collaboration of the Public Health functions of the NHS Boards of Grampian, Shetland, Orkney, Highland and the Western Isles. It received funding from RARARI until 2004 and from then on by each of the constituent NHS Health Boards on an Arbuthnott allocation basis. The funding covered the management costs of a Lead Clinician and Co-ordinator. The network was without a Co-ordinator during 2003/04 with a new post-holder in 2004 to the present date. The lead Clinician has not changed since 2002. Although this is a two year rotational post, the postholder changed posts during this time. Until the survey carried out in 2005, there had been no evaluation to assess the effectiveness of the network.

2.2 Geography and populations covered

The collaborating Health Boards serve a population of just under 900,000, which is less than a fifth of the Scottish population (17.6%) but covers nearly two thirds of the national land area (60%). The average population density is 23 per sq km (range of 8 to 60) and population numbers on the Islands range from 2 to 20,000. There are over 73 inhabited islands.

2.3 Remit of the NoSPHN

The remit of the North of Scotland Public Health Network is to “improve health and reduce health inequalities across the North of Scotland. To achieve this, those involved will work collaboratively, where this adds value, to plan and deliver equitable, high quality and effective public health services / activities for the benefit of the population of the North of Scotland”.

3. Findings against standards and criteria

3.1 Standard 1: Delivering a NoSPHN work plan

Criteria	Review findings
1. There is an agreed NoSPHN work-plan Elements Work plan and actions exist	Work plans have been developed and updated on a regular basis. The NoSPHN reviews and updates progress at its 2 monthly meetings. It logs the source of the work; expected outcomes; tasks involved, leads for the work, timescales and progress. Initially (2004), a review of NoSPHN with stakeholders informed the topics for the work plan. Determinants of the work plan include: the prioritised regional planning agenda of the NoSPG; national imperatives and issues raised via members of the NoSPHN steering group and outwith this; work arising from the NoSPHN work itself.
There is consultation and agreement with all levels of stakeholders in the development of the work plan	Agreement of the workplan at Health Board level is indirect through the NoSPG work including that of the NoSPHN where relevant, by membership of the NoSPG, and by DsPH. The composition of the steering group which was originally restricted to DsPH, and the identification of stakeholders i.e. the defined network, has been reliant on local intelligence and on local systems to disseminate appropriately. So far the inclusion has focussed on the "badged" public health workforce. The results of a recent survey indicated that a separate stakeholders group would be beneficial in widening the network more effectively.
There is a process for getting work items on the work plan which sources topics for consideration and prioritises work items	Specific criteria are applied to enable prioritisation. However, stakeholders interviewed suggested that this needed to be addressed by capacity issues so as to obviate the need for protected time of those involved in the project work.
2. Work plan actions are in place, are progressing and delivers the remit of the NoSPHN ELEMENTS Work plan actions have assigned personnel and set timescales	Work plans include action plans and timescales for projects that have been fully developed or scoped.
The process of assigning work/actions to personnel seeks equity of spread across Health Board areas and individuals in terms of appropriateness of skills or expertise and spread of workload between Health Boards reflected by equal representation of Health Board personnel in the assigned project work	There is no systematic process of ensuring equity of spread of work or resource across the Health Boards and resource and skills are assigned on a case by case basis. Where single disciplinary skills are used, all Health Boards are invited to share and in other cases, a single Health Board may take the burden of work so that all Boards may ultimately share the benefits from it. Interviews of stakeholders suggest that they were very comfortable with this approach. It was evident there was significant trusts between the Health

Criteria	Review findings
	Boards and each were happy that they were sufficiently involved in all the work and if not, that they were happy with another HB doing the work and they would pick up on it as appropriate.
There is a process to ensure project leads have time to undertake work on behalf of the NoSPHN	There is no protected time assigned to network activities and project leads are expected to negotiate time with line managers. It was evident that timescales are vulnerable or are protracted due to any local work prioritisation over regional work. The NoSPHN is recommending that all work for the network is recognised within departmental and staff objectives. However, interviewees during the peer review indicated that prioritisation of the work via capacity issues is preferable to protected time.
There is a review process of work plan actions which identifies and takes into account potential public/patient aspects	Patient and public involvement in the work of the network is not specifically addressed. It was indicated that this would be done if it was appropriate to any one work item-(this is further examined under standard 5)
Work plan objectives deliver the remit of the NoSPHN	The objectives of the work plan are contributory rather than directly delivering the remit of the NoSPHN which is to improve health and reduce inequalities in health across the North of Scotland. Therefore the remit and aim of the network would need to be reconsidered to outline specifically what the network can do through its workplan.
3. Work plan projects are delivered, on time and within resources ELEMENTS	
There is an effective reporting system in place to collect and collate NoSPHN work plan information	The NoSPHN steering group meets every two months and these are timed to consider two-way feedback from and to the NoSPG. Feedback is mostly by dual representation of one of the DsPH on the steering group and on the NoSPG and is verbal rather than written.
Each “project” has defined objectives and is monitored against any relevant timescales	This applies to all projects which have been scoped/developed. As noted under criterion 2, timescales are often reviewed and vulnerable due to pressures of non-network remits.
Final Project reports approved by NoSPG/NoSPHN Group (if timescale applicable)	Where timescales apply, these have been achieved.

Criteria	Review findings
4. A governance framework for NoSPHN is in place and reporting arrangements met ELEMENTS Governance framework/statement is developed by NoSPHN and the NoSPG	A Clinical Governance statement exists and is currently under review. As the NoSPHN is a sub-group of the NoSPG, it is subject to its governance framework.
Governance framework/statement is agreed by NoSPHN and the NoSPG	A statement was drafted by the NoSPHN in 2003 and submitted to the NoSPG. There is no evidence of it being agreed or approved of by the NoSPG.
Governance framework/statement includes a clear reporting arrangement and is being met at Regional (NoSPG), NHS Board and other funding bodies levels	The statement does not include a clear two way reporting arrangement other than an intention to formalise clinical governance arrangements across the 5 Health Boards to be endorsed by Board Chief Executives. The NoSPG receives an annual report from the NoSPHN but there is no formalisation of accountability in it. No explicit reporting exists between the network and the Health Boards other than through informal channels.
A risk assessment has been carried out and is monitored in respect of operation of the NoSPHN including communications and deliverables of the NoSPHN	A risk assessment has not been carried out.
There is a policy for intellectual property issues that may arise	A policy has not been developed.
There is evidence of the impact of the NoSPHNs reporting system at regional (NoSPG), NHS Board, other funding bodies levels	Very little physical evidence to support this but there are some indicators that it does have an impact. Less than 50% of stakeholders who were surveyed thought that there was some influence over NHS business, the remainder not knowing. The funding bodies (NHS Boards and NoSPG) agreed to continue the funding of NoSPHN. However, the stakeholders interviewed were positive about the networks influence particularly in work areas that are seen to be of use to Public Health and Planning e.g. the Health Intelligence work and the work on health inequalities.

Grading of Standard 1: Delivering a NoSPHN work plan

	% by grade of elements			Overall Grade
Criteria	Unmet	Partially met	Fully Met	
C1	0%	0%	100%	FULLY MET
C2	20%	20%	60%	PARTIALLY MET
C3	0%	0%	100%	FULLY MET
C4	50%	17%	33%	PARTIALLY MET
Overall	23%	12%	65%	PARTIALLY MET

3.2 Standard 2: The network or its processes influence actions or decisions

Criteria	Review findings
1. The NoSPHN influences the national agenda ELEMENTS The NoSPHN acts to influence the national agenda reactively to national requests/requirements and proactively on common issues to NoS e.g. remote and rural	There has been consultation and discussion between the NoSPHN either directly or through representation on its steering group and the emerging national public heath network. The NRAC Arbuthnott review received a briefing note from the NoSPHN on the request of the NoSPG. The recent survey of the NoSPHN showed 46% of responders indicating that the network had influence on the national agenda. Reactively the NoSPHN responded to national issues such as the transport strategy, the public health workforce development and Health Scotland joint working. Proactive work includes the membership of the lead clinician of NoSPHN on the national public health network steering group; the membership of NoS DPH on the Remote and Rural Strategy Group; and the NoSPHN Co-ordinator has been given membership on the Scottish Committee for Specialist Education and Training in Public Health to represent the needs of non-medics in remote and rural areas.
2. The NoSPHN influences the development of other public health networks ELEMENTS The NoSPHN is influencing/ has influenced the development of other public health networks	There was some evidence of the NoSPHN influencing both the national public health network (by means of the Lead Clinician of NoSPHN membership of the National network) and the developing local NoS one in Grampian (where the NoSPH Co-ordinator was on the interview panel for Grampian Co-ordinators post and with latter now being invited to NoSPHN steering group meetings).
3. The NoSPHN influences regional services ELEMENTS Regional services are influenced in terms of redesign; development (including new or existing services); access or delivery	Influence was evidenced by means of the bowel cancer awareness project being carried out, intended NoSPHN involvement in the Child Health NoSPG redesign and development of services work and previous involvement in planning regional services for CHD. The recent survey results were that 28% of respondents indicated that the network influences regional planning or design of services (the submitted evidence stated 59% but this assumed a denominator of 22, not the 47 that had responded to the question). However interviews of stakeholders supported this

Criteria	Review findings
	influence particularly in the areas of Health Protection, inequalities and cardiac services.
4. The NoSPHN influences policy ELEMENTS Policy is influenced at a regional level and local level	The recent survey results were that a quarter (26%) of respondents indicated that the network influences regional policy (the submitted evidence stated 55% but this assumed a denominator of 22, not the 47 that had responded to the question). There was no evidence that the breast feeding strategy work had led to any regional collaboration. Interviews of stakeholders suggested that there was no direct influence although the network may have afforded some co-ordination in the developing of policies.

Grading of Standard 2: **The network or its processes influence actions or decisions**

	% by grade of elements			Overall Grade
Criteria	Unmet	Partially met	Fully Met	
C1	0%	0%	100%	FULLY MET
C2	0%	0%	100%	FULLY MET
C3	0%	0%	100%	FULLY MET
C4	0%	100%	0%	PARTIALLY MET
Overall	0%	25%	75%	PARTIALLY MET

3.3 Standard 3: Providing added value

Criteria	Review findings
1. The establishment of the NoSPHN avoids duplication of effort, and recognises the importance of efficiency and economies of scale ELEMENTS Economies of scale due to the NoSPHN Is recognised by the majority (>50%) of key regionally working stakeholders and of steering group members and has been demonstrated	The recent survey indicated that 64% thought that the NoSPHN brought economies of scale mainly because it avoids duplication (60%) and allows sharing or standardisation of policies (57%). Submitted evidence also included the output of network collaboration and information sharing in a number of areas such as the NoSCAN e-mail discussion group for prioritisation bids. Interviews of stakeholders endorsed this. It was felt that-the network brought people together to increase understanding of each others roles and was an efficient way of using each others skills. In this respect use of communication technology and the co-ordinator as a point of contact was seen as very important. Critical mass was also highlighted as an economy of scale afforded by the NoSPHN.
Communication evident on a range of topics (3 or more) relevant to the remit of the NoSPHN and between different levels of stakeholders viz. Steering group; NoS Regional Planning group (NoSPG); NHS Board level (eg. Exec group) for all 5 NoSPHN health board areas; Key Public Health individuals/teams within organisations	Examples of communication within the steering group were given with various objectives such as information exchange, seeking views and agreement. The topics evidenced included medicines management at the Regional level, Criminal Justice Authorities and training around issues of sexual health. Communication with NoSPG is undertaken in a variety of ways and for various reasons including using the group as a vehicle for dissemination and submitting papers to meetings of the committee. At NHS Board level, communication is generally indirect with NoSPG and DsPH acting as conduits. The communication with individuals and teams with a public health remit is either specific in terms of work or general for instance in terms of CPD
2. Training opportunities and Continuing Professional Development (CPD) are provided across NoSPHN health board areas ELEMENTS	
Evidence of training opportunities and/or CPD events provided Events provided at least yearly and Events provided in at least 2 different locations across NoSPHN health board areas	CPD events are provided at least once on an annual basis and either in Aberdeen or Inverness. At a minimum, they are also made accessible to the entire “badged” public health workforce. It was noted that remote access in terms of IT communication to these events was made to ensure that those who could not travel would be able to benefit.
Views of the majority (> 50%) of stakeholders support that training opportunities and/or CPD are provided across NoSPHN health board areas	Of the 51% respondents of the survey who had indicated that the NoSPHN added value, 80% had indicated that this included providing CPD opportunities.
There is evidence that specific training/CPD events are being provided by NoSPHN (see also S4, C3A)	The NoSPHN provided CPD events to meet the specific needs for those progressing with the public health voluntary register. The value of the CPD events was also expressed by interview of

Criteria	Review findings
	several stakeholders who stated that CPD had filled gaps. It was realised that there had been a pragmatic approach to meeting the CPD needs of the network using both a top down and bottom up process.
There is evidence that information on training opportunities and/or CPD events is distributed to different levels of stakeholders i.e. Steering group NoS Regional Planning group (NoSPG)); NHS Board level (eg. Exec group) for all 5 NoSPHN health board areas; Key Public Health individuals/teams within organisations	Dissemination of training events was evidenced through the NoSPG and directly to the badged public health workforce.
3. Public Health policies are shared and commonalities exist across NoSPHN health board areas ELEMENTS There is evidence of 2 or more Public Health policies distributed across all five NoSPHN health board areas	There was no direct evidence of policies being shared across the NoSPHN although certain pieces of work were noted to have been shared across the network
There is evidence of the assessment of commonalities for 2 or more relevant Public Health policies carried out across all five NoSPHN health board areas	No evidence submitted.
The majority (>50%) of key regionally working stakeholders feel that the NoSPHN adds value to Public Health activity/regional planning across the North because it allows sharing of policies / standardisation of policies	Overall less than 50% of respondents (36%) indicated that the NoSPHN allows sharing of policies. Although 57% was noted in the submission, the true denominator was 47, not 30.
4. Information disseminated across the NoSPHN ELEMENTS Information is disseminated to all NoSPHN health board areas to (1) Facilitate collaboration on topics of mutual interest (2) Facilitate collaboration in relation to statutory requirements placed on all Health Boards (3) Allow a regional approach to a work issue e.g. service planning (4) Allow communication between health boards within areas of individuals expertise (5) Allow communication of public health related information from a national level	Examples of information dissemination was provided by NoSPHN where collaboration had been facilitated as in the case of scoping for the Prevention 2010 in the rural and remote context, and the NoSCAN e-mail group. Statutory Health Protection issues have been collaborated on where surge capacity agreement was evidenced and the collaboration in Regional planning issues- now a statutory activity for Health Board participation. There was also evidence of communication within areas of expertise as per the NoSPHN groups e.g. Health Intelligence between Health Boards and dissemination of national level public health information in respect of the FPH voluntary register. All these were well supported during interviews and particular note of the added value of the network was made in respect of support for those working towards the voluntary register and also the importance of the network allowing working together for the agenda in the North i.e. working on what is important to

Criteria	Review findings
	the North of Scotland. However, there was little evidence of information dissemination in respect of a regional approach to for example service planning The submitted evidence of input into the regional CHD strategy was of a generic nature. As indicated through interview, the potential influence is being processed more reactively than proactively.
Relevant methods are used to disseminate information and assist collaboration across all five NoSPHN health board areas (i) Evidence of 2 or more dissemination methods being used (ii) Evidence of potential dissemination methods in place (if different from (1) above)	A wide range of methods of dissemination is used by the network and in particular, very effective use of remote communication technology is made. Of particular note is the testing of various web-based methods such as iMeetings by the Health Intelligence scoping group of the network which was one of their objectives. This use of IT was clearly valued by stakeholders during interviews and was particularly noted in respect of the video linkage made available for most meetings. This was noted as important when many meetings are held in the central belt.
There are relevant methods used to disseminate information and assist collaboration with relevant organisations other than NHS Health Boards	Local Authority, academic groups, other NHS bodies such as NES have all been included in circulations around the CPD events provided by NoSPHN. Outwith the CPD events, communication with these bodies occurs by participation in some of the NoSPHN working groups.
A facility for personnel to access relevant contacts of expertise, knowledge or interest exists, is quality assured, is maintained	A "Who's Who for NoSPHN has been developed but is not yet available until the host web site (Hi-Net) is rebuilt. The network Co-ordinator and Lead Clinician are regularly used as points of contact. This was supported by others interviewed where in particular the NoSPHN Co-ordinator provided the single-point of contact to the network. It is recognised that this is the current practical situation but the time spent by the Co-ordinator and Lead Clinician as a consequence of their being first points of contact, in routing enquiries should be considered. A list of contacts and roles made available to stakeholders would address this. A system to quality assure a Who's Who has not been developed but it is suggested that it will need to be pragmatic e.g. a once a year update.
The majority (>50%) of key regionally working stakeholders feel that the NoSPHN adds value to Public Health activity/regional planning across the North because it provides reactive and proactive dissemination of information	Overall less than 50% of respondents (36%) indicated that the NoSPHN provides proactive and reactive dissemination of information. Although 57% was noted in the submission, the true denominator was 47, not 30. However, there was verbal evidence that information disseminated added value in terms of enabling co-ordinated input into national consultations or feeding into regional strategies.

Criteria	Review findings
5. Public Health knowledge, expertise and information can be accessed on-line ELEMENTS The NoSPHN makes available a range of on-line facilities	The networks web page is located on the NHS Grampian Hi-Net web site. This is under reconstruction and it is suggested that other links to it would increase the accessibility for those not aware of Grampians Hi-Net e.g. via each of the NHS Health Boards web sites. It was noted that there is an intention to implement a link from the NoSPG website to NoSPHN web page and that perhaps consideration of using the e-library remote and rural portal may be made.
The means of access to on-line facilities are disseminated through the NoSPHN	A briefing sheet was considered very informative regarding access to the network and written materials consistently provide contact information.
The majority (>50%) of stakeholders feel that the NoSPHN adds value by facilitating access to on-line facilities	Overall less than 50% of respondents (26%) indicated that the NoSPHN adds value by facilitating access to on-line facilities. Although 40% was noted in the submission, the true denominator was 47, not 30.
The level of uptake of online facilities is monitored	This is not currently done due to the host web-site being rebuilt. However it was noted that the NoSPHN intended to monitor this in the future.
6. Resources (staff and money) across NoSPHN health board areas are shared ELEMENTS There is evidence of resources being shared across some or all the NoSPHN Health Boards in respect of human, material and financial resources	Examples were given of NoSPHN work undertaken by single Health Boards on behalf of the others. Using NHS Grampians Hi-Net website to host and support the web page of the network is an example of shared resource. The NoSPH is funded by all five Health Boards with individual Boards contribution based on the proportionate allocation according to the Arthbuthnott formula.
7.NoSPHN provides single points of contact for issues it has identified or agreed to consider ELEMENTS There is evidence of details of single point contacts disseminated for 2 or more issues/areas identified	All written materials and the briefing sheet identify the network's Co-ordinator and Lead Clinician as the first point of contacts. The usefulness of this was verified by those interviewed. However, as indicated earlier, the availability of the Who's Who would allow more direct contact where appropriate for specific issues
The majority (>50%) of key regionally working stakeholders feel that the NoSPHN adds value by identifying single point of contacts for issues	Overall less than 50% of respondents (40%) indicated that the NoSPHN adds value by identifying single point of contacts for issues Although 63% was noted in the submission, the true denominator was 47, not 30.

Criteria	Review findings
8. NoSPHN confers benefits to individuals' quality of life ELEMENTS The majority (>50%) of key regionally working stakeholders feel that the NoSPHN increases social capital (e.g. reducing isolation, shared responsibilities)	Overall less than 50% of respondents (43%) indicated that the NoSPHN adds value by increasing social capital. Although 56% was noted in the submission, the true denominator was 47, not 30. However, during interviews it was evident that for single-handed public health staff or those in small teams, the network provided reassurance and an increased feeling of inclusiveness.
9. NoSPHN integrates and coordinates regional public health activities ELEMENTS The majority (>50%) of key regionally working stakeholders feel that regional public health activities are integrated/coordinated through the NoSPHN	Overall less than 50% of respondents (49%) indicated that the NoSPHN facilitated integration and/or co-ordination of NHS Board Public health activities/services. Although 64% was noted in the submission, the true denominator was 47, not 30. However, during interviews, it was clear that the network did afford co-ordinated public health activities. Examples were given in respect of CPD events and the response to national strategies of relevance to public health such as the Transport Strategy.

Grading of Standard 3: Providing added value

	% by grade of elements			Overall Grade
Criteria	Unmet	Partially met	Fully Met	
C1	0%	0%	100%	FULLY MET
C2	0%	0%	100%	FULLY MET
C3	100%	0%	0%	UNMET
C4	0%	40%	60%	PARTIALLY MET
C5	0%	50%	50%	PARTIALLY MET
C6	0%	0%	100%	FULLY MET
C7	0%	0%	100%	FULLY MET
C8	0%	0%	100%	FULLY MET
C9	0%	0%	100%	FULLY MET
Overall	13%	22%	65%	PARTIALLY MET

3.4 Standard 4: Supporting appropriate workforce capacity increases

Criteria	Review findings
1. The NoSPHN identifies workforce capacity issues ELEMENTS The NoSPHN has defined and monitors the public health workforce capacity across the NoS The NoSPHN has identified public health workforce issues across the NoS	 This is work in progress for the network with a workforce planning framework having been developed so far. This activity has still to be done.
2. Capacity issues are managed ELEMENTS The NoSPHN manages public health workforce issues in the (i) Short-term (ii) Longer-term	 Certain arrangements have been made whereby NHS Highland provides holiday Health Protection cover for NHS Western Isles and the DPH of NHS Shetland provides the DPH role and holiday cover to NHS Orkney. The CPHM in NHS Orkney also provides cover for NHS Shetland. These arrangements do not need the network. However NoSPHN provides added value to this support by formalising these arrangements and backing these up when or if needed. There are no longer-term plans in place and these are dependent on the workforce planning work once completed to identify the capacity issues.
3. Process in place to allow the development and acquisition of skills relevant to public health ELEMENTS Processes are in place to identify the CPD and training needs across the full range of public health workforce	 Examples of assessment of needs were given for a few specific groups e.g. staff progressing with the voluntary register of FPH; representation of the NoSPHN on the regional training group. For the wider public health workforce a pragmatic approach has been taken for example for those involved in health improvement, Health Boards were asked to identify their local needs. The planning of the CPD events includes consulting with Health Boards for suggested areas to be included.
4. Regional gaps in skills and knowledge are managed ELEMENTS Skills and knowledge gaps in the full range of the public health workforce are identified across the region Arrangements for bridging skills and knowledge gaps are made	 No additional evidence to that described under criteria 3 was submitted. The needs of those progressing with the voluntary register in the areas of Health Impact assessment and screening were met by providing CPD events.

Grading of Standard 4: **Supporting appropriate workforce capacity increases**

	% by grade of elements			Overall Grade
Criteria	Unmet	Partially met	Fully Met	
C1	0%	100%	0%	PARTIALLY MET
C2	0%	100%	0%	PARTIALLY MET
C3	0%	100%	0%	PARTIALLY MET
C4	0%	100%	0%	PARTIALLY MET
Overall	0%	100%	0%	PARTIALLY MET

3.5 Standard 5: Assuring quality

Criteria	Review findings
1. Management and reporting structures in place ELEMENTS There is a clear management structure (i) Lead clinician in post with roles and responsibilities documented (ii) Manager in post with roles and responsibilities documented Responsibilities, accountabilities and performance management are part of the host organisations contract of employment and performance planning arrangements for (i) Lead clinician of NoSPHN (ii) Manager of NoSPHN	Job descriptions for these two posts were provided. The Lead Clinician post is on a two year rotational basis and that of the Co-ordinator by secondment of a Specialist in Public Health. The Lead Clinicians role in the network has been made part of the current postholders job description with the host NHS Board. Reporting accountability and appraisal are to and by the chief executive of the Health Board. The Co-ordinator is line-managed by the Lead Clinician on behalf of the network as per the arrangements of the host Health Board.
2. The NoSPHNs remit is embedded in the objectives of the key NoSPHN personnel ELEMENTS The post-holders objectives include achievements of targets reflecting the remit of the NoSPHN for (i) Lead clinician of NoSPHN (ii) Manager of NoSPHN (iii) Steering group members	For both the posts of Lead Clinician and Co-ordinator of the NoSPHN, appraisal of achievement of the objectives are monitored according to the host Boards appraisal scheme. Incorporation of postholder objectives relating to the NoSPHN is variably included in the performance management of NoSPHN steering group members.
3. Work of the NoSPHN is reviewed for quality including use of evidence-based where appropriate ELEMENTS Activities and outputs (excluding training and CPD) carried out within the NoSPHNs business (e.g. as per work plan) are reviewed in relation to (i) Use of evidence-base where appropriate (ii) Accuracy (iii) Objectiveness (iv) Multidisciplinary aspects (v) Public/patient perspectives CPD/Training provided by the NoSPHN is quality assured	The outputs of the NoSPHN have not been subject to quality assurance. The recent stakeholder survey collected the perceptions of the effectiveness of the activity of the network Other than by participant evaluation at CPD events, these have also not been subject to quality assurance. However, there was clear verbal support for the value of the CPD provided by NoSPHN and the high uptake rates of the events bears testimony to their quality. Video-linkage was particularly considered a valuable quality of these events.
4. The performance of the NoSPHN is evaluated ELEMENTS The NoSPHN has been formally evaluated	There has been a recent survey of stakeholders which has been reported on.

Criteria	Review findings
5. Multidisciplinary working is implicit in the work of the NoSPHN ELEMENTS A multidisciplinary approach is adopted in relation to (i) Developing the work of the NoSPHN (ii) The scoping of individual projects	The steering group membership is multidisciplinary and many of the projects at the proposal stage have been subject to consultation with the steering group and sometimes more widely as in the case of Prevention 2010 project.
6. The activity of the NoSPHN is made accountable ELEMENTS Activity and outcomes of the NoSPHN are annually reported to all 5 of the NoSPHN Health Boards and feedback is received from these organisations	This is indirectly undertaken via the NoSPG to which the network submits an annual report as well as reporting the progress and outcomes of work relevant to the agenda of the NoSPG throughout the year. Health Boards are reported to by the NoSPG which will include NoSPHN reports. DsPH may also report to their Boards as appropriate as can the Chief Executives who are all members of the NoSPG.
7. NoSPHN activity is improved by review/audit ELEMENTS There are recommendations made and implemented to improve the effectiveness of the NoSPHN through audit/evaluation	The findings of the recent survey have identified several areas for improvement resulting in a number of recommendations. These have been published in the briefing sheet to members of the NoSPHN and some of them will be implemented by incorporation into the workplan.

Grading of Standard 5: Assuring quality

	% by grade of elements			Overall Grade
Criteria	Unmet	Partially met	Fully Met	
C1	0%	0%	100%	FULLY MET
C2	0%	0%	100%	FULLY MET
C3	0%	50%	50%	PARTIALLY MET
C4	0%	100%	0%	PARTIALLY MET
C5	0%	0%	100%	FULLY MET
C6	0%	0%	100%	FULLY MET
C7	0%	0%	100%	FULLY MET
Overall	0%	22%	78%	PARTIALLY MET

3.6 Standard 6: Establishing partnerships conducive to effective networking

Criteria	Review findings
1. Relationships with a wide range of stakeholders have been established ELEMENTS Relationship as a network with other statutory and voluntary organisations locally and regionally has been established viz (i) Local Authorities (ii) Community partnerships (iii) Other health-related organisations (iv) Managed Clinical Networks (v) Regional Networks (e.g. NoSCAN) (vi) Academic groups/organisations	Examples of these were provided. For Local Authority (LA) involvement, a project investigating health inequalities in Shetland and the uptake of LA staff of CPD events provided by NoSPHN. There has also been engagement with NES in terms of the virtual school of rural health and CPD events. Health Scotland has contributed to and participated in CPD events. NES has welcomed the remit of the NoSPHN as a way of taking up rural public health issues at a regional level. Some CHP staff have also participated in CPD events and health improvement issues for CHPs will form part of the next CPD event. Various academic groups have been involved in the work of NoSPHN and in CPD events. However, it was clear from some of the interviews that more engagement and understanding of remit and work agendas of NoSPHN would be of mutual benefit in identifying areas for collaboration. Although there has been engagement with the Regional Cancer managed clinical network (NoSCAN), there has not been any direct link with local MCNs. It is considered that for the NoSPHN to be effective at regional level, the understanding and contribution of local MCNs should be sought. This also applies to other existing or emerging local relevant networks such as those concerned with health improvement.
2. Involvement of the wider Public Health Workforce in the NoSPHN ELEMENTS Out with both the NoSPHN steering group and project leads, individuals or groups are (i) Aware of the NoSPHN (ii) Involved in the work of the NoSPHN	The extent of this awareness is not known and the boundary for it is equally unknown. So far the "badged" workforce has been the main focus of NoSPHN business. The recent survey was distributed to the CPD event circulation list and if that was taken to be the realistic public health workforce to be relevant to the public health function in NoS, excluding all those who were or had been involved in the work of the network then awareness was rated to be 69% of all those who responded. However, it is likely that the non-responders to the survey from the CPD population are more likely not to be aware of the NoSPHN than those who responded. It was evidenced that a number of activities/work items of NoSPHN involved staff outwith the networks steering group.

Criteria	Review findings
3. Two-way communications with partner organisations using remote technology is part of the NoSPHNs business ELEMENTS Regular use of video conferencing and web-based facilities with partner organisations is part of the NoSPHNs activity	This was one of the most notable strengths of the effectiveness and accessibility to members of the NoSPHN. Not only was this endorsed by many of those interviewed, but the influence the NoSPHN has had in encouraging by expectation of other bodies including national ones to follow has benefits for those in other remote Health Boards outwith the NoS. All of the steering group meetings and the CPD events are video-linked. Other bodies now encouraged to provide this facility include the Scottish Forum for Public Health and the National Health Impact Assessment Network. iMeetings and web-based discussion groups have also been used.

Grading of Standard 6: Establishing partnerships conducive to effective networking

	% by grade of elements			Overall Grade
Criteria	Unmet	Partially met	Fully Met	
C1	0%	100%	0%	PARTIALLY MET
C2	0%	100%	0%	PARTIALLY MET
C3	0%	0%	100%	PARTIALLY MET
Overall	0%	67%	33%	PARTIALLY MET

4. Summary of findings: Strengths and challenges

The nature of this evaluation is to assess the network against pre-determined parameters to try and judge its effectiveness. The summary of findings look at the strengths and weaknesses of the network as assessed against these parameters. It also raises questions as to the appropriateness of the original stated aims and aspirations of the network and about the opportunity costs of slavishly addressing all the perceived shortcomings. There needs to be some discussion about a pragmatic assessment of what is important to the effective running of the network and what should be addressed to improve it that would be the most effective way of achieving best value for money

The following provides a summary of the main findings in very brief terms for each of the six standards:

Standard 1: Delivering a NoSPHN work plan

STRENGTHS

- A workplan was agreed
- Actions were in place
- The workplan delivered the remit of the NoSPHN on time and within resources

CHALLENGES

- The remit of the NoSPHN needs clarifying
- Public & patient involvement should be reviewed to assess how it can be appropriately incorporated
- The governance arrangements need to be clearer
- Protected time was raised as an issue not in terms of how it could be achieved for the work of the network, but rather looking at how the work could be incorporated into the overall objectives of individuals and considered as part of their mainstream work. If there were issues about how to achieve the work for the network then this would be considered within the overall capacity of the individual

SUMMARY GRADING:

	Unmet	Partially Met	Fully Met	Overall
Overall	23%	12%	65%	PARTIALLY MET

Standard 2: The network or it's processes influence actions or decisions

STRENGTHS

- The National & Regional agendas were influenced, particularly the Regional
- There was top down and bottom up influence
- There was informal & formal influencing

CHALLENGES

- One of the stated aims of the network was that it should encourage the sharing of policies, looking for commonalities and standardising and influencing policy at a regional level It was not clear the degree to which policies at Regional & Local levels should be influenced or shared. See also Standard 3

SUMMARY GRADING:

	Unmet	Partially Met	Fully Met	Overall
Overall	0%	25%	75%	PARTIALLY MET

Standard 3: Providing added value

STRENGTHS

- Added value includes:
- Avoided duplication
- Reduces professional isolation
- Enabled better understanding of each others skills & roles
- Increased economies of scale
- Provided single points of contact
- Provided access to knowledge and expertise
- Provided a coherent NoS voice
- Integrated and co-ordinated regional public health activities

CHALLENGES

- There was little evidence of standardising and sharing of policies. While this seems an obvious priority for a regional network it was interesting that it had not become one of its areas of activity. It raised a question for discussion around whether it should or should not aspire to do this type of work.

SUMMARY GRADING:

	Unmet	Partially Met	Fully Met	Overall
Overall	13%	22%	65%	PARTIALLY MET

Standard 4: Supporting appropriate workforce capacity increases

STRENGTHS

- Work was in progress which included looking at workforce capacity issues in the short term (not in long term)
- A pragmatic approach had been taken for determining CPD/training needs

CHALLENGES

- One of the clear strengths of the network was the pragmatic approach which had been taken to involve people as they needed to be rather than everyone being informed about everything. One of the real challenges will be how to increase the capacity of the public health workforce while still remaining focussed and keeping within the constraints of the time available from the lead clinician and co-ordinator without overstretching them.

- The issue of the long term workforce capacity could be addressed alongside the work on the short term capacity.

SUMMARY GRADING:

	Unmet	Partially Met	Fully Met	Overall
Overall	0%	100%	0%	PARTIALLY MET

Standard 5: Assuring quality

STRENGTHS

- Management and reporting structures were in place
- There was multidisciplinary involvement across the NoSPHN

CHALLENGES

- Work was not formally reviewed for quality although it was discussed and commented on by many different people in different groups so had to be of sufficient quality to go through this process. As a formal mechanism to ensure quality, a system of peer review could be introduced.

SUMMARY GRADING:

	Unmet	Partially Met	Fully Met	Overall
Overall	0%	22%	78%	PARTIALLY MET

Standard 6: Establishing partnerships conducive to effective networking

STRENGTHS

- There was good two-way communication between the NoSPHN and various bodies of influence
- There was particularly good use of remote communication technology
- The network was seen to be a useful =resource for national bodies e.g. NES

CHALLENGES

- Beyond the 'badged' public health workforce, it was not clear how widespread the awareness of the NoSPHN was
- As an example, MCNs were presently not involved. Further consideration should be given to the involvement of MCNs in the work of the NoSPHN

SUMMARY GRADING:

	Unmet	Partially Met	Fully Met	Overall
Overall	0%	67%	33%	PARTIALLY MET

5. Recommendations

To be helpful to the network, these have been categorised into each of three areas:

1. Those that encourage the network to continue to perform in the areas that are evidently its strengths
2. Those that relate to areas that have hitherto not been identified by the previous survey and have not been incorporated into future changes to the network and it's processes
3. Those that compliment changes that the network has indicated it intends to implement in the future

Category 1
There were many strengths of the network evidenced from the self-assessment but also some that arose during the review day. These included a strong feeling of the Northern Regional context of its activity and also a sense of ownership by those interviewed. Endorsement of the accessibility and effectiveness of its Co-ordinator was also evident during the day. This gives the NoSPHN a firm basis on which to extend and consolidate its influence and effectiveness in the future.

Out of all the activities of the NoSPHN, the provision of CPD events appeared to be the very highly valued and therefore this should continue. It may be that the workforce issues work raises some areas of need in which the NoSPHN CPD programme could usefully address.

Equally as highly valued was the use of communication technology by the network. This included the routine use of video-linkage at all levels of NoSPHN business and the development of web-based facilities such as iMeetings.

The multidisciplinary representation of the work carried out was also evident and this will be further consolidated by the work in progress of the NoSPHN, for example, the formation of a stakeholder group.

Category 2
A range of areas comes under this category. Firstly the remit could usefully be reviewed. This would result in realist expectations of the network in terms of its output.

Patient/public involvement would ensure that the network will always consider the appropriateness of the wider context of its work.

Governance arrangements require review and more clarity. This should include a quality assurance system of the outputs of the network.

There was very little evidence of the network influencing policies. It may well be that this is not an area that the network should realistically consider part of its remit or that this function should be more systematically included in its work programme.

Category 3
It was noted to the Peer Review group that the network plans to form a stakeholder group. This will widen involvement in the network and allow closer links with Community Health Partnerships, Managed Clinical Networks and other bodies such as academia.

A Who's Who has already been compiled and this will allow access to specific contacts rather than the current system of the Networks Co-ordinator or Lead Clinician being the first points of contacts. It was felt that there could be greater awareness of access to the web page of NoSPHN. Currently the only link is from Grampian's Hi-Net web site although it was noted during the review that this would be extended to include a further link from the North of Scotlands Planning Group web site. The intended monitoring of the use of the web page should provide an estimate of its usage. It would seem appropriate to provide greater access by, for example, a link from all constituent Health Boards web sites.

The NoSPHN activity included the investigation of workforce issues but these are in the shorter term. Workforce issues in the longer term could usefully be included.

Finally, the NoSPHN has demonstrated excellent ways of working and provides a very useful example from which other networks relevant to Public Health could benefit. The pragmatic approach which has been adopted has proved to be very successful rather than trying to be all things to all people. Care should be taken to protect and value what has already been achieved, maintaining the same approach and living within the resources available to the network.

APPENDIX 1

Glossary of abbreviations

CPD:	Continuous Professional Development
CRH:	Centre for Rural Health
DsPH	Directors of Public Health
FPH:	Faculty for Public Health
MCNs	Managed Clinical Networks
NES	NHS Education for Scotland
NoS:	North of Scotland
NOSCAN	North of Scotland Cancer Network
NoSPG:	North of Scotland Planning Group
NoSPHN	North of Scotland Public Health Network

APPENDIX 2 – Assessment tools

North of Scotland Public Health Network

27TH OCTOBER 2006

SIX CORE STANDARDS OF THE NOSPHN:

SEVERAL CRITERIA (C…) FLOW FROM THE ABOVE CORE STANDARDS.

PEER REVIEWERS FRAMEWORK

STANDARD 1 (S1) - DELIVERING A NOSPHN WORKPLAN QUALITY IMPROVEMENT SCALES

Evidence Threshold	Assign as
No evidence or not met	NM
Partially met	PM
Fully met	M

Summary Position of Standard 1 on Quality Improvement Scale

Criterion	NM	PM	M	All	% Met
C1	0	0	3	3	100
C2	1	1	3	5	60
C3	0	0	3	3	100
C4	3	1	2	6	33
ΣC1-4	4	2	11	17	65[1]

Summary of grading result of Standard 1

Overall:	**Nos**	**%**
Unmet	**4**	**23**
Partially Met	**2**	**12**
Fully Met	**11**	**65**[1]

Rationale

Criterion	% Met	Reason for grade
C1	100%	All met
C2	60%	Exceptions were lack of patient/public aspects and an unrealistic remit
C3	100%	All met
C4	33%	Unclear Governance arrangement, no risk assessment or intellectual property policy
OVERALL [1]	65%	Partially met

Core Evidence

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S1, C1 There is an agreed NoSPHN work-plan	C1A Work plan and actions exist **C1A OVERALL**			**M**
	C1B There is consultation and agreement with all levels of stakeholders in the development of the work plan (i) NoSPHN Steering group (ii) NoS Regional Planning group (NoSPG) (iii) NHS Board level (eg. Exec group) for all 5 NoSPHN health board areas (iv) Key Public Health individuals/teams within organisations (consultation only) **C1B OVERALL**		M M M M	**M**
	C1C There is a process for getting work items on the work plan which: (i) Sources topics for consideration (ii) Prioritises work items **C1C OVERALL**		M M	**M**
	S1, CRITERIA 1 OVERALL			**M**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S1, C2 Work plan actions are in place, are progressing and delivers the remit of the NoSPHN	C2A Work plan actions have assigned personnel and set timescales (i) Lead officers identified (ii) Timescales stated **C2A OVERALL**		M M	**M**
	C2B The process of assigning work/actions to personnel seeks equity of spread across Health Board areas and individuals in terms of: (i) Appropriateness of skills or expertise (ii) Spread of workload between Health Boards reflected by equal representation of Health Board personnel in the assigned project work **C2B OVERALL**		M M	**M**
	C2C There is a process to ensure project leads have time to undertake work on behalf of the NoSPHN **C2C OVERALL**			**M**
	C2D There is a review process of work plan actions which identifies and takes into account potential public/patient aspects **C2D OVERALL**			**NM**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	C2E Work plan objectives deliver the remit of the NoSPHN **C2E OVERALL** *If this element is "Not Met" or Partially Met", specify (below) both the reason given and whether you consider it to be valid:* …… …… ……			**PM**
	S1, CRITERIA 2 OVERALL			**PM**
S1, C3 Work plan projects are delivered, on time and within resources	C3A There is an effective reporting system in place to collect and collate NoSPHN work plan information (i) A regular reporting system exists (ii) Feedback is received from the body which is reported to **C3A OVERALL**		M M	**M**
	C3B Each "project" has defined objectives and is monitored against any relevant timescales: (i) Health Intelligence Project (ii) Health Improvement Project (iii) Delivering for Health – remote and rural aspect of delivering anticipatory care		M M M	

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	C3B continued ….			
	(iv) Review of Public Health Workforce in the North		M	
	(v) Develop a regional approach to public health dental services		M	
	(vi) Ensure formal Surge Capacity arrangements are in place and are operational when required		M	
	(vii) Review the role of community hospitals		M	
	(viii) Review of Health Transport needs from a Public Health perspective		M	
	C3B OVERALL (If i-viii above are met <50% = NM, ≥50% = PM, 100% = M)			M
	C3C Final Project reports approved by NoSPG/NoSPHN Group (if timescale applicable)			
	(i) Health Intelligence Project		N/A	
	(ii) Health Improvement Project		M	
	(iii) Delivering for Health – remote and rural aspect of delivering anticipatory care		N/A	
	(iv) Review of Public Health Workforce in the North		N/A	
	(v) Develop a regional approach to public health dental services		M	
	(vi) Ensure formal Surge Capacity arrangements are in place and are operational when required		M	
	(vii) Review the role of community hospitals		M	

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	C3C continued … (viii) Review of Health Transport needs from a Public Health perspective **C3C OVERALL(Where applicable if i-viii above are met <50% = NM, ≥50% = PM, 100% = M)**		M	M
	S1, CRITERIA 3 OVERALL			M
S1, C4 A Governance framework for the NoSPHN is in place and reporting arrangements met	C4A Governance framework/statement is developed by: (i) NoSPHN Steering group (ii) North of Scotland Regional Planning group (NoSPG) **C4A OVERALL**		M M	M
	C4B Governance framework/statement is agreed by: (i) NoSPHN Steering group (ii) NoS Regional Planning group (NoSPG) **C4B OVERALL**		NM NM	NM

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	C4C Governance framework/statement includes a clear reporting arrangement* and is being met at: (i) NoS Regional level (NoSPG) (ii) NHS Board level (eg. Exec group) for all 5 NoSPHN health board areas (iii) Other funding body (RARARI) **C4C OVERALL** * The reporting should include information for comment/assessment/endorsement in addition to regular copies of agendas and minutes of the NoSPHNs steering group.		M NM M	PM
	C4D A risk assessment has been carried out and is monitored in respect of the: (i) operation of the NoSPHN including communications (ii) deliverables of the NoSPHN **C4D OVERALL**		NM NM	NM
	C4E There is a policy for intellectual property issues that may arise **C4E OVERALL**			NM

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	C4F There is evidence of the impact of the NoSPHNs reporting* system at: (i) NoS Regional level (NoSPG) (ii) NHS Board level (eg. Exec group) for all 5 NoSPHN health board areas (iii) Other funding body (RARARI) **C4F OVERALL** * The reporting should include information for comment/assessment/endorsement in addition to regular copies of agendas and minutes of the NoSPHNs steering group and the evidence of this having been considered by the bodys reported to.		M M M	M
	S1, CRITERIA 4 OVERALL			PM

STANDARD 2 (S2) – THE NETWORK OR ITS PROCESSES INFLUENCE ACTIONS OR DECISIONS QUALITY IMPROVEMENT SCALES

Evidence Threshold	Assign as
No evidence or not met	NM
Partially met	PM
Fully met	M

Summary Position of Standard 2 on Quality Improvement Scale

Criterion	NM	PM	M	All	% Met
C1	0	0	1	1	100
C2	0	0	1	1	100
C3	0	0	1	1	100
C4	0	1	0	1	0
ΣC1-4	0	1	3	4	75[1]

Summary of grading result of Standard 2

Overall:	**Nos**	**%**
Unmet	**0**	**0**
Partially Met	**1**	**25**
Fully Met	**3**	**75**[1]

Rationale

Criterion	% met	Reason for grade
C1	100%	All met
C2	100%	All met
C3	100%	All met
C4	0%	Partially met as influence on policy appears indirect through committee membership and co-ordination
OVERALL [1]	75%	Partially met

Core Evidence

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S2, C1 The NoSPHN influences the national agenda	C1A The NoSPHN acts to influence the national agenda: (i) Reactively to national requests/requirements (ii) Proactively on common issues to NoS e.g. rural & remote **C1A OVERALL**		M M	**M**
	S2, CRITERIA 1 OVERALL			**M**
S2, C2 The NoSPHN influences the development of other public health networks	C2A The NoSPHN is influencing/ has influenced the development of other public health networks **C2A OVERALL**			**M**
	S2, CRITERIA 2 OVERALL			**M**
S2,C3 The NoSPHN influences regional services	C3A Regional services are influenced in terms of: (i) Redesign (ii) Development (including new or existing services) (iii) Access or delivery C3A OVERALL		M M M	**M**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	S2, CRITERIA 3 OVERALL			**M**
S2, C4 The NoSPHN influences policy	C4A Policy is influenced at a: (i) Regional level (ii) Local level **C4A OVERALL**		PM PM	**PM**
	S2, CRITERIA 4 OVERALL			**PM**

STANDARD 3 (S3) – PROVIDING ADDED VALUE
QUALITY IMPROVEMENT SCALES

Evidence Threshold	Assign as
No evidence or not met	NM
Partially met	PM
Fully met	M

Summary Position of Standard 3 on Quality Improvement Scale

Criterion	NM	PM	M	All	% Met
C1	0	0	2	2	100
C2	0	0	4	4	100
C3	3	0	0	3	0
C4	0	3	2	5	60
C5	0	2	2	4	50
C6	0	0	1	1	100
C7	0	0	2	2	100
C8	0	0	1	1	100
C9	0	0	1	1	100
ΣC1-9	3	5	15	23	65[1]

Summary of grading result of Standard 3

Overall:	**Nos**	**%**
Unmet	**3**	**13**
Partially Met	**5**	**22**
Fully Met	**15**	**65**[1]

Rationale

Criterion	% met	Reason for grade
C1	100%	All met
C2	100%	All met
C3	0%	No evidence of policies being shared, assessment of commonalities or survey result supporting this as an added value
C4	40%	No evidence of the NoSPHN resulting in a regional approach to service planning, QA of Whos Who and survey results not supporting proactive/reactive dissemination of information as adding value?
C5	50%	Survey response did not support the added value of on-line facilities and there is no monitoring of web page use
C6	100%	All met
C7	100%	All met

C8	100%	All met
C9	100%	All met
OVERALL [1]	65%	Partially met

Core Evidence

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S3, C1 The establishment of the NoSPHN avoids duplication of effort, and recognises the importance of efficiency and economies of scale	C1A Economies of scale due to the NoSPHN: (i) Is recognised by the majority (>50%) of key regionally working stakeholders and of steering group members (ii) Has been demonstrated **C1A OVERALL**		M M	**M**
	C1B Communication evident on a range of topics (3 or more) relevant to the remit of the NoSPHN and between different levels of stakeholders: (i) Steering group (ii) NoS Regional Planning group (NoSPG) (iii) NHS Board level (eg. Exec group) for all 5 NoSPHN health board areas (iv) Key Public Health individuals/teams within organisations **C1B OVERALL**		M M M M	**M**
	S3, CRITERIA 1 OVERALL			**M**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S3, C2 Training opportunities and Continuing Professional Development (CPD) are provided across NoSPHN health board areas	C2A Evidence of training opportunities and/or CPD events provided (i) Events provided at least yearly (ii) Events provided in at least 2 different locations across NoSPHN health board areas **C2A OVERALL**		M M	**M**
	C2B Views of the majority (> 50%) of stakeholders support that training opportunities and/or CPD are provided across NoSPHN health board areas **C2B OVERALL**			**M**
	C2C There is evidence that specific training/CPD events are being provided by NoSPHN (see also S4, C3A) **C2C OVERALL**		M	**M**
	C2D There is evidence that information on training opportunities and/or CPD events is distributed to different levels of stakeholders: (i) Steering group (ii) NoS Regional Planning Group (NoSPG) (iii) NHS Board level (eg. Exec group) for all 5 NoSPHN health board areas (iv) Key Public Health individuals/teams within organisations **C2D OVERALL**		M M M M	**M**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	S3, CRITERIA 2 OVERALL			**M**
S3, C3 Public Health policies are shared and commonalities exist across NoSPHN health board areas	C3A There is evidence of 2 or more Public Health policies distributed across all five NoSPHN health board areas **C3A OVERALL**			**NM**
	C3B There is evidence of the assessment of commonalities for 2 or more relevant Public Health policies carried out across all five NoSPHN health board areas **C3B OVERALL**			**NM**
	C3C The majority (>50%) of key regionally working stakeholders feel that the NoSPHN adds value to Public Health activity/regional planning across the North because it allows sharing of policies / standardisation of policies **C3C OVERALL**			NM
	S3, CRITERIA 3 OVERALL			NM

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S3, C4 Information disseminated across the NoSPHN	C4A Information is disseminated to all NoSPHN health board areas to:			
	(i) Facilitate collaboration on topics of mutual interest		M	
	(ii) Facilitate collaboration in relation to statutory requirements placed on all Health Boards		M	
	(iii) Allow a regional approach to a work issue e.g. service planning		PM	
	(iv) Allow communication between health boards within areas of individuals expertise		M	
	(v) Allow communication of public health related information from a national level		M	
	C4A OVERALL			**PM**
	C4B Relevant methods are used to disseminate information and assist collaboration across all five NoSPHN health board areas			
	(i) Evidence of 2 or more dissemination methods being used		M	
	(ii) Evidence of potential dissemination methods in place (if different from (i) above)		M	
	C4B OVERALL			M
	C4C There are relevant methods used to disseminate information and assist collaboration with relevant organisations other than NHS Health Boards			
	C4C OVERALL			**M**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	C4D A facility for personnel to access relevant contacts of expertise, knowledge or interest: (i) Exists (ii) Is quality assured (iii) Is maintained **C4D OVERALL**		M PM M	**PM**
	C4E The majority (>50%) of key regionally working stakeholders feel that the NoSPHN adds value to Public Health activity/regional planning across the North because it provides reactive and proactive dissemination of information **C4D OVERALL**			**PM**
	S3, CRITERIA 4 OVERALL			PM
S3, C5 Public Health knowledge, expertise and information can be accessed on-line	C5A The NoSPHN makes available a range of on-line facilities **C5A OVERALL**			M
	C5B The means of access to on-line facilities are disseminated through the NoSPHN **C5B OVERALL**			M

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	C5C The majority (>50%) of stakeholders feel that the NoSPHN adds value by facilitating access to on-line facilities **C5C OVERALL**			PM
	C5D The level of uptake of online facilities is monitored **C5D OVERALL**			PM
	S3, CRITERIA 5 OVERALL			PM
S3, C6 Resources (staff and money) across NoSPHN health board areas are shared	C6A There is evidence of resources being shared across some or all the NoSPHN Health Boards in respect of: (i) Human resource (ii) Material resource (iii) Financial resource **C6A OVERALL**		M M M	M
	S3, CRITERIA 6 OVERALL			M

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S3, C7 NoSPHN provides single points of contact for issues it has identified or agreed to consider	C7A There is evidence of details of single point contacts disseminated for 2 or more issues/areas identified **C7A OVERALL**			M
	C7B The majority (>50%) of key regionally working stakeholders feel that the NoSPHN adds value by identifying single point of contacts for issues **C7B OVERALL**			M
	S3, CRITERIA 7 OVERALL			M
S3, C8 NoSPHN confers benefits to individuals quality of life	C8A The majority (>50%) of key regionally working stakeholders feel that the NoSPHN increases social capital (e.g. reducing isolation, shared responsibilities) **C8A OVERALL**			M
	S3, CRITERIA 8 OVERALL			M
S3, C9 NoSPHN integrates and coordinates regional public health activities	C9A The majority (>50%) of key regionally working stakeholders feel that regional public health activities are integrated/coordinated through the NoSPHN **C9A OVERALL**			M

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	S3, CRITERIA 9 OVERALL			M

STANDARD 4 (S4) – SUPPORTING APPROPRIATE INCREASE IN PUBLIC HEALTH WORKFORCE CAPACITY QUALITY IMPROVEMENT SCALES

Evidence Threshold	Assign as
No evidence or not met	NM
Partially met	PM
Fully met	M

Summary Position of Standard 4 on Quality Improvement Scale

Criterion	NM	PM	M	All	% Met
C1	0	2	0	2	0
C2	0	1	0	1	0
C3	0	1	0	1	0
C4	0	2	0	2	50
ΣC1-4	0	6	0	6	0[1]

Summary of grading result of Standard 4

Overall:	**Nos**	**%**
Unmet	**0**	**0**
Partially Met	**6**	**100**
Fully Met	**0**	**0**[1]

Rationale

Criterion	% met	Reason for grade
C1	0%	The work on workforce capacity is on-going
C2	0%	No long-term plans in place to address workforce issues
C3	0%	Met for specific groups of badged workforce, pragmatic approach to the wider PH population
C4	50%	Partially met, mainly met for specified workforce groups
OVERALL [1]	0%	Partially met

Core Evidence

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S4, C1 The NoSPHN identifies workforce capacity issues	C1A The NoSPHN has defined and monitors the public health workforce capacity across the NoS **C1A OVERALL**			**PM**
	C1B The NoSPHN has identified public health workforce issues across the NoS **C1B OVERALL**			**PM**
	S4, CRITERIA 1 OVERALL			**PM**
S4, C2 Capacity issues are managed	C2A The NoSPHN manages public health workforce issues in the: (i) Short-term (ii) Longer-term **C2A OVERALL**		M NM	**PM**
	S4, CRITERIA 2 OVERALL			**PM**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S4,C3 Process in place to allow the development and acquisition of skills relevant to public health	C3A Processes are in place to identify the CPD and training needs across the full range of public health workforce **C3A OVERALL**			**PM**
	S4, CRITERIA 3 OVERALL			**PM**
S4, C4 Regional gaps in skills and knowledge are managed	C4A Skills and knowledge gaps in the full range of the public health workforce are identified across the region **C4A OVERALL**			PM
	C4B Arrangements for bridging skills and knowledge gaps are made **C4B OVERALL**			PM
	S4, CRITERIA 4 OVERALL			**PM**

STANDARD 5 (S5) – THE NETWORK IS QUALITY ASSURED
QUALITY IMPROVEMENT SCALES

Evidence Threshold	Assign as
No evidence or not met	NM
Partially met	PM
Fully met	M

Summary Position of Standard 5 on Quality Improvement Scale

Criterion	NM	PM	M	All	% Met
C1	0	0	2	2	100
C2	0	0	1	1	100
C3	0	1	1	2	50
C4	0	1	0	1	0
C5	0	0	1	1	100
C6	0	0	1	1	100
C7	0	0	1	1	100
ΣC1-7	0	2	7	9	78[1]

Summary of grading result of Standard 5

Overall:	**Nos**	**%**
Unmet	**0**	**0**
Partially Met	**2**	**22**
Fully Met	**7**	**78**[1]

Rationale

Criterion	% met	Reason for grade
C1	100%	All met
C2	100%	All met
C3	50%	QA of CPD events met but review of the evidence base, objectiveness of NoSPHN outputs not
C4	0%	Survey of stakeholders but not a formal external review
C5	100%	All met
C6	100%	All met
C7	100%	All met
OVERALL [1]	78%	Partially met

Core Evidence

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S5, C1 Management and reporting structures in place	C1A There is a clear management structure			
	(i) Lead clinician in post with roles and responsibilities documented		M	
	(ii) Manager in post with roles and responsibilities documented		M	
	C1A OVERALL			**M**
	C1B Responsibilities, accountabilities and performance management are part of the host organisations contract of employment and performance planning arrangements for:			
	(i) Lead clinician of NoSPHN		M	
	(ii) Manager of NoSPHN		M	
	C1B OVERALL			**M**
	S5, CRITERIA 1 OVERALL			**M**
S5, C2 The NoSPHNs remit is embedded in the objectives of the key NoSPHN personnel	C2A The post-holders objectives include achievements of targets reflecting the remit of the NoSPHN for:			
	(i) Lead clinician of NoSPHN		M	
	(ii) Manager of NoSPHN		M	
	(iii) Steering group members		M	

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	C2A continued…. **C2A OVERALL**			**M**
	S5, CRITERIA 2 OVERALL			**M**
S5,C3 Work of the NoSPHN is reviewed for quality including use of evidence-based where appropriate	C3A Activities and outputs (excluding training and CPD) carried out within the NoSPHNs business (e.g. as per work plan) are reviewed in relation to: (i) Use of evidence-base where appropriate (ii) Accuracy (iii) Objectiveness (iv) Multidisciplinary aspects (v) Public/patient perspectives **C3A OVERALL**		PM PM NM PM NM	**PM**
	C3B CPD/Training provided by the NoSPHN is quality assured **C3B OVERALL**			**M**
	S5, CRITERIA 3 OVERALL			**PM**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S5, C4 The performance of the NoSPHN is evaluated	C4A The NoSPHN has been formally evaluated **C4A OVERALL**			PM
	S5, CRITERIA 4 OVERALL			**PM**
S5, C5 Multidisciplinary working is implicit in the work of the NoSPHN	C5A A multidisciplinary approach is adopted in relation to: (i) Developing the work of the NoSPHN (ii) The scoping of individual projects **C5A OVERALL**		M M	**M**
	S5, CRITERIA 5 OVERALL			**M**
S5, C6 The activity of the NoSPHN is made accountable	C6A Activity and outcomes of the NoSPHN are annually reported to all 5 of the NoSPHN Health Boards and feedback is received from these organisations **C6A OVERALL**			M
	S5, CRITERIA 6 OVERALL			**M**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S5, C7 NoSPHN activity is improved by review/audit	C7A There are recommendations made and implemented to improve the effectiveness of the NoSPHN through audit/evaluation **C7A OVERALL**			M
	S5, CRITERIA 7 OVERALL			**M**

STANDARD 6 (S6) – PARTNERSHIP PROCESSES ARE EFFECTIVE TO THE NETWORK QUALITY IMPROVEMENT SCALES

Evidence Threshold	Assign as
No evidence or not met	NM
Partially met	PM
Fully met	M

Summary Position of Standard 6 on Quality Improvement Scale

Criterion	NM	PM	M	All	% Met
C1	0	1	0	1	0
C2	0	1	0	1	0
C3	0	0	1	1	100
∑C1-3	0	2	1	3	33[1]

Summary of grading result of Standard 6

Overall:	**Nos**	**%**
Unmet	**0**	**0**
Partially Met	**2**	**67**
Fully Met	**1**	**33**[1]

Rationale

Criterion	% met	Reason for grade
C1	0%	Very little engagement with CHPs as yet and none with local MCNs
C2	0%	Extent of awareness outwith PH is not known
C3	100%	All met
OVERALL [1]	33%	Partially met

Core Evidence

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
S6, C1 Relationships with a wide range of stakeholders have been established	C1A Relationship as a network with other statutory and voluntary organisations locally and regionally has been established viz:			
	(i) Local Authorities		M	
	(ii) Community partnerships		PM	
	(iii) Other health-related organisations		M	
	(iv) Managed Clinical Networks		NM	
	(v) Regional Networks (e.g. NoSCAN)		M	
	(vi) Academic groups/organisations		M	
	C1A OVERALL			**PM**
	S6, CRITERIA 1 OVERALL			**PM**
S6, C2 Involvement of the wider Public Health Workforce in the NoSPHN	C2A Out with both the NoSPHN steering group and project leads, individuals or groups are:			
	(i) Aware of the NoSPHN		PM	
	(ii) Involved in the work of the NoSPHN		M	
	C2A OVERALL			**PM**

Criterion (C…)	Essential Elements of Criterion	Evidence Submitted (Referenced)	Sub Criteria (NM/PM/M)	Main Criteria (NM/PM/M)
	S6, CRITERIA 2 OVERALL			**PM**
S6,C3 Two-way communications with partner organisations using remote technology is part of the NoSPHNs business	C3A Regular use of video conferencing and web-based facilities with partner organisations is part of the NoSPHNs activity **C3A OVERALL**			**M**
	S6, CRITERIA 3 OVERALL			**M**

APPENDIX 3

Schedule for the Peer Review Evaluation of the NoSPHN on 26th/27th October 2006

26th October: At Craigmonie Hotel

5.30-7.30 pm Peer Reviewers meet to achieve the following objectives

1. Complete the PAF where agreement on position and grading against the criteria is established
2. Translate areas of uncertainty/non-consensus into questions/information to be sought from the interviews on the 27th
3. Compile a list of the questions/ information to be sought from each interview group (using pro-forma supplied)

7.45 pm Dinner

27th October: At Assynt House, Beechwood Park (South), NHS Highland

TIME	LOCATION	TASKS
09.00 – 09.25	Dr Baijal's office, 1st floor	➢ Settle in and confirm information to be sought from Group 1 interview
09.30 – 09.45	Board Room, Ground floor	➢ Group 1 interview
09.50 – 10.25	Dr Baijal's office, 1st floor	➢ (1) Confirm information obtained from group 1 interview (2) Review position against relevant criteria (3) Confirm information to be sought from Group 2 interview
10.30 – 10.45	Board Room, Ground floor	➢ Group 2 interview
10.50 – 11.25	Dr Baijal's office, 1st floor	➢ (1) Confirm information obtained from group 2 interview (2) Review position against relevant criteria (3) Confirm information to be sought from Group 3 interview
11.30 – 11.45	Board Room, Ground floor	➢ Group 3 interview
11.50 – 12.25	Board Room, Ground floor	➢ (1) Confirm information obtained from group 3 interview (2) Review position against relevant criteria (3) Confirm information to be sought from Group 4 interview
12.30 – 13.25	Board Room, Ground floor	➢ Working Lunch ➢ Start on the feedback slides
13.30 – 13.45	Board Room, Ground floor	➢ Group 4 interview
13.50 – 14.25	Board Room, Ground floor	➢ (1) Confirm information obtained from group 4 interview (2) Review position against relevant criteria
14.30 – 14.45	-	➢ Break
14.50 – 15.25	Board Room, Ground floor	➢ Preparation for feedback
15.30 – 16.00	Board Room, Ground floor	➢ Feedback session

Confirmation of next steps:

1. By 24th November draft report prepared (Chair assisted by Facilitator) & circulated to all Peer Reviewers and signed off by the Chair
2. Draft report to NoSPHN Lead & Co-ordinator for comments to be received by 22nd December

Final report issued by Chair on behalf of Peer Reviewers by January 19th 2007

APPENDIX 4

Grading guide for evaluation of NoSPHN by peer review

Validation of the self-assessed position against the criteria can be graded as per the Peer Reviewers Framework. The latter allows grading of each criterion, sub-criterion and divisions of sub-criteria as: M = Met; PM = Partially Met; NM= Not Met. This will be based on your assessment of the degree to which the network attribute has been met on the basis of the comments and evidence submitted as follows:

(5) Met= confident of it having been achieved

(6) Partially Met = evidence and belief that it's not been fully met and there is some way to go in achieving it to a satisfactory degree

(7) Not met = when there is no evidence of progress either due to there being no evidence submitted, or the evidence submitted being irrelevant or on the basis of the commentary provided indicating that it is not met.

Overall grading of the standards and criteria is based on rules of hierarchy of grading as follows:

(1) for an overall Met: when all divisions and sub-divisions have been graded as "Met"

(2) for overall Not met: when all sub-divisions and divisions are graded "not met"

(3) for overall Partially met: when divisions and sub-divisions have been graded differently i.e. met, not met or partially met in any combination

(4) Criteria or sub-criteria denoted as Not applicable (N/A) by the self-assessor should not be used in the overall grading unless it is the opinion of the peer reviewer that it should apply and therefore the grading should be "Not met".

The assignment of the overall grade for the standard can be summarised using the page immediately preceding the peer reviewers assessment of the particular standard in the Peer Reviewers framework.

APPENDIX 5

Interviews: Peer Review Evaluation of NoSPHN 27th October 2006

Representation	Base
Centre for Rural Health	Inverness
NHS Education Scotland	Inverness
Health Scotland	Edinburgh
(*) Mid CHP PHP, NHS Highland	Dingwall
Health Board/Local Authority, Shetland	Shetland
(*) CHP Management Mid CHP, NHS Highland	Dingwall
NHS Highland Planning/NoSPG	Inverness
DPH/NoSPG	Western Isles
NHS Exec/NoSPG	Shetland
PH Team/Vol Reg	Western Isles
DPH	Shetland
Health Promotion	Western Isles
(*) Voluntary Register / PHP / Council	Aberdeen
NoSCAN	Aberdeen
Health Promotion	Inverness
NoSPHN Steering Group/ Reg/HB Planning	Aberdeen
NoSPHN project lead	Aberdeen
Health Promotion / HI in CHPs	Orkney
Clinical Lead NoSPHN	Inverness
Co-ordinator NoSPHN	Inverness

(*) Not present