Evaluation of the North of Scotland Public Health Network

Telephone and e-mail survey

Final Report

February 2006

Summary

The North of Scotland Public Health Network (NoSPHN) is a collaboration between NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland and NHS Western Isles. The Network aims to link groups of public health and health improvement professionals, to work in a co-ordinated manner across organisations with a common strategic agenda to promote health improvement and reduce inequalities, thus maximising shared resources.

The North of Scotland Public Health Network was formalised in autumn 2002. It was agreed in 2005 that it should be formally evaluated. The overall aim of the evaluation was to demonstrate if the NoSPHN has been effective. The outcome of this evaluation will be used in particular to feedback to the North of Scotland Planning Group and key stakeholders; review lessons learned to improve the effectiveness of the Public Health Network in the North and inform the development and evaluation of other regional networks; inform bids for the future funding for the Network. The four main areas to be evaluated were:

- Delivery of the NoSPHN work plan
- The value placed on the Network by stakeholders
- Identifying where the Network / Network processes have influenced actions
- Identifying the added value of the Network

Three approaches to the evaluation of the NoSPHN were identified including a telephone survey of key stakeholders; E-mail survey of those with current limited involvement but who may be involved in the future; self-assessment of documentary 'evidence', with peer review to validate the findings. This report presents the findings of the first two approaches: the telephone survey and the e-mail survey. The surveys used the same questionnaire and the results were combined.

In total, 213 people were invited to participate in the surveys. 24 respondents were interviewed by telephone (60% response rate) and 39 respondents returned questionnaires by e-mail (23% response rate). The results showed that in general, the Network is seen as useful, fulfilling an important function and with great potential. The most frequently mentioned success of the Network was around training and CPD. This was the area that most respondents had been involved in and was mentioned in nearly all parts of the questionnaire. Other successful areas were around communication, networking with colleagues from other health boards and working on specific projects. Those who are actively involved in the Network were generally more positive about effectiveness of the Network. At present the added value appears to be with specific pieces of work rather than a more generalised collective, strategic approach to pursuing the public health agenda that was identified as an expectation by the respondents.

There were a number of responses talking about the great 'potential' of the Network, but they were not clear if it had actually achieved much as yet. Some respondents saw the Network as primarily for only a limited set of individuals involved in public health: a common suggestion was that the membership should be broadened further. Limited resources, including time, commitment and staff were identified as a problem for the Network. A number of respondents felt the Network was not of a high enough priority at a local level: they felt that it could achieve more if it were specified as part of individuals' work plans and it was a priority for the health boards.

Recommendations include responding to the suggestions made by respondents, such as promoting the work of the Network to a wider public health audience and focusing on completing projects currently underway to demonstrate some measurable outcomes.

1 Introduction

Public Health / health improvement networks have been defined as 'linked groups of public health / health improvement professionals, working in a co-ordinated manner across organisations and structural boundaries with a common strategic agenda to promote health improvement and reduce health inequalities for a given population, thus maximising shared resources in a co-ordinated way'.

The North of Scotland Public Health Network was formalised in autumn 2002. It was agreed in 2005 that, after being in place for 2 ½ years, the Network should be formally evaluated.

2 The North of Scotland Public Health Network (NoSPHN)

The remit of the North of Scotland Public Health Network is to improve health and reduce health inequalities across the North of Scotland through working together: but only where working together will be more effective. To achieve this remit, those involved in the Network work collaboratively (where this adds value) to plan and deliver equitable, high quality and effective public health services and activities for the benefit of the population of the North of Scotland.

The Network is not seen as a 'structure' but a vehicle for agreeing and delivering objectives of common interest across the North. In this way organisations, groups and individuals are drawn into the Network to achieve project objectives, thereby enabling the Network to evolve around agreed pieces of work.

The NoSPHN covers the NHS Board areas of NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland and NHS Western Isles. NHS Tayside are not fully participatory, but may link for specific projects or pieces of work when there is agreement as to the added value of involvement for such work.

2.1 Key objectives

The following were the key objectives of the NoSPHN for 2004-05:

- Ensure formal Surge Capacity [1] arrangements are in place and are operational when required
- Support information sharing across the North
- Deliver and support continuing professional development (CPD) opportunities across the North
- Deliver North of Scotland Regional Planning Group work plan / activities i.e.
  - Health Intelligence & Information Scoping project
  - Health Improvement Scoping project
  - Review and support regional groups and public health membership

[1] **Surge Capacity** – the ability to obtain Public Health (PH) mutual support when needed in an emergency, when the potential risk to the public's health outstrips the capacity of a single PH department (NHS Board)

- Deliver an effective communication system for the Network / public health activity across the North
- Ensure Governance arrangements are in place for the public health activities of the North

3 The evaluation process

The North of Scotland Public Health Network was formalised in autumn 2002. It was agreed in 2005 that it should be formally evaluated.

3.1 Overall aim

The overall aim of the evaluation is to demonstrate if the NoSPHN has been effective. The outcome of this evaluation will be used in particular to:

- feedback to the North of Scotland Planning Group (NoSPG)/ key stakeholders
- review lessons learned to improve the effectiveness of the Public Health Network in the North and inform the development and evaluation of other regional networks
- inform bids for the future funding for the Network.

3.2 Objectives

- To identify and agree what is to be evaluated and what aspects should be considered when judging performance
- To define the standard to be reached for the Network to be considered successful
- To identify the evidence to support the above
- To identify the target groups and processes for evaluation and implement
- To review lessons learned to improve the effectiveness of the Public Health Network in the North from the results of the evaluation.

3.3 Ownership

It was essential to ensure ownership of the process by all partner organisations: all stages of the evaluation were discussed and agreed at Network meetings.

3.4 Stakeholders (target groups)

For the purpose of the evaluation the key stakeholders of the Network were proposed to be those engaged in the Network activities and those to whom the Network is accountable. A further group of stakeholders were identified as those that might be involved in future activities or in further defining the activities of the Network i.e. all those involved in public health activities across the North.

3.5 What would a successful North of Scotland Public Health Network look like?

Following discussion with key stakeholders the following were identified as the measures against which the success of the Network should be measured:

- Delivery of the NoSPHN work plan
- The value placed on the Network by stakeholders
- Identifying where the Network / Network processes have influenced actions

- Identifying the added value of the Network
- Ensuring that structures are in place to support an increase in Pubic Health capacity in the North
- Ensuring that the Network is quality assured
- Demonstrating that partnership processes are in place to support effective networking
- Demonstrating that the Network is sustainable.

It was agreed that not all the criteria identified above could be measured at once. The Network steering group discussed and selected the first four as priority areas.

3.6 Methodology

Three approaches to the evaluation of the NoSPHN were identified:

- Telephone survey of key stakeholders
- E-mail survey of those with current limited involvement but who may be involved in the future
- Self-assessment of documentary 'evidence', with peer review to validate the findings

This report combines and presents the finding of the first two approaches: the telephone survey and e-mail survey. The peer-review process has still to report - due by July 2006.

4 Methods

4.1 Target population

For the purpose of this evaluation, the target population consisted of all those involved in public health across the region, i.e. existing or potential stakeholders. It was not possible to include every potential stakeholder. However, as many as possible were identified by including:

- all those who had already been directly involved in the Network in some way
- those on local (i.e. within the Health Boards) 'public health' mailing lists.

Any individuals who were not in post at the time of the surveys were excluded from the sample.

A sample of the individuals identified as above was selected for the survey by telephone interview: these individuals were the core stakeholders who were actively involved in the Network in some way. All others in the sample were selected for the survey by e-mail.

4.2 Recruitment

All those selected for telephone interview were e-mailed with an invitation to participate in the survey and a copy of the questionnaire. They were asked to return a form with contact and availability details. One reminder was sent.

All those selected for survey by e-mail were e-mailed the questionnaire with a covering note and asked to return the completed questionnaire by e-mail. One reminder was sent.

4.3 Data collection, processing and analysis

The same questionnaire was used for both surveys (Appendix 1). The questionnaire was initially developed by the NoSPHN co-ordinator and the Epidemiology and Clinical Effectiveness Manager (NHS Highland). It was discussed and amended by the NoSPHN Steering Group. Pilot interviews were conducted allowing further modifications and the development of guidelines for interviewers and e-mail respondents to enhance the validity and reliability of the tool.

The questionnaire was completed in one of two ways:

- Completion by interviewer (telephone survey)
- Self-completion by subject (for e-mail survey)

The telephone interviews were conducted by a medical student (NHS Shetland) and a Clinical Effectiveness Assistant (NHS Highland). The interviewers inputted the data from the completed e-mail and telephone questionnaires into an Access database developed for the survey. Analysis of the data was carried out by a Public Health Specialist Registrar (NHS Shetland).

4.4 Confidentiality

Respondents were assured that all individual responses to the survey would be treated in strict confidence. Names and any personal attributable information were not be used other than to record that the individual had responded and therefore did not require a reminder. No names were included on the database.

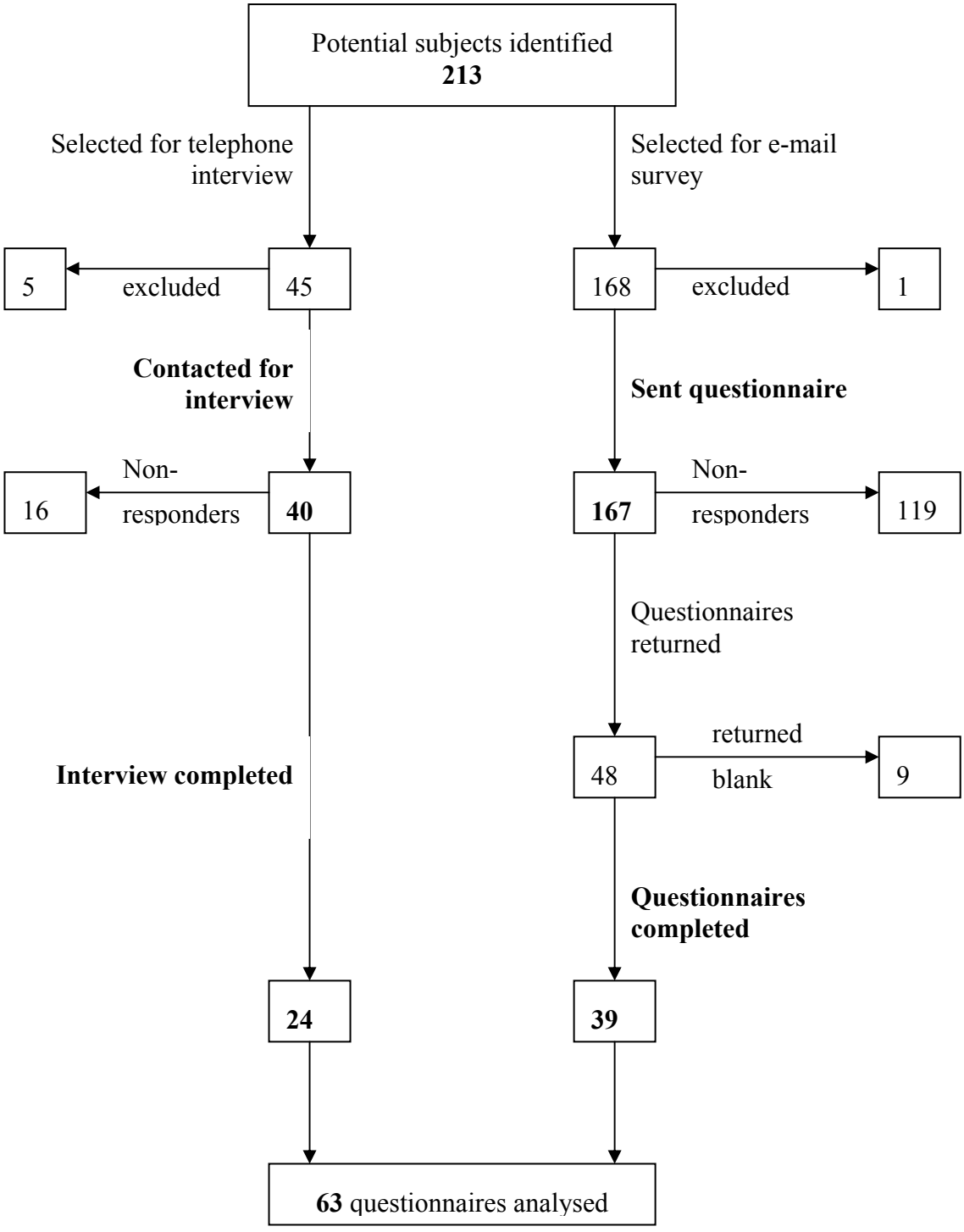
5 Results

5.1 Response rate

Initially, 45 potential participants were selected for telephone interview. Of these, 5 were not in post at the time of the evaluation. The remaining 40 were contacted by e-mail and asked to participate. Of these, 24 people responded and were subsequently interviewed, giving a response rate of 60%. Interviews were held between 1st August and 16th September 2005.

168 people were initially selected for the e-mail questionnaire. One was not in post at the time of the evaluation. Questionnaires were e-mailed out to the remaining 167, of whom 48 responded, giving a crude response rate of 29%. Only 39 of the returned questionnaires were completed (response rate of 23%): 9 were returned blank but with an explanatory comment. These 9 questionnaires were excluded from further analysis but the comments have been included in the discussion.

Of the 213 individuals in total who were invited to participate in the evaluation, 63 completed the questionnaire (either by interview or e-mail). This gives an overall response rate of 30%.


Potential subjects identified
213
Selected for telephone interview
Selected for e-mail survey
5
excluded
45
168
excluded
1
Contacted for interview
Sent questionnaire
16
Non-responders
40
167
Non-responders
119
Questionnaires returned
Interview completed
48
returned blank
9
Questionnaires completed
24
39
63 questionnaires analysed

5.2 Demographic information

5.2.1 Geographical Area

Respondents were asked which health board area or areas they covered in their work. As the table below shows, the majority were from Highland or Grampian with small numbers from the Island Boards and two respondents covering two health board areas. Four respondents covered the whole of the north of Scotland, three of these including Tayside, and one covered the whole of Scotland.

Geographical area	Telephone Interview	E-mail questionnaire	Total
Highland	8	19 (incl 1 covering 2 HBs)	27
Grampian	4	15	19
Orkney	3 (+1 covering 2 HBs)	1	4
Western Isles	2	2 (+1 covering 2 HBs)	4
Shetland	3 (incl 1 covering 2 HBs)	0	3
Tayside	0	1	1
North of Scotland	3 (inc Tayside) 1 (excl Tayside)	0	4
Scotland	0	1	1
Total no. questionnaires	**24**	**39**	**63**

Table 1 Respondents' geographical area of work

5.2.2 Type of job

It was difficult to categorise respondents by the job they did because job titles and work remits were so diverse. Four criteria were identified which could be used to categorise the posts held by respondents:

- the area of work, which ranged from a general description (e.g public health) to a specific remit (e.g breastfeeding)
- the job title of the post (e.g directors, heads of service, managers, officers)
- employer (e.g health board, local authority)
- professional background (e.g doctors, nurses, managers)

However, there was insufficient information to use these criteria in a meaningful way. Many respondents covered more than one area of public health practice. The questionnaire did not specifically ask which organisation the respondents worked for. Some job titles were too ambiguous to be clear if they were posts within a NHS Board, CHP, Local Authority or other organisation. Some posts were joint between 2 different organisations.

The only information that was available for all respondents was job title: so this was used to categorise the respondents as far as possible as shown in the table below.

Job title / area of work	Telephone Interview	E-mail questionnaire	Total
Director of Public Health	4	0	4
Consultant in Public Health Medicine / PH specialist	4	2	6
Public Health Practitioner	1	2	3
Other public health	2	3	5
Health Promotion Manager	3	0	3
Health Promotion Specialist	0	2	2
Health Improvement Officer	0	5	5
Other health improvement	1	2	3
Health intelligence, health information	3	1	4
NHS Board Chief Executive	2	0	2
Managed Clinical Network Manager	0	3	3
Cancer or palliative care	1	5	6
Other	3	14	17
Total	**24**	**39**	**63**

Table 2 Respondents' job title / area of work

5.2.3 Non-responders

Information on the geographical area was available for all those invited to participate in the evaluation. There was information on the job title or area of work for some groups who were invited to participate. The tables below show this information broken down into those who responded and those who did not.

Geographical area	Responder	Non-responder	Total
Highland	27	16	43
Grampian	19	59	78
Orkney	4	2	6
Western Isles	4	3	7
Shetland	3	1	4
Other	6	69	75
Total	**63**	**150**	**213**

Table 3 Non-responders: geographical area of work

Job title / area of work (selected)	Responder	Non-responder	Total
Director of Public Health	4	0	4
Consultant in Public Health Medicine	5	6	11
Public Health Practitioner	3	1	4
Health Promotion Manager	3	1	4
Health intelligence, health information	4	9	13
NHS Board Chief Executive	2	4	6
Other	42	144	170
Total	**63**	**150**	**213**

Table 4 Non-responders: job title / area of work

5.3 Involvement with NoSPHN

As expected, due to the selection process, all 24 telephone interviewees had heard of NoSPHN prior to the survey. Of the 39 who completed the e-mail questionnaire, 27 (69%) had heard of the Network and 12 had not; giving a total of 51 respondents who had heard of the Network.

The 9 respondents who sent in comments only did not answer this question. It was apparent from the comments that 4 of these had heard of the Network, but they either were not involved or knew nothing about its work. These questionnaires have been excluded from further analysis.

5.3.1 Level of involvement with NoSPHN

	Telephone interview	E-mail questionnaire	Total
Current active involvement	13	2	15
Previous active involvement	0	1	1
Current or previous partial engagement	6	5	11
As a commissioner of the work of the Network	2	0	2
Passive involvement only (awareness)	3	13	16
Relationship not known	0	6	6
Total number who had heard of Network	24	27	51
Never heard of Network	0	12	12
Total	24	39	63

Table 5 Level of involvement with NoSPHN

As expected, most of those who described themselves as being actively involved with the Network had been interviewed by telephone. There were a number of respondents who had not

heard of the Network and it can be assumed that probably a significant number of those who did not respond probably had not heard of the Network.

5.3.2 Involvement with different NoSPHN activities

The 51 respondents who had heard of the Network were asked which specific activities they had been involved in.

Type of activity		Number of respondents
Groups	Health Improvement Scoping Project	8
	Health Intelligence Scoping Project	10
	Network 'management' group	8
	Voluntary Public Health Register e-mail group	8
	NOSCAN / NoSPHN e-mail Group	13
Continuing Professional Development	25th April 2003 – North of Scotland Public Health Training Day, Inverness	13
	23rd September 2003 – NHS Prioritisation, Patients Rights and the Law, Aberdeen	4
	27th April 2005 – Network and CPD Event, Inverness	28
	Faculty of Public Health Scottish Affairs Committee: Annual Scottish Public Health Conference to be held in Aberdeen in November 2005	16
Other activities	Collaboration on emergency planning issues e.g. smallpox	7
	Public Health input to regional working groups e.g. Mentally Disordered Offenders Group	5
	Support to other North NHS Boards to provide Public Health Functions	11
	Responding to joint responses to consultation exercises e.g. on Diabetes	8
	Public Health input to regional MCNs e.g. Cancer	13
	Collaboration on health protection issues e.g. development of a Memorandum of Understanding for surge capacity	8
	Sharing of work / projects / policies etc. across the North / between NHS Boards	16

Table 6 Involvement with different NoSPHN activities

There were respondents involved in all the activities listed, again not surprising as most of the respondents would probably have heard of the Network through some kind of involvement in specific activities. The activity that had involved the highest number of respondents was the CPD event in April 2005, with 28 (55%) out of the 51 who had heard of the Network being involved in some way.

5.4 Expectations

These 51 respondents who had heard of the Network were asked what they expected of the Network. 47 gave a response: 4 either did not answer or stated they did not know. Some responses were very general such as 'add value' or 'improve effectiveness'. Others gave more specific expectations, with the most common themes being around:

- Sharing of information and best practice
- Networking
- Efficient use of workforce
- Education, training and CPD
- Specific projects carried out by the Network
- Peer support

From some of the respondents, there was also a sense that the Network should:

- provide leadership
- develop a strategic approach
- have more influence than individual organisations (and use it) – particularly through the North of Scotland Planning Group
- focus on issues specific to the region, remote and rural areas in particular.

5.5 How the Network adds value at present time

The 51 respondents who had heard of the Network were asked if they considered that the Network adds value to public health activity and regional planning in the North of Scotland. 30 (64%) of the 47 respondents answered this question thought the Network did add value; 14 did not know and 3 thought it did not.

Those who thought it did add value were given 10 options to describe in what way (respondents could choose as many as they wished):

Options	Number of responses (%) N=30
Avoids duplication of effort	18 (60%)
Provides training opportunities and CPD	24 (80%)
Provides communication on work in progress across the Region	24 (80%)
Allows sharing of policies / standardisation of policies	17 (57%)
Provides reactive and proactive dissemination of information	17 (57%)
Facilitates access to on-line facilities / interactive approaches to communication	12 (40%)
Ensures / provides shared resource (financial and staff)	12 (40%)
Identifies single point of contact for issues	19 (63%)
Demonstrates cost-effectiveness	3 (10%)
Other (included co-ordination / joint working; supporting some specific pieces of work)	7 (23%)

Table 7 How the Network adds value

The 3 respondents who felt the Network did not add value gave the following reasons:

- the Network will take time to demonstrate effects
- they work with colleagues nationally rather than regionally
- no evidence of any useful output as direct result of Network

A number of respondents commented that it was difficult to answer this question with a clear 'yes' or 'no'. They thought the Network "has the potential to add value" or "is starting to" "would like to think it does". One respondent commented that they thought that other topic – specific networks were better for acting as a single point of contact for issues.

5.6 Does the Network have influence over the business of the NHS?

The 51 respondents were asked if they thought the Network has influence over the business of the NHS at various levels. Nearly half the 47 respondents who answered this question (22, 46%) thought the Network did have influence at some level: almost the same number (21, 44%) did not know and 4 thought it did not have influence.

Those who said yes were asked in what areas the Network had influence, choosing all that applied from the following options:

Options: Influence over	Level	Number of responses (%) N=22
Agenda setting	National	3 (14%)
	Regional	10 (45%)
	Local	7 (32%)
Remote and rural issues	National	5 (23%)
	Regional	11 (50%)
	Local	7 (32%)
Service redesign / planning	National	1 (5%)
	Regional	13 (59%)
	Local	10 (45%)
Policy development / implementation	National	3 (14%)
	Regional	12 (55%)
	Local	7 (32%)
Events (CPD / conferences)	National	8 (36%)
	Regional	17 (77%)
	Local	13 (59%)

Table 8 Influence over the business of the NHS

In general, for those who answered the question, the Network is seen as having most influence at a regional level and least at a national level, with similar number of responses for each potential area of influence. Similar to the findings above on added value, CPD / conferences is the area that most respondents identified as where the Network has some influence.

The 4 who felt the Network did not have influence gave the following reasons:

- There was the potential, but no clear evidence yet.
- Peripheral to main agenda of health boards
- Only really involves DsPH

Comments from other respondents included:

- Not enough staff commitment
- Those on national bodies are not promoting the regional perspective
- The national and regional agenda is influencing the Network (rather than the other way around)
- The Network needs to influence in order to justify its existence
- The concern that some in the public health community want a national network – and this would be influenced mainly by the central belt, losing a focus on issues specific to the North of Scotland.

Respondents were also asked how the Network could be more influential. The themes identified here included:

- Needs to involve a wider range of people, especially those outwith 'traditional' public health
- Needs to become part of people's core work – included in job plans etc
- Concentrate on delivering the current work plan and demonstrating the Network's value
- Better communication within the region, before trying to influence nationally

5.7 Is the Network valued personally by those involved?

Respondents were asked if they personally valued the Network, and if so why? 36 (71%) of the 51 respondents who had heard of the Network said they did value it personally. 6 said they did not and 8 did not know. Respondents were given a choice of three reasons for valuing the Network and could add other reasons to their response. They could choose any number of reasons:

Reason for valuing network	**No of responses (%) N=36**
Facilitates integration and / or co-ordination of NHS Board Public Health activities / services	23 (64%)
Has increased my social capital	20 (56%)
Can influence regional service design or planning	26 (72%)
Other (including raises awareness of public health issues; education; access to expertise; has potential to achieve the above)	8 (22%)

Table 9 Reasons for valuing the Network

Respondents were asked to give specific examples of where they have valued the Network personally. These included:

Valuing the Network: (free text responses grouped)	**No of responses**
Contact with other colleagues (would have otherwise not happened)	6
Has reduced professional isolation / provided support	4
Training	4
Broader perspective	3
Opportunity to work at Regional level	2
Has reduced own workload	2
Practical – cover for annual leave	1
Specific pieces of work, including: Health Improvement Scoping project; Health Intelligence Scoping Project; Surge capacity work; NOSCAN.	14 in total

Table 10 Examples of personally valuing the Network

If respondents answered 'no' or 'do not know' they were asked if there was a reason for this. Most commented that the Network was not involved in the respondent's own area of work (health protection was mentioned twice). Another said it would be of more value of it was a higher priority, part of own work remit rather than optional. One commented that the Network was irrelevant as in their work area people already worked collaboratively and would continue to do so with or without the Network.

5.8 Rating of Network processes

Of the 51 respondents who had heard of the Network, 48 completed this section. They were asked to rate 16 processes on a scale of 1 to 5 according to how well they thought the Network carried out each particular process (where 1 = poor and 5 = excellent). There was also an option of 'don't know'. (Refer to Table 11 below)

Of the 48 respondents, 10 answered 'don't know' for all 16 processes (including one person who had described themselves as actively involved in the Network).

For the following processes, a high proportion of respondents (over 60%) answered 'don't know':

- That there is a clear risk management structure (81% of all respondents including 73% of those actively involved in Network)
- Relationship with other statutory and voluntary organisations (69% of all respondents including 53% of those actively involved in Network)
- That accountability lines are in place and working (65% of all respondents including 47% of those actively involved in Network)
- That governance arrangements are clear and working (63% of all respondents: 47% of those actively involved in Network)

Unsurprisingly, the group of respondents who identified themselves as actively involved in the Network consistently answered fewer questions with 'don't know' compared to all other respondents. They also consistently gave a higher average rating for all the processes except multi-disciplinary / multi-professional involvement, rated at 3.2 compared to the other respondents' 3.5 and relationship with other statutory and voluntary agencies which both groups rated low at 2.3.

The biggest differences between the two groups (one point or more higher rating by the active involvement group) were their ratings of:

- Management arrangements (1.5 points higher)
- Communication lines (1.4 points higher)
- Implementation of work plan (1.2 points higher)
- Relationships between partners (1.0 points higher)

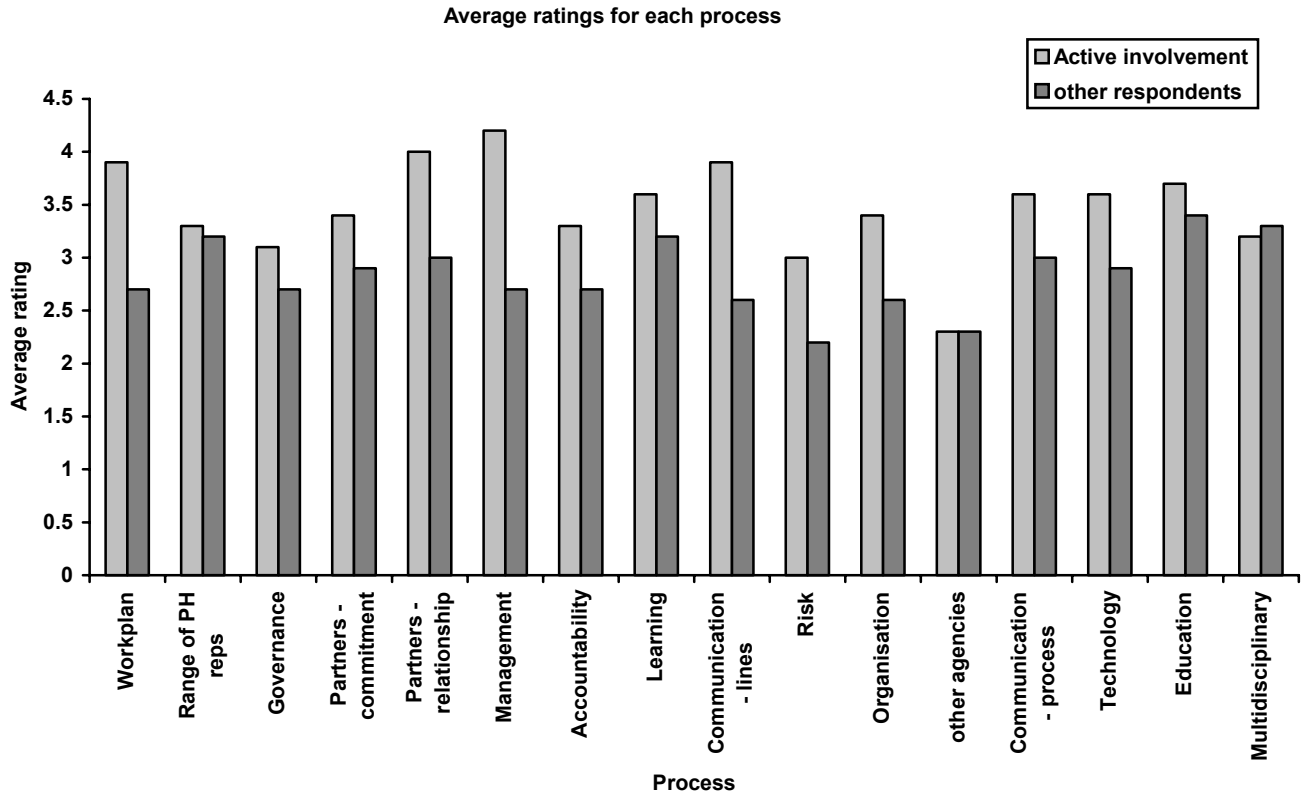
However, caution must be taken in interpreting the results because of the small numbers involved and the number of respondents who answered 'don't know'.

The most highly rated processes by the actively involved group were 'management arrangements' (average rating of 4.2) and 'relationships between partners' (4.0). The process rated poorest was 'relationship with other statutory and voluntary organisations' (2.3). The group of other respondents rated 'multi-disciplinary / multi-professional involvement' highest with an average rating of 3.5 and 'responding to educational and training needs' was rated at 3.4. The process with the lowest rating was 'risk management structure' (2.2)

	Respondents actively involved N=15		Other respondents N=33		All respondents N=48	
Process	**Mean rating**	**DK (%)**	**Mean rating**	**DK (%)**	**Mean rating**	**DK (%)**
Implementation of NoSPHN work plan	**3.9**	7 (47%)	**2.7**	24 (73%)	**3.6**	31 (65%)
Involvement or engagement with a range of public health community representatives across the North	**3.3**	2 (13%)	**3.2**	15 (45%)	**3.2**	17 (35%)
Governance arrangements (clear and working)	**3.1**	7 (47%)	**2.7**	23 (70%)	**2.9**	30 (63%)
Commitment of partners (demonstrated)	**3.4**	3 (20%)	**2.9**	15 (45%)	**3.1**	18 (38%)
Relationships between partners	**4.0**	5 (33%)	**3.0**	16 (48%)	**3.4**	21 (44%)
Management arrangements (in place and working)	**4.2**	2 (13%)	**2.7**	20 (61%)	**3.4**	22 (46%)
Accountability lines (in place and working)	**3.3**	7 (47%)	**2.7**	24 (73%)	**2.9**	31 (65%)
Capacity to learn (demonstrated)	**3.6**	5 (33%)	**3.2**	16 (48%)	**3.4**	21 (44%)
Communication lines (clear and working)	**3.9**	2 (13%)	**2.6**	16 (48%)	**3.2**	18 (38%)
Risk management structure (clear)	**3.0**	11 (73%)	**2.2**	28 (85%)	**2.6**	39 (81%)
Organisational structure clear	**3.4**	5 (33%)	**2.6**	21 (64%)	**3.0**	26 (54%)
Relationship with other statutory and voluntary organisations	**2.3**	8 (53%)	**2.3**	25 (76%)	**2.3**	33 (69%)
Processes for communication (in place and working)	**3.6**	1 (7%)	**3.0**	15 (45%)	**3.3**	16 (33%)
Technology being effectively used to support work	**3.6**	1 (7%)	**2.9**	18 (55%)	**3.2**	19 (40%)
Responding to educational and training needs	**3.7**	2 (13%)	**3.4**	15 (45%)	**3.5**	17 (35%)
Multi-disciplinary / multi-professional involvement or engagement	**3.2**	7 (47%)	**3.5**	17 (52%)	**3.4**	24 (50%)

Table 11 Rating of Network processes

The average ratings given by the two groups are shown in the graph below.



5.9 What is the Network doing well?

Respondents were asked what (in their opinion) they thought the Network did well. 42 of the 51 respondents who had heard of the Network completed this question: 32 gave one or more examples of something they thought the Network was doing or had done well. 9 answered 'don't know' and one specifically responded 'nothing'. The most common examples given have been grouped together below.

What does the network do well? (free text responses grouped)	No of responses (%) N=32
Bring public health practitioners together / making links / networking / communication	13 (41%)
CPD events / conferences	7 (22%)
Focusing on small number of projects (but no outcomes yet)	6 (19%)
Having a work plan	5 (16%)
Trying to look at what could add value on a regional basis	5 (16%)

Table 12 Responses to: 'What does the Network do well?'

Other examples included providing a focus, co-ordinating work, linking with NoSPG, addressing inequalities issues, evaluating itself, clear governance and management, actively going out and providing services, engaging with local authorities. There were a number of non-specific comments about generally progressing well.

Of the 9 respondents who could not give any examples, one noted that there had been no completed pieces of work yet. Another respondent thought it was not clear if working through the Network had made more efficient use of resources compared to working independently.

5.10 How could the Network be improved?

Respondents were asked how they thought the Network could be improved. 24 responded by giving one or more suggestions. These have been grouped in the table below:

How could the Network be improved? (free text responses grouped)	**No of responses (%) N=24**
Enabling more individuals to become involved • More publicity of work plan and how others can be involved / increase awareness of the Network / improve communication to PH community / set up a website • Become more multi-professional • More use of technology to create virtual network • Use different venues across the region	Total 13 (54%) (6) (4) (2)
Remit of Network / contents of work plan • Focus more on deliverables / outcomes • Increase / focus on educational / training remit • Bring NoS perspective to national consultations • More focus on issues specific to North of Scotland • Specific pieces of work undertaken on a regional basis	Total 8 (34%) (3) (2)
More time / resources / commitment to deliver work plan • Include Network activities in local work plans, embed in day to day work • Increase co-ordinator time • Increase resources	Total 4 (17%) (2)
Partnership working • Engage with other networks • More engagement with other statutory and voluntary agencies	Total 2 (8%)
Development of a regional public health service	1 (4%)

Table 13 Responses to: 'How could the Network be improved?'

5.11 What other issues could the Network usefully address?

The 51 respondents who had heard of the Network were asked: 'What specific issues could the Network usefully address, but isn't at the moment?' 24 respondents gave one or more suggestions:

What other issues could the Network address? (free text responses grouped)	No of responses (%) N=24
Planning and delivering public health services • Issues around the workforce: planning, training, recruitment and retention, capacity building. • Issues around the future configuration of Health Boards and Public Health in Scotland • Understanding how the Network fits with other regional groups • Response to Kerr report	Total 10 (42%) (5) (2) (2)
Remit and focus of the Network • Stronger focus on remote and rural issues • Agenda should be driven by health board plans • Co-ordinate local public health research • Public health input to community planning • Influence at the national level • Targeting inequalities • Horizon scanning	Total 8 (34%) (2)
Better involvement of public health community in the Network • Improve communication: web based bulletin board • 'Improve networking' • Wider multi-agency input	Total 4 (17%) (2)
Specific projects or issues: • Assessment of health improvement targets and outcomes • Tackling issues raised by smoking ban next year • New BCG requirements • Public health issues as a result of increased migrant workforce • Regeneration • Pharmaceutical public health • How best to engage with CHPs	
The Network should concentrate on current work plan because: there is no capacity to take on more work / there is a need to demonstrate results with that before taking on anything new.	4 (17%)

Table 14 Responses to: 'What other issues could the Network usefully address?'

It was noted that this question overlapped with the previous one on how the Network could be improved and some of the responses were similar. These included suggestions concerning wider multi-agency and multi-professional input, improving communication and engaging with other networks. Some of the issues related to planning and delivering public health services, such as recruitment and retention had not previously been mentioned. A number of potential projects were also identified. 17% of respondents felt that the Network should concentrate on the current work plan: deliver results from the current work plan before taking on more.

5.12 How can the Network help those not already involved?

The respondents who initially said they had not heard of the Network were given some information on the work and objectives of the Network and asked if they thought it could help them in their current remit. Of the 12 who had not heard of the Network, 7 answered this question 'yes'. They were asked to give examples. These were very general, including:

- Communication between staff in other health boards
- Joint working
- Sharing of good practice
- Dissemination of information

The 12 respondents were also asked what public health or regional planning activities they had been involved in across North NHS Boards. (This question was ambiguous and some gave examples of local public health activities). The examples given included:

- Other regional networks, including NOSCAN
- Regional services for mentally disordered offenders
- Regional services for eating disorders
- Mother and baby units.

6 Discussion

The overall response rate for the two surveys was 30%. However, it was much higher for the telephone interviews at 60% compared to the e-mail survey at 23%. This would suggest that the results from the telephone survey are probably a reasonably good reflection of how the Network is perceived by those involved with it. However few people responded to the e-mail survey and it is likely that many of the non-respondents had not heard of the Network, or did not know enough about it to complete the questionnaire. It is therefore more difficult to generalise the information obtained from the few people who did respond to the e-mail survey, particularly those who are only indirectly involved or not involved with the Network.

As might be expected, most of the respondents were individuals already involved in the Network, particularly those involved in the steering group and current projects. A number of the other respondents felt they knew very little about the Network other than one or two activities they may have been involved in (such as a CPD event), which made it difficult for them to comment. It was difficult to identify if there were any particular differences between responders or non-responders, because of the limited amount of information.

There were a number of e-mail questionnaires returned blank, but with some comments. These ranged from respondents who did not know why they were being asked to participate and had nothing to do with the Network; to those who had some knowledge but did not feel they could complete the questionnaire. It is of note that two of these responses were not from individuals

but on behalf of Public Health departments at NHS Tayside and Aberdeen University, who would be considered as stakeholders.

6.1 Common themes

A number of common themes arose in the analysis of the results. In general, the Network is seen as useful, fulfilling an important function and with great potential. Probably the most frequently mentioned success of the Network was around training and CPD. This was the area that most respondents had been involved in and was mentioned in nearly all parts of the questionnaire. One of the respondents, who was negative in all of their responses, did see training as the most positive aspect of the Network. Other successful areas were around communication, networking with colleagues from other health boards and working on specific projects. Those who are actively involved in the Network were generally more positive about the effectiveness of the Network, presumably because they are more closely involved.

The responses to the question on actual involvement and added value show that two main areas stand out: CPD / training and communication / sharing information, policies etc. This does seem to broadly reflect the main expectations identified by respondents. However, at present the added value appears to be with specific pieces of work rather than a more generalised collective, strategic approach to pursuing the public health agenda that had also been identified as an expectation.

There were a number of responses talking about the great 'potential' of the Network, but they were not clear if it had actually achieved much of this potential to date. Some respondents saw the Network as primarily for only a limited set of individuals involved in public health, some felt it was just for the Directors of Public Health. A common suggestion was that the membership should be broadened further.

Limited resources, including time, commitment and staff were identified as a problem for the Network. A number of respondents felt the Network was not of a high enough priority at a local level: they felt that it could achieve more if it were specified as part of individuals' work plans and it was a priority for the individual health boards. On the other hand, others felt that the Network should respond to the priorities of the health boards rather than impose its own agenda.

There was a concern that the Network had not actually completed any projects as yet and it was therefore difficult to assess how effective it was. It was felt by a number of respondents that the Network should concentrate on demonstrating some clear achievements before taking on any more work. However, one potential new area of work identified by respondents was workforce issues, including recruitment and retention, and capacity building.

The further discussion of the results is based on the four measures identified as a priority for the evaluation:

- Delivery of the NoSPHN work plan
- The value placed on the Network by stakeholders
- Identifying where the Network / Network processes have influenced actions
- Identifying the added value of the Network.

6.2 Delivery of the NoSPHN work plan

The respondents in the survey were not asked about delivery of specific aspects of the work plan. However, they were asked to rate the process of the implementation of the work plan on a scale of 1(poor) to 5 (excellent): the overall score was 3.6. The group of respondents who were actively involved in the process gave a mean rating of 3.9; implying they thought the work plan was being implemented well. However, those who were not actively involved rated it at 2.7, implying they did not think it was being particularly well implemented. This probably reflects the familiarity of the process by those more closely involved (and the fact that they are the ones implementing it).

The work plan itself was seen as a strength by a number of respondents when asked what the Network does well.

6.3 The value placed on the Network by stakeholders

The majority of the respondents who answered the question on valuing the Network, did value the Network personally (36 out of 51, 71%). The most common reasons for this included contact with other colleagues (that would not otherwise have happened); reducing professional isolation; providing support; and training.

The main reason for not valuing the Network was because it did not impact on the respondent's own area of work. Health protection was seen as one specific area where the Network did not have influence and was not involved in activities.

6.4 Identifying where the Network / Network processes have influenced actions

The Network was seen as influencing at a regional level (particularly around training and CPD), however influence at a local and national level was less clear. It was felt to be important that the Network did influence on a national level to keep north of Scotland issues on the national agenda, particularly around remote and rural issues. Some respondents commented that the Network needed to concentrate more on these particular issues. It was not clear how the Network could influence more, although it was commented that if some clear outcomes were demonstrated this would add credibility. There were comments that at present the Network is led by the national agenda rather than influencing it.

At a local level, one of the issues appears to be a perceived lack of commitment at health board level. However, it was noted that the health boards have their own agendas and priorities and if the Network is to influence at this level it will need to focus on these areas. Even if boards are committed, this does not help individuals become involved in the Network unless they have dedicated time and it is part of their own work remits.

6.5 Identifying the added value of the Network

The majority of respondents (30 out of 47 who answered the question, 64%) felt the Network did add value. This was seen mainly in CPD and training events (as before) and also communication of work in progress across the region. Some respondents found this question difficult to answer as they did not feel that the Network had necessarily demonstrated any added value as yet, but it had the potential to do so. As before, some felt that the Network had yet to achieve any measurable outcomes.

When asked what their expectations of the Network were, many respondents felt that added value in terms of reducing duplication, making best use of resources and sharing best practice and information was important. However, some respondents also stated that it was not clear if

this was happening as yet and that it may take more time to demonstrate. There were two examples of where the Network had reduced an individual's workload by sharing work and one example where the Network had been instrumental in sharing resources by covering annual leave.

Expectations of the respondents also included a sense of the Network providing leadership and a strategic approach, focusing on issues specific to the North of Scotland and providing greater influence than that achieved by individual health boards. These did not seem to be happening as yet, at least in the view of many of the respondents. They are, however, difficult activities to measure. There was a view that any added value identified so far had been seen in the work of individual projects rather than as part of an overall approach.

6.6 Strengths and limitations of evaluation

The survey by telephone interview gave a good response rate of 60%. However, it would have been impractical to attempt to survey the whole sample of 213 by telephone and so it was decided to invite the majority to participate by e-mail survey. The response to this was not as high at 23%, but probably reasonable considering the topic (which, given the responses that were received, was probably not familiar to all in the sample), the length of the questionnaire and the time of year (summer holiday period). It is possible that a shorter postal questionnaire, tailored to those less likely to have been involved in the Network, may have resulted in a higher response rate.

The questionnaire was discussed and amended by the NoSPHN Steering Group and piloted before being used in the survey. Guidelines for the interviewers were developed to increase validity. The majority of those who did complete the questionnaire answered all the questions and gave full answers and comments where requested. Some of the questions were perceived as being rather repetitive by respondents. However this did validate the results by showing similar themes being repeated throughout the questionnaires in response to slightly different questions. Sending out the questionnaire with the invitation to participate in the telephone survey may have helped to encourage subjects to participate and allowed them time to think about the answers before the interview, which may explain the full answers given by most respondents of the telephone interview. These questionnaires could be used again to repeat the survey after a period of time, either by telephone, e-mail or post; and the results compared. However, if used again it would be helpful to review some of the specific questions that respondents found difficult to answer (i.e. to give 'yes' / 'no' answers) or those that seemed repetitive (as the questionnaire is relatively long).

Although the members of the project team who did the telephone interviews, entered the data and completed the analysis and writing up were not entirely independent (they all worked in North of Scotland health boards), they were not members of the NoSPHN Steering Group. This was to reduce bias as far as possible without going to an external project team, but could not eliminate it.

7 Conclusion and recommendations

The results show that in general, the Network is seen as useful, fulfilling an important function and with great potential. The most frequently mentioned success of the Network was around training and CPD. Other successful areas were around communication, networking with colleagues from other health boards and working on specific projects. Those who are actively involved in the Network were generally more positive about effectiveness of the Network. At present the added value appears to be with specific pieces of work rather than a more

generalised collective, strategic approach to pursuing the public health agenda that was identified as an expectation by the respondents.

There were a number of responses talking about the great 'potential' of the Network, but they were not clear if it had actually achieved much as yet. Some respondents saw the Network as primarily for only a limited set of individuals involved in public health: a common suggestion was that the membership should be broadened further. Limited resources, including time, commitment and staff were identified as a problem for the Network. A number of respondents felt the Network was not of a high enough priority at a local level: they felt that it could achieve more if it were specified as part of individuals' work plans and it was a priority for the health boards.

7.1 Recommendations

It is recommended that a number of suggestions made by respondents be considered by the NoSPHN Steering Group:

- Publicise the work of the Network to a wider public health community and encourage more individuals to become involved
- Consider how the Network can work more closely with local health boards to ensure both that individuals have the capacity to take on Network activities and that the work of the Network reflects priorities of the boards.
- Continue with CPD and training activities: this is seen as a particular strength
- Consider how the Network can increase influence at a national level
- Consider workforce issues (but see recommendation below)
- Concentrate on completing pieces of work currently underway and delivering measurable outcomes before taking on new areas of work

In addition it is recommended that:

- The survey be repeated after a period of time to see where progress has been made
- The results of this survey be used to publicise the activities of the Network

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NoSPHN Steering Group

Appendix 1

Evaluation of North of Scotland Public Health Network (NoSPHN)
Telephone and E-mail Survey

For the purposes of this survey the NoSPHN covers the NHS Board areas of NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland, NHS Western Isles (and NHS Tayside where there is agreement as to the added value of involvement).

Section A: About You

A1. Post Title (verify) ……..

A2. Health Board Area(s) covered ……

A3. If you have a particular area of responsibility, please specify below (discretionary):

A4. Time in Post ……..

Section B: Relationship with NoSPHN

B1. (i) Had you heard of the NoSPHN prior to this survey? **Yes / No**

7.1.1 If 'No' go to Section D

(ii) If yes, what describes your relationship with the Network most accurately?

- ☐ Current active involvement (e.g. with projects / management of the Network)
- ☐ Previous active involvement

- ☐ Current or previous partial engagement
- ☐ As a commissioner of the work of the Network
- ☐ Passive involvement (e.g. awareness only)

B2. (i) What do you expect of the Network for, e.g.

You personally?
The NoS Public Health Workforce?
Your organisation? etc.

.....

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(ii) In what activities of the Network have you been involved?

Please tick as many as appropriate:			Tick all that apply
Groups	(a)	Health Improvement Scoping Project	
	(b)	Health Intelligence Scoping Project	
	(c)	Network 'management' group	
	(d)	Voluntary Public Health Register e-mail group	
	(e)	NOSCAN / NoSPHN e-mail Group	

Continuing Professional Development	(f)	25th April 03 – North of Scotland Public Health Training Day, Inverness	
	(g)	23rd September 03 – NHS Prioritisation, Patients Rights and the Law, Aberdeen	
	(h)	27th April 2005 – Network and CPD Event, Inverness	
	(i)	Faculty of Public Health Scottish Affairs Committee – Annual Scottish Public Health Conference to be held in Aberdeen on 10th and 11th November 05 – **in planning**	

Other activities eg: (please specify)	(j)	Collaboration on emergency planning issues e.g. smallpox	
	(k)	Public Health input to regional working groups e.g. Mentally Disordered Offenders Group	
	(l)	Support to other North NHS Boards to provide Public Health Functions	
	(m)	Responding to joint responses to consultation exercises e.g. on Diabetes	
	(n)	Public Health input to regional MCNs e.g. Cancer	
	(o)	Collaboration on health protection issues e.g. development of a Memorandum of Understanding for surge capacity	
	(p)	Sharing of work / projects / policies etc. across the North / between NHS Boards	

Other (please specify) e.g. opportunistic sharing of info	(z)		

(iii) In what additional public health or regional planning activities have you been / are you involved in across the North NHS Boards? Please specify below:

(iv)

Section C: Your opinions about the NoSPHN and its work

C1. (i) Do you consider the Network has added value to public health activity / regional planning in the North?

Yes / No / Don't know

If 'No' go to question C1 (iv), if 'Don't know' go to question C2

(ii) If yes, then is it because it:

		Tick all that apply
(a)	Avoids duplication of effort	
(b)	Provides training opportunities and CPD	
(c)	Provides communication on work in progress across the region	
(d)	Allows sharing of policies/standardisation of policies	
(e)	Provides reactive and proactive dissemination of information	
(f)	Facilitates access to on-line facilities/interactive approaches to communication	
(g)	Ensures / provides shared resource (financial and staff)	
(h)	Identifies single points of contact for issues	
(i)	Demonstrates cost-effectiveness	
(z)	Other (specify):	

(iii) If you ticked any of the above, can you give an example:

.....

.....

.....

Go to question C2

(iv) If no, is there any reason for this?

.....

.....

.....

C2. (i) Do you consider the Network has influence over the business of the NHS at local*, regional and national levels? *(* Local is Health Board or Sub Health Board area)*

Yes / No / Don't know

If 'No' go to question C2 (iv), if 'Don't know' go to question C3

(ii) If yes, then is it over:

			Tick all that apply
(a)	Agenda setting	National	
		Regional	
		Local	
(b)	Remote and rural issues	National	
		Regional	
		Local	
(c)	Service redesign/planning	National	
		Regional	
		Local	
(d)	Policy development / implementation	National	
		Regional	
		Local	
(e)	Events (CPD / conferences)	National	
		Regional	
		Local	
(z)	Other (please specify)		

(iii) If you ticked any of the above, can you give an example(s) of where the Network has been influential:

.....

.....

(iv) If no, why not?

(v) How do you think the Network could be more influential in any areas of activity:

C3. (i) Do you <u>personally</u> value the Network?

Yes / No / Don't know

If 'No' go to question C3 (iv), if 'Don't know' go to question C4

(ii) If 'yes', then is it because it:

		Tick all that apply
(a)	Facilitates integration & / or coordination of NHS Board Public Health activities / services	
(b)	Has increased my social capital (e.g. makes me feel less professionally isolated / allows sharing of responsibilities and activities)	
(c)	Can influence regional service design or planning	
(z)	Other (please specify)	

(iii) If you ticked any of the above, can you give an example of where the Network has been of value to you personally:

Go to question C4

(iv) If no why?

C4. (i) How well do you rate the following Network processes? Please grade on a scale of 1-5 (1=poor and 5=excellent).

		Please circle grade for each process below
(a)	Implementation of the NoSPHN work plan	1 2 3 4 5 Don't Know
(b)	Involvement of or engagement with a range of public health community representatives across the North	1 2 3 4 5 Don't Know
(c)	Governance arrangements (clear and working)	1 2 3 4 5 Don't Know
(d)	Commitment of partners (demonstrated)	1 2 3 4 5 Don't Know
(e)	Relationships between partners	1 2 3 4 5 Don't Know
(f)	Management arrangements (in place and working)	1 2 3 4 5 Don't Know
(g)	Accountability lines (in place and working)	1 2 3 4 5 Don't Know
(h)	Capacity to learn (demonstrated)	1 2 3 4 5 Don't Know
(i)	Communication lines (clear and working)	1 2 3 4 5 Don't Know
(j)	Risk management structure (clear)	1 2 3 4 5 Don't Know

		Please circle grade for each process below
(k)	Organisational structure clear	1 2 3 4 5 Don't Know
(l)	Relationship with other statutory and voluntary organisations	1 2 3 4 5 Don't Know
(m)	Processes for communication (in place and working; (e.g. e-mail / web based etc.))	1 2 3 4 5 Don't Know
(n)	Technology being effectively used to support work	1 2 3 4 5 Don't Know
(o)	Responding to educational and training needs (proactively and reactively)	1 2 3 4 5 Don't Know
(p)	Multidisciplinary / multi professional involvement or engagement	1 2 3 4 5 Don't Know

C5. (i) In your opinion, what is the Network doing well?

.....

.....

.....

C6. (i) How could the Network be improved?

.....

.....

.....

C7. (i) What specific issues could the Network usefully address but isn't at the moment?

.....

.....

.....

Section D: Those not having prior knowledge of NoSPHN

This section is to be completed only by respondents of the telephone survey who answered 'No' to Section B Question 1

These are the objectives/function of the NoSPHN:

Public Health / health improvement Networks have been defined as 'linked groups of public health / health improvement professionals, working in a co-ordinated manner across organisations and structural boundaries with a common strategic agenda to promote health improvement and reduce health inequalities for a given population, thus maximising shared resources in a co-ordinated way'.

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 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.

Key objectives (2004/05) – examples of current objectives:

- Ensure formal Surge Capacity arrangements are in place and are operational when required
- To support information sharing across the North
- To deliver and support CPD opportunities across the North
- To deliver North of Scotland Regional Planning Group work plan / activities i.e.
    - Health intelligence & information Scoping project
    - Health Improvement Scoping project
    - Review and support regional groups and public health membership

- Deliver an effective communication system for the Network / public health activity across the North
- Ensure Governance arrangements in place for the public health activities of the North

D1. (i) Do you think the Network could potentially help you in your current remit?

Yes / No / Don't Know

If 'No' go to question D1 (iii), if 'Don't Know' go to question D2

(ii) If yes please specify how:

.....

.....

.....

Go to question D2

(iii) If No please specify why:

.....

.....

.....

D2. (i) In what **public health** or regional planning activities have you been / are you involved in across the North NHS Boards? Please specify below: