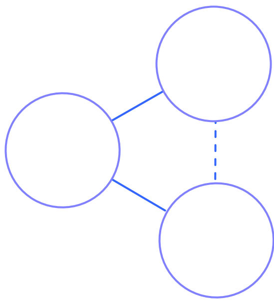

public health commissioning network

...one year on

A report of the evaluation of the
Public Health Commissioning Network
Nov 2008-Nov 2009

www.phcn.nhs.uk

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Executive summary

Background

To support the World Class Commissioning initiative a Public Health Commissioning Network (PHCN) was set up in November 2008, funded by the Department of Health, with the aim of encouraging knowledge sharing between individuals in Primary Care Trusts and partner organisations throughout England. The funding was for a one year pilot between November 2008 and November 2009.

Methods

An evaluation was carried out by a survey of key stakeholders during August and September 2009, to assess what had worked well, and what hadn't, and the impact of the Network over the first year of the pilot. The survey included open and closed questions, and Likert scale responses. In addition to the survey membership statistics were compiled from Network administration records.

Thematic analysis was performed on the qualitative data from the survey, with themes categorised under the Donabedian headings of structure, process and outcome.

Findings

The main findings of the survey were:

- There was good support for the principle of a network of public health commissioners and sharing work between organisations. Many individuals suggested the current network should continue, with its value improving over time;
- More people heard of the network through colleagues than by any other route, and good representation was achieved across England. The emailed PHCN newsletter in PDF format was well received;
- There were simple barriers to membership for many individuals – the weekly commitment of a number of hours dedicated to the network; the need for a memorandum of understanding between PHCN and the PCT; and the complexity of the secure website. The existence of these barriers was evident both in the quantitative and qualitative findings;
- Increased involvement of other commissioning colleagues; and ensuring that the Network had clear DH and PCT Chief Executive-level backing, were also consistent findings;
- There was good support for the majority of suggestions on how the Network could be improved, with additional proposals made by respondents

A critique and discussion of the findings is presented in the full report.

Recommendations

Based on the findings of the evaluation, six recommendations are made to ensure that PHCN meets the needs of its users, whilst improving their experience:

1. Continue national funding for a network of public health commissioners for a further year
2. Simplify the network structure, removing barriers to entry
3. Simplify the PHCN website, making it faster and less confusing to access
4. Expand the content of the existing PHCN email newsletter
5. Expand membership of PHCN, through a revised communications strategy
6. Use a more streamlined, core team to provide these functions nationally

More detail is given for each recommendation in the main report.

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1. Introduction

1.1 Background

1.1.1 The expectations of Primary Care Trusts (PCTs) in their role as commissioners of healthcare on behalf of their local population were made explicit by the Department of Health (DH) with the launch of the World Class Commissioning programme at the end of 2007. PCTs were expected to become informed, competent commissioners, to achieve the best possible health outcomes locally whilst maintaining financial balance.

1.1.2 To complement the World Class Commissioning initiative, and in recognition of limited local capacity yet high expectations of knowledge and expertise in commissioning, the idea of a national public health commissioning network was mooted. This would give individuals involved in commissioning – in PCTs and partner organisations – the potential to share their experiences and knowledge across England, in return making use of the skills of others elsewhere.

1.2 Project Board

1.2.1 In November 2007 the NHS National Knowledge Service, led by the Chief Knowledge Officer Sir Muir Gray, set up a national Project Board including representation from the DH, PCTs, Faculty of Public Health (FPH), Association of Directors of Public Health (ADsPH) and Association of Public Health Observatories (APHO), to develop a specification for such a network and secure funding for a pilot.

1.2.2 A formal Project Initiation Document was signed off by the Board in March 2008 and funding was agreed for a one year pilot commencing in November 2008, from the Commissioning and System Management Directorate of the DH.

1.3 Pilot delivery

1.3.1 The one year pilot of the Public Health Commissioning Network (PHCN) was delivered by a small national team working at Knowledge into Action, Oxford, on behalf of NHS Supporting Public Health. The public-facing website was developed in-house, with the secure network web interface provided by the Improvement and Development Agency (IDeA).

1.4 The evaluation

1.4.1 This evaluation focuses on the delivery of the PHCN pilot, adopting a classical Donabedian approach by analysing the structure, processes and outcomes of the initiative. Whilst the evaluation is technically internal – conducted by the Project Manager – it is based entirely on the views of external stakeholders sought by email survey. This approach hopefully balances the desire to give an objective assessment of the successes and failures of the pilot in its first year, with an expedient use of time and resources in performing the evaluation.

1.4.2 This report describes the evaluation methods and findings, and provides recommendations for the continuing development of the Network to meet the needs of its users, in response to their feedback.

2. Methods

2.1 Membership statistics

2.1.1 Membership statistics were calculated from a centrally held Microsoft Excel sheet with details of all PHCN contacts and members; and cross-checked against details held on the PHCN website of the number of individuals signed up to the website.

2.2 Stakeholder questionnaire

2.2.1 An online questionnaire of 23 questions was available for 6 weeks between 10 August and 21 September 2009, in which respondents could describe their involvement (if any) in PHCN, and answer a variety of open and closed questions about the Network, giving 'free text' or Likert scale responses. The questionnaire was designed using Survey Monkey (www.surveymonkey.com); a list of the questions is given in Appendix 1.

2.2.2 Invitations to complete the survey were sent by email to all 315 people held in the PHCN contact database. This included people who were members of PHCN, had expressed an interest in PHCN in the past, or were from partner organisations. A link to the survey was also placed in the PHCN newsletter; and on the PHCN website (both public and secure sections).

2.3 Qualitative analysis

2.3.1 Qualitative ('free text') answers from the online survey were downloaded into Microsoft Excel and manually coded. Thematic analysis was then performed, based on the dominant codes and trends. Where relevant, responses were also categorised as relevant to the project's structure (set up of Network), processes (how it runs in practice) and outcomes (impact on commissioning in PCTs).

2.3.2 Whilst the qualitative responses are not statistically representative of the 'average' user of PHCN, the themes raised are a useful way of confirming and understanding in detail the causes of some of the quantitative patterns seen. The quotes highlighted here are selected as being representative of the general themes.

2.4 Background

2.4.1 A summary of the intended structures, processes and outcomes, as described at the outset of the project, are given in the Findings section. These are described in more detail in the Project Initiation Document (PID) compiled by the Project Board in March 2008.

3. Findings

3.1 Questionnaire response rate

3.1.1 47 people answered the questionnaire, 40 in its entirety. This represents a response rate of 14.9% (47/315). Most respondents (73.5%) were from a PCT.

3.2 Structure

3.2.1 Background

3.2.2 A small Project Team was set up, based in Oxford, to project manage and provide professional input to the Network (Appendix 2). A budget for £150,000 was available for the 1 year pilot (Appendix 3).

3.2.3 Individuals in PCTs and partner organisations (e.g. local authorities) who were involved in commissioning were eligible to join PHCN. Becoming a member ('partner') in the Network entailed taking a national lead on a commissioning topic, from a list of around 100. Additional topics could be suggested by members. As a Topic Lead the individual was asked to commit *circa* 4 hours per week to maintaining useful links and resources on a secure PHCN website, and encouraging other members to upload service specifications, needs assessments and similar documents to the website to share with others. In return the Lead would gain access for their organisation to resources in all other topic areas. A Memorandum of Understanding (MOU) was developed to clarify the responsibilities of PHCN and the individual. The secure PHCN website contained tools to encourage knowledge sharing and collaboration, including discussion forums, user-editable pages ('wikis') and document libraries.

3.2.4 Two letters were sent by post to every Director of Public Health (DPH) in each of the 152 PCTs in England, informing them of the development of PHCN and encouraging their participation. The letters were sent by Sir Muir Gray on behalf of PHCN, the first in conjunction with the ADsPH. In addition PHCN was discussed on the phone with all the Regional Directors of Public Health (RDsPH), and presentations were made to various groups of DsPH around the country, and at international and national conferences with a public health audience. A public-facing website (www.phcn.nhs.uk) was also set up by the Project Manager containing more details on the project and instructions for joining.

3.2.5 Quantitative findings

3.2.6 Over three quarters (77.5%) of questionnaire respondents agreed with the statement 'Many commissioning tasks are repeated separately in PCTs across the country. The NHS could be made more efficient if there was better sharing of information and experience between organisations.' Of the remainder, none disagreed although the rest (22.5%) gave a more detailed response.

3.2.7 The commonest way to find out about PHCN was from colleagues (38.3%), then direct email or letter from PHCN (36.2%)

3.2.9 Of 14 people answering the question who didn't currently lead on a topic for PHCN, 71.4% (n=10) said they would *not* be willing to do. The main reasons cited for this were a lack of time; and not feeling qualified to lead on a topic.

3.2.10 Qualitative findings

3.2.11 Many individuals were supportive of the concept of the Network, citing benefits such as peer support in making difficult choices, and savings in effort, time and money. The need for such a Network in the current economic climate was also described.

> “ *The underlying concept is absolutely right (daft to have lots of PCTs replicating work). I think this is vital as so much duplication is a waste of time and resource* ”

> “ *Keep up the good work. This site is extremely useful to those of us in small organisations who don't have the time / skills to commit to commissioning* ”

> *Strongly support the concept of sharing and trying not to reinvent the wheel at every turn*

3.2.12 In contrast, some people argued that the theory of networks was more attractive than the benefits from them; that if commissioning is to be centralised then public health departments should be allocated topics centrally and appropriately resourced; and that public health should reach out more to commissioners to share knowledge.

> *Networks: impossible to argue against the theory, near impossible to extract any value in practice*

> *I do not think there is a need for a public health commissioning network but I do think there is a need to create a better understanding of how to manage population health among commissioners. Public health… needs to come out of the ivory tower*

3.2.13 Some comments also suggested that in order for an initiative to gain acceptance and be prioritised at PCT-level it needed to be made mandatory by the DH or SHA, otherwise other work would take precedent.

3.2.14 There were a number of suggestions that the structure of the Network and web interface were more complex than they needed to be.

> *It has possibly been made overly complex and does not recognise that people are often working on a wide range of topics*

> *When you are the only bod in your outfit and want quick answers, you don't want to be confronted with something that gets you to join a million subgroups*

3.2.15 The responsibilities associated with being a partner in the Network were often thought to be too onerous:

> *The time commitment to be signed up as a lead is very high (4 hours per week)*

> *Need support at work to take on this sort of thing - just not enough hours in the day to fire-fight what comes in through the door*

3.3 Process

3.3.1 Background

3.3.2 A workshop was held on 24 November 2008 in London, to which all prospective members were invited. 44 individuals attended, the majority Consultants or Directors of Public Health. The day included hands-on sessions demonstrating how to register with PHCN and use the website to upload documents and take part in discussions. All attendees were requested to upload documents which may be of interest to others, to the website.

3.3.3 For those people who couldn't attend the workshop, and all subsequent requests for membership, individuals needed to contact the Project Manager by email or through the public website, with an outline of

their area of interest and some basic background information (place of work and job title). On receipt of a request which met the criteria for membership – active in commissioning on behalf of the NHS or its partners – a standard email was sent back which included details of how to register and login to access the PHCN secure website and a one-sided quick user guide to the PHCN website. Prospective members were asked to think about which topic area they would like to lead on, from a list of suggested topics.

3.3.4 If an individual did not appear to meet the criteria for joining PHCN they were sent a standard response asking for more information about their application; a standard response and policy was also agreed for representatives of FESC (Framework for procuring External Support for Commissioners) organisations, to ensure fair access to those involved in NHS commissioning whilst protecting against commercial gain from NHS knowledge.

3.3.5 New partners in the Network were prompted when they first joined, and intermittently thereafter, to identify a topic area they would be willing to lead on. Once a topic had been agreed they were sent a Memorandum of Understanding (MOU) between PHCN and the individual's employing organisation, setting out the responsibilities of each party in contributing to the Network.

3.3.6 Regular email newsletters were sent every 2-3 months to Network members and those expressing an interest in joining PHCN. The newsletters contained information on current PHCN membership, 'Focus on Commissioning' workshops to which all members were invited, and tips on how to join and use PHCN. Recipients were asked to forward this within their organisation to anyone else who may be interested in the Network.

3.3.7 The Project Team Information Scientist systematically entered links to principal resources for each topic in a wiki on each topic homepage, to encourage members and topic leads to edit these and upload their own resources.

3.3.7 Weekly meetings were held between the Project Manager and Project Team, and a Network Board was convened and met in May 2009 to discuss progress with the Network and future plans.

3.3.8 A Quality Assurance (QA) group was to be set up to peer review and grade the standard of documents posted to the website.

3.3.9 Quantitative findings

3.3.10 At 12 October 2009, there were 143 individuals from around the country registered to use the PHCN website, and a total of 295 people who had expressed an interest in the Network or joined the website. When contacts were categorised by the PCT area in which they work (i.e. for the PCT, LA or other organisation within the PCT boundary), 76% of PCT areas were represented on the Network, with the majority of PCT areas having a contact within the PCT (89% of areas contact within PCT, or within PCT and outside PCT; 11% of areas contact outside PCT only). The contacts included 79 Directors or Consultants in Public Health, representing 80% of the PCTs in the Network.

3.3.11 Following email agreement of topics on which to lead, MOUs were sent to contacts in 39 PCT areas, with only 3 areas responding later that they would no longer be able to lead on the topic as described in the MOU. However, of the 36 remaining areas, only 2 MOUs were received back by PHCN fully signed. Of 5 people who had been assigned a topic to lead on for PHCN who answered the evaluation survey, only 1 (20%) had contributed anything to the website, with insufficient time a factor cited for non-contribution.

3.3.12 In addition to contacts from specific regions, there were 74 contacts coded as 'non-geographical'. This coding represented any individual not working for a locality-based organisation, including national organisations (e.g. DH and charities) and regional organisations (e.g. SHAs).

3.3.13 Of those not joining the PHCN website, the main reason (40%) was not understanding how to join. The PHCN website was, on average, rated 'OK', 'good' or 'very good' or better in all categories (ease of use; relevance; accuracy; timeliness; presentation and design; ease of access; content). However, only 17% of respondents (n=8) had ever used the discussion forums, 2% (n=1) the wiki pages, and 10.6% (n=5) the library. This was corroborated by statistics from the PHCN website itself, with very few active discussion forums during the pilot period (5), and fewer contributions to web-editable documents (wikis), the majority of the latter being made by the Project Team Information Scientist. In light of this lack of activity by members the QA group was not convened during the pilot period.

3.3.14 In contrast, the newsletter was generally well received, with the mode of delivery, email, rated as 'OK', 'good' or 'very good' by all respondents (100%). The length (2-3 pages) was also rated as OK, good or very good by

92%. The content and presentation were thought to be OK, good or very good by 91.5% and 92.3% respectively.

3.3.15 The PHCN pilot phase remained within the £150,000 budget (Appendix 3).

3.3.16 Qualitative findings

3.3.17 Some people commented on the coverage of the Network throughout England:

> *Good linkage across the country*

3.3.18 The extent to which localities get involved in this type of initiative was also discussed:

> *There is a lot of good will and commitment to seeing the network work*

> *Lack of enthusiasm from some PCTs (head in the sand attitude!)*

> *People don't see it as their core job*

It was also felt membership from outside public health should be further encouraged:

> *Wider engagement from finance and commissioning directors in PCTs, and practice-based commissioners*

3.3.19 A lack of user-generated content on the website was noted:

> *The network appears to be moribund for the topics I have joined. There's no forum dialogue and few active postings of materials*

It was also suggested that some people would preferentially use the Network to seek help with their problems rather than share their own knowledge – or an expectation that knowledge would not need to be supplied by members:

> *I get the sense that there are lots of people looking for the answers, but no one supplying them*

3.3.20 The need for the MOU was also questioned:

> *I am not sure that the contract is necessary*

3.4 Outcome

3.4.1 Background

3.4.2 The main purpose of PHCN was to connect individuals to each other in order to share documents and experiences, thereby improving commissioning efficiency and outcomes.

3.4.3 An outcome indicator, '% of PCTs represented which agree that Network has helped their organisation address World Class Commissioning (WCC) competencies 6, 8 or 9', was included in the original funding bid to the DH for the Network, along with the percentage of PCTs involved in the Network.

3.4.4 Quantitative findings

3.4.5 76% of PCT areas were represented on the Network at the start of month 11 of the pilot, with the majority of PCT areas having a contact within the PCT. The contacts included 79 Directors or Consultants in Public Health.

3.4.6 Although PHCN members have not been formally polled on the contribution of PHCN to their WCC competencies, given the process findings of the evaluation it is likely that few would consider the Network has made a significant impact on their WCC rating.

3.4.7 As stated earlier, the majority of contacts found the newsletter useful, with 91.5% of survey respondents rating the content as OK, good or very good.

3.4.8 Qualitative findings

3.4.9 Despite the low levels of activity on the Network website, this did not mean PHCN as a whole was not considered valuable:

> “*Keep up the good work. This site is extremely useful to those of us in small organisations who don't have the time / skills to commit to commissioning*”

> “*An excellent - and currently the best - site for obtaining up to date and relevant info on commissioning issues from a PH perspective*”

> “*Useful to have instant access to a great network of colleagues for information sharing*”

> “*It's great – just needs more people in the club*”

> “*It's early days - all the evidence suggests at this stage the network is only forming, and really productive work commences in year 2 and really starts to deliver in year 3*”

4. Discussion

4.1 Critique of methods

4.1.1 While most of the evaluation was based on responses from a survey of external stakeholders, it was nonetheless conducted by the Project Manager and was thus an 'internal' evaluation. Although an external process was considered, it was felt the current approach optimally balanced objectivity and opportunity costs. Similarly, an online survey was felt to be a more expedient and cost-effective method for evaluation rather than telephone or face to face interviews with stakeholders.

4.1.2 Although a survey response rate of 15% is not unusual for evaluations of this type, the interpretation of the results would have been strengthened had more stakeholders participated. There is the possibility of systematic bias among non-responders, with individuals who were least satisfied with PHCN not replying preferentially. However the diverse opinions expressed in the qualitative findings suggest that any bias present would not have significantly affected the overall result. Interviewing members of the Project Team may have provided further detail for the 'process' evaluation.

4.1.3 The mixture of closed, open and Likert scale questions appeared to give respondents a good opportunity to provide both positive and negative feedback about PHCN. Responses were often frank and accompanied by both an explanation and, in the case of criticism, a suggestion for improvement.

4.1.4 The quantitative data on PHCN membership and use of web tools gives a potentially limited view of the activity catalysed by the Network. Whilst use of the website was encouraged for discussions between members, it was possible that conversations and links were taking place outside the formal Network via email or phone, after making initial contact through the Network. Such activity was not captured but would still be a significant outcome.

4.2 Main findings

4.2.1 There was very good support for the principle of a network of public health commissioners and sharing work between organisations, especially in anticipation of the forthcoming economic constraints facing the NHS. Many individuals suggested the current network should continue, with its value improving over time as its use becomes embedded in corporate culture.

4.2.2 More people heard of the network through colleagues than by any other route, and good representation was achieved across England. These findings suggest 'viral' marketing techniques and raising awareness at conferences and by phone with key regional contacts, were effective. The emailed PHCN newsletter in PDF format was also well received.

4.2.3 It appeared there were simple barriers to membership for many individuals – the weekly commitment of a number of hours dedicated to the network; the need for an MOU between PHCN and the PCT; and the complexity of the secure website with multiple topics and forums within which to share work. The existence of these barriers was evident both in the quantitative and qualitative findings.

4.2.4 Increased involvement of other commissioning colleagues; and ensuring that the Network had clear DH and PCT Chief Executive-level backing, were also consistent findings.

4.2.5 Although not specifically mentioned in survey responses it is possible that the workload experienced by PCTs to address the emerging swine flu pandemic during the period of the Network pilot may have had a negative impact on time available to contribute to the Network.

4.3 Addressing the findings

4.3.1 Included in the evaluation questionnaire were a number of possible changes to the structure and function of PHCN, along with open questions asking respondents to suggest how the Network could be improved. The feedback from this part of the questionnaire is given in Section 5, below.

4.3.2 Based on the results of the evaluation a number of recommendations have been made (Section 6.2).

5. Potential changes to PHCN

5.1 Suggested changes

5.1.1 In an effort to make the most efficient use of stakeholder consultation, a number of possible changes to PHCN were listed in the questionnaire, with respondents invited to grade their acceptability on a five point Likert scale (‘very poor’ to ‘very good’), and provide any additional comments on how the Network could be improved.

5.1.2 The changes suggested were: remove need for password / security on entering site; remove obligation for members to contribute a set amount of time each week; remove obligation for members to lead on a topic on behalf of the Network; simple directory of members' names and topics they are experienced in, for anyone to search; remove discussion forums; regular briefings on particular topics and interventions of interest; add general commissioning news to the monthly e-newsletter; add a 'swap shop' to the monthly e-newsletter, with individuals offering to share information or requesting help; ‘Casebook’ for individuals to upload or search for a brief summary of a piece of work; CPD credits for certain activities on PHCN - e.g. contributing to the Casebook; and add videos explaining particular topics or concepts.

5.2 Quantitative findings

5.2.1 For the changes suggested a majority agreed with the following proposals (ranked in order of most popular first, according to the proportion of respondents rating the proposal as ‘good’ or ‘very good’):

- Simple directory of members (72.3% good or very good suggestion)
- Regular briefings (68.5%)
- CPD credits for activities on PHCN (63.9%)
- ‘Casebook’ of projects (62.9%)
- Swap shop (62.5%)
- Add general commissioning news to newsletter (55.9%)
- Remove obligation to lead a topic (52.9%)
- Remove minimum time obligation (51.5%)

5.2.2 For the remaining suggestions, adding videos and removing the need for passwords were less popular, although there was still a majority broadly in favour, rating the ideas as ‘OK’, ‘good’ or ‘very good’ (adding videos, 76.4%; removing passwords, 61.8%).

5.2.3 The proposal to remove discussion forums was unpopular, with 65.7% rating it as a ‘poor’ or ‘very poor’ idea. This result was surprising and at odds with the findings that only 17% of survey respondents had ever used the discussion forums, and only 5 discussion threads had ever been contributed to on the PHCN website in 11 months.

5.3 Qualitative findings

5.3.1 Face-to-face workshops and regional, as well as national, networking, were suggested by some:

> “ *This sort of development needs to gel with more face to face events, and then e-networking becomes more realistic* ”

> “ *Create regional subgroups to improve peer support and encouragement to contribute, while still maintaining national network arrangements* ”

5.3.2 Many suggestions described the type of content the Network could focus on:

An area where strategic commissioning plans, SLAs and APHRs are placed could be useful

I would like to read detailed case studies, including information sources that other commissioners have found useful, literature reviews, interviews with commissioners, career prospects, recommended training courses etc.

A 'call for information' from all senior PH staff/departments on particular topics might be useful

There was one suggestion for a database of ongoing projects, in the same vein as trials databases:

A site where all projects are identified would be useful. You could flag them as in progress, completed etc.

6. Conclusions and recommendations

6.1 *Conclusions*

6.1.1 This evaluation has found widespread support for a network among public health commissioners; and that many of the features of the current PHCN are valued. However, there is also strong evidence from a survey of key stakeholders that the current model of the network – that members are asked to commit to a certain amount of time each week, and contribute to a shared, secure website – is creating an artificially high barrier to participation for many potential users.

6.1.2 Interestingly, 'lower technology' communications such as the existing email newsletter and face-to-face events, and suggested new features such as a 'Casebook' of project summaries and a 'swap shop' in the newsletter, are popular.

6.1.3 Despite contrasting with the widespread adoption of 'web 2.0' technologies elsewhere in government and business, older web technologies are presumably popular among the public health workforce because of their simplicity and ease of access. (A desirable side-effect is that they may also be less costly to set up and maintain.) That many had heard of the Network by 'word of mouth' is encouraging, and evidence of existing networking which PHCN can bring together nationally. Such 'viral' channels should be exploited, as well as continuing direct communication.

6.2 *Recommendations*

6.1.4 On the basis of the findings in this report, the following recommendations are made on how the Public Health Commissioning Network should evolve – to continue to meet the needs of its users whilst improving their experience and lowering barriers to membership, in the most cost-effective manner.

6.1.5 Recommendation 1

Continue national funding for a network of public health commissioners for a further year.

This will allow PHCN to develop in line with the survey findings reported here, in particular creating a more simplified, open structure; and to take advantage of the significant contacts built up during the first year.

A further evaluation should be carried out at the end of the second year to determine the impact of these recommendations on the use and usefulness of a public health commissioning network. If the evaluation finds no significant impact on commissioning outcomes following the recommended revisions, the concept of a formal network for public health commissioning should be abandoned.

6.1.6 Recommendation 2

Simplify the network structure, removing barriers to entry.

a. Remove weekly time commitment required for membership;

b. Remove need for Memorandum of Understanding between PHCN and host organisation;

c. Remove need for members to lead on a set topic;

d. Reposition network as a means of connecting individuals to each other, through provision of a member directory, and various channels to highlight good practice and encourage sharing of work (see Recommendation 5, below); and as a conduit for information relevant to public health commissioners from key partner organisations (e.g. NICE, Information Centre, APHO et al.)

6.1.7 Recommendation 3

Simplify the PHCN website, making it faster and less confusing to access.

a. Remove all username and password requirements, making it accessible from any web browser, with all content openly available;

b. Stop using the IDeA web interface, thereby removing 'web 2.0' tools including discussion forums, blogs and wikis, transferring any significant collection of knowledge to the new system;

c. Provide a simple, public directory of members with any particular areas of interest they have, and by geographical region;

d. Add new features including a 'Casebook' of brief summaries of members' work (for which individuals would gain CPD credits); and provide a means of distribution for relevant information from partner organisations (links to own website or host on their behalf)

6.1.8 Recommendation 4

Expand the content of the existing PHCN email newsletter

To include commissioning news; a 'swap shop' section where individuals can offer or request help for particular problems; highlights of new additions to the Casebook; signpost to relevant new publications from partner organisations, e.g. NICE, Information Centre, APHO et al.; a noticeboard to advertise relevant courses, lectures, etc., for free. Other sections could be added (e.g. reviews of books relevant to commissioning) based on user feedback.

6.1.9 Recommendation 5

Expand membership of PHCN, through a revised communications strategy

a. Use the PHCN email newsletter as the main means of communication with PCT and partner organisations, sending to all DsPH (+/- Chief Executives) and PCT Comms teams, for onward distribution to their partners;

b. Seek voluntary regional 'ambassadors' for PHCN to encourage membership of the network in their area and sharing of knowledge;

c. Encourage the organisation of regional meetings or workshops for public health commissioners (eligible for CPD credits), providing a suggested agenda and invitees;

d. Continue to present updates on the Network at conferences, and encourage members to pass on the newsletter to their colleague;

e. Encourage use of the network to share knowledge and information on low- and high-value interventions – for example through a national call for work summaries, to be made available through the Casebook on the website

6.1.10 Recommendation 6

Use a more streamlined, core team to provide these functions nationally

A business case will be submitted to the DH on the basis of providing the functions above, which are likely to require a smaller resource to fund than the first year pilot.

Acknowledgements

We would like to thank everyone who took part in the PHCN evaluation survey, and all those who have helped shape PHCN thus far, including the Project Board, all current members, and Supporting Public Health. Thank you.

Glossary

ADsPH	Association of Directors of Public Health
APHO	Association of Public Health Observatories
APHR	Annual Public Health Review
CPD	Continuing professional development
D(s)PH	Director(s) of Public Health
DH	Department of Health
FESC	Framework for procuring External Support for Commissioners
FPH	Faculty of Public Health
IDeA	Improvement and Development Agency
LA	Local authority
MOU	Memorandum of Understanding
PCT	Primary Care Trust
PDF	Portable document format
PHCN	Public Health Commissioning Network
PID	Project Initiation Document
QA	Quality assurance
RD(s)PH	Regional Director(s) of Public Health
SLA	Service-level agreement
WCC	World Class Commissioning

Appendix 1. Survey questions

The following questions were answered through an online survey. Depending on their responses, participants were asked to skip to the next relevant question during the survey.

No.	Question	Possible responses
1.	How did you hear about the Public Health Commissioning Network (PHCN)?	Colleague(s) / Direct email from PHCN / Direct letter from PHCN / Conference presentation / PHCN website / PHCN newsletter / Other (please specify)
2.	Do you currently receive the PHCN email newsletter?	Yes / No
3.	Please rate the newsletter based on the choices below. Method of delivery (email) Content Length Presentation & design Do you have any other comments on the newsletter?	Very poor / Poor / OK / Good / Very Good (for each) Free text
4.	Have you attended any of the Commissioning Focus workshops (so far these have been on Kidney Care and Familial Hypercholesterolaemia)?	Yes / No
5.	Are you member of the PHCN website (i.e. you have joined the PHCN Community of Practice website)?	Yes / No / Don't know
6.	Are there any particular reasons why you have not joined the PHCN website (i.e. the PHCN Community of Practice)?	Not sure how to join PHCN Community of Practice / Don't think it will be worthwhile / Not enough time to commit / Have requested to join but not heard back / Requested to join but refused membership / Technical problems accessing website(s) / Not personally involved in commissioning / Do not work for a PCT or Local Authority / Are there any other reasons?
7.	Have you ever logged on to the PHCN website (i.e. PHCN Community of Practice)?	Yes / No / Don't know
8.	Why have you never logged in to PHCN?	Not a member / Not sure how to log in / Log in looks too complicated / Forgotten password / No time / Other (please specify)
9.	Could you please rate the PHCN (Community of Practice) website for the following: Content Ease of use Relevance Accuracy Timeliness Presentation & design Ease of access (logging in etc.) Do you have any other comments on the PHCN website?	Very poor / Poor / OK / Good / Very good (for each) Free text
10.	Which of the following features of the PHCN website have you used?	Discussion forums / Wikis (user-editable pages) / Library / Membership list / Alerts
11.	Have you been assigned a topic to lead on for PHCN?	Yes / No / Don't know
12.	Have you contributed anything on that topic to the PHCN website?	Yes / No / Can't remember
13.	Are there any particular factors which mean you have not contributed as a topic lead?	Unsure what should contribute / Unsure scope of topic / Insufficient time / Don't think is worthwhile / No reward for contributing / Technical problems using website / Any other factors?

14.	Would you be willing to lead on a topic for the PHCN? (This would involve roughly 0.5 days / week keeping up-to-date with a topic and posting any relevant news, guidelines, example service specs etc. in that field on the PHCN website, and answering any questions from others elsewhere)	Yes / No / Not sure
15.	What factors mean it would be difficult for you to lead on a topic?	Don't feel qualified / know enough on any of the topics / Insufficient time to contribute / Not a good use of my time / Don't think should routinely share information with people outside my organisation / Technical difficulties using website / Other (please specify)
16.	What, if anything, works well about the Public Health Commissioning Network?	Free text
	What, if anything, doesn't work well about the Public Health Commissioning Network?	Free text
17.	Please rate the following changes to PHCN being considered - is each a good (or poor) idea?	Very poor / Poor / OK / Good / Very good (for each)
	Remove need for password / security on entering site	
	Remove obligation for members to contribute a set amount of time each week	
	Remove obligation for members to lead on a topic on behalf of the Network	
	Simple directory of members' names and topics they are experienced in, for anyone to search	
	Remove discussion forums	
	Regular briefings on particular topics and interventions of interest	
	Add general commissioning news to the monthly e-newsletter	
	Add a 'swap shop' to the monthly e-newsletter, with individuals offering to share information or requesting help	
	Casebook' for individuals to upload or search for a brief summary of a piece of work	
	CPD credits for certain activities on PHCN - e.g. contributing to the Casebook	
	Add videos explaining particular topics or concepts	
18.	Do you have any comments on any of the above, or suggestions for other changes?	
19.	Do you have any further suggestions on how the Public Health Commissioning Network could be improved - to help individuals who work in commissioning share information with each other and learn from each others' practice? Please suggest any improvements or new features you think would help.	Free text
20.	'Many commissioning tasks are repeated separately in PCTs across the country. The NHS could be made more efficient if there was better sharing of information and experience between organisations.' Do you agree?	Yes / No / It's not as simple as a Yes/No answer... (please explain)
21.	Please give any final comments, suggestions or feedback on PHCN or this survey below (leave blank if none).	Free text
22.	The following questions are optional but will help us understand more about our audience, so please answer them if you are able. What is your job title?	Free text
23.	What type of organisation do you work for?	PCT / Local Authority / SHA / Voluntary sector / Other NHS / Other (please specify)

Appendix 2. Project team

The PHCN project team consisted of the following members:

Name	Role	Whole-time equivalent
Sir Muir Gray	Director	0.4
Dr Ash Paul	Co-ordinator	0.4
Dr Tom Porter	Project Manager	0.2
Anne Brice	Information Scientist	0.25
Nicola Pearce-Smith	Information Scientist	0.25
Rosemary Lees	Administrative support	0.4
Ann Southwell	Administrative support	0.2
Sarah Moore	Administrative support	0.2
Dr Alison Hill	Director, SPH	0.025

Appendix 3. PHCN budget

The following is a breakdown of the £150,000 budget provided by the DH for the first year of the PHCN pilot:

Category	Cost
Staff costs (note – excludes indirect costs for administrative support, Project Manager and Director)	£84,185
Office costs/overheads	£24,300
Travel and other expenses	£6,515
Ad hoc input	£19,500
CoP Web interface and hardware costs	£8,000
Advertising	£2,500
Introductory workshop	£5,000
TOTAL	£150,000